NIGERIA GOVERNORS' FORUM

Health Sector Expenditure and Institutional Review

A State-level Report

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Foreword

Nigeria is facing significant challenges in achieving optimal health outcomes for its citizens. Despite its economic standing as a leading African nation, public healthcare spending falls short of the 15% of expenditure and US$86 per capita thresholds needed to address health challenges. While the government has outlined a strategic path forward through successive national health policies aiming for Universal Health Coverage by 2030, translating these plans into tangible improvements remains a challenge. At the sub-national level, healthcare systems are experiencing resource allocation inefficiencies and increased fragmentation of health authorities.

This Health Sector Expenditure and Institutional Review is a critical resource to support the country's health agenda. By providing an in-depth analysis of how Nigerian States finance health sector development and the role of institutional structures, the report provides new evidence that will empower policymakers to make evidence-backed decisions that address critical health challenges including high mortality, high morbidity, and poor health-related quality of life outcomes which are being exacerbated by the country's growing population, the "double burden" of communicable and non-communicable diseases, as well as rising human resource migration.

This report is an important resource for the Forum to engage with its partners in the health sector, including the Federal Ministry of Health and Social Welfare and non-government partners. More than a comparative review, the report is designed to help ease the paucity of public finance data in public health studies. It will provide new data for the research community to conduct further research. It will also provide evidence for the development community to provide stylised policy support and more resilient health programmes .

I would like to express my sincere appreciation to all those who contributed to this report. Their dedication and hard work have been instrumental in its completion.

Dr. Abdulateef O.T Shittu

Director General

Nigeria Governors' Forum

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The report benefitted from the contributions of public financial management experts (Chinedu Eze and Chris Rowe) who were the principal authors of the expenditure review, and public health experts (Edwin Nwobodo, Nneka Ukachi Onwu and Amina Mohammed Baloni) who authored the health programmes and institutional reviews.

The report was prepared under the supervision of the project lead, David Nabena, who was the editor. It was delivered under the State Level Public Finance Support and Digital Transformation programme of the Nigeria Governors' Forum.

All State-level public finance data used in this report can be accessed via the website: https://www.publicfinance.ngf.org.ng/.

For comments and questions regarding this report, please send an email to dnabena@ngf.org.ng.

All errors and omissions are the responsibility of the authors and do not reflect the views of the NGF.

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Acronyms

AIDS	Human Immunodeficiency Virus
ANC	Antenatal Care
APER	Annual Performance Evaluation Report
BHCPF	Basic Health Care Provision Fund
BPS	Budget Policy Statement
CACOVID	Coalition Against COVID-19
CBN	Central Bank of Nigeria
CBO	Community-Based Organisations
CHEWs	Community Health Extension Workers
CHIPS	Community Health Influencers and Promoters Agents
COFOG	Classification of Functions of Government
COVID-19	Coronavirus disease
CRF	Consolidated Revenue Fund
CSO	Civil Society Organisations
DFF	Decentralised Facility Financing
DMA	Drug Management Agency
EFU	Economic and Fiscal Update
EIR	Expenditure and Institutional Review
EMR	Electronic Medical Records
EOC	Emergency Operations Centre
ExCo	Executive Committee
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
FSP	Fiscal Strategy Paper
GAVI	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GHE	Government Health Expenditure
GPFS	General-Purpose Financial Statements
HAP&C	Health and Poverty Reduction Cluster/Component

HCD	Human Capital Development
HCH	Honourable Commissioner of Health
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
HQ	Headquarters
HRH	Human Resource for Health
HRM	Human Resource Management
HRQoL	Health-Related Quality of Life Outcomes
ICU	Intensive Care Units
IGR	Internally Generated Revenue
IMF	International Monetary Fund
IPSAS	International Public Sector Account Standards
LGA	Local Government Authority
LGHA	Local Government Health Authority
LICs	Low-Income Countries
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rates
MDAs	Ministries, Departments and Agencies
MICS	Middle-Income Countries
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rates
MoH	Ministry of Health
MTSS	Medium-Term Sector Strategy
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NCD	Non-Communicable Diseases
NCDC	Nigeria Centre for Disease Control and Prevention
NCOA	National Chart of Account
NDP	National Development Plan

NDHS	Nigeria Demographic Health Survey
NGF	Nigeria Governors' Forum
NGN	Nigerian Naira
NGO	Non-Governmental Organisation
NHA	National Health Act
NHIA	National Health Insurance Authority
NICS	National Immunisation Coverage Survey
NIMNCH	National Integrated Maternal, Newborn and Child Health
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMEP	National Malaria Elimination Programme
NNPC	Nigerian National Petroleum Corporation
NSHDP	National Strategic Health Development Plan
NTBLCP	National Tuberculosis and Leprosy Control Programme
OAU	Organisation of African Unity
ODA	Overseas Development Assistance
OECD	Organisation for Economic Cooperation and Development
OOPE	Out-Of-Pocket Expense
PFM	Public Financial Management
PHC	Primary Health Centre
PHCUOR	Primary Health Care Under One Roof
PPE	Personal Protective Equipment
PPM	Planned Preventive Maintenance
PPP	Public-Private Partnership
RMWs	Registered Midwives
RNS	Registered Nurses
SACA	State Committees on AIDs
SBA	Skilled Birth Attendance
SCH	State Commissioner for Health
SDGs	Sustainable Development Goals

SHIS	State Health Insurance Service
SHoA	State House of Assembly
SMoH	State Ministry of Health
SOML	Save One Million Lives
SPHCDA	State Primary Health Care Development Agency
SSB	Sugar-Sweetened Beverages
SWaP	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendants
TWG	Technical Working Group
UHC	Universal Health Coverage
UMICs	Upper Middle-Income Countries
UN	United Nations
UNDP	United Nations Development Programme
US$	United States Dollar
WDC	Ward Development Committee
WHO	World Health Organisation

Executive Summary

Nigeria faces a complex challenge in achieving good health outcomes for its citizens. Despite being one of the largest economies in Africa, the country spends far less per person on healthcare than the World Health Organisation (WHO) recommends. The government isn't without a roadmap though. A series of national health policies - first in 1998, revised in 2004, and the third developed in 2016 - with Universal Health Coverage (UHC) by 2030 as the ultimate goal, lay the groundwork for the government's plan for the sector. Translating policy into action remains a work in progress. The National Health Act (NHA) of 2014, a cornerstone legislation, awaits full implementation while national policies struggle to gain traction at the sub-national level, hindering a unified approach.

This Expenditure and Institutional Review (EIR) serves as an important tool to support the government's agenda to advance healthcare in the country, particularly at the sub-national level. The report will equip policymakers with new knowledge needed to make informed decisions that will strengthen health resource allocation and management, using insights on how State governments in Nigeria finance the development of the sector and the role of existing institutional arrangements.

Key Findings

1. Health Expenditure: Total health expenditure by the 36 States of the federation was N505 billion in 2022 - at 7% of their total spending - up from N484 billion in 2021. In 2023, the 36 States budgeted N923.31 billion for the sector - an increase of 83% from the total actual expenditure in 2022. The report notes that budget performance for the sector averages around 63% year-on-year, indicating that the actual spending for 2023 may fall well below the N923.31 billion target. The average health spending of State governments is N14 billion annually, with wide variations from State to State.

2. Health Planning: Only 15 States had a medium-term health sector strategy (MTSS) covering at least the 2024 budget year. Evidence showed that there were other cases of alternative planning documents and frameworks used internally by the health ministries to guide resource allocation for the sector. Some of these alternative tools provide a prescription of the activities, outputs, and outcomes similar to what is attainable in the MTSS, although driven at the health ministry level.

3. Healthcare Prioritisation: 61.83% of the aggregate health budget of the 36 States from 2021-2023 was allocated to public health services and health administration, leaving 38.17% for hospital services (26.17%), outpatient services (10.5%), medical products appliances and equipment (1.22%), and health research and development (0.28%).

4. Health Expenditure Classification: States' inability to present their health expenditure by specific services (e.g. primary care, secondary and tertiary healthcare programmes) and disease categories (e.g., infectious diseases, non-communicable diseases, maternal and child health) is because the National Chart of Accounts (NCOA) was developed based on the global standard Classification of Functions of Government (COFOG) which did not provide these classifications of health spending. Full implementation of the programme segment of the NCOA will help rectify this issue in future years.

5. Capital vs Recurrent Spending: The average ratio of capital to recurrent spending for the sector is 33%:67%, indicating greater focus by State governments on the administration of healthcare services. Some States have not followed this trend. In Ebonyi (85%:15%), Rivers (72%:28%), Kaduna (63%:37%), Delta (59%:41%), Sokoto (58%:42%) and Jigawa (55%:45%) capital spending outweighs recurrent spending. The report however noted instances of miscoding some recurrent items (e.g. drugs, and medical materials like PPE) as capital expenditure.

6. External Funding: State governments depend on 16% of their health budgets from external sources, including aid, grants, and loans. Grant and international aid programmes were the primary sources of non-discretionary capital funding for most States, with less than a quarter of them seeking loan options to finance their capital projects in the sector. This low uptake could be due to limitations in securing loans, or a disinterest in pursuing these financing options.

7. Per Capita Spending: In 2022, the average State health per capita spending was N2,383.54 (US$5.63 at the 2022 average rate of N423.41 to 1 US$) - over 15 times below the minimum investment of US$86 per person recommended by the WHO to address basic healthcare needs. This amount varied considerably by State, with Delta N7,917 (US$18.70) and Lagos N5,451 (US$12.88) spending multiple times higher than most States. 6 States spent below N1,000 (US$2.35) per person. The wide disparity in healthcare spending across States is creating a multi-tiered healthcare system, where access to quality care depends on where people live.

8. Fragmented Health System: The report identified a high level of health governance fragmentation in many States, due to the diversity of funding sources for the sector, diffused accountability, limited coordination and disparity in compensation and working conditions for health workers. Collaboration among health institutions, partners, and Civil Society Organisations (CSOs) is generally demand-based, lacking a structured framework for regular engagement.

9. Oversight of Partner Funds: Oversight of partner funds by States faces critical hurdles. In most States, partners manage their funds while implementing State health programmes. Implementing partners report to their donors, not the State, creating a potential for duplicate funding streams for some programmes.

Attempts at partner basket funding mechanisms have seen limited success due to partners' preference for retaining control over their funds and limited transparency on spending plans and actual expenditures. This could weaken the sector-wide approach (SWAp) or basket funding concept of managing health funds.

10. Health Budget Management Centres: Each State has about 10 health budget management centres. The report notes that these centres receive frequent streams of resources that are not captured in the health budget. The report identified a lack of collaboration and cooperation among health agencies, resulting in duplication of effort, waste, and a fragmented healthcare system.

11. Diffused Policymaking: Mirroring the national structure, each State has a State Council on Health which functions as the State's premier healthcare policymaking body. It fosters collaborative planning, policy alignment with national goals, and strategic direction for health initiatives within the State. This report notes that in many States, these Councils meet infrequently due to factors ranging from low political will and convening power, lack of funds and limited coverage of policy grounds. Some States have not held a meeting since their Council was established.

12. Diffused Accountability: Health institutions answer to multiple entities, including the Health Commissioner (HCH), a Board of Directors, the State Executive Council and the Governor. This can make it difficult to hold anyone accountable for results. For donor programmes, implementing partners are primarily accountable to their funders rather than the State, creating disparate measures of health programmes' effectiveness and reporting structures.

13. Informal Referrals: Referral systems across health institutions are generally unstructured, one-directional, and lack mechanisms for feedback on referred patients. Many facilities store patient records manually using traditional paper methods. The absence of digital records management systems presents an opportunity for the deployment of simple and affordable electronic medical records (EMR) systems by healthcare intermediaries.

14. Intergovernmental Funds: Funds from the Basic Health Care Provision Fund (BHCPF), National Health Insurance Act (NHIA), Health and Poverty Reduction Cluster/Component (HAP&C), National Tuberculosis and Leprosy Control Programme (NTBLCP), and the National Malaria Eradication Programme (NMEP) come with specific disbursement plans, monitoring, and evaluation processes involving federal, State, and donor partners. These often run parallel to existing mechanisms of State budget oversight. The challenges associated with centrally designed interventions include a mismatch between national programmes and local priorities, rigid programme implementation structures, potential for inflated procurement costs when done centrally, high central management overhead, duplication of efforts with existing State programmes, and difficulty in

assessing centrally collected data. While intergovernmental funds offer significant advantages for healthcare development, there are potential downsides. One concern is that these funds might inadvertently disincentivise States from raising investments in the sector. Additionally, overreliance on these funds can create a situation of vulnerability if the flow of resources is disrupted.

15. Financial Sustainability: The long-term viability of current health expenditures is constrained by the absence of reliable government data coupled with the uncertain headwinds facing the economy of States, including an ongoing cost-of-living crisis. There is consensus among stakeholders that as much as there should be a push for more money for health, there should be an equal counter-push for more health for the money through increased efficiency and accountability.

16. Growing Population and Aging Society: Nigeria's elderly population is projected to reach 10% of the total by 2050, and the healthcare system will need to adapt to address the rising prevalence of chronic diseases like heart disease, diabetes, and cancer, which are more common among older adults. The fast-declining traditional social security system is aggravating the problems of care for the elderly as this is yet to be replaced with planned services for this population group.

17. Shifting Disease Burden: "Double Burden" of Communicable and Non-Communicable Diseases: Nigeria, like many developing countries, is experiencing rapid epidemiological and demographic transitions from communicable to non-communicable diseases (NCDs) which have resulted in the so-called double burden of diseases. The prevalence of NCDs is predicted to rise in the coming decades, bringing with it an additional health burden. This trend puts a double strain on healthcare resources as treatments are needed for both types of illnesses.

18. Human Resource Migration, Understaffed Facilities, and Medical Tourism: Operational health facilities and institutions show asynchrony in terms of their location and place of need, equipment availability, and the skilled human resources for health (HRH) to operate and deploy them. Documented cases show new facilities built without sufficient healthcare professionals, drugs, or equipment, suggesting a political prioritisation of the physical construction of health centres over functionality. The report highlights a shortage of healthcare workforce, exacerbated by low morale and limited replacements for those leaving the workforce.

19. Spending - Outcome Correlation: The report reveals no strong correlation between health expenditure (total or per capita) and key metrics like Skilled Birth Attendance (SBA) rate, child mortality, or Penta 3 coverage. Increased health spending can contribute to improved health outcomes, as research shows, however, the lack of a clear spending-outcome link and trend data presents a

limitation in data tracking and management. This missing link also highlights the importance of other factors like resource allocation efficiency, healthcare infrastructure availability, and service delivery efficiency.

Key Recommendations

At 7% of total expenditure and an average per capita of N2,383.54 (US$5.63) in 2022, healthcare systems at the state level are underfunded. Government spending on healthcare is far below the recommended targets. Even when funds are budgeted, only 63% are released, further limiting health programme objectives. High out-of-pocket expenses at over 77% of total healthcare spending and limited health insurance coverage at less than 5%, have meant that a large share of the population who struggle to pay for essential medical services are unable to access healthcare. Drawing on the report's findings, the report proposes a set of actionable recommendations.

A. **Optimise Resource Allocation and Utilisation**

1. **Increase Health Spending**: High-level advocacy and consensus building through platforms like the NGF can help strengthen political action for increased government spending on healthcare from 7% of total State government expenditure and ensure budgeted funds are released in full, from 63% currently. Two immediate actions can be taken: (i) the health budget-release gap can be closed to secure up to N350 billion in addition to what State governments spend annually, and ii) the health tax, the excise duty of N10 per litre on sugar-sweetened beverages (SSBs), can be ring-fenced to fund healthcare delivery in the country. Development partners, CSOs, NGOs, community organisations, and patient advocacy groups can also lead the charge in health advocacy by raising awareness and consciousness about critical issues and sharing successful healthcare delivery programmes across States. This will foster peer learning and healthy peer pressure.

2. **Align Donor Priorities and Development Aid**: Where State governments depend on over 15% of their health budget from external sources, including aid, grants, and loans, the sector will benefit from an Official Development Assistance (ODA) framework that addresses current coordination challenges in mobilising, deploying, managing, and tracking donor funds within the government's planning and budgeting system. The success of this framework would hinge on enforcement mechanisms, capacity building and institutional strengthening for health budget management centres.

3. **Achieving Allocative Efficiency.** The lack of a clear spending-outcome linkage demonstrates the importance of an MTSS which helps secure policy-based allocation of resources. To ensure comprehensive coverage of all health sector expenditures, the budget ministries need to provide more accurate statistical reporting and expand the scope of the General-Purpose Financial Statements (GPFS) to include a comprehensive programme, function, and location

segment for all statutory financial reports. A comprehensive GPFS, combined with reporting of primary health spending in the financial reports of local governments will ensure full transparency in health sector reporting.

4. **Streamlining Health Data Management**: Each State's health information system should capture activity-based metrics (e.g., number of patients seen and other patient management data) and outcome-based metrics (e.g., mortality rate reduction, and improvement in specific health indicators) to provide governments with a clearer picture of how resources are used (even at the facility level) and the impact on health outcomes. Additionally, health programmes should be required to establish clear baselines and measurable outcomes for effective monitoring and evaluation. To ensure data quality, investing in trained personnel and robust verification processes is essential.

5. **Mobilising Private Health Investment**: Nigeria's national public-private partnership (PPP) policy already presents a mechanism to promote long-term healthcare development at the State level, where private partners can share the responsibility of infrastructure provision, maintenance, and service delivery. This model can expand the limited headroom for health financing, allowing governments to focus on areas like public health initiatives and social welfare. To maximise the success of PPPs in healthcare, two key steps are crucial: first, States need to identify their most pressing health needs, such as new hospitals, specialised clinics, equipment upgrades, or telemedicine infrastructure; second, these needs must be matched with projects suitable for PPPs. Ideally, these projects should generate revenue streams (user fees, diagnostics services) or achieve significant cost savings (through efficient management) to attract private sector investment.

6. **Maximising Counterpart Funds**: To improve the effectiveness of the counterpart funding system for federal health programmes in Nigeria, a shift towards a more collaborative approach is needed. State government concerns about misalignment, limited flexibility, and procurement inefficiencies highlight the need for programme designs that are integrated with local health systems. Decentralising programme implementation while maintaining clear national health goals and guidelines can empower States to tailor interventions and improve efficiency. Additionally, streamlining central management structures and data-sharing practices through technology platforms will reduce administrative costs and improve State-level response and planning.

B. **Institutional Reforms and Capacity Building**

7. **Improving Coordination**: We can strengthen information exchange within the national healthcare system by going beyond formal methods like standardised reports, dedicated communication lines, and joint meetings to collaborative and learning channels like exchange programmes for health administrators. These peer learning opportunities will help health officials share working

practices and gain valuable insights from one another's experiences. This will also help foster a seamless exchange of health data and programme knowledge across national, State, and local health agencies.

8. **Strengthening the Regulatory Capacity of the Health Ministry:** Nigeria's healthcare system at the State level, with up to 10 budget management centres (including the Ministry of Health, State Primary Health Care Development Agency (SPHCDA), Hospital Management Board (HMB), State Health Insurance Service (SHIS), and the Drug Management Agency (DMA)), is fragmented and difficult to coordinate. To address this, we recommend strengthening the role of the health ministry to provide oversight of the system and ensure consensus on policies, spending and reporting. Steps that can be taken may include policy changes that strengthen the role of health ministries, investing in training and resources for the health ministry; and developing clear communication and collaboration protocols for all healthcare authorities in the system.

9. **Strengthening M&E Systems**: We propose a two-pronged approach to strengthen M&E in the sector. Firstly, strengthen M&E operations including standardised M&E frameworks across all health institutions that define clear objectives, indicators, data collection methods, and reporting processes for each facility. Secondly, build capacity for prioritising activities based on impact and health outcomes, such as capacity-building programmes for public health professionals and decision-makers on M&E principles, data analysis, and cost-effectiveness assessments for outcome-based planning and data-driven decision-making.

C. **Expand Coverage and Equity**

10. **Scaling Up Health Insurance**: Increasing health insurance coverage is crucial for ~95% of the population not covered by any means of healthcare coverage. The Basic Health Care Provision Fund's focus on targeted interventions aligns with this goal.

11. **Prioritising Primary Care**: Expanding and improving primary healthcare services, especially in rural areas, will address existing inequities in healthcare coverage. This includes ensuring a more equitable distribution of qualified healthcare workers, quality facilities, and good governance practices across urban and rural areas. Evidence-based Human Resource Management (HRM) systems, with incentives for rural postings, can play a vital role in achieving this. Local governments should collaborate with the State and the federal government on the implementation of primary healthcare programmes and initiatives.

1. Introduction

1.1 Background and Motivation

Nigeria faces a complex challenge in achieving good health outcomes for its citizens. Despite being one of the largest economies in Africa, the country spends far less per person on healthcare than the World Health Organisation (WHO) recommends. The government isn't without a roadmap though. A series of national health policies - first in 1998, revised in 2004, and the third developed in 2016 - with Universal Health Coverage (UHC) by 2030 as the ultimate goal, lay the groundwork for the government's plan for the sector. Translating policy into action remains a work in progress. The National Health Act (NHA) of 2014, a cornerstone legislation, awaits full implementation while national policies struggle to gain traction at the sub-national level, hindering a unified approach.

Building on the legal principles of the healthcare system set out in the NHA, the country's National Strategic Health Development Plans (NSHDP) serve as the roadmap for the sector, translating concrete plans with specific actions and timelines for the government. The NSHDP has undergone two iterations - the NSHDP I (2010-2016) focused on strengthening the health system, particularly at the primary healthcare level, while NSHDP II (2018-2022) focused on lingering and emerging health issues while improving the involvement of the sub-national governments with stronger ownership of the documents. The NSHDP I yielded major successes such as the domestication of the Primary Health Care under One Roof (PHCUOR) policy, the passage of the NHA which includes the Basic Health Care Provision Fund (BHCPF) for UHC, and the launch of a comprehensive National Health Policy. Aligned with national priorities and targets, all States have a State Strategic Health Plan derived from the NSHDP II.

Government spending on healthcare has seen a significant increase in recent years, with the health expenditure of the federal government tripling from N305.1 billion in 2016 to N876.4 billion in 2022. Despite this progress, however, public health spending still falls below the country's basic needs. Recognising this gap, the Federal Government of Nigeria (FGN) in 2022 pledged to increase annual allocations to the health sector, aiming to reach 10% by 2028, up from an average of 4.5% (Government of Nigeria, 2022). The national budget allocation for healthcare is complemented by other ring-fenced financing instruments like the BHCPF which is

financed from 1% of the Consolidated Revenue Fund (CRF) of the federal government and donor support to provide additional resources for the vulnerable population (estimated at 60% of the country's total population) through a basic package of care. The BHCPF provides resources directly to primary health centres (PHCs) and through the National Health Insurance Authority (NHIA)/State Social Health Insurance Agencies (SHIAs).

There's a long way to go. The current allocation falls below 10% of the national budget, and per capita spending is below the WHO recommended target of US$86 per capita to address health challenges (The Royal Institute of International Affairs, 2014; ONE, 2022). Underinvestment in the sector is reflected in concerning health indicators. The country's maternal mortality rate of 576 deaths per 100,000 live births is one of the highest in the world (2.6 times the global average). Child mortality remains unacceptably high, exceeding those of other Sub-Saharan African countries, with 1 in 8 children dying before reaching their fifth birthday. 25% of households in the country spend more than 10% of their income on health (Hafez, 2018).

Unlike other sectors, support from international organisations like GAVI, the Global Fund and the Gates Foundation play a vital role in bridging the sector's funding gap. These contributions have been particularly crucial for specific health programmes like malaria control, HIV/AIDS and vaccination. Efforts have also been underway to tap into the potential of the private sector, building on the valuable contributions recorded during the COVID-19 pandemic. In 2020, the Coalition Against COVID-19 (CACOVID), a private sector task force set up in partnership with the federal government of Nigeria, the Nigeria Centre for Disease Control (NCDC) and the WHO, was instrumental in mobilising N38.6 billion to fight the pandemic (CACOVID, n.d.).

This EIR serves as an important tool to support the government's agenda to advance healthcare in the country, particularly at the sub-national level. The report will equip policymakers with new knowledge needed to make informed decisions that will strengthen health resource allocation and management, using insights on how State governments in Nigeria finance the development of the sector and the role of existing institutional arrangements.

1.2 Our Methodological Approach

This report investigates how health expenditure at the State level translates to health outcomes and identifies opportunities for maximising the value for every Naira invested in healthcare. It will use evidence on how resources are allocated and managed in the sector to provide valuable information for improved planning, policy adjustments, institutional strengthening, more effective and efficient spending and strategic investments. The EIR methodology employs a mixed research approach, combining both quantitative and qualitative data collection methods.

- Expenditure Review: Actual spending by health ministries, departments and agencies for 2021 and 2022 and budget data for 2023 were analysed to provide a broad overview of the health spending patterns of all 36 States in the country.
- Rapid Qualitative Review: Data collection leveraged both secondary and primary sources. A rapid review was carried out using questionnaires disseminated to all 36 States between October 2023 and January 2024 to gather cross-sectional data aligned with the review objectives. Case studies were also carried out for States with the highest and least health expenditure - two from each geopolitical zone.
- Stakeholder Engagement: The EIR adopted a participatory approach, incorporating focus group discussions (FGDs) and key informant interviews. The information gathered through these discussions was analysed using descriptive statistics and narrative analysis methods.

The EIR seeks to answer three (3) key questions:

- **Budgeting Processes:** How effectively are resources allocated for healthcare development across Nigerian States?
- **Institutional Structures:** Are the existing institutional arrangements for coordinating health policies and programmes optimal?
- **Coordination Mechanisms:** How efficiently are health development activities coordinated among the different levels of government (federal, State, and local)?

1.3 Report Structure

This report is structured into four (4) parts. Part 1 covers the introductory sections, with the background and motivations stated and the methodological approach described.

Part 2 covers a detailed analysis of the health spending patterns of State governments, looking at nine (9) key metrics. We look at the quality of health expenditure by the 36 States from 2021, when the National Chart of Accounts (NCOA)[1] was adopted by all State governments in the country, to 2023. Before 2021, budgets were not prepared using a common standard, which meant that there was a great deal of difficulty for budget, finance and account officers to classify and record government financial transactions, and there was limited room to carry out a comprehensive expenditure review covering all States of the federation.

[1]The NCOA is a complete list of budget and accounting codes uniquely grouped into tables for budgeting, tracking, managing, and reporting budgetary and accounting items in an orderly, efficient, and transparent manner.

Box 1: Tracking Public Spending with the NCOA

- Administrative Segment - who is spending the money?
- Economic Segment - what is the nature of the expenditure (i.e., what is the money being spent on)?
- Functional Segment - what is the purpose of the expenditure?
- Programme Segment - how does the expenditure help achieve policy priorities?
- Fund Segment - source (where is the money coming from)?
- Location Segment - where is the benefit of the expenditure?

This report uses actual expenditure data for 2021 and 2022 sourced from the audited financial statements of States,[2] while budget figures (original budget) are used for the year, 2023. The section reports nine (9) key indicators:

- **Total health expenditure (actual):** This provides a consolidated overview of the total spending on healthcare by all State governments.
- **Health expenditure by each State:** This presents a state-by-state comparison of health expenditure, revealing variations in spending priorities.
- **Sector budget performance:** We assess how well States are adhering to their health budgets.
- **Health expenditure (share of total expenditure):** This reveals the relative importance placed on healthcare compared to other sectors.
- **Medium-Term Sector Strategy Planning:** We explore how States are planning for their current and future healthcare needs.
- **Structure of health expenditure:** We review the distribution of health expenditure across health services.
- **Capital versus recurrent expenditure:** This section breaks down health sector expenditure into two - recurrent expenditures for the cost of health sector administration, and capital expenditures on health facilities, equipment, research etc.

[2]Cross River, Delta (recurrent expenditure) and Akwa Ibom (capital expenditure) 2022 actual data sourced from the 2023 State budget documents (reported as actual for the previous year); 2021 data for Benue (capital expenditure), Ogun actual data for 2021 sourced from the 2022 budget documents (reported as actual for the previous year); Niger State 2021 data only captures its recurrent expenditure.

- **Funding sources for the sector:** We explore the funding mix of health spending, examining the contributions from federal transfers, State allocations, and other sources like user fees or industry levies.
- **Distribution of health resources:** We analyse how health expenditures are distributed across States, showing per capita and regional disparities.

