



# Improving Budget Credibility in Primary Health Services in Nigeria



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# Summary of Key Findings

# 1

To address budget credibility in sectors like primary health and immunization in Nigeria, understanding specific deviations in expenditure is crucial. Different tactics are needed to address deviations between released and budgeted cash, as compared to addressing differences between utilized and released cash.

# 2

Primary health services face significant budget credibility risks related to the Basic Health Care Provision Fund (BHCPF) in all 36 states, but these issues are hard to track. An issue in Anambra is the absence of explicit BHCPF funding in the state's budget, making it challenging to measure deviations accurately. Policymakers must anticipate and address risks such as inaccessibility to federal BHCPF funds due to eligibility criteria non-compliance, which may involve baseline assessments and capacity building for Primary Health Care Centres.

# 3

In the health sector, weak budget credibility is driven by procedural, regulatory, and political obstacles in Oyo and Anambra states, as well as at the federal level. These bottlenecks result in deviations in procurement for Primary Health Centers (PHCs) and must be addressed individually, as suggested in the report.

# Introduction

Nigeria's federal government had budgeted 87.1 trillion naira for improving infrastructure and service delivery for its growing population in the ten years between 2013 and 2022. Have these budgeted sums translated to commensurate improvements in the quality of over 22,300 primary healthcare centres nationwide? Has access to quality and affordable healthcare or overall service delivery across the public sector improved, given their budgeted sums in the past ten years? In the next ten years, we estimate the government would budget at least 150 trillion naira; how can stakeholders ensure that these budgets deliver commensurate value?

Budget credibility (or budget realism, as some policymakers prefer to refer to it) is an essential metric in governance worldwide. According to Renzio and Cho, it reflects a government's ability to accurately and consistently meet its expenditure and revenue targets. (Renzio, 2020). In Nigeria, analysis of



**A country's performance in its Budget credibility metric foretells how effectively a government can achieve its infrastructure and service delivery goals outlined in its expenditure targets - no matter how laudable those goals may seem on paper.**

budget credibility as it affects revenue targets approved in the budget is pretty straightforward -- this can readily be

calculated as the difference between the final revenue recorded by the government and that budgeted at the start of the fiscal year. However, analysing budget credibility as it affects expenditure targets approved in the budget is not straightforward.

At the federal level, Nigeria experiences two levels of deviation of its expenditures from budgeted sums that contribute to the overall budget credibility and, by extension, service delivery. First, there are deviations between what is budgeted and what is recorded as cash released for expenditures. Second, there are deviations between cash released for expenditures and the actual amount utilised for the expenditures. Both observations contribute to forming a more complete picture of the country's budget credibility situation on the expenditure spectrum. Unpacking why both forms of deviations persist, and the severity with which each deviation lasts lays the groundwork for thinking through targeted solutions to improve the country's overall budget credibility.

BudgetIT's Research and Policy Advisory team thinks of Budget credibility as the degree to which the actual utilisation of public funds (for budgeted expenditure) deviates or differs from planned expenditures recorded in the budget at the commencement of any fiscal year. This emphasis on "actual utilisation" is vital for the Nigerian context because there exists the risk that journalists and citizens could interpret cash released for expenditures as announced by the government as actual expenditures made, whereas the reality is significantly different.

A country's performance in its budget credibility metric foretells how effectively a government can achieve its infrastructure and service delivery goals outlined in its expenditure targets - no matter how laudable those goals may seem on paper. Weak budget credibility, signalled by large deviations or volatility in revenue and expenditure projections, often compromises the best development plans for infrastructure, improved service delivery, and quality of life.

This study focuses on Oyo and Anambra states, and the federal government. Oyo state is in South West Nigeria, with an estimated population of 9.29 million<sup>1</sup>,

and 913 Primary Health Care Centres<sup>2</sup>. Anambra state is in South East Nigeria, with an estimated population of 6.36 million people and 740 Primary Health Care Centres<sup>3</sup>.

Though the drivers of budget credibility on the revenue end of public finance are well documented, this report will focus on budget credibility as it affects revenue and expenditure. They include unrealistic revenue projections in the budget, weak revenue collection mechanisms, revenue leakages, and weak accountability mechanisms.



<sup>1</sup> Said population figures are based on the NBS Population set of 2006 and extrapolated to determine 2021 numbers.

<sup>2</sup> This number may include Health Care facilities other than PHCs, that offer Primary health care. See Federal Ministry of Health. Nigeria Health Facility Register (Website). Available at: <https://www.hf.health.gov.ng/statistics/tables>. Date accessed-26/04/2022.

<sup>3</sup> See Federal Ministry of Health. Nigeria Health Facility Register (Website), op.cit. Date accessed-26/04/2022.

# Methods

This research examines budget credibility trends over time in primary health care services and immunisation. It intends to discover the key drivers of budget credibility trends observed in Anambra, Oyo State, and at the Federal Government level. It employs a mixed-method approach with the following:

**Quantitative Analysis:** Data was mined from budget documents of Anambra, Oyo, and the federal government for a trend analysis on budget credibility for the period covering 2017-2021 in primary health care services and immunisation.