Part 3 of the report reviews the healthcare institutional system which is the engine for the success of the sector. The following areas are covered:

- **Inventory of Key Players:** We provide a general overview of the key healthcare institutions and agencies at the national and State levels.
- **Institutional Coordination:** We assess the level of interaction between health institutions and partners and civil society organisations.
- **Safeguarding Resources:** We analyse the mechanisms in place to ensure transparency, oversight, and accountability in the allocation and utilisation of health resources.
- **Promoting Efficiency:** This section reviews current mechanisms for performance evaluation of health institutions and personnel.
- **Financial Sustainability:** An evaluation of the viability of current expenditure patterns was conducted to assess whether current funding levels are sustainable for the long-term development of the health sector.
- **Outcome Analysis:** This section seeks to establish a correlation between expenditure patterns and health outcomes.

Having reviewed the fiscal and institutional systems, Part 4 presents actionable strategies to optimise resource allocation and management in the sector.

2. Expenditure Review

2.1 Total Sector Spending at the State level

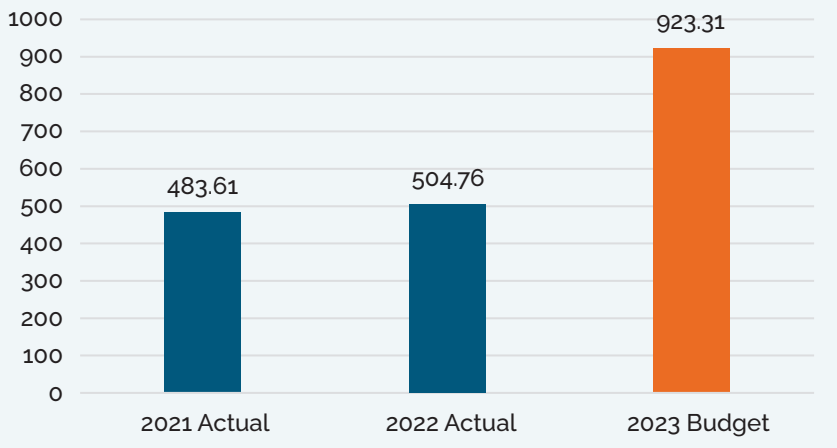
Health expenditure includes all expenditures for the provision of health services, family planning activities, nutrition activities and emergency aid designated for health, but excludes the provision of drinking water and sanitation. Given the current nature of budgets in the country, there are some expenditures on health by other ministries, departments and agencies (MDAs). For example, the Government House in many States operates a government house clinic/hospital with their budgets captured under the Government House budget rather than the Ministry of Health (MoH). State Committees on AIDs (SACA) and other health agencies are also reported under the Government House.

Given these typologies, some health spending data may not be captured when solely reviewing the budget and actual expenditure of the MoH, its departments, parastatals, facilities and institutions. The use of functional segment reports which track the purpose of the expenditure rather than the administrative segment which tracks who is spending the money (see Box 1) would have provided a holistic view of the total health sector expenditure, but this is not currently available because of the "incompleteness" of the functional segment reports in States' annual budgets and the lack of statistical reports[3] in the General-Purpose Financial Statements (GPFS)[4]. Total health expenditure (actual) by the 36 States of the federation was N505 billion in 2022 - accounting for 7% of their total expenditure - up from N484 billion in 2021.

In 2023, the 36 States budgeted a total of N923.31 billion for the sector - an increase of 83% from the total actual expenditure in 2022. The report notes that budget performance for the sector averages around 63% year-on-year, indicating that the actual spending for 2023 may fall well below the N923.31 billion target.

[3]The programme, function, and location segment reports of the statutory financial statements.
[4]The GPFS templates are used by the three tiers of governments in the preparation of their financial statements. In addition to the Statutory Financial Statements, the GPFS includes Budget Performance Reports and full-year statistical reports.

Figure 1: Total Health Expenditure for the 36 States (NGN Billion), 2021 –23

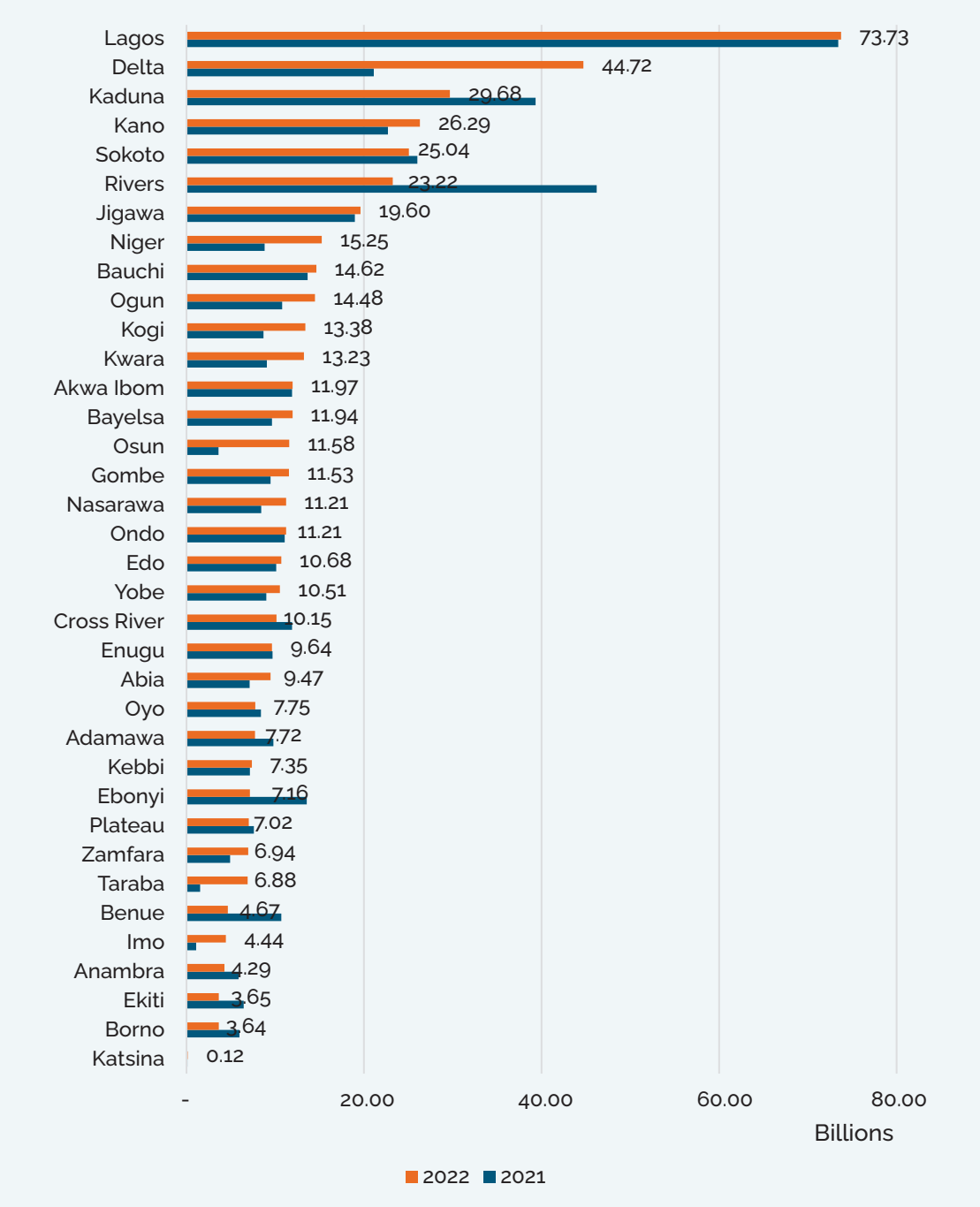


Source: 2021 and 2022 Audited Financial Statements of States, 2023 Budgets of States

2.2 Size of Health Spending by States

The average health spending of State governments is N14 billion annually, with wide variations from State to State. Lagos recorded the highest spending of N73.7 billion in 2022 compared with N124 million in Katsina State. Health expenditure by the top 7 States (Lagos (N73.7 billion), Delta (N44.72 billion), Kaduna (N29.68 billion), Kano (N26.3 billion), Sokoto (N25 billion), Rivers (N23.2 billion) and Jigawa (N19.6 billion) accounted for nearly 50% of the total spending of all States in the federation. In the previous year 2021, Lagos also recorded the highest health spending at N73.4 billion followed by Rivers State (N46.2 billion) and Kaduna State (N39.3 billion). Two factors influence this data - firstly the level of resources available to the States - Lagos is Nigeria's economic hub and among the largest cities in Sub-Saharan Africa, Delta and Rivers are the top oil-producing States, while Kano and Kaduna are the two largest economies in northern Nigeria. The second factor relates to Jigawa, in that the salaries of all PHC facilities are paid through the State budget (this equates to circa N10 billion per annum, which is captured as a grant from the Local Government Areas (LGAs) to the State, and then as an expenditure of the State in the health sector).

Figure 2: Health Expenditure by States, Actual, 2021 –22



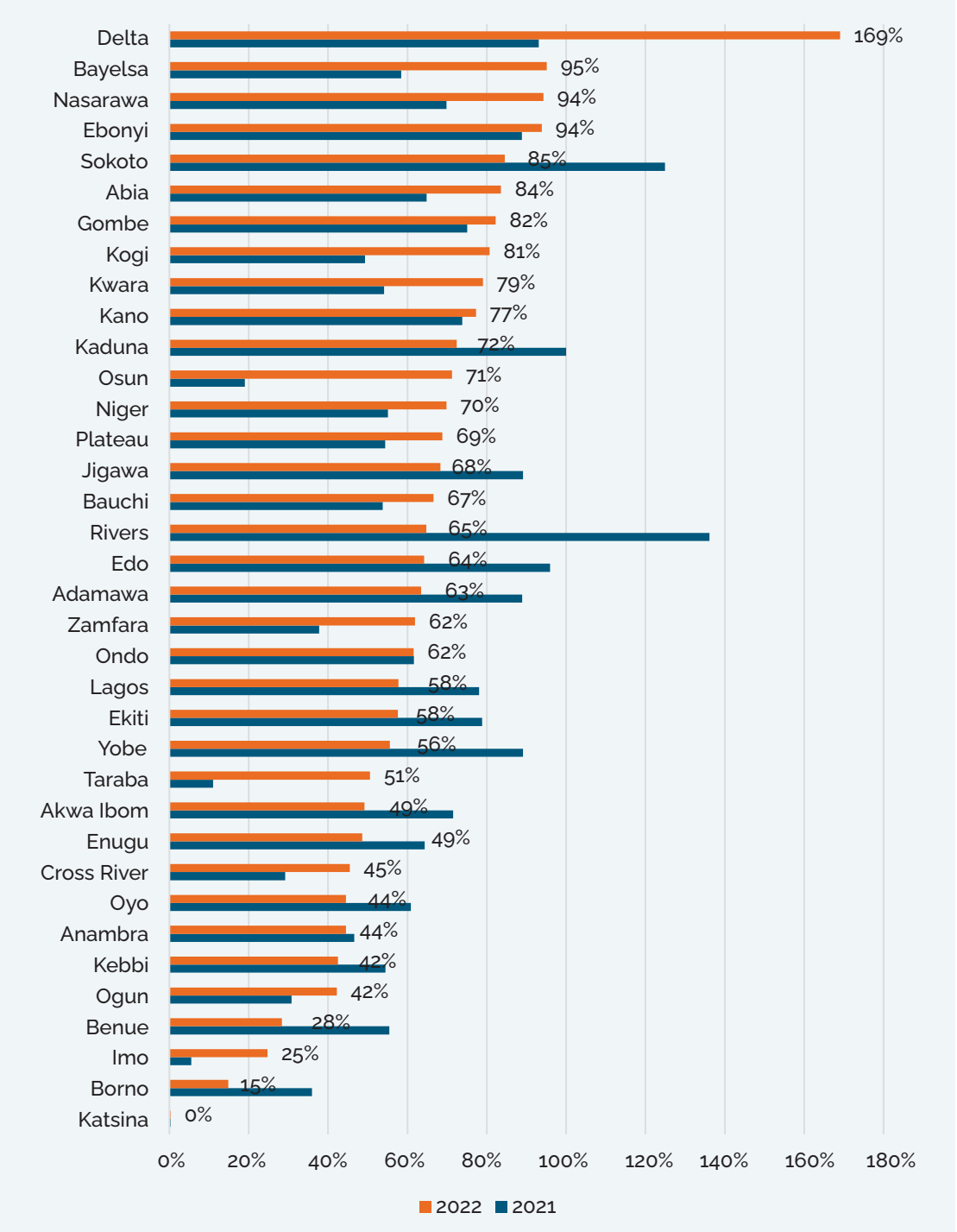
Source: 2021 and 2022 Audited Financial Statements of States.

2.3 Sector Budget Performance

This section reviews the allocation to the health sector as a proportion (percentage) of the State's total expenditure, establishing the variation between what was allocated for the sector in the budget, and what was expended in the budget year. Budget performance was at an average of 63% year on year. Only 7 States (Delta,

Nasarawa, Ebonyi, Sokoto, Gombe, Kano, and Kaduna) recorded an average budget performance above 70% year on year.

Figure 3: Health Sector Budget Performance, 2021–22

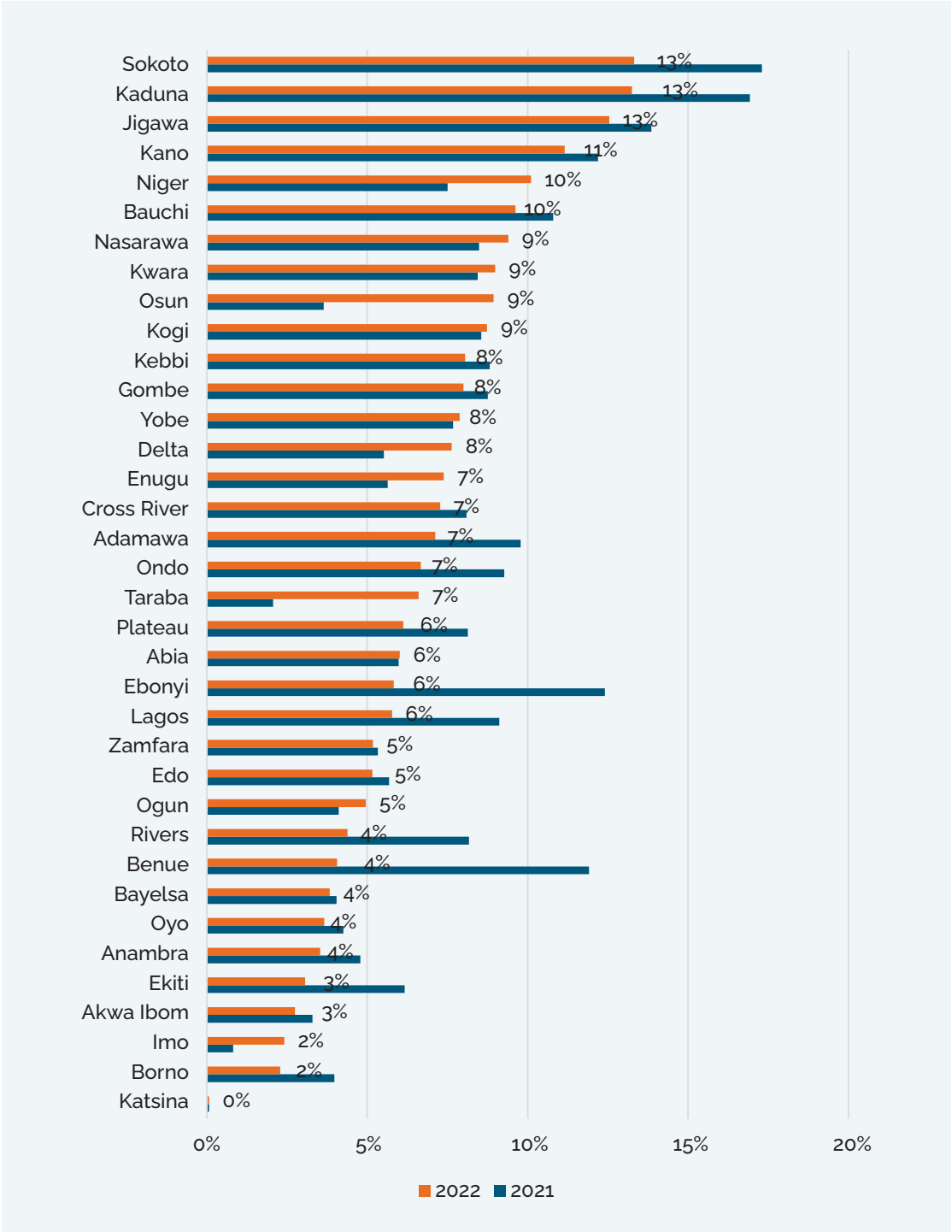


Source: Calculated based on data from the 2021 and 2022 Audited Financial Statements of States.

2.4 Sector Expenditure (share of total expenditure)

Because of the low budget performance in the sector which averaged 63% during the review period, this section prioritised actual expenditure figures (what governments spent) rather than budget figures (what governments proposed to spend). Figure 4 shows that the average share of health expenditure (% of total expenditure) across the 36 States is 7%. Only 6 States (Sokoto, Kaduna, Jigawa, Kano, Niger and Bauchi) recorded over 10% in their health sector spending. In 2021, Kaduna and Sokoto exceeded the 15% threshold set over two decades ago in the 2001 Abuja Declaration. In 2001, African Heads of State, in Abuja, Nigeria, pledged to increase their health spending to a minimum of 15% of their budget (OAU, 2001). This was in recognition of the importance of public health spending in resuscitating healthcare systems in the continent, and the potential economic benefits for their citizens.

Figure 4: Health Sector Expenditure (Share of Total Expenditure), 2021–22



Source: Calculated based on data from the 2021 and 2022 Audited Financial Statements of States.

2.5 Medium-Term Sector Strategy Planning for the Sector

A survey was carried out in November 2023 to ascertain whether States have an up to date (covering up to the 2024 budget year) Medium Term Sectors Strategy (MTSS) for the health sector. The use of an MTSS is important as it helps assess the maturity of policy and planning within the sector, and the extent to which the sector is contributing to the core objectives of Public Financial Management (PFM), namely:

i. Aggregate Fiscal Discipline

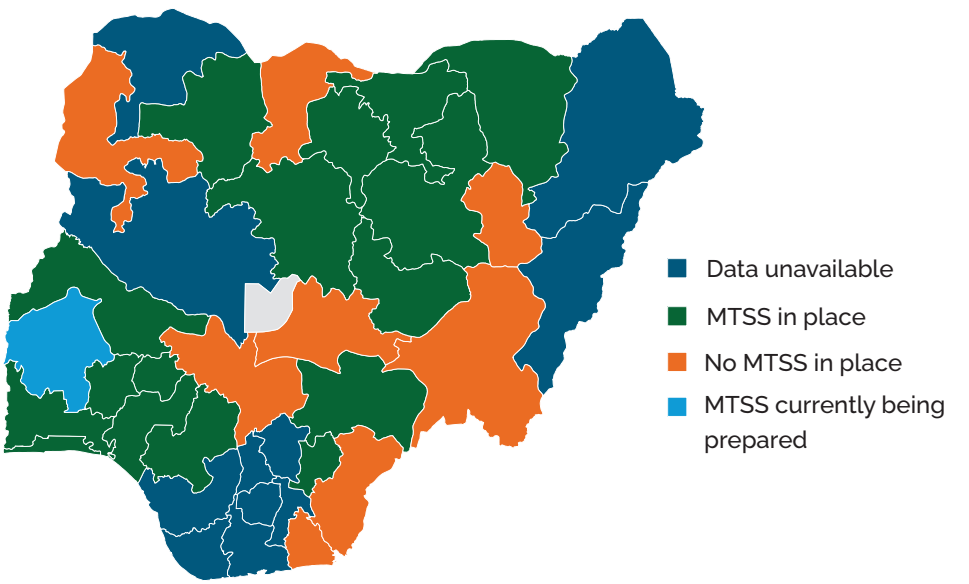
ii. Policy-Based Allocation of Resources; and

iii. Value for Money

The MTSS provides the linkage between the policies of the government and its annual budgets (and actual expenditures). It captures health activities, outputs, outcomes, and impacts in the sector. When the programme segment of the NCOA (see Box 1) is applied to the MTSS and the annual budget, it is possible to ascertain the extent to which policy priorities are reflected in the budget (PFM Core Objective 2). If actual expenditures are recorded against the programme segment, and proper monitoring and evaluation is undertaken to assess the extent to which outputs, outcomes, and impacts have been achieved, it is then possible to ascertain the value for money from expenditures within the sector (PFM Core Objective 3). Without an MTSS, it is difficult to align budget allocations to policy and assess the impact of expenditures on health sector outcomes.

Unlike development plans which are aspirational and loosely costed, MTSSs are more practical, fully costed with ceilings and priorities. The use of an MTSS may be viewed as an indicator of the strategic priority given to the sector, but it's not definitive.

Figure 5: Status of Health MTSS in Nigerian States



Across the 36 States surveyed, only 15 had a health MTSS covering at least the 2024 budget year. Evidence shows that there are cases of alternative planning documents and frameworks used at the ministry level by other States to guide resource allocation for the sector, besides the formal MTSS which is 'State-wide'. Some of these alternative tools provide a prescription of the activities, outputs, and outcomes similar to what is attainable in the MTSS, although driven internally by the health ministry.

The survey did not interrogate the MTSSs to ascertain whether the documents set out the projects and programmes that will be carried out in the sector, how much each programme and project will cost, where the money will come from, and who will carry out the activities.

2.6 Structure of Health Expenditure

This section presents the health sector expenditure of States at a disaggregated level. The following dimensions of analysis were envisaged:

i. Allocation across various health services (e.g., primary care, secondary care, tertiary healthcare programmes).

ii. Spending on different disease categories (e.g., infectious diseases, non-communicable diseases, maternal and child health).

iii. Administrative and operational costs; and

iv. Capital versus recurrent costs.

Dimensions i-iii were not possible at this time. The reasons for this are explained below.

The NCOA, which has six segments of coding (see Box 1), should allow for the above dimensions of analysis to be conducted.

Despite the progress in budgeting practices, particularly in relation to the domestication of the NCOA in the Annual Budget, some challenges remain which make it very difficult to break down expenditures under these categories. There are three main issues:

- Inability to accurately apply the NCOA coding to the budgets and actual expenditure;
- Inadequate content and low level of accuracy of the Financial Reports of State governments; and
- Up to and including 2023 budgets, the lack of a detailed programme segment coding.

Starting with the distribution of expenditures across types of healthcare (e.g., basic, secondary, tertiary), this is not explicitly possible through the NCOA. The functional segment is based on the global standard Classification of Functions of Government

(COFOG) which was developed and is sponsored by the International Monetary Fund (IMF) and the Organisation for Economic Cooperation and Development (OECD). It includes several main classifications of healthcare but is not classified under the three main types listed above (i - iii). The relevant coding is presented in Table 1.

Table 1: Functional Classification of the Health Sector

Code	Description	Level	Level Description
707	**Health**	**1**	**Function**
7071	**Medical Products, Appliances, and Equipment**	**2**	**Sub-Function**
70711	Pharmaceutical Products	3	Detailed Function Item
70712	Other Medical Products	3	Detailed Function Item
70713	Therapeutic Appliances and Equipment	3	Detailed Function Item
7072	**Outpatient Services**	**2**	**Sub-Function**
70721	General Medical Services	3	Detailed Function Item
70722	Specialised Medical Services	3	Detailed Function Item
70723	Dental Services	3	Detailed Function Item
70724	Paramedical Services	3	Detailed Function Item
7073	**Hospital Services**	**2**	**Sub-Function**
70731	General Hospital Services	3	Detailed Function Item
70732	Specialised Hospital Services	3	Detailed Function Item
70733	Medical and Maternity Centre Services	3	Detailed Function Item
70734	Nursing and Convalescent Home Services	3	Detailed Function Item
7074	**Public Health Services**	**2**	**Sub-Function**
70741	Public Health Services	3	Detailed Function Item
7075	**R & D Health**	**2**	**Sub-Function**
70751	R & D Health	3	Detailed Function Item
7076	**Health N.E.C.**	**2**	**Sub-Function**
70761	Health N.E.C.	3	Detailed Function Item

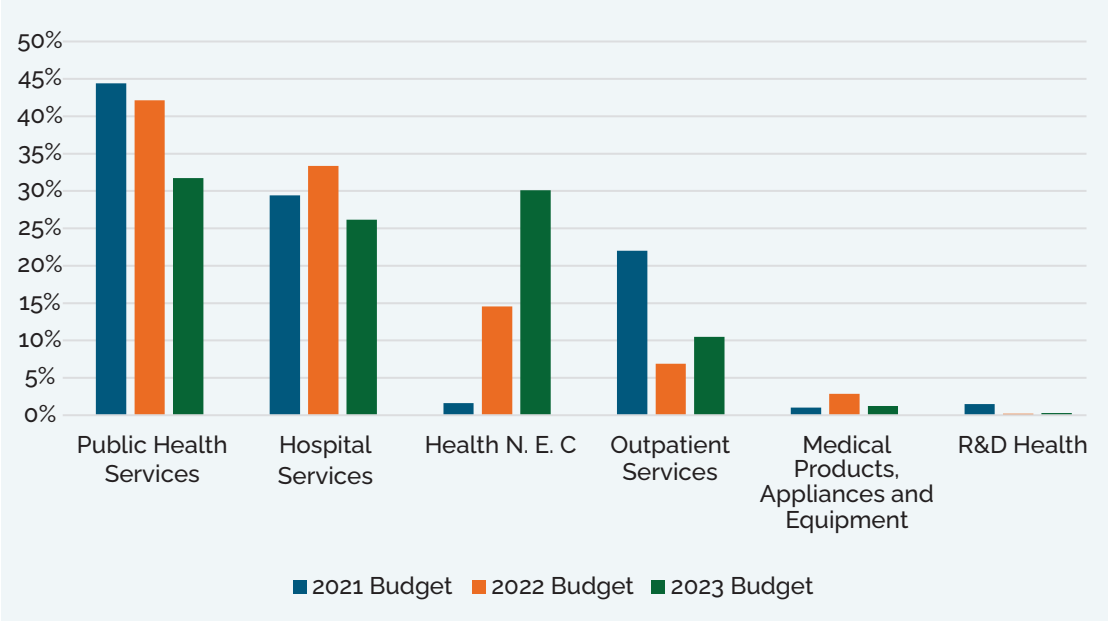
Besides not catering for the three levels of healthcare services, other challenges with using the functional segment data are (i) poor quality of the application of the functional segment to budgets, (ii) lack of a set of "Statistical Reports" in the General Purpose Financial Statements of State Governments that are consistent with the statutory reports based on the International Public Sector Account Standards (IPSAS), and (iii) lack of a detailed statistical data on State budgets and accounts. We present these expenditures coded to the functional segment under Function 707 in Table 2 and Figure 6.

Table 2 Function Segment Report of the Health Budget of States, 2021 – 23

Code	Function	2021 Budget	2022 Budget	2023 Budget
707	**Health**	**744,472,020,200**	**795,031,804,664**	**835,050,691,121**
7071	Medical Products, Appliances and Equipment	7,740,738,391	22,733,025,054	10,221,212,707
70711	Pharmaceutical Products	6,872,723,467	15,614,901,476	9,946,812,707
70712	Other Medical Products	481,711,441	6,663,198,467	228,200,000
70713	Therapeutic Appliances and Equipment	386,303,483	454,925,112	46,200,000
7072	Outpatient Services	163,766,604,248	54,835,922,265	87,697,266,625
70721	General Medical Services	126,691,304,609	35,777,412,022	61,119,089,890
70722	Specialised Medical Services	36,205,641,450	17,018,027,635	25,279,394,312
70723	Dental Services	105,153,189	253,058,830	-
70724	Paramedical Services	764,505,000	1,787,423,779	1,298,782,423
7073	Hospital Services	219,120,979,623	265,298,802,962	218,550,425,033
70731	General Hospital Services	164,704,159,359	211,044,123,106	153,616,051,087
70732	Specialised Hospital Services	39,828,105,163	50,574,600,391	61,720,946,346

70733	Medical and Maternity Services	1,873,549,973	2,371,292,914	2,686,367,601
70734	Nursing and Convalescent Services	12,715,165,128	1,308,786,551	527,060,000
7074	Public Health Services	330,676,898,019	334,959,566,020	265,095,669,900
70740	Public Health Services	330,676,898,019	334,959,566,020	265,095,669,900
7075	R&D Health	11,156,914,107	1,588,178,742	2,307,568,972
70750	R&D Health	11,156,914,107	1,588,178,742	2,307,568,972
7076	Health N. E. C	12,009,885,811	115,616,309,621	251,178,547,883
70760	Health N. E. C	12,019,885,811	115,616,309,621	251,178,547,883

Figure 6: Distribution of the Health Budget of States by Function Classification,2021–23



Source: Budgets of States, 2023; NGF Public Finance Database, 2024

Notes: *R&D Health includes the administration and operation of government agencies engaged in applied research and experimental development related to health; grants, loans and subsidies to support applied research and experimental development related to health undertaken by non-government bodies such as research institutes and universities.*

Health N.E.C. covers the administration, operation or support of activities such as formulation, administration, coordination and monitoring of overall health policies, plans, programmes and budgets; preparation and enforcement of legislation and standards for the provision of health services, including licensing of medical establishments and medical and paramedical personnel; production and dissemination of general information, technical documentation and statistics on health.

61.83% of the aggregate health budget of the 36 States for the years 2021, 2022 and 2023 was allocated to public health services and health administration, leaving 38.17% for hospital services (26.17%), outpatient services (10.5%), medical products appliances and equipment (1.22%), and health R&D (0.28%).

The Nigeria Governors' Forum (NGF) Secretariat has supported the deployment of the five levels of the programme segment to help identify the level of health care service. Levels 1-3 of the programme segment are presented later in this sub-section, but the fifth level, activity (two digits), has been deployed to make the distinction between the levels of health care in the 2024 State budgets.

- 01 Primary
- 02 Secondary
- 03 Tertiary
- 04 Multiple / Other

An analysis based on this coding will be possible from 2024 onwards for budgets. The broader issues of reporting on actual expenditures remain.

The dimensions of analysis related to (ii) expenditures on different health categories (e.g., infectious diseases, non-communicable diseases, maternal and child health) and (iii) administrative and operational costs, should be possible through a combination of the administrative, economic and programme segments.

As noted above, the administrative segment of the NCOA identifies the responsibility centre for expenditures (and for collecting revenues). The largest share of expenditures under the health sector will be coded to Main Organisation 0521 which is the Ministry of Health, which incorporates all its departments, agencies and parastatals. The standard structure of Main Organisation 0521 as per the NCOA is presented in Table 3.

Table 3: Administrative Segment Coding for the Health Sector

Code	Description	Level	Level Description
05	**Social Sector**	**1**	**Sector**
0521	**MINISTRY OF HEALTH**	**2**	**Main Org**
052100200100	State Health Insurance Scheme	3	MDA
052100300100	Primary Healthcare Management Board/Agency/Commission	3	MDA
052102600100	University Teaching Hospital	3	MDA
052110200100	Hospital / Health Services Management Board / Agency	3	MDA
052110300100	Traditional / Alternative Medicine Board	3	MDA
052110400100	School of Nursing and Midwifery	3	MDA
052110500100	Health Facilities Accreditation and Monitoring Agency	3	MDA
052110600100	School of Health Technology	3	MDA
052111300100	Drugs Management Agency	3	MDA
052111400100	Material Testing Laboratory	3	MDA

State governments can add MDAs to the above structure, and Main Organisation (i.e. Ministries). There are relatively few deviations from the above Main Org code for the health sector.

The economic segment coding distinguishes expenditures related to infrastructure, salaries etc. However, the quantum of data collection needed to present data on these items for the health sector alone, and for budget and actual expenditure, is not yet feasible.

Finally, the programme segment of the NCOA should help further analyse budgets in future years. The health sector (planning sector) coding for the 2024 budgets under the programme segment is presented in Table 4.

Table 4: Programme Segment Coding for the Health Sector

Code	Description	Level	Level Description
04	**Health**	**1**	**Sector**
0401	Effective governance of the health system	2	Objective
040101	Legal, policy, regulations and standards,	3	Programme

	guidelines and protocols development and reviews		
040102	Human and Institutional Capacity Performance Management	3	Programme
040103	Health sector coordination mechanisms	3	Programme
040104	Integrated supportive supervision	3	Programme
0402	Community engagement and participation in health	2	Objective
040201	Community interventions	3	Programme
040202	Community structures	3	Programme
0403	Enhancement of the delivery of Essential Package of Health Services (EPHS) to all citizens	2	Objective
040301	Reproductive, maternal and neonatal health	3	Programme
040302	Child health	3	Programme
040303	Adolescent health	3	Programme
040304	Communicable diseases	3	Programme
040305	Non-communicable diseases	3	Programme
040306	Nutrition	3	Programme
040307	Emergency services	3	Programme
0404	Provision of the right number and skill mix of competent, motivated, and productive Human Resources for Health (HRH)	2	Objective
040401	Pre-service training	3	Programme
040402	HRH Performance management	3	Programme
040403	In-service training (continuing Health)	3	Programme
0405	Provision of adequate and modern health infrastructure for health services delivery	2	Objective
040501	Functional health facilities	3	Programme
040502	Planned Preventive Maintenance (PPM)	3	Programme
040503	Facility electrification, water and sanitation	3	Programme
0406	Provision of quality, affordable, available, and safe medicines, vaccines, and other	2	Objective

	health commodities		
040601	Sustainable drug supply	3	Programme
040602	Vaccines supply chain	3	Programme
0407	Evidence generation and utilisation	2	Objective
040701	Routine information system	3	Programme
040702	Surveys and facility assessments	3	Programme
040703	Research and development (Institutional Review Board, Clinical Trials)	3	Programme
040704	Monitoring and Evaluation (M&E)	3	Programme
0408	Institution and maintenance of a responsive public health emergency preparedness system	2	Objective
040801	Integrated national disease surveillance	3	Programme
040802	Public health laboratories	3	Programme
040803	Emergency Operation Centres (EOC)	3	Programme
0409	Provision of universal health coverage and financial risk protection for citizens	2	Objective
040901	Mobilising equity contributions and vulnerable group funds	3	Programme
040902	Mobilising employers' contributions to the State Social Health Insurance Scheme	3	Programme
0410	Health Sector Expenditures Not Elsewhere Classified	2	Objective
041001	Health Not Elsewhere Classified	3	Programme

In addition to levels 1-3 of codes (sector, objective, programme), the fifth level of the programme segment, i.e. Activity, was used to identify the level of healthcare service (Primary, Secondary, Tertiary or Others/Multiple).

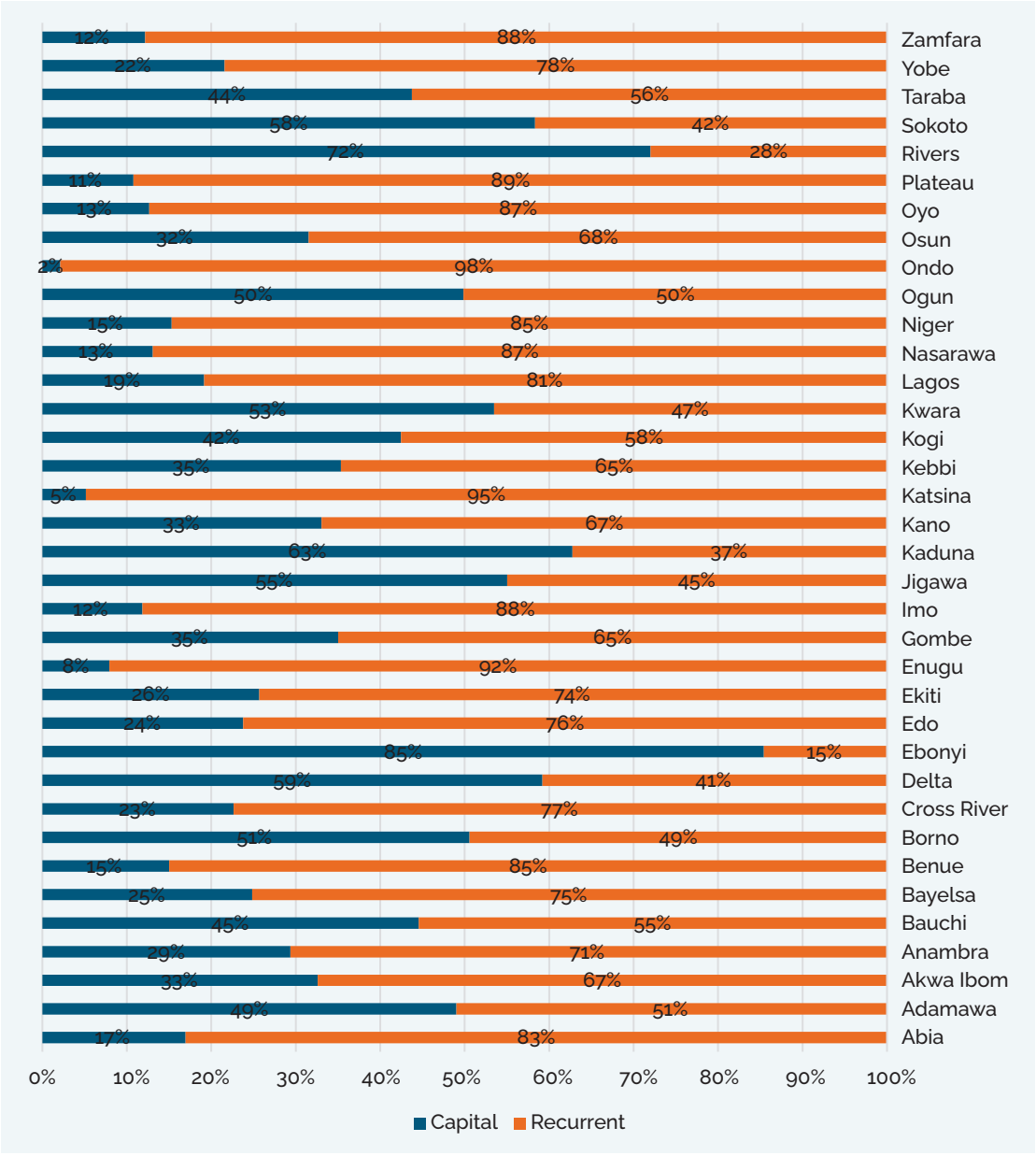
2.7 Capital versus Recurrent Costs

This section evaluates health allocations for recurrent expenditure i.e., spending for the administration of healthcare, including personnel and maintenance costs, and spending on capital expenditure, including tangible (e.g., purchase of x-ray machines, and construction of hospitals or clinics) and intangible assets (such as skills of physicians, research into diseases etc). The report noted instances of miscoding some recurrent items (e.g. drugs, and medical materials like PPE) as

capital items.

For the 2021-2022 period, the average ratio of capital to recurrent spending for all 36 States was 33%:67%, indicating greater spending by State governments on the administration of healthcare services. Some States have not followed this trend. In Ebonyi (85%:15%), Rivers (72%:28%), Kaduna (63%:37%), Delta (59%:41%), Sokoto (58%:42%) and Jigawa (55%:45%), capital spending outweighs recurrent spending.

Figure 7: Capital: Recurrent Expenditure Ratio, % Average, 2021 - 22



Source: Calculated based on data from the 2023 Budgets of States, NGF Public Finance Database, 2024

The distribution of health expenditure for the 2021-2022 period varies across States. This distribution may be categorised into four groups:

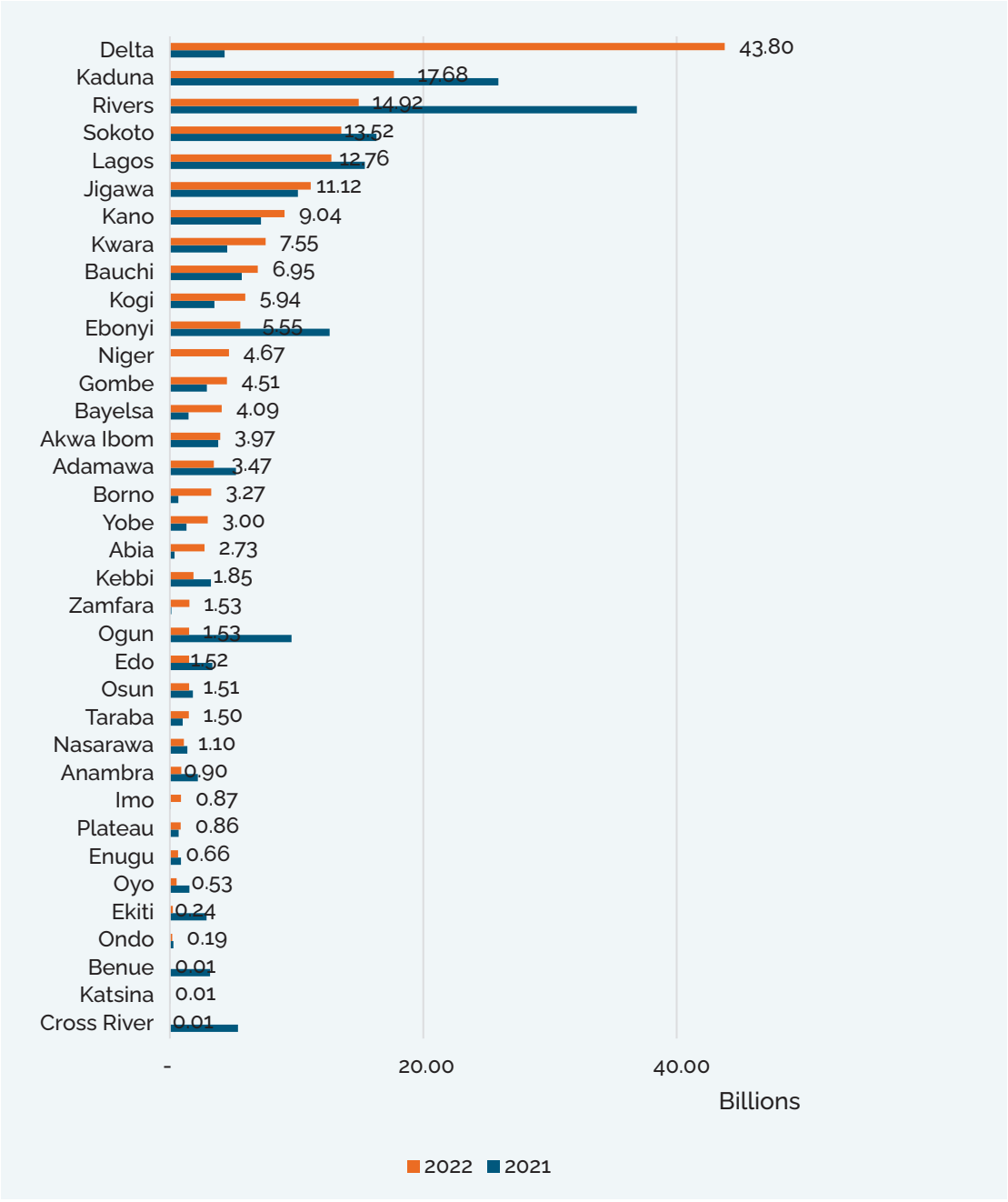
- Category 1 - States with very high capital expenditure and very low proportion for recurrent spending (i.e., more than 80% capital and less than 20% recurrent).
- Category 2 - States with moderately high capital expenditure and average proportion for recurrent spending (i.e., between 50% and 80% for capital)
- Category 3 - States with a substantial proportion of capital expenditure (i.e., between 25% and 49% for capital).
- Category 4 - States with very high recurrent expenditure and very low capital expenditure (i.e., less than 25% for capital expenditure).

Category 1	Ebonyi
Category 2	Rivers, Kaduna, Delta, Sokoto, Jigawa, Kwara, Borno, Ogun
Category 3	Adamawa, Bauchi, Taraba, Kogi, Kebbi, Gombe, Kano, Akwa Ibom, Osun, Anambra, Ekiti, Bayelsa
Category 4	Edo, Cross River, Yobe, Lagos, Abia, Niger, Benue, Nasarawa, Oyo, Zamfara, Imo, Plateau, Enugu, Katsina, Ondo

Source: Calculated based on the 2022 actual expenditures of States

In nominal terms, the States that recorded the highest capital spending in 2022 were Delta (N43.8 billion), Kaduna (N17.7 billion), Rivers (N14.9 billion), Sokoto (N13.5 billion), Lagos (N12.8 billion) and Jigawa (N11.1 billion). These 6 States account for 60% of the total capital spending of all 36 States in the health sector. In 2021, Rivers, Kaduna and Sokoto were at the forefront of health capital spending with N36.9 billion, N25.9 billion and N16.3 billion respectively.

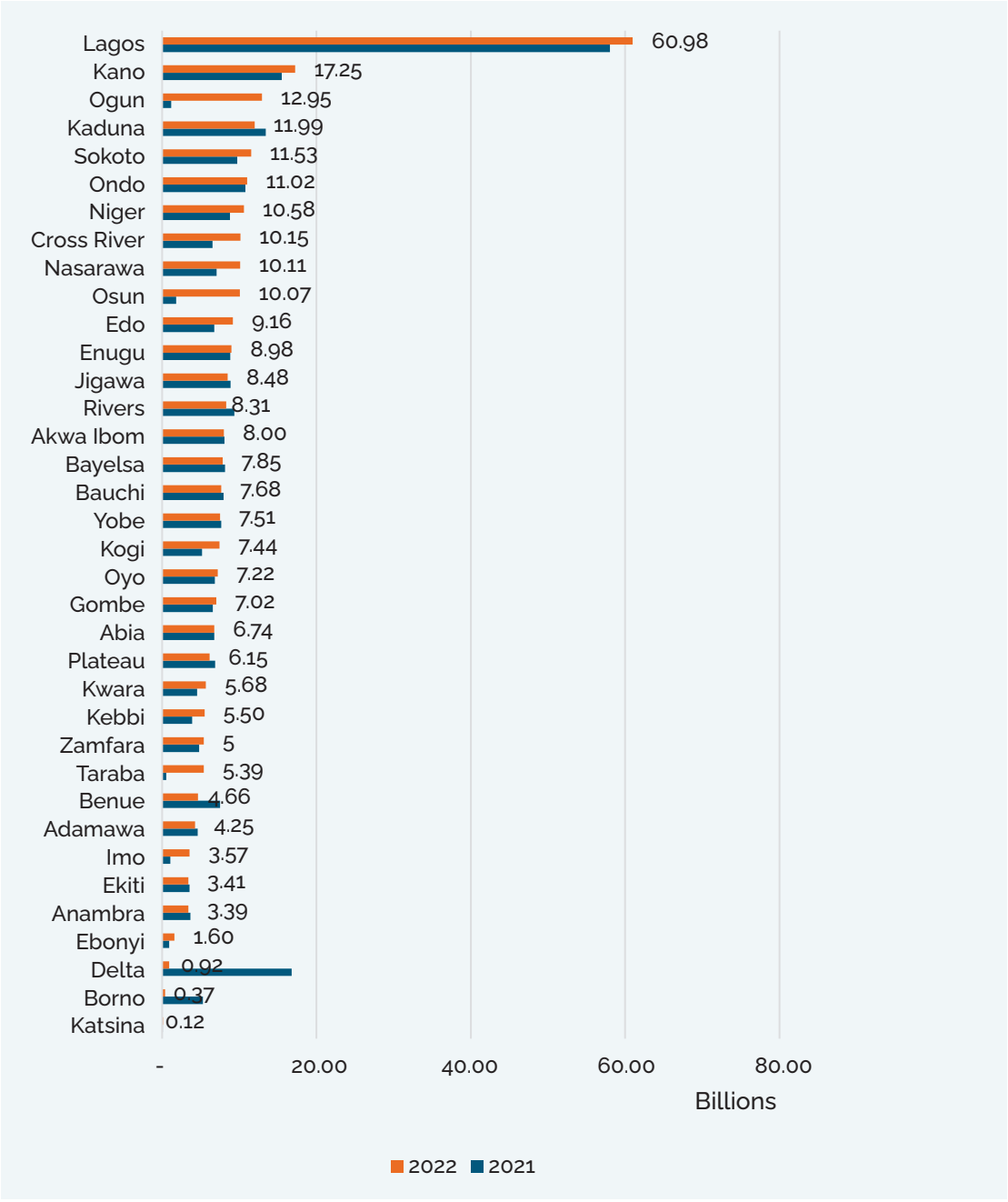
Figure 8: Health Sector Capital Expenditure for the 36 States (NGN), 2021–22



Source: 2021 and 2022 Audited Financial Statements of States.

On the other hand, Lagos (N61 billion), Kano (N17.2 billion), Ogun (N12.9 billion), Kaduna (N12 billion) and Sokoto (N11.5 billion) ranked highest in terms of health recurrent expenditure.

Figure 9: Health Sector Recurrent Expenditure for the 36 States (NGN), 2021-22



Source: 2021 and 2022 Audited Financial Statements of States.

This report does not assess the optimal balance of capital and recurrent spending. This will vary depending on the state of existing healthcare infrastructure, the size and needs of the population and the availability of resources. Without enough capital expenditure, the healthcare system will lack the physical capacity to serve the population. People may have to travel long distances for basic care, or facilities

may be overcrowded and outdated. Without enough recurrent expenditure, even the best facilities will struggle to function. There will not be enough staff to provide care, or essential medicines and supplies may be in short supply.

The two spending components are also mutually reinforcing. Capital investments will result in additional health facilities and other social benefits which in turn necessitate the employment of additional doctors, nurses, and other health professionals to run the facilities. Also, a reasonable amount will be required to be spent on the operation and maintenance of these facilities. Without adequate funding for personnel and operations, facilities risk service disruptions and potential deterioration. Underfunding of either capital or recurrent (personnel and overhead) expenditures will have an impact on the sector.

2.8 Funding Sources for the Sector

Funding for the sector comes from three (3) main sources - general government revenues (Federal, State and Local Governments), contributions from development partners, and private sector (both for-profit and faith-based/not-for-profit organisations) via health facilities and equipment or production and provision of HRH for the sector, etc. (which for the health sector could be significant).

2.8.1 State Funding

For State governments, these sources can be further grouped into five (5):

- **Recurrent Revenues**
  - Federation Account Revenues (e.g. Statutory Allocation, Mineral Derivation, Value Added Tax and other federation account revenue transfers);
  - Independent Revenues (tax and non-tax revenues collected in the State);
- **Capital Receipts**
  - Aid and Grants (aid being financing that is received in-kind - i.e. money that does not flow through a State bank account);
  - Loans; and
  - Other Receipts (e.g. sale of State assets, refunds (e.g. Paris Club), etc)

The health sector generates a moderate amount of independent revenue (from the sale of drugs and medicines, etc.), receives various grants, loans and other receipts (see Table 5), and is also funded from the State's "Main Envelope" of discretional funds.

Due to the structure and content of the Financial Statements of State governments and poor record-keeping of receipts that do not flow through the main treasury of the State, it is difficult to ascertain the precise level of external funding that States have received. For this reason, the 2023 budget has been used as the basis for the

analysis in this section.

We start by presenting the recurrent revenues (collected by the Ministry of Health and its associated departments, agencies and parastatals) and capital receipts related to the health sector in the 2023 budgets of the 36 States, and the extent to which they cover the recurrent costs and capital investments of the sector. The report notes that historically, the performance of revenues and capital receipts in terms of actual collections versus the budget vary significantly.

Table 5: Health Sector Revenue and Expenditure in the 2023 Budgets of States

State	Health Sector Expenditure			Health Sector Revenue and Receipts		Share of Health Expenditure funded from Health Revenue	
	Recurrent Expenditure	Capital Expenditure	Total Expenditure	Independent Revenue	Capital Receipts	Independent Revenue	Capital Receipts
Abia	5,531,601,200	5,761,507,400	11,293,108,600	1,958,054,400	6,903,136,900	17.34%	61.13%
Adamawa	5,759,587,000	6,549,973,890	12,309,560,890	3,089,917,000	2,246,352,000	25.10%	18.25%
Akwa Ibom	15,249,656,230	13,107,500,000	28,357,156,230	330,000,000	454,000,000	1.16%	1.60%
Anambra	4,511,440,620	6,203,780,519	10,715,221,139	429,248,635	-	4.01%	0.00%
Bauchi	10,393,161,139	20,022,784,827	30,415,945,966	93,528,000	6,635,630,574	0.31%	21.82%
Bayelsa	8,926,740,385	4,450,000,000	13,376,740,385	8,800,000	-	0.07%	0.00%
Benue	13,478,432,888	2,982,945,907	16,461,378,795	7,913,460,541	4,173,539,319	48.07%	25.35%
Borno	8,703,644,000	11,346,766,000	20,050,410,000	2,075,489,000	1,822,080,000	10.35%	9.09%
Cross River	5,482,651,498	8,409,250,698	13,891,902,196	670,532,413	75,604,075	4.83%	0.54%
Delta	16,692,851,128	13,919,000,000	30,611,851,128	44,500,000	-	0.15%	0.00%
Ebonyi	1,001,200,000	6,668,200,000	7,669,400,000	19,294,227	600,000,000	0.25%	7.82%
Edo	12,435,400,000	17,844,732,502	30,280,132,502	1,640,020,000	1,100,000,000	5.42%	3.63%
Ekiti	6,253,660,480	1,580,247,091	7,833,907,570	734,755,407	1,089,820,458	9.38%	13.91%
Enugu	8,619,884,570	4,370,750,000	12,990,634,570	1,460,211,500	1,125,000,000	11.24%	8.66%
Gombe	7,866,945,000	6,965,000,000	14,831,945,000	818,600,000	2,600,000,000	5.52%	17.53%
Imo	3,312,230,347	8,949,076,900	12,261,307,247	997,927,543	1,455,363,061	8.14%	11.87%

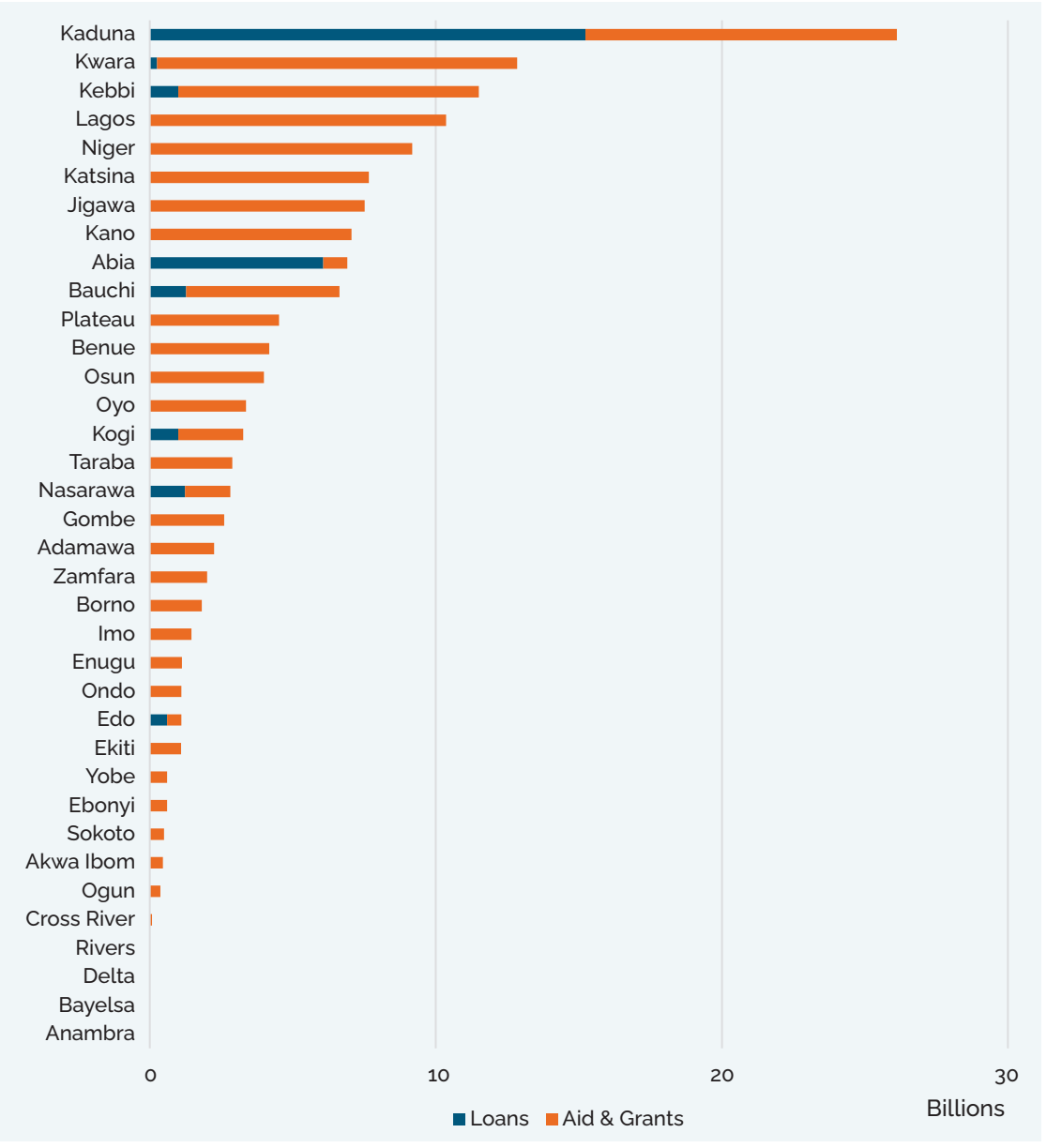
Jigawa	14,455,456,000	14,832,864,000	29,288,320,000	1,889,473,000	7,513,000,000	6.45%	25.65%
Kaduna	17,360,291,002	41,731,761,674	59,092,052,676	1,818,981,766	26,118,850,769	3.08%	44.20%
Kano	16,508,258,226	23,743,892,894	40,252,151,119	657,163,000	7,049,679,718	1.63%	17.51%
Katsina	8,889,183,429	24,191,255,764	33,080,439,193	2,217,734,281	7,662,340,950	6.70%	23.16%
Kebbi	7,244,479,148	9,435,473,888	16,679,953,037	286,561,000	11,505,400,163	1.72%	68.98%
Kogi	10,603,884,847	8,614,278,561	19,218,163,408	519,545,278	3,264,000,000	2.70%	16.98%
Kwara	4,926,845,303	15,096,881,648	20,023,726,951	1,623,640,000	12,846,122,614	8.11%	64.15%
Lagos	102,190,162,094	24,095,921,375	126,286,083,469	30,413,123,514	10,354,522,997	24.08%	8.20%
Nasarawa	13,541,444,923	5,067,674,900	18,609,119,823	3,076,453,301	2,814,344,745	16.53%	15.12%
Niger	11,113,423,510	17,003,551,312	28,116,974,822	283,206,604	9,171,947,944	1.01%	32.62%
Ogun	13,954,515,751	37,579,401,866	51,533,917,618	4,643,419,411	373,000,000	9.01%	0.72%
Ondo	12,118,000,161	11,871,200,000	23,989,200,161	27,271,000	1,101,200,000	0.11%	4.59%
Osun	14,390,155,920	3,527,374,700	17,917,530,620	4,012,741,000	3,989,951,290	22.40%	22.27%
Oyo	11,421,749,008	24,936,309,800	36,358,058,808	2,654,848,355	3,363,155,885	7.30%	9.25%
Plateau	7,139,331,830	3,728,901,200	10,868,233,030	1,003,980,000	4,516,818,400	9.24%	41.56%
Rivers	10,027,099,029	31,500,000,000	41,527,099,029	300,000,000	-	0.72%	0.00%
Sokoto	10,429,506,973	16,436,203,578	26,865,710,551	310,119,040	500,000,000	1.15%	1.86%
Taraba	6,495,499,247	8,308,909,408	14,804,408,655	600,732,759	2,884,341,038	4.06%	19.48%
Yobe	9,653,841,000	9,858,686,000	19,512,527,000	1,082,750,000	600,000,000	5.55%	3.07%
Zamfara	8,616,665,099	7,324,000,000	15,940,665,099	363,949,358	2,000,000,000	2.28%	12.55%
Total	445,298,878,986	478,016,058,301	923,314,937,287	80,070,031,335	147,909,202,900	8.67%	16.02%

Source: Budgets of States, 2023

In the 2023 budgets of States, Kaduna State proposed the highest capital receipts, pulling in a substantial N26 billion, 18% of the total amount proposed by States. Grant and international aid programmes were the primary sources of non-discretionary capital funding for most States, with less than a quarter of them seeking loan options to finance their capital projects in the sector. This low uptake could be due to limitations in securing loans, or a disinterest in pursuing these financing options.

In competition for limited development funding, States with a strong capacity to implement reforms tied to receiving funds are more likely to attract these critical resources.

Figure 10: Health Sector Capital Receipts, 2023



Source: Budgets of States, 2023

2.8.2 Private Sector Investments

Private sector funding for healthcare in Nigeria comes from three main sources, namely;

- Household out-of-pocket private payments for health services;
- Private sector investments in setting up private hospitals; and
- Private sector donations for health services.

Information on funding from any of the three sources is not available.

2.8.3 External Funding, including Donor Contributions and Grants

External funding in this instance is considered as funding coming from outside the State government. Typically, this will come from the following sources:

- Federal government (including BHCPF and Central Bank of Nigeria (CBN) loans)
- Contributions from local governments
- Aid, grants and loans from development partners.

Table 6 provides a breakdown of the budgeted receipts for health financing, broken into nature and source.

Table 6: Health Sector Aid, Grants and Loans in the 2023 Budgets of States

Nature	Source				Total	
	Foreign		Domestic			
	Amount	Share	Amount	Share	Amount	Share
Aid	24,237,658,014.51	24.26%	7,782,238,331.00	16.22%	32,019,896,345.51	21.65%
Loan	23,719,394,860.00	23.74%	2,919,674,245.05	6.08%	26,639,069,105.05	18.01%
Grant	51,968,554,071.31	52.01%	36,480,683,378.23	76.03%	88,449,237,449.54	59.80%
Other	-	0.00%	801,000,000.00	1.67%	801,000,000.00	0.54%
Total	99,925,606,945.82	67.56%	47,983,595,954.28	32.44%	147,909,202,900.10	100.00%

As shown in Table 6, the most significant contributor is grants, both from domestic and foreign sources. These include:

- The Basic Health Care Provision Fund (from the federal government)
- UNICEF, the UN system
- World Bank programmes including Save One Million Lives (SOML)
- The Gates Foundation
- Others

In total, aid, grants and loans in the 2023 Budgets of the 36 States made up 16.02% of the total expenditure in the sector. Full details of these capital aid, grants, loans and other receipts are presented in Table 7.

Table 7: Health Sector Aid, Grants and Loans in the 2023 Budgets of States – Individual Items

State	Receipt Description	Budget Provision	Nature	Source
Abia	World Bank Innovation Dev. & Effectiveness in the Acquisition of Skills	762,500,600	Loan	Foreign
Abia	World Bank Nigeria Women Project	1,200,000,000	Loan	Foreign
Abia	World Bank Saving One Million Lives World Bank/Federal Min. of Health	320,000,000	Loan	Foreign
Abia	World Bank Accelerating Nutrition Results in Nigeria (ARIN)	90,000,000	Loan	Foreign
Abia	Federal Government Basic Health Care Provision Fund	538,124,900	Loan	Domestic
Abia	5% Premium Contribution from Formal Sector (State)	452,025,200	Grant	Domestic
Abia	UNICEF Programme	75,338,500	Grant	Foreign
Abia	Multilateral Aids / Grants from Development Partner UNFPA	16,893,200	Grant	Foreign
Abia	Multilateral Aids/ Grants from Development Partner WHO	75,338,500	Grant	Foreign
Abia	Multilateral Aids /Grants from Development Partner TCI- World Bank	220,415,400	Grant	Foreign

Abia	Federal Government of Nigeria Basic Health Care Provision Fund	2,152,500,600	Loan	Domestic
Abia	World Bank State Optimal Nutrition Project	1,000,000,000	Loan	Foreign
Adamawa	Adamawa State Immunisation Plus Malaria Progress by Accelerated Coverage and Transforming Services Project (IMPACT)	300,000,000	Grant	Domestic
Adamawa	FMOH - Saving One Million Lives Programme for Results-SOML P&R	500,000,000	Grant	Domestic
Adamawa	Mother and Child Week Outreach EU-UNICEF	7,652,000	Grant	Foreign
Adamawa	Family Health International (FHI)	76,000,000	Grant	Foreign
Adamawa	WHO, ARFH-Tuberculosis and Leprosy Control	7,700,000	Grant	Foreign
Adamawa	World Bank - Malaria Control	110,000,000	Grant	Foreign
Adamawa	TIB - Hospital Equipment	132,000,000	Grant	Foreign
Adamawa	UNFPA - Sexual and Reproductive Health	33,000,000	Grant	Foreign
Adamawa	GLOBAL FUND - Malaria Control	55,000,000	Grant	Foreign
Adamawa	Basic Healthcare Provision Fund (Federal)	550,000,000	Grant	Domestic
Adamawa	Basic Healthcare Provision Fund (State)	275,000,000	Grant	Domestic
Adamawa	Control of HIV & AIDS - World Bank	200,000,000	Aid	Foreign

Akwa Ibom	WB Neglected Tropical Diseases	100,000,000	Grant	Foreign
Akwa Ibom	EU Basic Health Care Provision Fund	354,000,000	Grant	Foreign
Bauchi	Human Resource for Health Project Activities (HWMA USAID)	21,000,000	Grant	Foreign
Bauchi	LG Contributions to Bauchi State Health Trust Fund 3% for Supervisory activities	10,000,000	Grant	Domestic
Bauchi	UNICEF Project (Core Technical Committee)	10,000,000	Grant	Foreign
Bauchi	Local Government Council Contribution BSPHCDA	50,000,000	Grant	Domestic
Bauchi	Basic Health Care Provision Funds Contribution to Primary Health Care Dev. Agency	394,221,751	Grant	Domestic
Bauchi	BMGF/Dangote Foundation - Support to Routine Immunisation	338,834,926	Aid	Foreign
Bauchi	UNICEF - Support to (Nutrition, CMAM, MNCH, Immunisation, IMCI, FP and Soc. Mobilisation)	82,200,000	Grant	Foreign
Bauchi	European Union - UNICEF	400,000,000	Grant	Foreign
Bauchi	Breakthrough Action Nigeria (BAN)	800,000,000	Grant	Foreign
Bauchi	Integrated Health Programme (IHP USAID)	1,200,000,000	Grant	Foreign
Bauchi	Advancing Nutrition (USAID)	679,788,333	Grant	Foreign

Bauchi	FHI Solution (BMGF)	30,000,000	Grant	Foreign
Bauchi	PLAN INT. Aspire Project in Health (GAC)	154,069,695	Grant	Foreign
Bauchi	World Health Organisation Aid for Bauchi State Primary Health Care Development in the State	40,000,000	Grant	Foreign
Bauchi	IMPACT Project	1,265,944,260	Loan	Foreign
Bauchi	10% BHETFUND for Secondary Facilities	38,637,500	Grant	Domestic
Bauchi	3% BHETFUND Hospitals Management Board	11,591,250	Grant	Domestic
Bauchi	Construction of ICT Infrastructure (BETFUND)	10,000,000	Grant	Foreign
Bauchi	Capital Domestic Grants (BHETFUND)	20,000,000	Grant	Foreign
Bauchi	Capital Domestic Grant (BETHFUND)	20,000,000	Grant	Foreign
Bauchi	Bauchi Health Trust Fund to Bauchi State Specialist Hospital	10,000,000	Grant	Domestic
Bauchi	1%Local Government Contribution for Health Projects	50,000,000	Grant	Domestic
Bauchi	Formal Sector Contribution to Health Care Service Delivery	350,000,000	Aid	Domestic
Bauchi	OVC Dedicated Fund (15% Social Packages)	13,350,000	Aid	Domestic
Bauchi	BHETFUND (10% Equity Trust)	68,886,000	Grant	Foreign
Bauchi	1% LGA Contribution for	90,587,531	Grant	Domestic

	Health Care Service Delivery			
Bauchi	Federal Government Basic Health Care Provision Fund	350,000,000	Grant	Domestic
Bauchi	1% of Each LGCs Monthly Statutory Allocation for Health Care Service Delivery	91,358,155	Grant	Domestic
Bauchi	Endowment from Individuals for Health Care Service Delivery	35,161,172	Aid	Domestic
Benue	Current Foreign Grants: World Bank-HIV III Programme	10,000,000	Grant	Foreign
Benue	Foreign Aid: United Nations Development Programme - Human Capital Development (State-Wide)	30,000,000	Aid	Foreign
Benue	Current Domestic Aid - Saving One Million Lives (SOML)-Maternal and Child Health (World Bank)	1,200,000,000	Grant	Foreign
Benue	A grant from Saving One Million Lives (SOML) Benue State Ministry of Health (SMoH) - World Bank	25,000,000	Grant	Foreign
Benue	National Health Insurance Scheme (NHIS) Contribution for Basic Health Care Provision Fund (BHCPF)	495,672,000	Grant	Domestic
Benue	National Primary Health Care Development	400,000,000	Grant	Domestic

	Agency (NPHCDA) Decentralised Facility Financing - DFF for Basic Health Care Provision Fund (BHCPF)			
Benue	Current Domestic Grants: AIDS Prevention Initiative in Nigeria (APIN)/(ICRC) Public Health Initiative	10,000,000	Grant	Domestic
Benue	Current Domestic Grants: Immunisation Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACT), World Bank	1,500,000,000	Grant	Foreign
Benue	Current Domestic Grants: Basic Health Care Provision Fund (BHCPF)	488,667,319	Grant	Domestic
Benue	Current Domestic Grants: Local government Health Authorities (LGHA)	14,200,000	Grant	Foreign
Borno	Donor Agencies (Individual Organisation Philanthropist): Provision of Electricity	10,500,000	Grant	Domestic
Borno	FGN Grant For Basic Healthcare Provision Fund: Contributory Healthcare Programme	544,882,000	Grant	Domestic
Borno	75% Dangote Foundation, 25% PHC MOU: Rehabilitation of Hospital / Health Centres	127,656,000	Grant	Domestic
Borno	45% of 1% FGN-CRF for BHCPF: Rehabilitation of	389,042,000	Grant	Domestic

	Offices.			
Borno	United Nations Children's Fund (UNICEF PHC Services): Acquisition of Computer Software.	500,000,000	Grant	Foreign
Borno	75% of Bill & Milinda Gate Foundation, 25% PHC MOU: Control of Outbreak of Communicable Diseases, Funds, Nutrition, Reproductive Health and Family Planning Programmes.	250,000,000	Grant	Foreign
Cross River	State Malaria Elimination Programme (SMEP)	75,604,075	Grant	Domestic
Ebonyi	Expected Receipt for Primary Health Care	200,000,000	Grant	Domestic
Ebonyi	Basic Health Care Provision Fund to Ebonyi State Health Insurance Agency	400,000,000	Grant	Domestic
Edo	FGN/IFAD Livelihood Improvement Family Enterprises - Niger Delta (LIFE-ND) Project	600,000,000	Loan	Foreign
Edo	FGN Health Intervention Fund	500,000,000	Grant	Domestic
Ekiti	Immunisation Plus and Malaria Progress by Accelerating Coverage and Transforming Service (IMPACT) Projects	506,820,458	Grant	Foreign
Ekiti	National Programme for Immunisation (NPI) and Integrated Material Childhood Illness	25,000,000	Grant	Foreign

	(Nutrition)			
Ekiti	Immunisation Programme	120,000,000	Grant	Foreign
Ekiti	National Primary Health Care Development Agency (NPHCDA) Gateway	238,000,000	Grant	Domestic
Ekiti	Basic Health Care Provision Fund	200,000,000	Grant	Foreign
Enugu	Health Reform Programme (FMCH)	125,000,000	Grant	Domestic
Enugu	Basic Healthcare Provision Fund	1,000,000,000	Grant	Domestic
Gombe	Health System Support	100,000,000	Grant	Foreign
Gombe	Basic Health Care Provision Fund	1,200,000,000	Grant	Domestic
Gombe	Gombe State Malaria Elimination Program	1,300,000,000	Grant	Foreign
Imo	Tuberculosis Control Programme	100,000,000	Grant	Domestic
Imo	Tuberculosis Control Programme Public Health Department, Ministry of Health	76,257,600	Grant	Domestic
Imo	Imo-China Educational Programme (Project to be financed by China-SICAS Qinugo City Educational Board China) (Imo-China Investment and Trade Centre)	20,000,000	Grant	Foreign
Imo	UNFPA Asst. Projects Under Min. of Health	87,733,099	Grant	Foreign
Imo	Leprosy and Buruilli Alcer Control Programme	5,000,000	Grant	Domestic

Imo	Tuberculosis Control Programme	29,379,733	Grant	Domestic
Imo	UNFPA Asst. Projects Under Min. of Health	87,733,099	Grant	Foreign
Imo	UNICEF Assisted Projects (Ministry of Health)	226,549,765	Grant	Foreign
Imo	Imo State Primary Health Care Development Agency (ISPHCDA)	596,160,000	Grant	Foreign
Imo	UNICEF Assisted Projects (Ministry of Health)	226,549,765	Grant	Foreign
Jigawa	Basic Healthcare Provision Fund Receipts	800,000,000	Grant	Domestic
Jigawa	Basic Healthcare Provision Fund Receipts	485,000,000	Grant	Domestic
Jigawa	UNICEF Primary Healthcare Grants	330,000,000	Grant	Foreign
Jigawa	Global Alliance for Vaccine (GAVI) Fund Grants	670,000,000	Grant	Domestic
Jigawa	Local Govt Capital Contributions for Basic Healthcare	122,000,000	Grant	Domestic
Jigawa	Local Government Reimbursement - 60% PHCD Staff Cost	5,106,000,000	Grant	Domestic
Kaduna	Construction and equipping of 300-bed Specialist Hospital Project (IsDB)	15,230,950,000	Loan	Foreign
Kaduna	Neglected Tropical Disease Control Programme (ONCHO)	138,000,000	Grant	Foreign

Kaduna	Kaduna State Tuberculosis and Leprosy CP Drug Resistant TB (DRTB)	417,290,463	Grant	Foreign
Kaduna	Strengthen the system for quality assurance and quality control of malaria diagnostic treatment (Malaria Programme)	4,882,751,826	Grant	Foreign
Kaduna	PHC and Routine Immunisation MoU (BMGF/DfID/UNICEF)	252,000,000	Grant	Foreign
Kaduna	Basic Health Care Provision Fund (BHCPF) - SPHCB	1,017,000,000	Grant	Domestic
Kaduna	60% Contribution from LG for PHC's Capital Projects	3,640,075,515	Grant	Domestic
Kaduna	Basic Health Care Provision Fund (BHCPF) - KADCHMA	540,782,965	Grant	Domestic
Kano	LGCs Contribution for Technical Schools (MoE)	55,000,000	Grant	Domestic
Kano	BUA Foundation Grant for Malaria & Polio Eradication Support	40,000,000	Grant	Domestic
Kano	Dangote Foundation Malaria Intervention Grant	42,000,000	Grant	Domestic
Kano	Grant from UNICEF for Implementation of Health, EASH, Nutrition and other Related Programmes	940,578,656	Grant	Foreign
Kano	World Bank Saving One Million Lives for Result Project	500,000,000	Grant	Foreign
Kano	Certification of ODF-	45,000,000	Grant	Foreign

	claimed communities (UNICEF-supported grant)			
Kano	Routine Immunisation Against Early Child Diseases Support Grant from Dangote	274,588,686	Grant	Domestic
Kano	Basic Health Care Provision Fund (BHCPF) - FGN Grant	1,950,000,000	Grant	Domestic
Kano	Global Fund for Malaria	417,189,875	Grant	Foreign
Kano	1% Grant from LG for Health trust fund	820,984,228	Grant	Domestic
Kano	Grant from NPHCDA to PHCMB	1,000,000,000	Aid	Domestic
Kano	1% CRF Equity (Vulnerable) (KACHIMA)	964,338,272	Grant	Domestic
Katsina	Clinton Health Access Initiative (CHAI) Aid	44,255,090	Aid	Foreign
Katsina	Noor Dubai Foundation Aid to Support Eye Surgery	89,782,500	Aid	Foreign
Katsina	Global Fund on Malaria & Tuberculosis Commodities	6,161,843,096	Aid	Foreign
Katsina	Local Govt. Contribution to free Medicare Scheme for Pregnant & Children Under 5yrs (IR)	122,400,000	Grant	Domestic
Katsina	Polio Eradication and Routine Immunisation Programme (UNICEF) ER	668,988,865	Aid	Foreign
Katsina	Basic Health Care Provision Funds FGN (1% of FGN Statutory Allocation) (IR)	575,071,399	Aid	Domestic

Kebbi	Primary Healthcare Under One Roof (African Development Bank Loan)	1,000,000,000	Loan	Foreign
Kebbi	USAID Support for Human Resource for Health (HRH)	2,500,000,000	Grant	Foreign
Kebbi	GAVI Support on Health System Strengthening (HSS)	681,884,593	Grant	Foreign
Kebbi	Primary Healthcare Under One Roof (local government grants)	860,000,000	Grant	Domestic
Kebbi	National Health Insurance Scheme (NHIS)	1,200,000,000	Grant	Domestic
Kebbi	Integrated Health Programme (IHP) USAID Grant	5,263,515,570	Grant	Foreign
Kogi	Save One Million Lives (Programme for Result)	200,000,000	Grant	Domestic
Kogi	Accelerating Nutrition Results in Nigeria	100,000,000	Loan	Foreign
Kogi	5% Basic Salary State Government Contribution for Formal Sector Health Insurance Scheme	1,564,000,000	Grant	Domestic
Kogi	Basic Healthcare Provision Fund (BHCPF)	500,000,000	Grant	Foreign
Kogi	Immunisation Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACTS)	900,000,000	Loan	Foreign
Kwara	Federal Ministry of Health Support for NPI Activities	4,000,000,000	Aid	Domestic

Kwara	World Bank Support for Neglected Tropical Diseases	7,259,740,000	Aid	Foreign
Kwara	FG PEPFAR Contribution for the control of HIV/AIDS	385,310,547	Grant	Domestic
Kwara	FG Global Fund Support on Malaria and HIV/AIDS	306,217,502	Grant	Domestic
Kwara	FG Grant on Basic Health Care Provision Fund (BHCPF)	644,854,565	Grant	Domestic
Kwara	World Bank Loan on Immunisation Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACT)	250,000,000	Loan	Foreign
Lagos	Macey Health Initiative, Private Domestic Support	45,511,805	Aid	Domestic
Lagos	Youth Power Ecosystem 4 Adolescent Health (YPE4AH) (Organised Private Sector)	622,500,000	Aid	Domestic
Lagos	Malaria diagnostic testing and conditional subsidies to target ACTs in the retail sector: The TESTsmART trial	539,500,000	Aid	Foreign
Lagos	TB, Leprosy and Buruli Ulcer Control Program (TB-LON 3 Project)	197,647,070	Aid	Foreign
Lagos	Donation of 8 MICU Ambulances	305,297,655	Aid	Domestic
Lagos	Support to improve maternal and newborn health	207,500,000	Aid	Foreign

Lagos	Accelerating TB Case Notification in Lagos State	6,309,641,140	Aid	Foreign
Lagos	Several activities aimed at supporting the health system at all levels to have strengthened organisational capacities and systems to provide services for the prevention and treatment of HIV in women, children, adolescents, and young people, including in emergencies	12,450,000	Aid	Foreign
Lagos	Children, adolescents, and women have equitable access to and use improved and quality, high-impact maternal, neonatal and child health interventions and adopt healthy life practices.	30,556,035	Aid	Foreign
Lagos	Strengthened national capacity and delivery of routine immunisation	12,450,000	Aid	Foreign
Lagos	UNITAID funded Secondary Prevention of Cervical Cancer using optimal screening and treatment models	1,909,000,000	Aid	Foreign
Lagos	Strengthening Resilient and Sustainable Systems for Health in Lagos State	162,469,292	Aid	Foreign
Nasarawa	AHF donation of Condoms @162,000*8	1,296,000	Grant	Foreign
Nasarawa	Domestic Commercial Bank Loan for Nasarawa	1,000,000,000	Loan	Foreign

	Infectious Disease & Research Centre			
Nasarawa	World Bank Grant for Intervention in the Health Sector	700,000,000	Grant	Foreign
Nasarawa	Federal Government Project (BHCPF) For PHCs	229,048,745	Loan	Domestic
Nasarawa	UNICEF Support for Immunisation	240,000,000	Grant	Foreign
Nasarawa	Support from the World Bank for the Health Sector	100,000,000	Grant	Foreign
Nasarawa	National Council of Disease Control (NCDC)- 800 Nos. of Deep Freezers	6,500,000	Other	Domestic
Nasarawa	National Council of Disease Control (NCDC) 350kg Meent Incinerator	60,000,000	Other	Domestic
Nasarawa	Save One Million Lives (SOML) (Re-Roofing Admin Block)	14,500,000	Other	Domestic
Nasarawa	Support from Achieving Health Nigeria Initiative (AHNI)	6,000,000	Aid	Foreign
Nasarawa	Support from Equitable Health Access Initiative (EHAI)	7,000,000	Aid	Foreign
Nasarawa	Anti Malaria Grant from World Bank	450,000,000	Grant	Foreign
Niger	Basic Health Provision Fund (BHCPF) (FGN) Provision of a minimum package of Health Service & Fiscal Space for PHCs	1,043,922,698	Grant	Domestic

Niger	Strengthening the Primary Health Care System (Primary Health Care under one Roof)	210,076,426	Grant	Foreign
Niger	Nutrition Coordination, Provision of Commodities & Scale-up of Nutrition Sites from United Nations Children's Fund (UNICEF)	163,000,000	Grant	Foreign
Niger	Centre for Clinical Care and Clinical Research/Accelerating Control of the Epidemic (CCCR/ACES)	227,091,700	Grant	Foreign
Niger	Society For Family Health (SFH)	475,580,523	Grant	Foreign
Niger	SFH/USAID/ICHSSA	237,790,261	Grant	Foreign
Niger	Clinton Health Access Initiative	30,000,000	Grant	Foreign
Niger	Heartland Alliance (USAID): HIV Health prevention Services, Trauma & Mental Health Treatment Services	235,785,200	Grant	Foreign
Niger	Malaria Consortium (WHO) Universal Health Coverage, reduction in Malaria & other Communicable Diseases	860,000,000	Grant	Foreign
Niger	Management Science for Health (MSH) Integrating HIV & AIDS into PHC (PEPFAR)	165,000,000	Grant	Foreign
Niger	Neglected Tropical Diseases Control, Treatment and Prevention (NTD)	67,000,000	Grant	Foreign

Niger	Integrated Disease Surveillance Report (IDSR) Outbreak Response/Emergency Operation Centre (EOC)	1,838,055,166	Grant	Foreign
Niger	Palladium Data FI Improved Covid-19 Response	1,700,000	Grant	Foreign
Niger	CoPREP (WB): upgrading of Response Laboratory, Provision of Lab Equipment & Vaccination	1,559,507,277	Grant	Foreign
Niger	Tuberculosis and Leprosy Control Programme	132,689,768	Grant	Foreign
Niger	Health Promotion "Routine Humanisation Governance"	68,500,000	Grant	Foreign
Niger	Routine Immunisation Health System Strengthening	643,629,029	Grant	Foreign
Niger	Smile For Mother's Reducing Maternal Death caused by Postpartum Haemorrhage	45,000,000	Grant	Foreign
Niger	Accelerating Nutrition Results in Nigeria (ANRiN/WB) Provision of basic nutrition package for under five	1,167,619,896	Grant	Foreign
Ogun	Basic Health Care Project (WHO, UNICEF AND UNFPA)	373,000,000	Grant	Domestic
Ondo	Grants from WHO, UNFPA and Public Private Mix Intervention Fund on Human Health Promotion	61,200,000	Grant	Foreign

Ondo	Domestic Grant from FGN in Support of Implementation of Contributory Health Insurance Scheme	320,000,000	Grant	Domestic
Ondo	Health Insurance Contribution to Health Insurance Scheme	720,000,000	Other	Domestic
Osun	Grant From Global Fund for Malaria and Tuberculosis Control Project - for Capital Expenditure	1,851,153,200	Grant	Foreign
Osun	Grant From Global Fund for Malaria and Tuberculosis Control Project - For Recurrent Expenditure	128,545,790	Grant	Foreign
Osun	Health Insurance Premium Paid on Behalf of Vulnerable Population from Federal Government	482,292,000	Grant	Domestic
Osun	Foreign Grants from UNICEF For Primary Health Care Projects	831,022,000	Grant	Foreign
Osun	A grant from Basic Health Care Provision Fund for Direct Facility Funding (DFF), Community Health Influencers Promoters and Services (Chips) and Midwives Engagement	617,346,300	Aid	Domestic
Osun	Domestic Aid from the Federal Government for the Procurement of Drugs and Medical Consumables to Primary	61,000,000	Aid	Domestic

	Health Facilities in the State			
Osun	Foreign Grants from UNICEF for Primary Health Care Projects	18,592,000	Grant	Foreign
Oyo	Grant for Health Impact from the World Bank	866,900,000	Grant	Foreign
Oyo	Primary Health Care Board	2,496,255,885	Grant	Domestic
Plateau	Malaria Control Programme	12,000,000	Grant	Foreign
Plateau	River Blindness	5,578,400	Grant	Domestic
Plateau	TB/Leprosy Control	218,640,000	Grant	Foreign
Plateau	T.B. AND Leprosy Control	20,000,000	Grant	Foreign
Plateau	LYMPHATIC FILARIASIS	8,000,000	Grant	Foreign
Plateau	NHIS - BHCPF	60,000,000	Grant	Domestic
Plateau	Presidential Malaria Initiative for State	3,900,000,000	Grant	Foreign
Plateau	Capital Domestic Aids	157,000,000	Aid	Domestic
Plateau	Carter Centre	50,000,000	Aid	Foreign
Plateau	Lymphatic Filariasis	600,000	Grant	Foreign
Plateau	Plateau State Agency for Control of AIDS	85,000,000	Grant	Foreign
Sokoto	Integrated Health Programme (USAID)	200,000,000	Grant	Foreign
Sokoto	Primary Health Care Under One Roof	300,000,000	Grant	Domestic
Taraba	UNICEF AID to Taraba Agency for Control of HIV/AIDs	25,000,000	Grant	Foreign
Taraba	UNICEF AID to support	107,308,396	Grant	Foreign

	Primary Healthcare and Education			
Taraba	Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM)	360,000,000	Grant	Foreign
Taraba	World Health Organisation (WHO) Grant for Children Good Nutrition and Healthcare	100,000,000	Grant	Foreign
Taraba	National Agency for the Control Aids-State Programme Implementation Unit (NACA SPIU)	50,000,000	Grant	Foreign
Taraba	UNICEF Grant for Health Activities in the State	20,000,000	Grant	Foreign
Taraba	Marie Stopes for Healthcare Sexual Reproduction	30,000,000	Grant	Foreign
Taraba	Global Alliance on Vaccine and Immunisation/UNICEF Grant for Public Health Service	595,262,648	Grant	Foreign
Taraba	Helen Keller International Support to Maternal and Child Health Weeks	150,000,000	Grant	Foreign
Taraba	WHO grant for primary healthcare delivery	250,000,000	Grant	Foreign
Taraba	UNICEF Grant for Basic Health Care Provision Fund for Primary Care Health Facilities in the State	261,769,994	Grant	Foreign

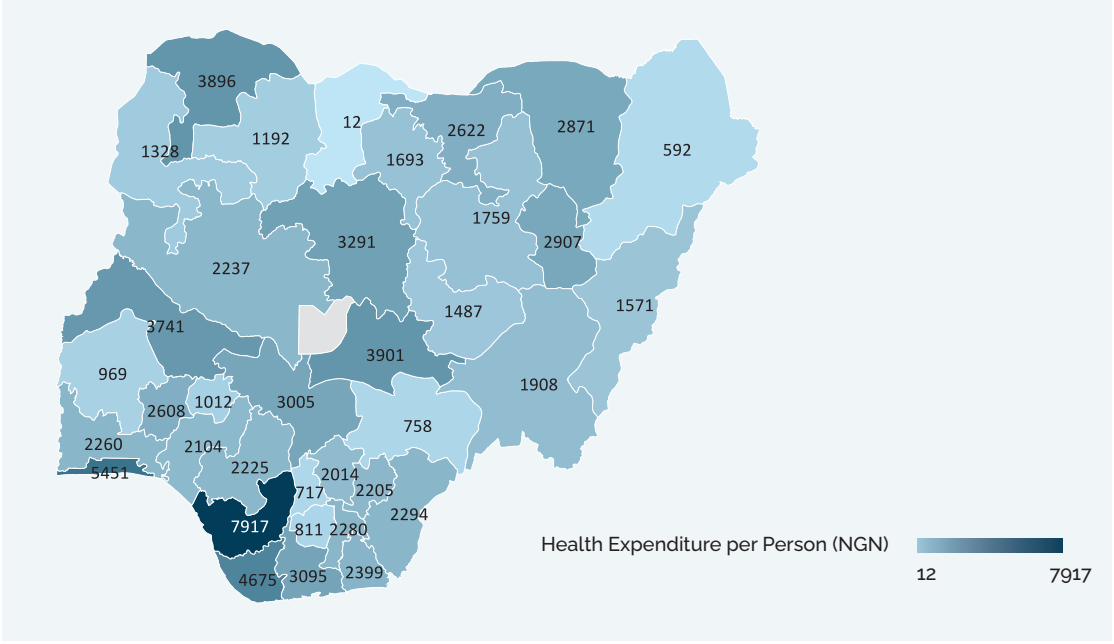
Taraba	Marie Stopes for Healthcare Sexual Reproduction	150,000,000	Grant	Foreign
Taraba	Management Science for Health (MSH) on Malaria Control	100,000,000	Grant	Foreign
Taraba	North East Development Commission to Provide Support on Essential Drugs	260,000,000	Grant	Foreign
Taraba	RISE Support on HIV/AIDS Control Activities	250,000,000	Grant	Foreign
Taraba	KNCV & TB Foundation to Control Tuberculosis	150,000,000	Grant	Foreign
Taraba	SYDANI to Provide Logistics for Health Commodities	5,000,000	Grant	Foreign
Taraba	Rotary to Support Immunisation Awareness/POLIO Eradication	5,000,000	Grant	Foreign
Taraba	Red Cross to Provide Support during Accidents & Emergencies	15,000,000	Grant	Foreign
Yobe	FGN Basic Health Care Provisional Fund (BHCPF)	600,000,000	Grant	Foreign
Zamfara	World Bank Grant for GAVI Programme	2,000,000,000	Grant	Foreign

2.9 Distribution of Health Resources

This section seeks to highlight equity considerations of health interventions in the country. Equity in health financing is crucial for achieving health-related goals,[5] including UHC, human capital development (HCD), the Sustainable Development Goals (SDGs), and emergency preparedness (UNDP, 2019). Equity means ensuring that everyone has fair access to healthcare, regardless of their socio-economic status, gender, place of residence, or other characteristics. In 2022, State governments spent an average of N2,383.54 (US$5.63 at the 2022 average rate of N423.41 to 1 US$) on healthcare per person.[6] This amount varied considerably by State, with Delta N7,917 (US$18.70) and Lagos N5,451 (US$12.88) spending multiple times higher than most, and 6 States spending below N1,000 (US$2.35) per person. The wide disparity in healthcare spending across States is creating a multi-tiered healthcare system, where access to quality care depends on where people live.

The World Health Organisation (WHO) recommends a minimum investment of US$86 per person to address basic healthcare needs. While this report acknowledges the challenges of reaching this benchmark due to Nigeria's competing development priorities, the current spending falls far short of the current means. This underfunding is impeding the functionality of the healthcare system to serve the population effectively.

Figure 11: Spending Gap: How much does your State invest in your health?



Source: Calculated based on data from the 2022 Audited Financial Statements of States and projected data from the 2020 NBS Demographic Statistics Bulletin.

[5]The WHO's cross-programmatic efficiency analysis is a diagnostic approach used to identify key inefficiencies within and across health programmes and the overall health system that constrain the system.
[6]Calculated based on actual health expenditure for the year and population data projected from the NBS Demographic Bulletin (NBS, 2020).

Equitable financing for healthcare is a significant challenge in the country. An equitable health system ensures that the poor and vulnerable populations have access to health services and financial protection against spending shocks which are capable of driving people into poverty. Equity in health financing also enhances emergency preparedness by ensuring that essential health services are available and accessible to everyone during times of crisis, such as epidemics, natural disasters, and conflicts. The BHCPF is programmed to address significant measures of equity in care provision for the poor and vulnerable. It allocates resources for a package of essential services for women and children delivered through PHCs nationwide. Analysing BHCPF spending can provide valuable insights into how resources are used for these priority groups.

Some States provide free maternal and child health services such as Enugu and Ekiti, while others like Jigawa, recognising the vulnerability of the elderly, allocate budgets for their care. However, tracking these expenditures is not possible due to similar reasons mentioned earlier. In Kaduna State, the government dedicates 1% of its CRF to fund a social security trust fund targeted at poor and vulnerable households, but this fund also faces typical operational challenges due to delayed releases and insufficient cash backing.

There are also concerns about the lack of equity consideration in the design and delivery of the vertical health programmes in the mould of NMEP, TB/HIV programmes and other similar programmes. The BMPHS[7] does not adequately address gender and equity issues. Women and adolescent girls outside of pregnancy who are potentially vulnerable and in need of support to ensure they receive the care they need, are not recognised in the BHCPF classification of vulnerable groups. Young people also have unique health needs and are faced with challenges in accessing healthcare, such as poor access to comprehensive sexuality education, contraception information and services and youth-friendly sexual and reproductive health services. Their inability to obtain quality sexual and reproductive health information and services significantly contributes to early childbearing, which has a detrimental impact on the wellbeing of young mothers.

National programmes such as the National Integrated Maternal, Newborn and Child Health (NIMNCH) Strategy and the National Malaria Elimination Programme (NMEP) are also aimed at the most vulnerable population groups. These government-led initiatives aim to improve access to quality maternal and child health services (MCH) and combat malaria. There are however challenges in measuring their effectiveness and equity impact. The funding sources for such programmes are multiple, vertical and spread across the tiers of the health system. Many of the interventions reviewed did not specify baselines, outcomes/impacts or clear metrics for assessing progress and outcomes as required.

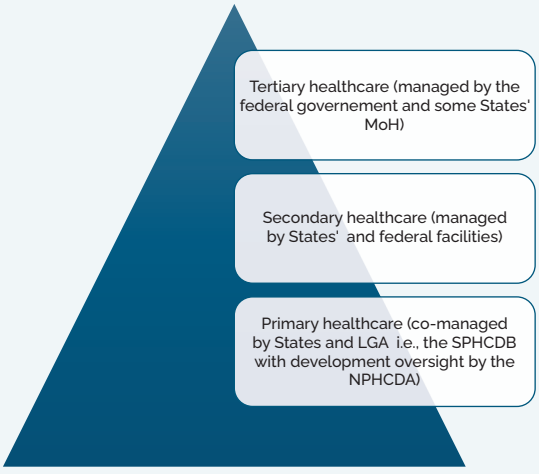
[7]Basic Minimum Package of Health Service Package defined in the NHSDP2 (2018-2022)

3. Institutional Review

3.1 Inventory of Key Players

This section examines the institutional arrangements for healthcare delivery at the state level. It describes the roles and responsibilities of various government agencies and institutions involved in policymaking, planning, management, and coordination. The broad process and structure for healthcare delivery in Nigeria are outlined below with the designated entry point being the primary healthcare level. Federal, State, and local governments all share the responsibility of overseeing and managing the different levels of healthcare delivery in the country. The concurrent legislative right of the federating units effectively enables the States to manage care delivery across primary, secondary and even tertiary levels, although traditionally, primary healthcare delivery has been the purview of State and local governments.

Figure 12: Three Broad Levels of Care Delivery in Nigeria



The key national institutions for healthcare delivery are outlined in Table 8, with State equivalents in most cases required to help organise healthcare delivery at the sub-national level where they have a core responsibility for primary care delivery. The National Council on Health serves as the central authority for healthcare policymaking in Nigeria, guiding the development and implementation of a coordinated national healthcare delivery system.

Table 8: Federal Health Institutions and their Mandates

1. **National Council on Health**	The highest policymaking body for healthcare in Nigeria.
2. **Federal Ministry of Health (FMoH)**	Supervisory and Policy direction of the national health system.
3. **National Health Insurance Authority (NHIA)**	Oversees the national health insurance scheme and provides accessible, affordable, and qualitative healthcare for all Nigerians.
4. **National Primary Health Care Development Agency (NPHCDA)**	Responsible for improving the effectiveness and efficiency of primary health care delivery. The agency aims to create healthy communities across Nigeria and make health and well-being a priority for everyone, especially the most vulnerable.
5. **Nigeria Centre for Disease Control and Prevention (NCDC), and the Public Health Laboratories**	The national public health institute with the mandate to lead the preparedness, detection and response to infectious disease outbreaks and public health emergencies.
6. **Nigerian Institute of Medical Research (NIMR)**	Responsible for conducting research into diseases of public health importance in Nigeria and developing structures for the dissemination of research findings while providing the enabling environment and facilities for health research and training in cooperation with the federal and State ministries of health
7. **National Institute for Pharmaceutical Research and Development (NIPRD)**	Mandated to apply appropriate modern science and technological resources to stimulate the local production of drugs through effective collaboration with the industry and experts within and outside Nigeria. To develop herbal and phytomedicines to pilot the state of commercialisation and quality standards for phytomedicine.

8.	**National Agency for Food and Drug Administration and Control (NAFDAC)**	Charged with the responsibility to protect and promote public health by instituting an effective and efficient regulatory system that ensures only the right quality food, drugs and other regulated products are manufactured, exported, imported, advertised, distributed, sold, and used.
9.	**National Agency for the Control of AIDS (NACA)**	A multi-sector HIV response agency with a significant health expenditure profile. NACA was established in February 2000 to coordinate the activities of HIV/AIDS in the country.
10.	**Hospitals and Federal Medical Centres/Training Centres**	Service delivery windows of the federal government mostly consist of specialist healthcare facilities incorporating health staff training institutions.
11.	**Research and Regulatory Agencies**	Research institutes and regulatory bodies of health professionals (quasi-agency of government).

At the State level, there is an archetypical institutional arrangement that is modelled after the national structure. State health institutions are listed in Table 9 with their core functions, accountability lines as well as their scope and funding sources. Mirroring the national structure, each State has a State Council on Health which functions as the State's premier healthcare policymaking body. It fosters collaborative planning, policy alignment with national goals, and strategic direction for health initiatives within the State. The Council also facilitates coordination and harmonisation of health activities and interventions across various stakeholders. This report notes that in many States, these Councils meet infrequently due to factors ranging from low political will and convening power, lack of funds and limited coverage of policy grounds. Some States have not held a meeting since their Council was established

Table 9: State Health MDAs and Accountability Lines

Institution	Core Function	Core funding source	Accountability lines	Scope/Tiers
1. State Council on Health	The State Council on Health is the highest public health policy-making body in the State.	• State budget • Project-based funding from external sources like donors or NGOs.	• State Executive Council (ExCo) • Ministry of Health	Primary Secondary and Tertiary health services
2. State Ministry of Health	Policy, planning, supervision, and coordination of the health sector	The State government health budget shared among the components of the sector	ExCo	Primary and Secondary or Tertiary
3. State Primary Health Care Development Agency/Board	Control and management of the primary health care facilities and services in the State	Component budget	• ExCo • Ministry of Health • NPHCDA • SPHCDA Board • Chairmen of the LG Authorities	Primary
4. Hospital Management Board	Management of the hospitals/secondary health facilities[8]	Component budget	• ExCo • Ministry of Health • Agency Board	Secondary

[8]Teaching hospitals operate under their legal frameworks and are primarily accountable to the Governor through their management boards. While the Health Commissioner doesn't directly oversee them, they do represent the hospitals' concerns and defend their funding requests before the Executive Council (ExCo).

5. State Health Insurance/ Contributory Schemes[9]	Management of the State UHC /health schemes	Component budget	• ExCo • Ministry of Health • SHI Board • NHIA	Primary, Secondary and Tertiary
6. Drug Management Agency	Drug revolving fund /procurement and sale of drugs and consumables	Component budget	• ExCo • Ministry of Health • DMA Board	Primary, Secondary and Tertiary healthcare facilities
7. Health Training Institutions • Schools of Health Technology • University and Colleges/ Schools of Nursing	Training of all categories of health professionals ranging from medical doctors and pharmacists to nurses with Bachelor's degrees (BScN). It also includes training for allied health professionals like medical rehabilitation therapists and mid-cadre health technologists such as Community Health	Component budget	• ExCo • Ministry of Health • Various Boards and Senate per the Universities	Primary, Secondary and Tertiary

[9]There are multiple accountability lines for this agency. Funds in aid and cash come from multiple streams including the federally managed NHIA that competes with and regulates the operations of the SSHIAs.

		Extension Workers (CHEWs), medical laboratory technicians, and pharmacy technicians. Finally, the system provides training for nursing leadership roles, specifically Registered Nurses (RNs) and Registered Midwives (RMWs).				
8.	Local Government Health Authority	Local government-level control and management of Primary Healthcare facilities and personnel under the superintendence of the SPHCDAs.	LG budget	SPHCDA	Primary	
9.	Private sector Investors, Faith Based Organisations, Community, /Philanthropy	Management of health facilities and institutions	Private funds	Boards	Primary, Secondary and Tertiary	

10. Households/ Individuals	Purchase of health services	Out-of-pocket expense (OOPE)	None	Primary, Secondary, and tertiary
11. Donors/ Partners	Support of varied health interventions across the country	Donor funds	Federal, State or Local government, Donor	Mainly primary and secondary

This report identified levels of fragmented health governance in many States, with records of the following:

- **Multiple Sources of Funds:** State health spending comes from various sources beyond the government's budget allocation, including philanthropy, community contributions, private sector investors and out-of-pocket payments. In many cases, there are multiple funding streams for the implementation of health programmes.
- **Diffused Accountability:** Health institutions answer to multiple entities, including the Health Commissioner (HCH), a Board of Directors, the State Executive Council and the Governor. This can make it difficult to hold anyone accountable for results. For donor programmes, implementing partners are primarily accountable to their funders rather than the State, creating disparate measures of health programmes' effectiveness and reporting structures.
- **Limited Coordination:** There's a lack of collaboration and cooperation among health agencies resulting in the duplication of effort, waste, and a fragmented healthcare system.
- **Staff Disparity and Sustainability:** Donor-funded programmes employ or train dedicated staff for their projects. These staff receive better compensation and working conditions compared to their government counterparts. This disparity can create tension and raise concerns about long-term sustainability once donor funding ends.

3.2 Flow of Funds

While government budget allocations form the core, it is not the primary source of health financing as previously established. Individuals significantly contribute through out-of-pocket payments and insurance, including for essential services. Philanthropic donations from organisations and individuals also play a vital role, supporting infrastructure development to patient bills. Private investors are also joining the mainstream, establishing healthcare facilities and providing specialised services, while communities are stepping up to raise funds to support specific healthcare initiatives.

3.2.1 Public Health Budgeting

At the overarching level, State governments follow a multi-step process for public health budgeting. This is described in Table 10.

Table 10: State Budgeting Process

S.N	Budget Activity	Responsibility
Budget Planning and Preparation		
1	Sector Performance/ Review (previous year's Budget Performance Report)	Health Sector MDAs with support from the Ministry of Budget and Planning
2	Collection of spending, revenue and expenditure performance data - budgeted and actual, macroeconomic indicators etc. for the preparation of the Economic and Fiscal Update (EFU), Fiscal Strategy Paper (FSP) and the Budget Policy Statement (BPS) - EFU-FSP-BPS	Health Sector MDAs
3	Issue Budget Calendar	Ministry of Budget and Planning
4	Preparation of the EFU-FSP-BPS	Ministry of Finance, Ministry of Budget and Planning, Office of the Accountant General, State Internal Revenue Service, and other relevant MDAs
5	Submit EFU-FSP-BPS draft to ExCo	Ministry of Finance, and Ministry of Budget and Planning
6	Exco's review of the EFU-FSP-BPS document	Executive Council
7	Submission of the EFU-FSP-BPS document to, and approval by SHoA	State House of Assembly
8	Medium Term (3-year) sector ceilings circulated (indicative ceilings may be issued earlier)	Ministry of Budget and Planning
9	Develop/ Update Medium Term Sector Strategies	Health Sector MDAs/ Sector Teams
10	Issue Budget Call Circular	Ministry of Budget and Planning
11	Preparation and submission of the 1st draft budget (incorporating updated MTSS budgets) by MDAs	Health Sector MDAs/ Sector Teams/ Budget Department
12	Collation of MDAs 1st budget draft	Ministry of Budget and

		Planning
13	MDAs Budget Defence/ negotiations	Health Sector MDAs/ Ministry of Budget and Planning
14	Revision of draft submission of budget estimates	Ministry of Budget and Planning
15	Consolidation of MDA budget estimates	Ministry of Budget and Planning
Budget Approval		
16	Submission of draft budget estimates to the ExCo	Ministry of Budget and Planning
17	Further revision and resubmission to the ExCo/Governor	Ministry of Budget and Planning
18	ExCo presentation of the budget proposal to the State House of Assembly	Governor
19	House of Assembly review and passage/Presentation for Governor's Assent	SHoA
20	Budget sign-off by the Governor	Governor
21	Public presentation of the Approved Annual Budget	Commissioner of Budget and Planning, Commissioner of Finance, and other key PFM actors.
22	Publication of the Budget, including Citizens Budget, online	Ministry of Budget and Planning
'Floating' Activities		
A	Internal budget retreats, for example for budget planning and budget presentations.	Various
B	External budget retreats, for example, stakeholder/ CSO engagement in Sector Reviews, EFU/FSP/BPS preparations, and MDA budget preparation.	Various

Although this is the general framework for health budgeting, slight variations exist from State to State, such as the level of interaction with civil society and community members, and the quality of sector performance reviews. Once funds are appropriated, the Commissioner for Health submits requests in the form of memos to the Executive Council (ExCo) for specific allocations to health agencies. Recurrent

expenses (overhead and salaries) are typically disbursed directly without explicit requests and approvals.

The report notes challenges in the oversight of partner funds by State governments. In many States, partners are responsible for managing their allocated funds to carry out State health programmes.. Implementing partners report to their donors, not the State, creating a potential for duplicate funding streams for programmes. Attempts at partner basket funding mechanisms have seen limited success due to partners' preference to retain control over their funds and limited transparency on spending plans and actual expenditures. This could weaken the sector-wide approach (SWAp) or basket funding concept of managing health funds. Intergovernmental health activities are also disrupted by ad-hoc state budget allocations, which complicate reporting, accountability, and overall programme management. For instance, the M&E processes of such interventions including data utilisation and availability are operationally challenged by the line of data reporting being to the donor instead of the government. This makes it difficult to access and accept such data for use.

3.2.2 Health Budget Management Centres

There are about 10 health budget management centres in each State (see Table 12). The report notes that these centres receive frequent streams of resources that are not captured in the health budget. For instance, the State Primary Health Care Development Boards (or Partners) receive sundry support including training and supplies from their national counterparts that are not captured in the State health expenditure. Each institution has its budgetary provision and is expected to apply for the release of budgeted funds or as in the approved procurement plan through a memo presented by the HCH.

Table 11: Major Budget Management Centres and Agencies of the Ministry of Health, Federal and States

Institutions and Programmes	Primary Funding Stream
Federal Ministry of Health, NIMR, NPHCDA, NACA, NIPRD, NHIA, Federal Medical Centres, Federal Teaching Hospitals, and allied institutions including training schools, public health labs, health regulatory councils and limited support to State health instititions.	**FGN Health Budget** Disbursed to implementing Health MDAs and majority domiciled at the NPHCDA. **Basic Health Care Provision Fund** (direct deduction from the CRF ~1%) funding PHC development and the provision of basic health services to the poor. Some subventions from States.
State Ministry of Health, SPHCDA, HMB, SSHIA, DMA, State Hospitals, PHCs, Teaching Hospitals, health training institutions and limited support to the LG health system	**State Budget**
Local Government PHC facilities and sundry health activities and programmes including HRH	**Local Government Health Budget**
Community Community, Private sector/Philanthropy, OOPE, CBO and NGOs	**Sundry support/unbudgeted**
Vertical Health Programmes Over 25 vertical and centrally managed health programmes in Nigeria by donors/implementing partners, bilateral and multilateral partners	**Donors/Partners**

Table 12: Main and Alternate Sources of Funds for Key Public Health Budget Management Centres at the State level

Health Institutions/Budget Management Centres	Other sources of funds
1. State Ministry of Health, HQ	State Health Budget either flows through the SMoH to the MDAs or directly to the MDAs in some States. Presentation, defence and securing of approvals for all health MDAs at ExCo is by the HCH
2. State Social Health Insurance Agency/State Health Contributory Health Schemes (SSHIA/SHCS)	1. NHIA 2. Partners in the ecosystem 3. Premiums/IGR
3. State Primary Health Care Development Board (SPHCDB)	1. NPHCDA 2. Partners 3. LG Authority 4. Community
4. State Action Committee on AIDS (SACA)/AIDS Control Programme in the Ministry of Health	1. NACA 2. Partners
5. Drug Management Agency and all its equivalents in States (DMA)	1. Sustainable Drug Supply Scheme 2. Partners 3. Philanthropies or other domestic resources 4. IGR
6. Health Programmes Vertical and local (a typical State has over 20 vertically managed or controlled health programmes)	1. Line Budgets of respective FMoH vertical Programmes 2. Partners supporting specific programmes such as Malaria, TB or others
7. Hospital Management Board (HMB)	A. Partners/Donors

[10]This is more frequently incorporated in the health budget of States even if it carries out a multi-sector activity for AIDS/HIC response.

[11]Many of the DMAs operate as trading outfits and are expected to make and declare profits.

8.	Health facilities and their services	1. SMoH 2. HMB 3. SPHCDA 4. Partners
9.	Emergency Operations Centres (EOC)[12]	1. The NCDC 2. Partners 3. FMoH 4. SMoH, others.
10.	Health System Management and Operations	Sundry sources
11.	Others not directly involved in healthcare delivery include Regulatory and Research Institutions under the overall supervisory ambit of the Ministry of Health	Research Institutes Regulatory bodies

3.2.3 The Basic Health Care Provision Fund

The Basic Health Care Provision Fund (BHCPF) was established by the National Health Act of 2014 as a critical source of funding for healthcare at the national and State levels. This Act mandates a minimum of 1% of the federal government's consolidated revenue to be directly allocated to healthcare. Grants from international donor partners and the private sector as contained in the NHA 2014 also make up the fund. The operational guideline for the BHCPF was established in 2021, two years after the initial fund disbursement in 2019.

Half of the funds are dedicated to the provision of a basic package of services, and 20% for essential drugs, vaccines and consumables for PHC facilities in the country (see Table 13). The Act encourages States and local governments to dedicate a similar 1% of their revenues to healthcare. The fiduciary arrangement for the gateways also specifies how and where the accounts will be maintained and disbursed, including a 25% counterpart funding by the local government health authorities as specified in the National Health Insurance Act and the revised BHCPF guidelines.

[12]Substantial funds being expended at various EOCs include sundry support in the form of training, equipment and consumables which are centrally provided by the National Health Budget/NCDC.

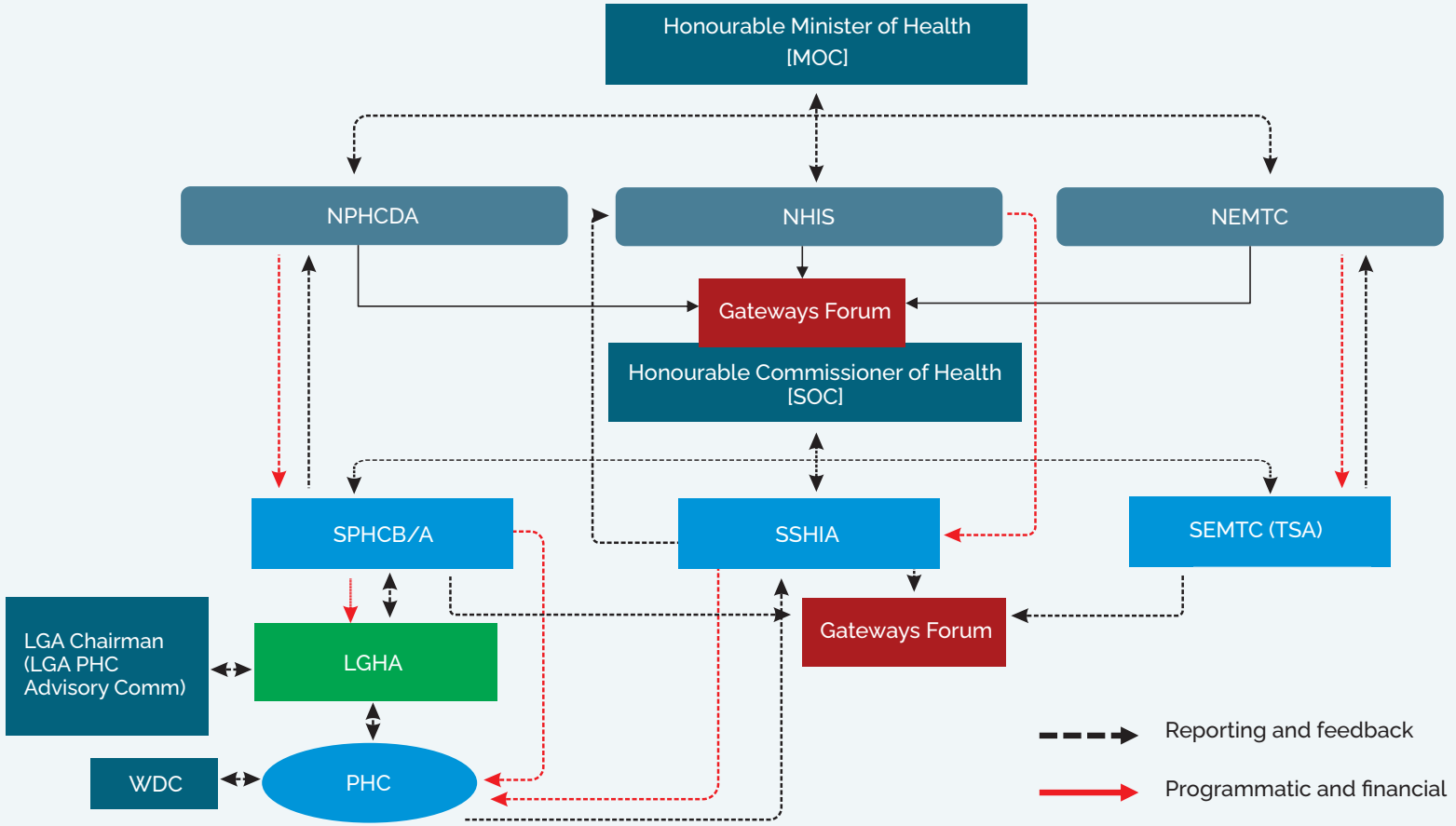
Table 13: Gateways of the BHCPF

Gateway	Allocation		Details
NHIA	50%		Provision of a basic package of services in PHC facilities
NPHCDA	45%	20%	Essential drugs, vaccines and consumables in PHCs
		15%	Provision and maintenance of facilities, equipment and transportation in PHCs
		10%	5% to support the availability of Midwives 5% to support CHIPS Agent
NEMTC	5%		Respond to health emergencies through the establishment of an emergency ambulance service in Nigeria

Table 14: Basic Minimum Package of Health Services (BMPHS)

Primary Level Care	Secondary Level Care
1. General consultation with prescribed drugs	1. Consultation with prescribed drugs
2. Health education for the prevention of diseases	2. Emergencies outside the usual residence
3. Primary care Surgery	3. Admission
4. Primary Care Mental Health	4. Treatment and procedures that cannot be handled at the primary level but are covered by BMPHS.
5. HIV/AIDS/Sexual Transmitted Diseases	5. Treatment of opportunistic infections as defined in the HIV Treatment Protocol
6. Primary care Paediatrics	6. Paediatric conditions
7. Primary Care Internal Medicine	7. Internal Medicine (Adult)
8. Primary Care Maternal, Neonatal & Child Care	8. Obstetrics & Gynaecology
9. Primary Care Emergency Services	9. Surgery
10. Basic Laboratory Services	10. Dental Care
	11. Ophthalmology
	12. ENT
	13. Physiotherapy
	14. Laboratory Services

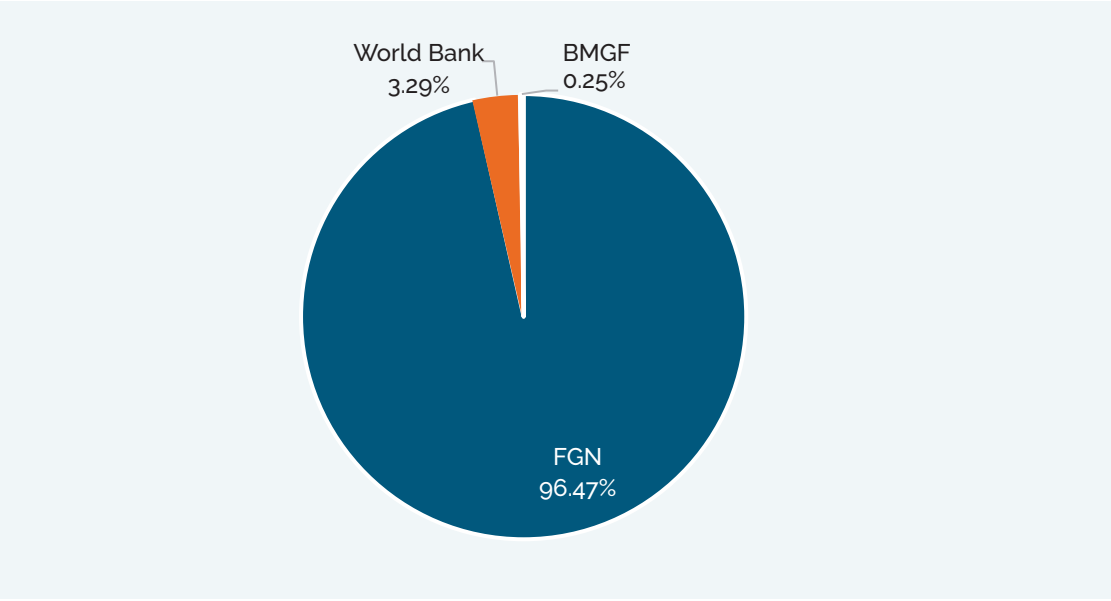
Figure 13: Governance Structure of the BHCPF



Source, NPHCDA, 2024

The total disbursement by the NPHCDA Gateway since the fund was created in 2018 (up to 2023) is N48.1 billion, comprising N2.6 billion and N45.5 billion for operational and programmatic funds respectively. 97% of these contributions (N46.8 billion) have come from the federal government, while the World Bank (N1.6 billion) and BMGF (N120.3 million) have contributed 3.29% and 0.25% respectively (see Figure 14).

Figure 14: Sources of the NPHCDA Gateway Fund, 2019 - 2023



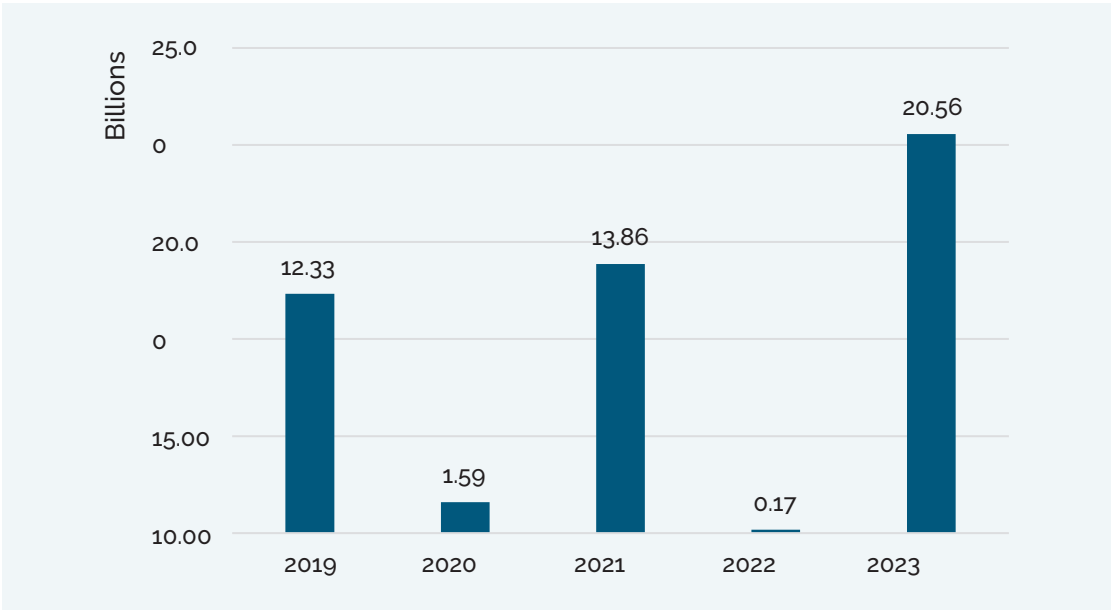
Source, NPHCDA, 2024

The Federal Ministry of Health reports that only 90% of primary healthcare facilities (7,886 out of 8,809) have been authorised to receive funds from the BHCPF, with ongoing efforts to reach the remaining 10%. There are also challenges with enrolment and funding. Less than 1% of the vulnerable population is currently being covered. This is very low and is compounded by low awareness of the BHCPF and the basic services offered at PHCs. Less than 10% of the population access services at the PHCs in as many as 14 States, though these facilities receive N300,250 quarterly. Reports highlight poor rates of releases and the under-utilisation of released funds amidst challenges related to State funding shortfalls and potential misuse of BHCPF funds by SHIAs to fund operational services.

The NPHCDA has identified challenges impacting the smooth operation of the programme including slow retirements by States, delayed submission of M&E reports which make it difficult for the agency to track progress, inadequate functionality of the State Oversight Committees to coordinate implementation at the State level and disagreements about the mandates of the State Health Insurance Agencies which create confusion and potentially hinder the programme's operations.

Given that States are to commit to addressing deficiencies before the authorization of their PHCs, not all PHCs have been authorized to receive funds. Out of the 8,800 PHC facilities, 87%, a total of 7,630 health facilities across the 35 States (excluding Rivers State) and the FCT have been authorised to receive funds. Disbursements through the NPHCDA Gateway have so far been unstable, with only 3 major disbursements in 2019, 2021 and 2023 since the first injection of funds by the federal government in 2018[13] (see Figure 15). While the BHCPF offers significant advantages for healthcare development, there are potential downsides to consider. One concern is that these funds may inadvertently disincentivise States from raising investments in the sector. Additionally, overreliance on this fund can create a situation of vulnerability if the flow of resources is disrupted.

Figure 15: Yearly Disbursement of the NPHCDA Gateway Fund, 2019-2023



Source, NPHCDA, 2024

The Federal Ministry of Health has committed to making the BHCPF more effective, transparent, efficient and equitable, providing quality health care to the people in a redesigned BHCPF. This redesigned BHCPF will focus on a strong foundation in the primary healthcare sector and a new agreement (compact) to tackle current challenges. To address equity and reach, the government plans to mobilise and pool more resources from partner agencies and the private sector. The approach aims to increase the number of PHCs receiving essential funding (DFF) and link PHCs to secondary health facilities to create a smoother referral system and effective use of national emergency services.

[13]In June 2018, President Muhammadu Buhari signed the 2018 Budget Appropriation Bill into law, providing N55.15 billion for the BHCPF.

Other changes in the compact include refining the Vulnerable Group Fund to become a more robust risk-pooling system. The redesigned BHCPF is expected to address bottlenecks that previously caused delays in the disbursement of funds at both the federal and State levels.

3.3 Interaction between levels of health institutions, partners and civil society organisations

Collaboration among health institutions, partners, and civil society organisations (CSOs) generally takes place informally, lacking a structured framework for regular engagement. The typical scenarios of collaboration identified during this study include the following:

- **Technical Assistance:** Donors and their implementing partners provide varied support to States in the form of funding, technical assistance, provision of equipment and drugs, and other health commodities.
- **Informal Referrals:** Referral systems across health institutions are generally unstructured, one-directional, and lack mechanisms for feedback on referred patients. Most facilities still store patient records manually using traditional paper methods. The absence of digital records management systems presents an opportunity for healthcare intermediaries to provide simple and affordable electronic medical record (EMR) systems.
- **Ad-Hoc Cooperation:** Demand-based, Ad-Hoc collaboration exists among healthcare professionals.
- **Exchange Programmes:** Student participation in practical training and the use of clinical sites (hospitals, PHCs) represent some structured interaction.

The report also identified practices in selected States that demonstrated strong institutional collaboration with regular communication, resource sharing and central coordination. These include:

- **Yobe State:** This State has a structured referral system with weekly specialist consultations from federal hospitals. The State government also provides support to some federal health institutions in the State in the form of subventions, land, vehicles, etc.
- **Ebonyi State:** For many years, the federal specialist hospital served as the teaching hospital for the State medical school.
- **Taraba State:** This State demonstrates strong institutional collaboration with all levels of healthcare institutions, with regular visits, resource allocation, and central coordination by the State Ministry of Health. A Partners Coordination Forum domiciled within the State Ministry of Health oversees the activities of partners working in the State.

- **Enugu State:** A "cross-referral" system exists where traditional birth attendants (TBAs) refer patients to health facilities (PHCs and hospitals).
- **Ekiti State:** Interactions with CSOs exist in the form of policy guidance, implementation reports, capacity building, meetings and official memos through a Health Partners Coordinating Committee.
- **Lagos State:** The State is building a 120-150 hospital-bed Medical Park (MediPark) through a PPP to offer a comprehensive range of advanced specialist medical and diagnostic services. The US$247.3 million project is being constructed on a former school of nursing site, signifying a repurposing of existing infrastructure for improved healthcare delivery. In April 2021, the State also began the construction of Massey Children's Hospital, a 150-bed specialist hospital for children which the government says will be the largest children's hospital in sub-Saharan Africa.

Across States, CSOs and Community-Based Organisations (CBOs) play a vital role in the healthcare system. They generally monitor and report shortcomings in service delivery and overall facility management. CSOs also provide crucial oversight during the health budget process, they track budget allocations and implementation to ensure resources are used effectively. Some of these findings are detailed in the table below for selected States.

Table 15: Role of partners in the health system, selected States

State (surveyed)		Partners	Interactions with CSOs/CBOs
1.	Rivers	1) Participation in partners' forum meetings. 2) Membership in Technical Working Groups (TWG) 3) Co-implementation of agreed programmes 4) Infrastructure provision support 5) Financial aid/grants 6) Provision of commodities and consumables, including vaccines	1) Participation in partners' forum coordination mechanisms 2) Monitoring and evaluation 3) Co-implementation
2.	Enugu	1) Part of the coordination platform	1) Monitoring, oversight and reporting

		2) Joined-up planning and implementation 3) Joint funding through GCCC grants	2) Budgeting and budget reviews 3) Facility governance via WDC/FHC and Town Unions
3.	Taraba	1) Participation in partners' forum meetings 2) Advisory meetings	1) CSOs provide general oversight 2) Monitoring of health activities notable 3) Health budget preparation and presentations. 4) Health interventions at community levels
4.	Yobe	1) Provision of financial support. 2) Technical assistance. 3) Construction /infrastructure provision, etc.	1) Advocacy 2) Budget consultations for citizens' needs.
5.	Osun	1) Development Partners Forum where partners interact with the government vis a vis their plans and implementation challenges. 2) Members of committees like the State Oversight Committee on the BHCPF and others.	1) Development Partners Forum where the Partners officially interact with the government vis a vis their plans and implementation. 2) Members of committees like the State Oversight Committee on the BHCPF and others.
6.	Kwara	1) Quarterly meetings of all donor partners and CSOs with the Partners' Unit of the state Ministry of Health to discuss planned and executed activities and projects.	1) Quarterly meetings of all donor partners and CSOs with the Partners' Unit of the State Ministry of Health to discuss planning, and 2) Executed activities and projects.

The report highlights the implication of this quality of engagement for healthcare governance in Nigerian States. The findings show that the relationship is a) positive, but b) unstructured and variable, c) and could be more mutually beneficial, efficient and d) comprehensive.

i. Policymaking: The State Council on Health, the highest policymaking body, is inactive in many States. This creates a significant challenge in establishing a common policy and strategic direction for the sector.

ii. Fragmented Relationships: Interactions between the State and health institutions are unstructured and variable. This lack of an enforceable framework hinders accountability and efficiency.

iii. Limited Private Sector Engagement: The report notes a remarkable absence of private sector actors in State health structures and processes. This lack of involvement excludes valuable expertise and resources from the healthcare ecosystem.

3.4 Mechanisms for transparency, oversight, and accountability in the allocation and utilisation of resources

Effective allocation and utilisation of resources in the health sector is crucial to ensure that whatever comes to the sector is transparently administered and accounted for. This is carried out through mechanisms of transparency, accountability, and oversight. The report identified at least five (5) accountability structures for healthcare administration and delivery, as follows

i. Budget Transparency: All States have published health sector budgets included in their comprehensive budget, online or in print. This allows for public scrutiny by the public. Quarterly budget performance reports published by States also ensure that there is regular reporting; while legislative oversight practised through the State House of Assembly Committees on Health, Public Accounts, and Finance review the budgets and hold the government accountable. While health budgets and performance reports are being improved, significant gaps remain, particularly in financial statements where data for two States was unavailable in 2022.

ii. Audits: Internal and external audits are conducted to ensure proper budgeting practices. All Health sector MDAs are required to have an internal audit unit whose responsibility is to ensure proper financial procedures are followed and report any infraction to the internal control department in the Office of Accountant General for investigation and sanction if necessary. The external audit is performed by the Office of the Auditor General of the State on all financial transactions of the State (including all health sector MDAs).

iii. Civil Society Engagement: CSOs and NGOs participate in budgeting and implementation processes, adding another layer of accountability. They are also involved in the preparation of the citizens' budget and communicating the needs of vulnerable groups in the health budget.

iv. PHC MoUs: In States like Yobe, Katsina, Kano, Kaduna, Borno, Kebbi and Bauchi, joint government-partner funding for primary healthcare is subject to a strict accountability framework which ensures resources are efficiently utilised.

v. Intergovernmental Funds: Funds from the BHCPF, NHIA, HAP&C, NTBLC, and NMEP come with specific disbursement plans, monitoring, and evaluation processes involving federal, State, and donor partners. These often run parallel to existing mechanisms of State budget oversight, although there are efforts in some States like Kaduna to ensure that they are captured in the annual operating plan (AOP) for the health sector and subjected to the same accountability frameworks as the overall health budget.

Beyond these structured mechanisms, transparency and accountability in the sector are fostered through the provision of up-to-date data and reports by other stakeholders. This information helps the public to track how resources are utilised. Measuring programme performances through well-defined indicators, periodic surveys and programme reviews provide valuable insights. This report notes that the frequency of programme performance reviews does not always meet the ideal quarterly target, but most States conduct these surveys at least twice a year. To strengthen the role of data-driven accountability, the report recommends the following:

i. Open Data: Making healthcare data readily available to the public to help monitor resource utilisation and progress in programme implementation.

ii. Performance Monitoring: Regular programme reviews and surveys to assess the impact of allocated resources on health outcomes.

iii. Staff Training: States should provide additional training to ministry staff on budgeting, tracking, and evaluation to improve the execution of health budgets.

3.5 Mechanisms for performance evaluation of health institutions and personnel

The health system depends on a well-functioning network of personnel and institutions. To achieve optimal results, both need to be evaluated and improved continuously. This section highlights the mechanisms for performance measurement adopted by States.

Performance Measurement: States follow public service provisions to assess staff performance. In specific circumstances, specialised evaluation mechanisms have

been created, such as the State Task Force on Immunisation, led by Deputy Governors, which monitors progress on immunisation in each State. In recent times, the mandate of the task force has been expanded to cover oversight of PHC services. National surveys such as the

Nigeria Demographic and Health Survey (NDHS), Multiple Indicator Cluster Survey (MICS), National Immunisation Coverage Survey (NICS) and facility surveys are also used to evaluate progress and service readiness.

Performance measurement activities are carried out through institutional evaluations and individual assessments. Institutions are evaluated through departments in the ministry, for example, the Medical Services Department or the Hospital Management Board is responsible for evaluating secondary facilities. Some States employ tools like the Annual Performance Evaluation Report (APER) to assess staff performance via their supervising officers. This report observes a gap in the use of these data as metrics of accountability for institutions and individuals alike. These metrics, backed by patient satisfaction surveys and productivity studies can provide a wealth of information on service delivery and clinical outcomes that can be used to improve transparency and ensure that healthcare providers are held accountable for their performance.

Accreditation and Regulatory Oversight: State oversight is carried out through the State Ministries of Health which holds regulatory authority over public and private facilities. Private facilities undergo accreditation processes before they commence operations to ensure adherence to set standards. Facilities deemed non-compliant during accreditation are subject to predetermined fines or, in severe cases, closure. Some States, like Lagos, have dedicated agencies for facility evaluation and service delivery standards. In Ekiti, a dedicated transformation and service delivery unit in the Governor's office monitors performance and service delivery, complementing the health ministry's efforts.

Data-Driven Improvement and Benchmarking: Routine data collection track service coverage against targets set at the national and State level, based on the SDG targets, and national and global priorities. These are analysed quarterly and annually to determine progress. The achieved coverage is then used to assess progress and inform plans on how to make improvements. The use of this data varies across States. To achieve meaningful progress, these analyses should be used to inform realistic targets and tailored implementation plans.

Community Engagement and Feedback: There are various mechanisms of community engagement in the sector. PHC services are more successful when communities are involved in the planning, implementation, and monitoring of health activities. Stronger community involvement has been linked to better coverage and outcomes, as evidenced by the success of the polio eradication programme which

had religious and traditional leaders at the forefront. When communities are actively involved in designing and delivering healthcare services, they become more invested in their success. This leads to higher service utilisation, improved health literacy, and ultimately, better health outcomes. Ward Development Committees (WDCs) serve as a recognised structure for community engagement.

CSOs and NGOs also play an active role in providing care and advocating for improved healthcare access for vulnerable groups. Regular community surveys conducted by health authorities and NGOs/CSOs provide valuable alternative feedback. These can be systematised at the national and State level to strengthen service delivery improvement efforts.

National Health Accounts (NHA): There is a public call for more efficient use of allocated health resources given the current limited government fiscal headroom. This is why cost-benefit and efficiency analyses are important to assess the return on investment for interventions, identifying those with high impact and cost-effectiveness. Regularly conducted National Health Accounts (NHAs) provide crucial data on health spending and expenditure at the national and State levels. Unfortunately, the lack of regular NHAs (the latest available for 2017) has hindered informed decision-making on health funding and outcomes. Institutionalising regular NHAs is essential to strengthen government decisions on resource allocation and service effectiveness in the sector.

3.6 Financial Sustainability

State health officials reported that resources are allocated in line with their health targets, facilitated by a) robust reviews or situational analyses and planning, b) consultation during budgeting, c) prioritisation of planned activities, d) sector allocation defended at varied levels such as at the Planning Ministry, the State Assembly as well as e) justification of applications of authority to spend/budget releases. These steps serve to align spending with targets.

The long-term viability of current health expenditures is constrained by the absence of reliable government data to inform spending prioritisation, coupled with the uncertain headwinds facing the economies of States, including an ongoing cost-of-living crisis. State governments may be appropriating as much as their competing needs and fiscal space allow, but there is a deficiency in the extent of releases on the one hand (at 63%), and the level to which budget management centres are held accountable.

State governments have increased their health allocations, but the combined amount - now over N500 billion and at 7% of their total expenditure - remains insufficient to deliver a functional healthcare system at that level of government.

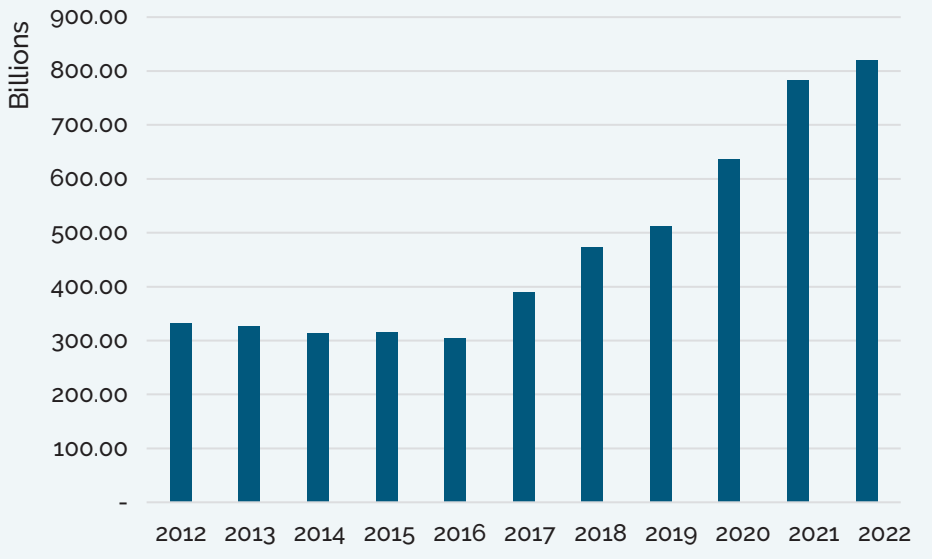
Calls for increased health funding are only part of the solution. There is consensus

that as much as there should be a push for more money for health, there should be an equal counter-push for more health for the money through increased efficiency and accountability. There are reports of absenteeism, procurement-related frauds, under-the-counter payments, health financing-related corruption, and employment-related corruption in the health systems. A 2020 study identified the drivers of corruption in the sector in Nigeria to include underpaid health professionals who are tempted to find alternative income sources, lack of resources which creates opportunities for diversion, weak governance structures with poor oversight and accountability, and a culture that discourages reporting wrongdoing (Onwujekwe. et al, 2020). The study concluded that a few solutions are feasible but acknowledges that even these will require sustained efforts to address the underlying challenges. The current system also features multiple layers of funding for health activities, potentially leading to duplication of efforts by the federal, State, and local governments.

Is the federal health spending increasing?

The federal budget for the health Sector has more than doubled over the last decade, increasing by a compound annual average of 9.5% from N331.3 billion in 2012 to N820.2 billion in 2022. By 2023, the total allocation for the health sector was N1.58 trillion, accounting for 8% of the country's total budget of N20.51 trillion. This is an improvement compared to the 5.4% allocated in 2022. In general, the allocation continued to range between 4-8 % of the annual budget of the government, falling way below the 15% agreed at the Abuja declaration.

Figure 16: Federal government's budget allocation to the health sector, 2012 - 22



Source: Federal Ministry of Budget and National Planning, 2023

Reliance on donor funding risks health programmes

Nigeria's health sector heavily relies on donor funding, particularly for vital programmes like lifesaving vaccines, drugs, HIV/AIDS treatment and TB prevention, and other public health issues. While this support has been critical, there are concerning signs such as the following:

i. Donor Fatigue: Reports suggest a potential decline in donor enthusiasm ("donor fatigue") and a decrease in overall funding spurred by the re-emergence of global nationalism.

ii. Unsustainable Model: Donor funding was never intended to be a permanent solution.

Between 2005 and 2018, a total of US$6.2 billion was invested in the HIV response in Nigeria (NACA, 2020). US$126 million was also invested in HIV commodity expenditure in 2018 (PEPFAR, 2020). More than 81% of these funds came from international donors, while public and private funds accounted for about 18% and 1%, respectively. Funding from external sources as a proportion of total HIV expenditure also decreased from 92.3% in 2008 to 82.81% in 2018 (NACA, 2019a). Overall, total spending by PEPFAR - the largest external funder of HIV programmes in Nigeria - declined by approximately 18%, from US$372 million in 2015 to US$303 million in 2017. This declining trend in funding for critical health interventions in the country poses a significant threat to the sustainability of the HIV response. The universal strategy for addressing the funding challenge includes a) implementation of a national resource mobilisation strategy, b) more innovative financing of the sector, and c) ensuring more health for the money available i.e. increased level of prudence and accountability across the tiers of care. While securing additional funding is crucial, improving the competency of healthcare system managers in deploying resources efficiently is equally essential.

Counterpart funding arrangement for federally managed funds

The healthcare system relies on "counterpart funding," such as the BHCPF, where States, and in some cases, local governments must contribute cash to access federally managed health funds and other vertical health programmes. While this approach aims to incentivise State government participation in specific areas of healthcare, State officials revealed some concerns:

- **Misalignment:** Centrally designed programmes do not always fit the unique geopolitical and cultural contexts of individual States.
- **Limited Flexibility:** State governments feel constrained by rigid programme implementation structures and struggle to meet centrally determined standards. This was particularly evident with the Basic Health Care Provision Fund (BHCPF) administration.

- **Procurement Inefficiencies:** States reported instances where centrally procured materials, like insecticide-treated bed nets, arrived at inflated prices compared to State-level procurement.
- **High Central Management Costs:** Concerns arose about the substantial operational costs associated with centralised programme management, including frequent supervisory trips by federal officials.
- **Loss of Funding:** States face the risk of losing allocated funds if they fail to meet counterpart contribution deadlines. In many cases, States that don't budget for their share jeopardise their chances of accessing these funds.
- **Duplication in Funding:** States and local governments may continue budgeting for programmes like malaria control, even when receiving grants from the National Malaria Elimination Programme.
- **Data Inaccessibility:** Health information collected through centrally-managed programmes often bypass State systems, hindering State-level planning and programme development.

Growing Population and Aging Society

At 5.5 live births per woman and a population growth rate of 3.2% annually, Nigeria has one of the fastest-growing populations in the world. It is estimated to reach 400 million people by 2050, becoming the world's third most populous country, placing immense pressure on healthcare resources. The health per capita spending of States is likely to fall short of a) growth in the general population, b) the addition of older persons in the population with attendant increase in demand for healthcare, c) the uncertain growth of the economy and the fiscal space, and d) the political imperative to prioritise health. With an uncertain economic future, State governments may struggle to meet the increased healthcare demands of a growing and ageing population. As the elderly population is projected to reach 10% of the total, the healthcare system will need to adapt to address the rising prevalence of chronic diseases like heart disease, diabetes, and cancer, which are more common among older adults. The fast-declining traditional social security system is aggravating the problems of care for the elderly as this is yet to be replaced with planned services for this population group.

Shifting Disease Burden: "Double Burden" of Communicable and Non-Communicable Diseases

Nigeria, like many developing countries, is experiencing rapid epidemiological and demographic transitions from communicable to non-communicable diseases (NCDs) which have resulted in the so-called double burden of diseases. NCDs like cardiovascular diseases (hypertension, stroke, and coronary heart disease), diabetes mellitus, cancers, sickle cell disease, and chronic obstructive airway

diseases (including asthma) contribute significantly to adult mortality and morbidity. Others include mental health disorders, violence, road traffic injuries, and oral and eye pathologies. The prevalence of NCDs is predicted to rise in the coming decades.

This trend puts a double strain on healthcare resources as treatments are needed for both types of illnesses. The National Health Finance Policy 2021 anticipates that a) the total health expenditure should, at least, be 4% - 5% of GDP; b) out-of-pocket expenditures do not exceed 30-40% of total health expenditure; c) 90% of the population should be covered by prepayment and risk pooling schemes; and d) 100% of the vulnerable population are covered by social assistance and safety-net for a good level of adequacy of health finance in the country.[14] Achieving these goals will require substantial financial resources and strategic allocation to address existing and emerging health challenges.

HRH migration, understaffed facilities, and potential demand from medical tourism

Nigeria's 40,821[15] operational health facilities and institutions show asynchrony in terms of their location and place of need, equipment availability, and the skilled HRH to operate and deploy them. Documented cases show new facilities built without sufficient healthcare professionals, drugs, or equipment, suggesting a political prioritisation of the physical construction of health centres over functionality.

Despite investments in training new health professionals, there is a significant undocumented shortage of critical health professionals across healthcare centres in the country. Doctors, nurses, and paramedical staff, including radiographers and rehabilitation specialists, are leaving the country for better opportunities. Compounding the challenge is the need for upgraded diagnostic facilities in hospitals. Facilities require new equipment and skilled personnel to operate and maintain them.

The country also faces a substantial financial burden due to medical tourism. The growing demand for complex medical procedures like transplants, robotic surgery, advanced cardiovascular interventions, and sophisticated cancer treatments necessitates the development of advanced healthcare services in the country.

Broadening the funding base for national healthcare

The government is actively seeking ways to diversify its health funding sources

[14]National Health Finance Policy, 2017.

[15]In 2019, the Nigerian Health Facility Register produced by the Federal Ministry of Health, estimated a total of 40,821 operational health facilities in Nigeria. This figure incorporates private and public facilities at all levels of care (primary, secondary, and tertiary).

beyond traditional methods. For the most part, the 2020 pandemic helped highlight the need for significant investments in the sector. Some of these initiatives include the following:

i. **Boosting Government Revenue:** The national government aims to increase its revenue-to-GDP ratio from around 11% to 18% by 2025. This strategy involves improving tax collection and promoting fiscal responsibility.

ii. **Innovative Financing Mechanisms:** Exploring new avenues like health taxes are on the table such as introducing new taxes or increasing existing ones, such as the recently introduced sugar tax on carbonated drinks. In 2021, Nigeria imposed an excise duty of N10 per litre on sugar-sweetened beverages (SSBs), becoming the second developing country in sub-Saharan Africa to do so.

iii. **Expanded Health Insurance:** The revised National Health Insurance Act[16] aims to increase mandatory health insurance coverage for 83 million poor Nigerians who cannot afford to pay premiums as recommended by the Lancet Nigeria Commission. This broader pool of insured individuals will generate more revenue for healthcare services at the federal and State levels.

iv. **Engaging the Private Sector:** The government plans to support private sector involvement in healthcare to boost health revenues and mitigate health tourism through initiatives like a) low-interest loans for healthcare professionals (doctors, nurses, midwives, CHEWs) to establish primary care facilities in underserved semi-urban and rural areas. These loans will be repaid through a unique system such as deductions from capitation funds allocated to the facilities through the Social Health Insurance Scheme (SHIS) once a minimum number of subscribers is reached. This initiative services to promote service delivery and financial sustainability: b) matching grant programmes to incentivise private sector investments based on subscriber numbers; c) public awareness campaigns to encourage health insurance enrolment.

v. **Ring-fenced national-level investments:** The Nigerian National Petroleum Corporation (NNPC) Limited is investing US$58 million into the construction of 14 new medical centres and the upgrade of two intensive care units (ICUs) across the country's six geopolitical zones. The Nigeria Sovereign Investment Authority (NSIA) is also constructing 22 modern diagnostic centres with advanced radiology and pathology services as well as 6 cardiac catheterisation labs across the six geopolitical zones. These facilities will be located within existing tertiary healthcare institutions, leveraging existing infrastructure for improved efficiency.

[16]National Health Insurance Authority Act 2022.

3.7 Health Outcomes

The National Development Plan (NDP) 2021-2025 outlines a roadmap for improving health outcomes in Nigeria. It defines key objectives with clear performance indicators and targets:

i. **Infant Mortality:** The baseline rate in 2021 was 74 deaths per 1,000 live births. The goal is to reduce this to 40 per 1,000 live births by 2025.

ii. **Maternal Mortality:** The baseline rate in 2021 was 814 deaths per 100,000 live births. The target is to bring this down to 500 per 100,000 live births by 2025.

iii. **Universal Health Coverage:** The plan aims to achieve a 10% increase in UHC by 2025.

iv. **Life Expectancy:** The goal is to raise life expectancy from a baseline of 54.3 years in 2021 to 56 years by 2025.

Each State government has developed a strategic plan aligned with the NDP. These plans incorporate the national targets while acknowledging specific circumstances. Each State defines its baseline data and sets realistic targets within its strategic and operational plans. The plans outline strategies to improve health indicators and allocate resources within their budgets to achieve these goals.

There have been other contributions that emphasise the use "ideal population outcome metrics" that reflect a population's overall health and wellbeing (Parrish, 2010). These metrics encompass three dimensions:

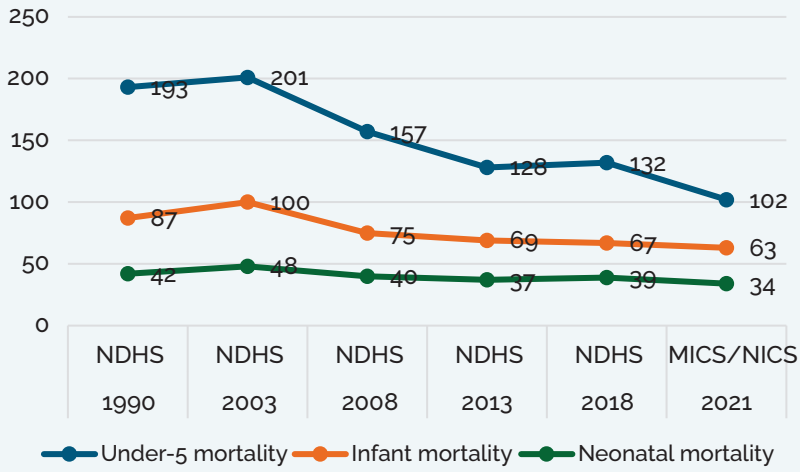
i. **Mortality Outcomes:** These measure death rates, such as infant and maternal mortality rates.

ii. **Morbidity Outcomes:** These focus on the incidence and prevalence of diseases within a population.

iii. **Health-Related Quality of Life Outcomes (HRQoL):** These capture the impact of health on a person's ability to function and live a fulfilling life.

Nigeria may have recorded some strides in reducing child mortality rates and meeting key immunisation milestones but the general data paints a concerning picture. National demographic surveys from the 2013 NDHS, 2018 NDHS (NPC, 2019), and 2021 MICS (NBS, 2022) show that the country is off track to meeting the health-related SDGs by 2030. The SDG target for under-five mortality is 25 deaths per 1,000 live births by 2030, but under-five mortality in the country increased between 2013 and 2018, rising from 128 to 132 deaths per 1,000 live births according to the NDHS. By 2021, a notable improvement to 102 per 1,000 live births was reported in the MICS/NICS, although still four times higher than the SDG target.

Figure 17: Mortality Rates, 1990 – 2021



Neonatal mortality rates show a similar trend, recording a marginal improvement from 37 to 34 deaths per 1,000 live births in the last decade, which is about three times higher than the SDG target of 12 deaths per 1,000 live births. The increase in neonatal mortality to 39 per 1,000 live births in 2018 before the decline to 34 per 1,000 deaths in 2021 raises concerns about the long term stability of quality neonatal care. Infant mortality declined from 69 to 63 deaths per 1,000 in 2021. Expanded routine and mass vaccination campaigns across Nigeria over the last two decades have likely contributed to the reduction in under-five mortality rates. A core focus of the SDGs is increasing DPT-containing pentavalent vaccine coverage in children under one year old. The National Strategic Health Development Plan 2010 (NSHDP2) sets a target of 90% coverage using the pentavalent vaccine (DPT-Hib-Hb) as an indicator.[17,18] To date, general vaccination coverage remains low, with the COVID-19 pandemic exacerbating this problem.

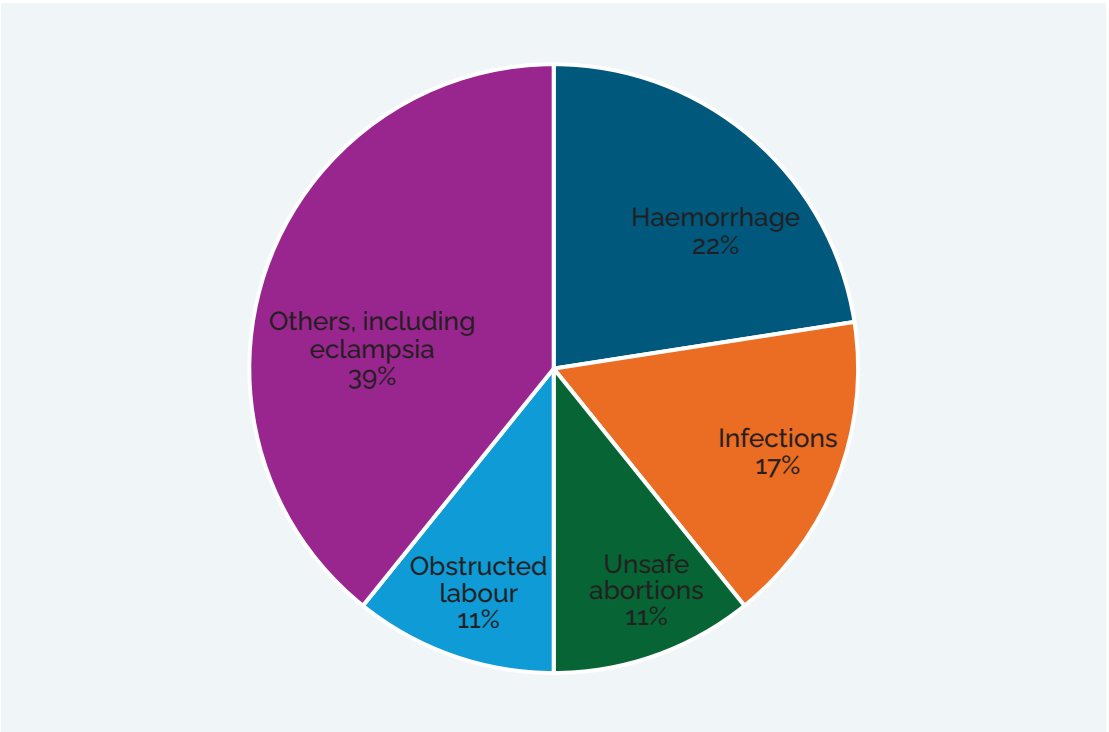
Skilled birth attendance in 2018 was 67% and 50.7% in 2021 against facility delivery of 39% and 49% from NDHS 2018 and MICs in 2021 respectively. This shows a poor state of maternal care in terms of quality and access with a higher percentage of home deliveries especially in States in the northern region. Closely related, adolescent pregnancy rate is high at 75% due to cultural and religious beliefs, inadequate human resources, and poor health infrastructure. Table 16 highlights the disparity in healthcare access and outcomes across States.

[17]United Nations, Sustainable Development Goals Progress Chart 2022, 2022.
[18]Federal Ministry of Health, National Strategic Health Development Plan, 2010.

Table 16: Maternal and Child Health Indicators

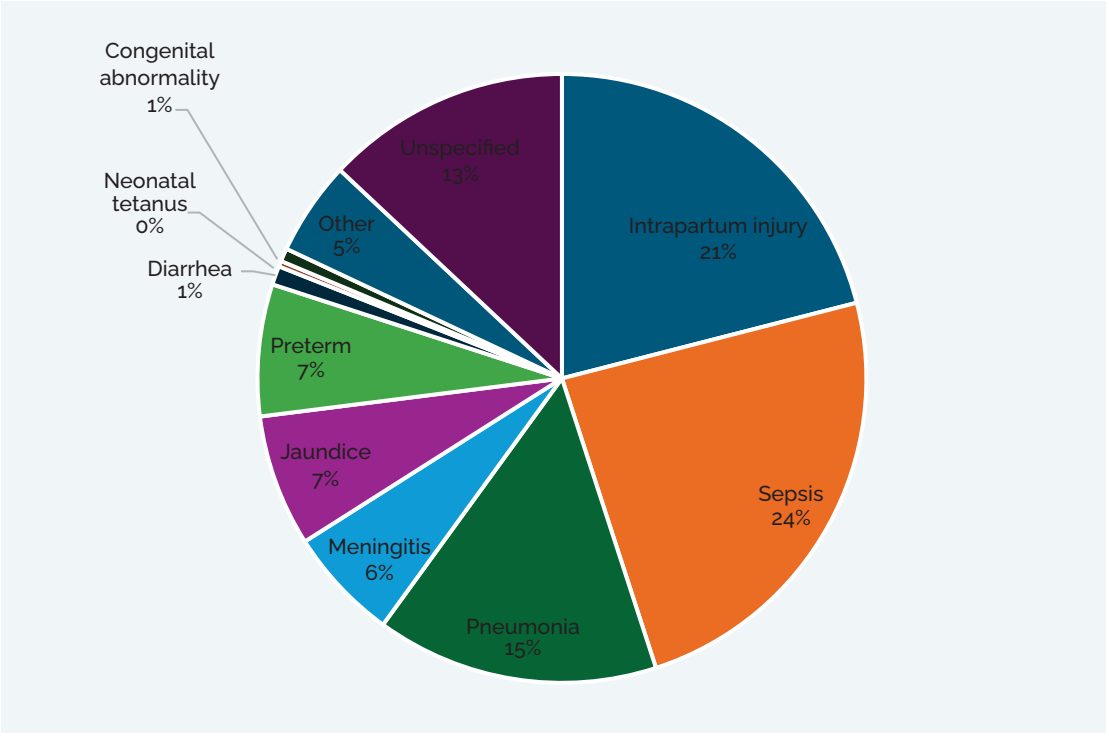
Indicators	NDHS 2018	MICS/NICS 2021
Infant Mortality	67/1000	63/1000
Neonatal Mortality	39/1000	34/1000
Under-five Mortality	132/1000	102/1000
Fully Immunised Child	31%	36%
Penta3 Coverage	50%	57%
ANC4	57%	69.4%
Skilled Birth Attendant	67%	50.7%
Home Delivery	59%	51%
Facility Delivery	39%	49.0%
Post Natal Care<2daysneonate	38%	62.4%
mCPR	12%	18.2%
Met Demand for Modern Methods	34%	39.9%
Exclusive Breast Feeding (< 6 months)	29%	34%
Adolescent Birth Rate	NA	75

Figure 18: Causes of Maternal Mortality



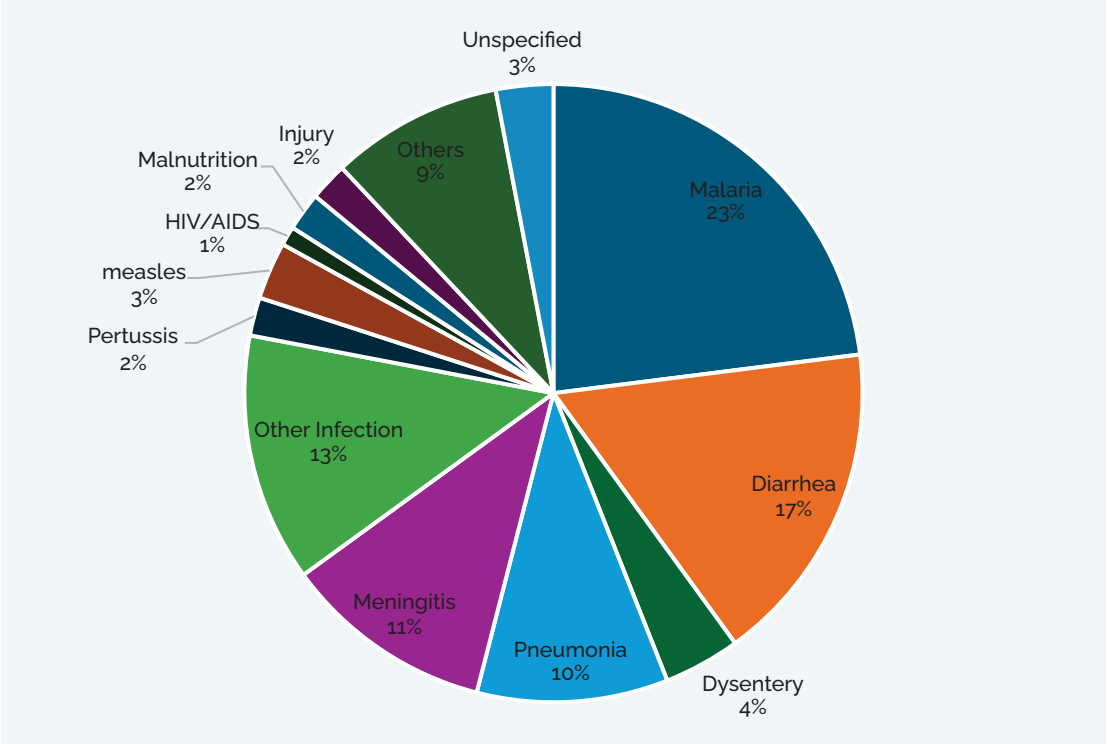
Source: Federal Ministry of Health. (2010)

Figure 19: Causes of Neonatal Mortality



Source: Odejimi, et al. (2022)

Figure 20: Causes of Under -5 Mortality



Source: Odejimi, et al. (2022)

Neonatal Mortality: Ebonyi, Anambra, Enugu, and Yobe have the lowest neonatal mortality rates (1-10 per 1,000 live births). Conversely, Rivers has the highest rate (70 per 1,000), followed by Ogun, Ekiti, and Edo (52-56 per 1,000).

Under-five Mortality: Lagos has the lowest under-five mortality rate (15 per 1,000), followed by Anambra (22 per 1,000) and Ebonyi/Osun (24 per 1,000). These States meet the 2030 target of under 25 per 1,000. Sokoto, Kebbi, Jigawa, and Bauchi have the worst under-five mortality rates (174-202 per 1,000).

Maternal Health: The WHO recommends at least 8 antenatal care visits for pregnant women throughout their pregnancy. This includes an initial visit during the first trimester, followed by regular checkups throughout the pregnancy journey. These antenatal visits are crucial for monitoring the health of both mother and baby, identifying potential risks early, and ensuring a positive pregnancy outcome. Comprehensive antenatal care is an indicator of the reproductive and maternal health dimension of SDG 3.8, which focuses on achieving UHC (NBS, 2022).

Imo recorded the highest skilled birth attendance (SBA) rate of 96.7% and the highest completion of the recommended 4 antenatal visits (ANC 4) at 96.1%. Anambra and Enugu follow closely at 95.9% and 91.8% respectively. Lagos with an SBA of 91.1% recorded an ANC 4 visit of 94.2%, second to Imo, while Anambra came third for ANC 4 visits at 93.4%. Katsina and Sokoto have the lowest SBA rates (14.4-14.5%), with Sokoto performing slightly better in ANC 4 visits (27.4%). Bauchi, Zamfara, Jigawa, and Kebbi also have concerningly low SBA and ANC 4 rates.

Regional Disparities: The southeast zone leads in maternal health and neonatal mortality outcomes, with the highest ANC service completion rates (blood pressure check, urine, and blood tests). The northwest zone has the poorest health outcomes and lowest ANC service completion. Bayelsa, Akwa Ibom (south-south), Kano, and Katsina (northwest) have the highest traditional birth attendance rates, contrasting with low rates in the southeast.

Malaria and HIV Prevalence: The prevalence and incidence of diseases paint a picture of a population's overall health burden. This is an indicator of morbidity outcomes. The SDGs aim to "end all epidemics" from AIDS, tuberculosis, malaria, and neglected tropical diseases by 2030, alongside combating waterborne and other communicable diseases. The 2021 data reports that malaria prevalence is highest in Kebbi (49%) and Zamfara (36.6%), and lowest in Lagos (2.6%). Anambra (5.4%), Borno (5.6%), and Kwara (5.6%) also have low malaria prevalence. HIV prevalence is highest in Akwa Ibom and Benue (4.8% and 4.3%), and lowest in Jigawa, Katsina, Yobe, and Zamfara (0.3% - 0.4%). This data highlights a regional disparity, with the northwest and northeast zones having lower HIV rates.

Immunisation (Penta 3 coverage): Despite a significant global decline in childhood immunisation rates, several States are showing positive signs in Penta 3 coverage (vaccination including DPT). No State reached the national target of 90%, with the highest records in Enugu (56.1%) and Lagos (55.4%) above the national average of 32.2%. A concerning trend is shown when compared with global pre-pandemic levels. Between 2019 and 2021, the WHO reported a global decline of 5 percentage points in Penta 3 coverage - the steepest drop in over 30 years.[19] This decline was attributed to disruptions in service delivery during the COVID-19 pandemic.

Wellbeing: This metric assesses the impact of health on an individual's overall wellbeing - physical, mental, and social. It identifies areas where healthcare interventions can improve quality of life. The 2021 MICS provides data on women's average satisfaction scores and the percentage reporting happiness (very or somewhat). The survey used standardised questionnaires for people aged 15-49 and 15-24 to gauge happiness, life satisfaction, and perceived improvements in the past/future year. Kogi has the highest percentage of happy/somewhat happy females (90.4%), followed by Bauchi (88.7%), Edo (88.5%), and Ebonyi (87.8%). On average satisfaction scores, Zamfara and Imo share the highest score of 7.7, followed by Kano (7.4) and Ebonyi (7.3). Conversely, Abia (5.1) and Adamawa (5.2) have the lowest satisfaction scores. Ironically, Zamfara, despite the highest satisfaction score, has only 41.4% of females reporting happiness, ranking last among the States (NBS, 2022).

Financial Risk Protection: The NHA paints a concerning picture of out-of-pocket expenditure. In 2017, 77.7% of healthcare costs came directly from patients' pockets. The government's contribution (federal and other schemes combined) only reached 22.3%. This heavy reliance on out-of-pocket spending poses a significant barrier to achieving UHC and financial security for citizens. The country's goal has been to reduce out-of-pocket expenses to below 20%. Expanding health insurance coverage is crucial to achieve this, presumably through the NHIS (now NHIA). Launched in 2022, it covers only 4-5% of the population, primarily those in the formal sector. This leaves the majority of the informal sector and vulnerable groups exposed to financial risk in case of illness.

Recent efforts offer a glimmer of hope. Government and donor programmes are providing some social support in the form of conditional cash transfers and household uplifting initiatives. The NSHDP2 estimates these programmes cover 30% of the population with some form of risk protection. The 2021 survey revealed a stark reality. The national average of females with health insurance or receiving social benefits is 2.8%. The share is 10.8% in Ebonyi State, followed by 8.1% in Lagos. States like Sokoto, Kogi, Adamawa, and Taraba have close to zero coverage.

[19]United Nations, Sustainable Development Goals Progress Chart 2022

For any type of social support or benefit such as conditional cash transfers, Akwa Ibom leads with 55.9% coverage, followed by Adamawa at 48.7% and Kano at 41.2%, while Oyo and Enugu lag at 5.7% and Ondo at 6.3%. These discrepancies highlight the need for a multipronged approach to public health management in the country.

Table 17: Health expenditure and selected health outcome indicators for Nigeria's 36 States

State	2021					2022					Neonatal Mortality rate	Infant Mortality Rate	Child Mortality (/1000LB)	Under - five Mortality (/1000LB)	ANC within the first 4 months	Skilled Birth Attendan-ce (%)	ANC 4th Visit	Early Initiation of BF	Exclusive BF	Penta 3 Cov	Fully Immunised	Malaria Prevalence (NMEP)	TB Treatment Coverage	HIV (HIV Sector Report 2021)	Women covered by any health insurance(%)	House-holds with any social support or benefits	Average Satisfaction Score	Women who are happy or somewhat happy
	Health Budget (US$, 000)	Health Expenditure, Actual (US$, 000)	Health Budget Performa-nce	Health Expenditure (% of Total Government Expenditure)	Health Expenditure Per Capita (US$)	Health Budget (US$, 000)	Health Expenditure, Actual (US$, 000)	Health Budget Performance	Health Expenditure (% of Total Government Expenditure)	Health Expenditure Per Capita (US$)																		
Abia	27,412	17,777	64.80%	6.0%	4.39	26,760	22,362	83.60%	6.0%	5.38	19	55	64	115	35.3	86.9	81.8	25.9	19.4	40.1	14.4	14.5	32	2	0.6	8.2	5.1	60.3
Adamawa	27,582	24,530	88.90%	9.8%	5.13	28,755	18,232	63.40%	7.1%	3.71	25	51	13	63	23.7	71.2	74.6	21.1	53.7	16.1	7.5	10.7	44	1.1	0.2	48.7	5.2	80.9
Akwa Ibom	41,625	29,764	71.50%	3.3%	6.05	57,525	28,271	49.10%	2.7%	5.67	31	41	8	49	20.8	36.6	81.7	31.2	18.4	54.2	26.3	30.1	48	4.8	3.2	55.9	6.9	75.2
Anambra	31,543	14,702	46.60%	4.8%	2.51	22,771	10,128	44.50%	3.5%	1.69	6	17	5	22	37.9	95.9	93.4	20.8	23.8	43.4	18.6	5.4	60	2.2	3.6	8	7	82.2
Bauchi	63,634	34,193	53.70%	10.8%	4.25	51,897	34,537	66.50%	9.6%	4.16	45	89	70	153	5.1	17.4	43.3	12.3	26.4	13.3	1.1	31.7	49	0.4	0.3	39.4	5.7	88.7
Bayelsa	41,315	24,135	58.40%	4.0%	9.65	29,660	28,207	95.10%	3.8%	11.04	37	70	32	100	17.2	33.9	50.9	36	5.8	28.8	15.5	16.7	15	1.6	4.2	15.3	5.7	66.1
Benue	48,213	26,729	55.40%	11.9%	4.43	38,849	11,021	28.40%	4.1%	1.79	18	31	11	42	15.3	59.1	47.2	47.4	56.8	30.1	5.1	17.6	42	4.3	2.5	6.6	6.6	80.1
Borno	41,477	14,901	35.90%	4.0%	2.48	57,969	8,598	14.80%	2.3%	1.40	36	79	66	140	14.4	32.3	43	53.6	40.8	16.5	4.5	5.6	30	1.2	0.7	32.7	5.7	66.3
Cross River	102,107	29,802	29.20%	8.1%	6.87	52,706	23,976	45.50%	7.3%	5.42	21	41	27	67	24.5	55.2	80.1	23.8	*	44	12.6	23.6	51	1.6	1.3	7.4	6.7	80.7
Delta	56,729	52,829	93.10%	5.5%	9.55	62,482	105,608	169.00%	7.6%	18.70	52	64	27	89	26.3	74.8	77.4	24.4	27.3	45.9	25.9	10	32	1.7	2.8	19.7	7.1	82.8
Ebonyi	38,134	33,890	88.90%	12.4%	10.71	18,013	16,905	93.80%	5.8%	5.21	1	3	21	24	27.8	90.9	78.9	33.6	4.1	54	19	25.7	25	0.7	10.8	13.5	7.3	87.8
Edo	26,385	25,308	95.90%	5.7%	5.40	39,292	25,227	64.20%	5.2%	5.26	52	63	19	81	44.6	90.8	74.9	45	13.3	47.6	21.2	22.6	5	1.6	2.1	12.6	6.7	88.5
Ekiti	20,463	16,127	78.80%	6.2%	4.58	14,987	8,630	57.60%	3.1%	2.39	53	67	16	82	29.7	77.8	75.6	24.1	*	53.2	30.3	20.8	22	0.6	1.3	19.3	6.2	85.8
Enugu	37,765	24,301	64.30%	5.6%	5.22	46,818	22,763	48.60%	7.4%	4.76	8	24	41	64	50.2	91.8	85.6	11.3	36.6	56.1	37.3	24.3	17	1.9	3.6	5.7	5.4	74.7
Gombe	31,637	23,746	75.10%	8.8%	6.17	33,115	27,222	82.20%	8.0%	6.87	37	65	56	117	8.9	36.9	35.9	23.5	30.7	28.2	8.7	17.7	34	1.1	2.9	23.6	6.8	86.1
Imo	50,291	2,766	5.50%	0.8%	0.52	42,392	10,483	24.70%	2.4%	1.92	14	36	21	57	44.9	96.7	96.1	6.7	12.6	53	37.6	15.5	32	1.5	3.1	15.7	7.7	66.6
Jigawa	53,258	47,468	89.10%	13.9%	6.56	67,781	46,291	68.30%	12.5%	6.19	53	95	88	174	14.8	22.2	45.5	7.8	29.8	29.8	8.6	25.4	34	0.3	1.5	39.1	6.1	69.6
Kaduna	98,508	98,480	100.00%	16.9%	11.22	96,772	70,090	72.40%	13.3%	7.77	47	73	58	127	18.6	42.7	72.3	13	41.1	29.2	10.5	16.2	104	0.9	3.8	19.6	6	62
Kano	76,924	56,789	73.80%	12.2%	3.76	80,300	62,086	77.30%	11.2%	4.00	44	87	67	148	6.6	27	48.5	9.1	10.1	27.2	8.1	25.5	82	0.5	3.9	41.2	7.4	86.7
Katsina	90,097	259	0.30%	0.1%	0.03	94,365	293	0.30%	0.1%	0.03	49	89	77	159	3.5	14.4	41.5	27	21.3	18.9	1	29.3	88	0.3	1.2	27.7	5.8	85.6
Kebbi	32,851	17,880	54.40%	8.8%	3.34	40,905	17,367	42.50%	8.1%	3.14	43	95	92	179	11	23.3	36.8	8.9	66	24.9	7.4	49	70	0.6	0.4	28	5.9	82.7
Kogi	44,052	21,732	49.30%	8.5%	5.00	39,164	31,599	80.70%	8.7%	7.10	27	52	16	67	28.9	73.5	73	46.3	29.5	28.5	12.2	15.9	53	0.9	0.2	6.5	6.1	90.4
Kwara	41,889	22,675	54.10%	8.4%	6.59	39,540	31,247	79.00%	9.0%	8.84	18	30	12	42	40.3	79	77	42.6	57.6	36.2	20	5.6	17	0.8	2	6.8	5.7	69.8
Lagos	235,483	183,873	78.10%	9.1%	13.86	301,577	174,139	57.70%	5.8%	12.88	11	15	60	15	51.8	91.1	94.2	14.1	57.4	55.4	39.3	2.6	56	1.2	8.1	12	6.8	83.7
Nasarawa	30,181	21,088	69.90%	8.5%	7.56	28,087	26,476	94.30%	9.4%	9.21	24	43	24	65	20.9	55.5	45.2	22.9	42.2	21.5	5.2	15.3	85	1.6	1.1	10.2	6.6	86.9
Niger	40,000	22,022	55.10%	7.5%	3.33	51,555	36,014	69.90%	10.1%	5.28	20	44	18	61	28.8	38.8	55.4	12.7	57.7	40.3	7.1	20.7	48	0.6	1.6	15.4	6.8	78.2
Ogun	87,588	26,947	30.80%	4.1%	4.31	81,007	34,196	42.20%	5.0%	5.34	56	68	19	85	27.6	71.3	68	9.4	33.2	25.3	12.8	24.9	47	1.1	1.7	14.6	6.2	69.4
Ondo	44,997	27,736	61.60%	9.3%	5.33	43,007	26,475	61.60%	6.7%	4.97	18	31	35	64	26.9	60	68.5	36.5	51.5	45	29.8	26.7	30	0.9	2	6.3	7	89.7
Osun	47,594	9,064	19.00%	3.6%	2.07	38,387	27,355	71.30%	8.9%	6.16	12	17	8	24	34.3	76	90.5	74.5	61.1	49.4	24.7	19.3	195	0.8	1.8	11.7	7	84.7
Oyo	34,448	20,971	60.90%	4.3%	2.68	41,148	18,305	44.50%	3.7%	2.29	31	40	18	57	26.1	82.4	76.3	40.8	58.7	30	14	20.9	61	0.8	2.6	3.2	6.4	80.6
Plateau	34,885	18,972	54.40%	8.1%	4.12	24,092	16,575	68.80%	6.1%	3.51	44	78	30	105	32.5	67	69.9	36.4	38.6	37.5	18.6	18.8	34	1.3	2.4	7	6.3	75.6
Rivers	85,037	115,727	136.10%	8.2%	15.76	84,705	54,844	64.70%	4.4%	7.31	70	87	15	100	32.7	71.4	64.3	12.1	26	58	38	8.6	113	3.6	3	30	5.8	80.7
Sokoto	52,151	65,147	124.90%	17.3%	10.45	69,951	59,149	84.60%	13.3%	9.20	34	104	109	202	12.9	14.5	27.4	10.3	30.7	5.1	0	35.9	176	0.4	0	22.8	6.2	88.9
Taraba	35,127	3,877	11.00%	2.1%	1.10	32,123	16,252	50.60%	6.6%	4.51	29	61	23	83	26.2	35.6	40.5	12.7	33.7	14.1	2.2	17.9	66	2.5	0.1	25.8	5.4	85.3
Yobe	25,239	22,494	89.10%	7.7%	6.30	44,650	24,820	55.60%	7.9%	6.78	10	25	28	52	8.4	47.5	53	31.4	23.6	33.1	17.9	20.5	33	0.4	4.5	22.2	6.8	79.9
Zamfara	32,498	12,271	37.80%	5.3%	2.17	26,468	16,387	61.90%	5.2%	2.81	31	83	58	136	6.7	19	17.4	46.2	35	10.6	0	36.6	48	0.4	0.6	10.5	7.7	41.4
Average	**53,031**	**33,638**	**62.70%**	**7.5%**	**5.32**	**54,155**	**33,115**	**63.30%**	**7.0%**	**5.63**	**31**	**56**	**38**	**89**	**24.6**	**57.2**	**63.5**	**26.5**	**34.5**	**34.6**	**15.6**	**20.2**	**54.9**	**1.3**	**2.4**	**19.2**	**6.4**	**78.5**

Sources: NDHS 2018; MICS/NICS 2021; NBS, 2022, NPC, 2022; Audited Financial Statements of States, 2021,2022; NGF Public Finance Database, 2024

3.7.1 State-level Health Spending and Outcomes

The sector's reliance on out-of-pocket expenditure creates a major barrier to the steerage of UHC outcomes. Research suggests that a threshold of less than 20% out-of-pocket spending is crucial to realise universal coverage (The Royal Institute of International Affairs, 2014). A study by Thomas (2020) highlighted a correlation between high out-of-pocket expenditure and higher maternal mortality rates (MMR). It suggests that limited access to public funding for healthcare disproportionately impacts maternal health outcomes.

Other studies highlight a direct link between public health spending and reduced child mortality, although the picture isn't entirely clear. Findings by Musgrove (1996) and Filmer and Pritchett (1997) show that factors like income inequality, women's education, and cultural diversity play a major role in child mortality rates. They find that the positive impact of health spending on child mortality is observed in high and middle-income countries, with minimal effect in low and lower-middle-income nations. Interestingly, Dhrifi (2019) finds that unlike developed countries where private healthcare spending benefits child mortality, the opposite may be true for low-income settings. In these contexts, public health spending appears to have a more positive impact on child mortality outcomes.

These results highlight the complexity of factors influencing health outcomes. While public health spending is undoubtedly important, it is not the sole driver in low-income countries. Addressing income inequality, promoting women's education, and strengthening public health systems are crucial aspects of improving child health outcomes.

The section that follows presents findings on the impact of State government health spending and its relationship with health outcomes. Key highlights :

- No clear correlation: the data shows no strong correlation between health expenditure (total or per capita) and key metrics like SBA rate, child mortality, or Penta 3 coverage. Increased health spending can contribute to improved health outcomes, as research shows, however, the lack of a clear spending-outcome link and trend data presents a limitation in data tracking and management. This missing link highlights the importance of other factors like resource allocation efficiency, healthcare infrastructure availability, and service delivery efficiency. Factors such as income, women's education, and ethnolinguistic fragmentation also matter.
- High Expenditure, Varied Results: Delta, despite recording the highest per capita spending in 2022 at N7,917 (US$18.70), ranks 12th out of 36 States on the Sustainable Basic Assurance (SBA) index, with below-average records in neonatal and infant mortality. This suggests that high aggregate spending

does not necessarily translate into better health outcomes. Similarly, Lagos consistently spends more than double the national average on health per capita; however, its health outcomes perform below some low-spending States. Ebonyi presents a contrasting case. Despite low spending of N4,276.98 (US$10.71) in 2021 and N2,205 (US$5.21) in 2022, the State has the lowest neonatal and infant mortality rates of 1 and 3 per 1,000 respectively. Ebonyi's SBA score is 91%, far above the average of 57.2% for States. In Anambra State, the government achieved and surpassed the national and SDG 2030 targets for low infant, child, and neonatal mortality with one of the lowest (34/36 States) per capita expenditures of N717 (US$1.56) per person. Sokoto presented the highest child mortality and under-five mortality rates, with low SBA, although it ranked high on health expenditure per capita N3,896 (US$9.20) - 4/36 States. These contrasting results highlight the complexity of achieving positive health outcomes. While financial resources are undoubtedly crucial, other factors play a significant role, including the identification and targeting of problem areas and impact points. Examining successful models in Ebonyi and Anambra could provide valuable insights for other States. (see Table 17).

- Low Spending, Poor Outcomes: Katsina and Taraba have some of the lowest health expenditures and per capita spending, along with very poor maternal and child health outcomes. Katsina reported an SBA of 14.4%, child mortality of 77 per 1,000, and under-five mortality of 159 per 1,000. Taraba equally recorded an SBA of 35.6%, infant mortality of 61 per 1,000, child mortality of 23 per 1,000, and under-five mortality of 83 per 1,000. They highlight the negative impact of poor health funding (see Table 16).

Figure 21: Health Expenditure per Capita/ Neonatal Mortality Rate

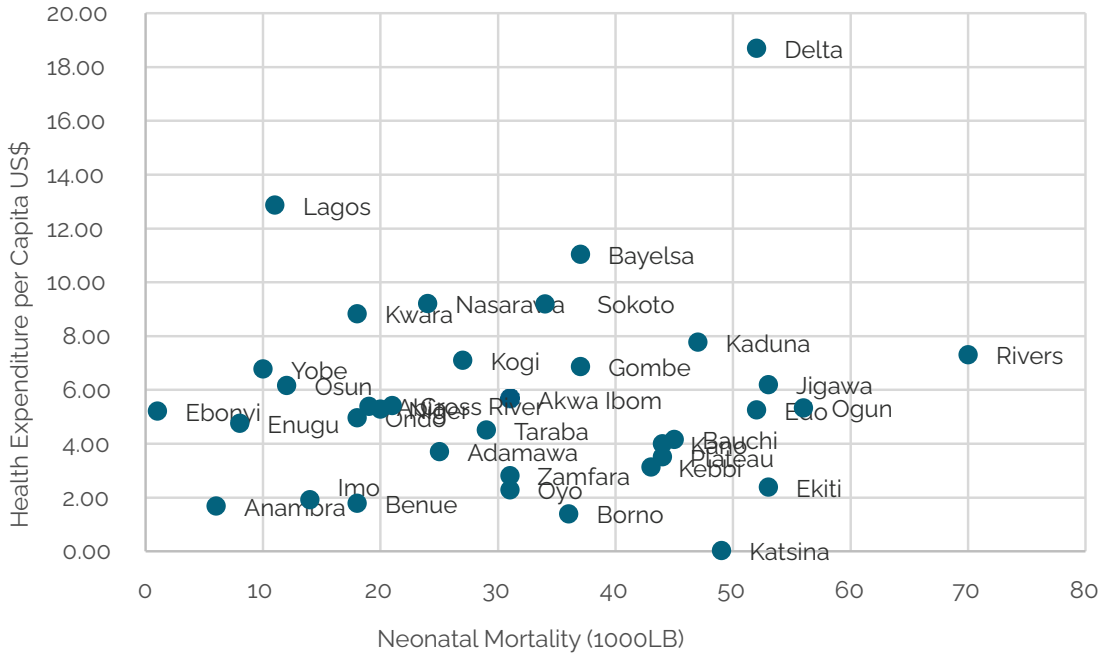


Figure 22: Health Expenditure per Capita/ Infant Mortality Rate

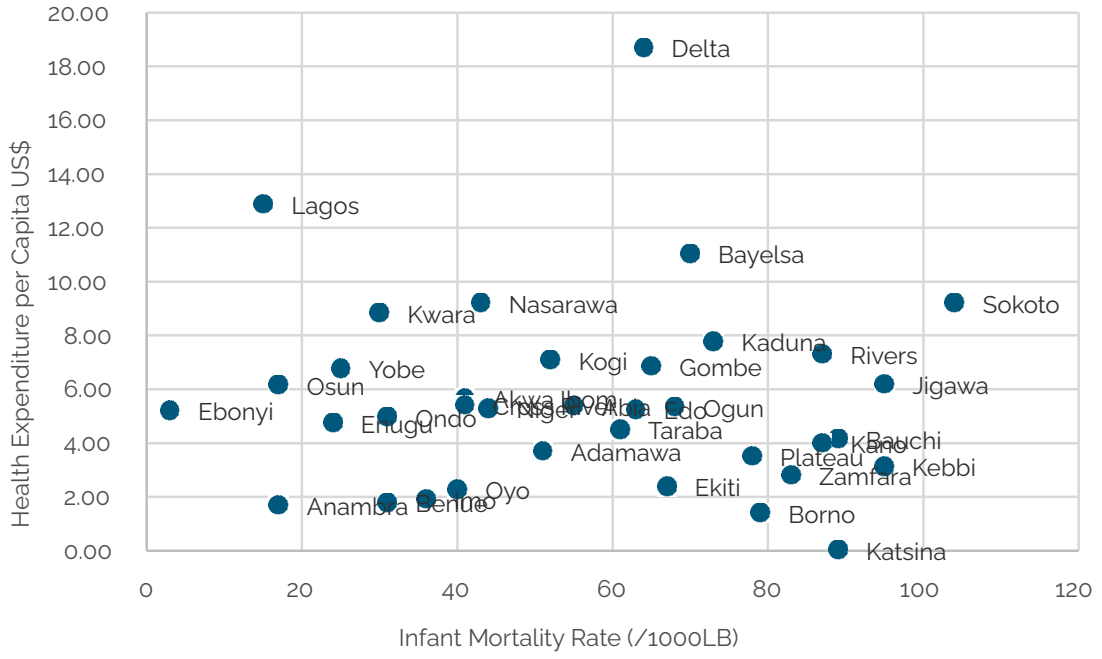


Figure 23: Health Expenditure per Capita/ Child Mortality

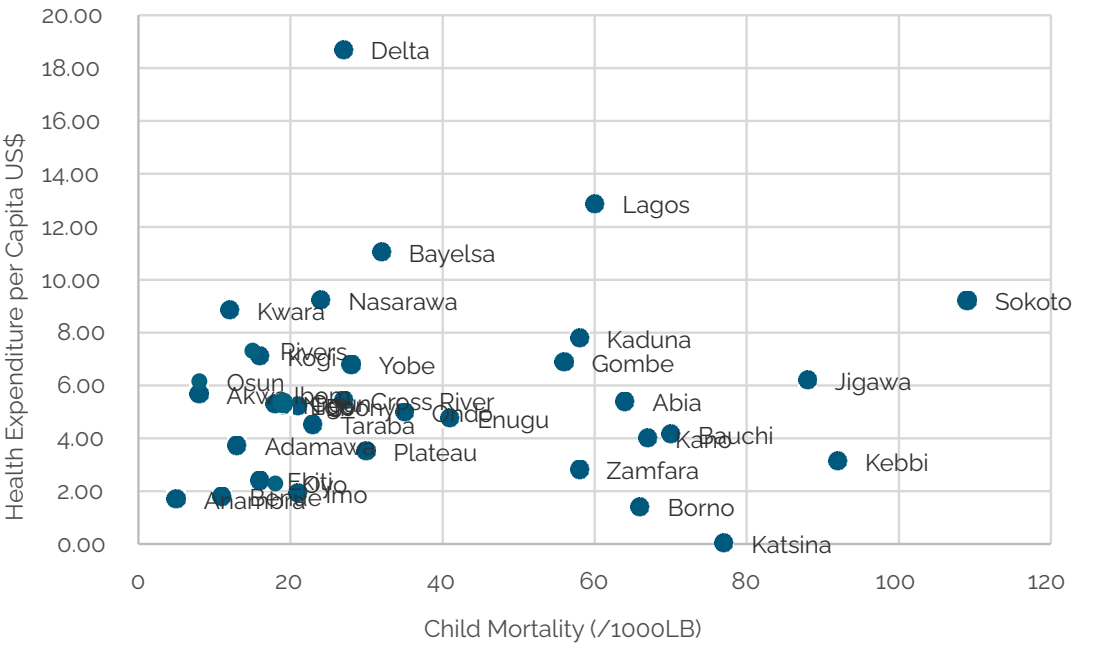
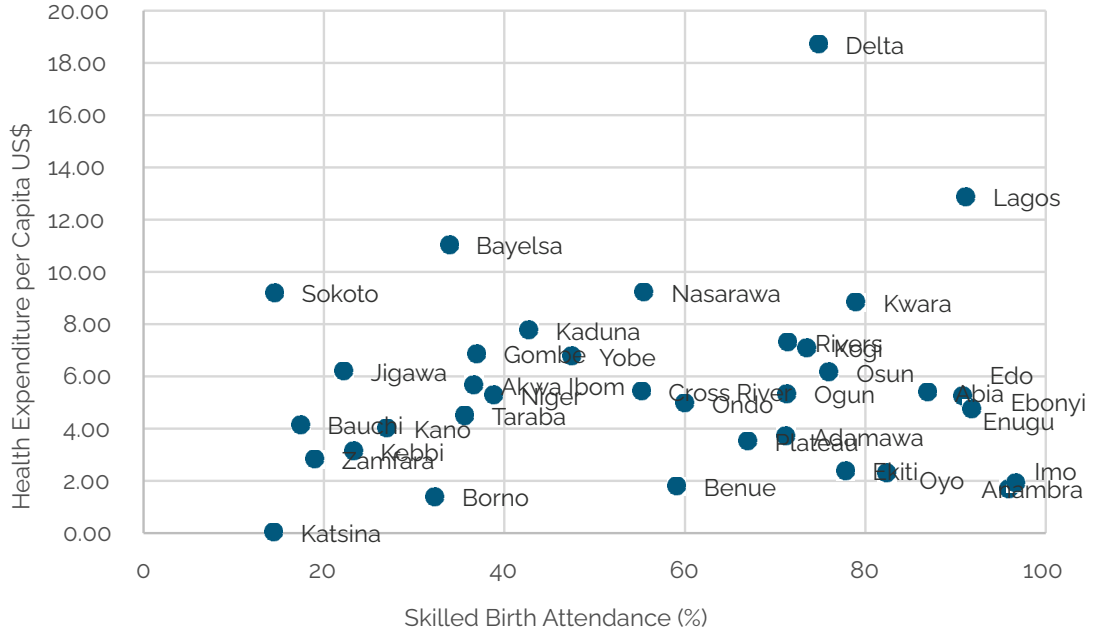


Figure 24: Health Expenditure per Capita/ Skilled Birth Attendance



While a recommended spending benchmark has not been agreed upon by State governments in Nigeria, the Abuja Declaration (2001) suggested allocating 15% of the government's budgets to health. The WHO also proposes a 5% GHE/GDP target to help governments achieve the minimum of their health outcomes, coverage, and financial risk status. These targets remain elusive for many countries, including 94% of low-income countries (LICs), 82% of Middle-income countries (MICs), and 75% of Upper middle-income countries (UMICs) who have not met them (The Royal Institute of International Affairs, 2014).

The report identified an improvement in State health spending, but the overall performance fell short of the desired targets. Only two States, Kaduna and Sokoto, exceeded this target in 2021. Jigawa and Kano came close with their health expenditure (% of total expenditure) reaching 12.2% and 13.9% respectively. In 2022, no State achieved the 15% health spending threshold. The highest was recorded in Sokoto, Kaduna, and Jigawa, at 13%, highlighting the need for sustained advocacy and policy support.

Authority	Health Expenditure, % of Budget	Health Expenditure Per Capita
AU/WHO/SDG Target	15% and 5% GHE/GDP	US$86
National Target	15%	US$29
States Average, 2022	7%	US$5.63

The findings call for deeper investigation into how States are utilising their health budgets and the relationship between spending, service delivery, and health outcomes.

4. Key Recommendations

At 7% of total expenditure and an average per capita of N2,383.54 (US$5.63) in 2022, healthcare systems at the state level are underfunded. Government spending on healthcare is far below the recommended targets. Even when funds are budgeted, only 63% are released, further limiting health programme objectives. High out-of-pocket expenses at over 77% of total healthcare spending and limited health insurance coverage at less than 5%, have also meant that a large share of the population who struggle to pay for essential medical services are unable to access healthcare.

Drawing on the report's findings, we propose a set of actionable recommendations.

A. Optimise Resource Allocation and Utilisation

1. **Increase Health Spending:** High-level advocacy and consensus building through platforms like the NGF can help strengthen political action for increased government spending on healthcare from 7% of total State government expenditure and ensure budgeted funds are released in full, from 63% currently. Development partners, CSOs, NGOs, community organisations, and patient advocacy groups can lead the charge in health advocacy by raising awareness and consciousness about critical issues and sharing lessons of successful healthcare delivery programmes across States. This will foster peer learning and healthy peer pressure.

2. **Align Donor Priorities and Development Aid:** Where State governments depend on over 15% of their health budget from external sources, including aid, grants, and loans, the sector will benefit from an ODA framework that addresses current coordination challenges in mobilising, deploying, managing, and tracking donor funds within the government's planning and budgeting system. The success of this framework would hinge on enforcement mechanisms capacity building and institutional strengthening for the health budget management centres.

3. **Achieving allocative efficiency:** The lack of a clear spending-outcome linkage demonstrates the importance of an MTSS which helps secure policy-based allocation of resources. To ensure comprehensive coverage of all health sector expenditures, the budget ministries need to expand the scope of the GPFS to

include a comprehensive programme, function, and location segment for all statutory financial reports. A comprehensive GPFS, combined with reporting of primary health spending in the financial reports of local governments will ensure greater transparency in health sector reporting.

4. **Streamlining health data management:** Each State's health information system should capture activity-based metrics (e.g., number of patients seen and other patient management data) and outcome-based metrics (e.g., mortality rate reduction, and improvement in specific health indicators) to provide governments with a clearer picture of how resources are used (even at the facility level) and the impact on health outcomes. Additionally, health programmes should be required to establish clear baselines and measurable outcomes for effective monitoring and evaluation. To ensure data quality, investing in trained personnel and robust verification processes is essential.

5. **Mobilising Private Health Investment:** Nigeria's national public-private partnership (PPP) policy already presents a mechanism to promote long-term healthcare development at the State level, where private partners can share the responsibility of infrastructure provision, maintenance, and service delivery. This model can expand the limited headroom for health financing, allowing governments to focus on areas like public health initiatives and social welfare. To maximise the success of PPPs in healthcare, two key steps are crucial: first, States need to identify their most pressing health needs, such as new hospitals, specialised clinics, equipment upgrades, or telemedicine infrastructure; second, these needs must be matched with projects suitable for PPPs. Ideally, these projects should generate revenue streams (user fees, diagnostics services) or achieve significant cost savings (through efficient management) to attract private sector investment.

6. **Maximising counterpart funds:** To improve the effectiveness of the counterpart funding system for federal health programmes in Nigeria, a shift towards a more collaborative approach is needed. State government concerns about misalignment, limited flexibility, and procurement inefficiencies highlight the need for programme designs that are integrated with local health systems. Decentralising programme implementation while maintaining clear national health goals and guidelines can empower States to tailor interventions and improve efficiency. Additionally, streamlining central management structures and data-sharing practices through technology platforms will reduce administrative costs and improve State-level response and planning.

B. Institutional Reforms and Capacity Building

7. **Improve Coordination:** We can strengthen information exchange within the national healthcare system by going beyond formal methods like standardised

reports, dedicated communication lines, and joint meetings to collaborative and learning channels like exchange programmes for health administrators. These peer learning opportunities will help health officials share working practices and gain valuable insights from one another's experiences. This will also help foster a seamless exchange of health data and programme knowledge across national, State, and local health agencies.

8. **Strengthen the regulatory capacity of the health ministry:** Nigeria's healthcare system at the State level, with up to 10 budget management centres (including the Ministry of Health, State Primary Health Care Development Agency (SPHCDA), Hospital Management Board (HMB), State Health Insurance Service (SHIS), and the Drug Management Agency (DMA)), is fragmented and difficult to coordinate. To address this, we recommend strengthening the role of the health ministry to provide oversight of the system and ensure consensus on policies, spending and reporting. Steps that can be taken may include policy changes that strengthen the role of health ministries, investing in training and resources for the health ministry; and developing clear communication and collaboration protocols for all healthcare authorities in the system.

9. **Strengthening M&E Systems:** We propose a two-pronged approach to strengthen M&E in the sector. Firstly, strengthen M&E operations including standardised M&E frameworks across all health institutions that define clear objectives, indicators, data collection methods, and reporting processes for each facility. Secondly, build capacity for prioritising activities based on impact and health outcomes, such as capacity-building programmes for public health professionals and decision-makers on M&E principles, data analysis, and cost-effectiveness assessments for outcome-based planning and data-driven decision-making.

C. Expand Coverage and Equity

10. **Scaling Up Health Insurance:** Increasing health insurance coverage is crucial for ~95% of the population not covered by any means of healthcare coverage. The Basic Health Care Provision Fund's focus on targeted interventions aligns with this goal.

11. **Prioritising Primary Care:** Expanding and improving primary healthcare services, especially in rural areas, will address existing inequities in healthcare coverage. This includes ensuring a more equitable distribution of qualified healthcare workers, quality facilities, and good governance practices across urban and rural areas. Evidence-based Human Resource Management (HRM) systems, with incentives for rural postings, can play a vital role in achieving this. Local governments should collaborate with the State and the federal government on the implementation of primary healthcare programmes and initiatives.

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