**Qualitative Analysis:** Key Informant Interviews (KIIs) were conducted with selected state and non-state actors. The objective was to generate in-depth information via Learning about the drivers and the impact of budget deviations on service delivery in primary health care services and immunisation. Also, to ascertain the key drivers of budget credibility trends observed in Anambra and Oyo State.

In addition, primary and secondary data were gathered. The primary component was achieved via KIIs with purposively selected respondents<sup>4</sup>. The secondary data came via desk review on the existing International Budget Partnership (IBP) data and other leading literature on budget credibility, research findings on budget credibility issues in International Budget Partnership (Strengthening Public Accountability for Results and Knowledge program) SPARK focus states, annual budgets, and budget implementation reports. Similarly, a review of the Fiscal Responsibility Act and Public Procurement Laws of Anambra and Oyo State was conducted to ascertain if some procedural rules or regulations cause a lag in the system and result in the low utilisation of available government revenues. Data and responses sourced using the above data collection techniques and approaches were triangulated for increased quality and reliability.

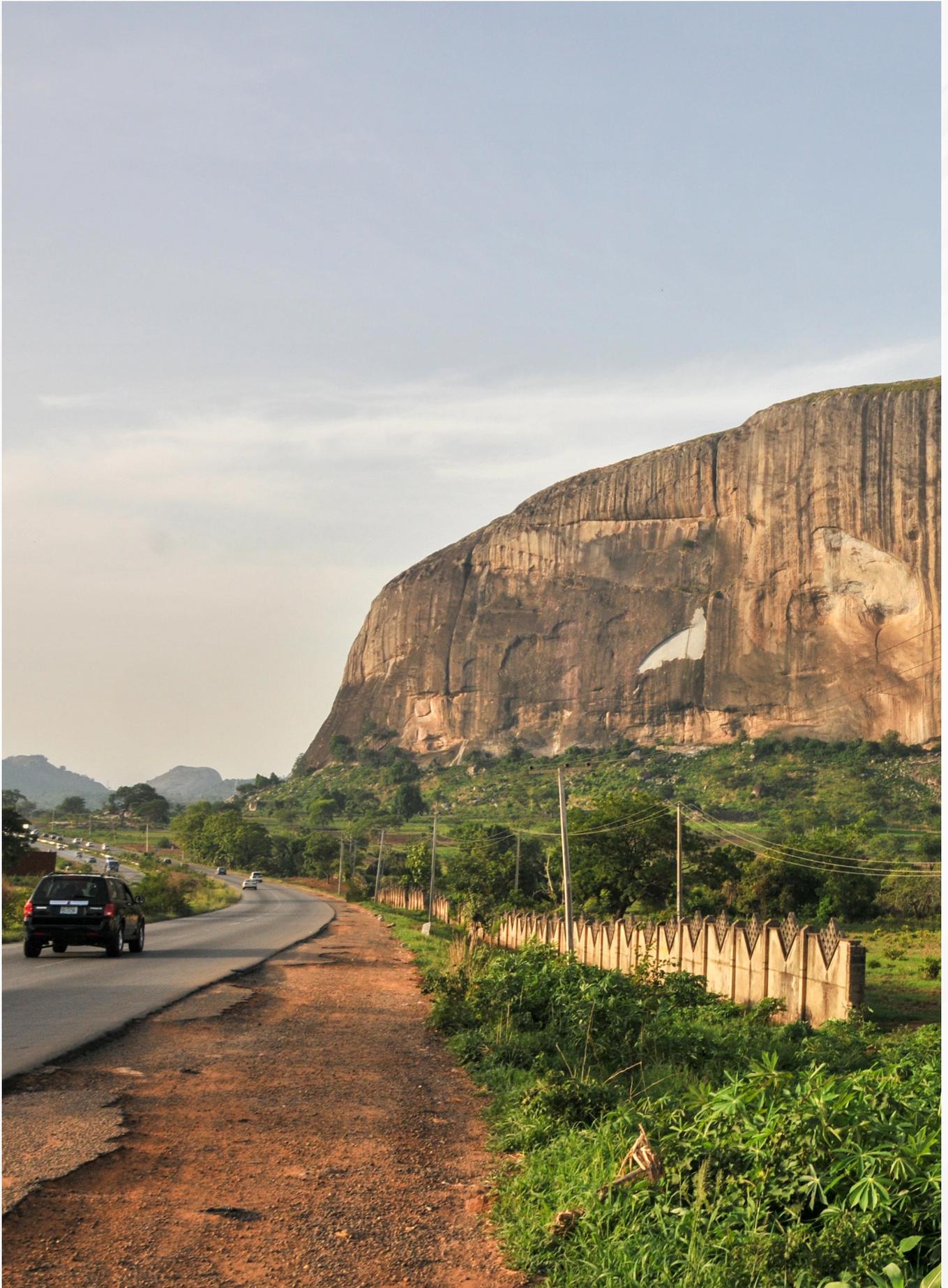
## Research Questions

- What are the budget credibility trends for the health sector in budget data mined between 2017 and 2021?
- What are the effects of budget deviations on service delivery in primary health care services and immunisation in focus states and at the federal level?
- What are the root causes of budget credibility trends observed in the focus states?
- Are there procedural rules or regulations that cause low utilisation of available government revenues?
- What contextual factors or hidden variables lead to low budget credibility?
- What can be done to improve budget credibility in the focus areas of the research?



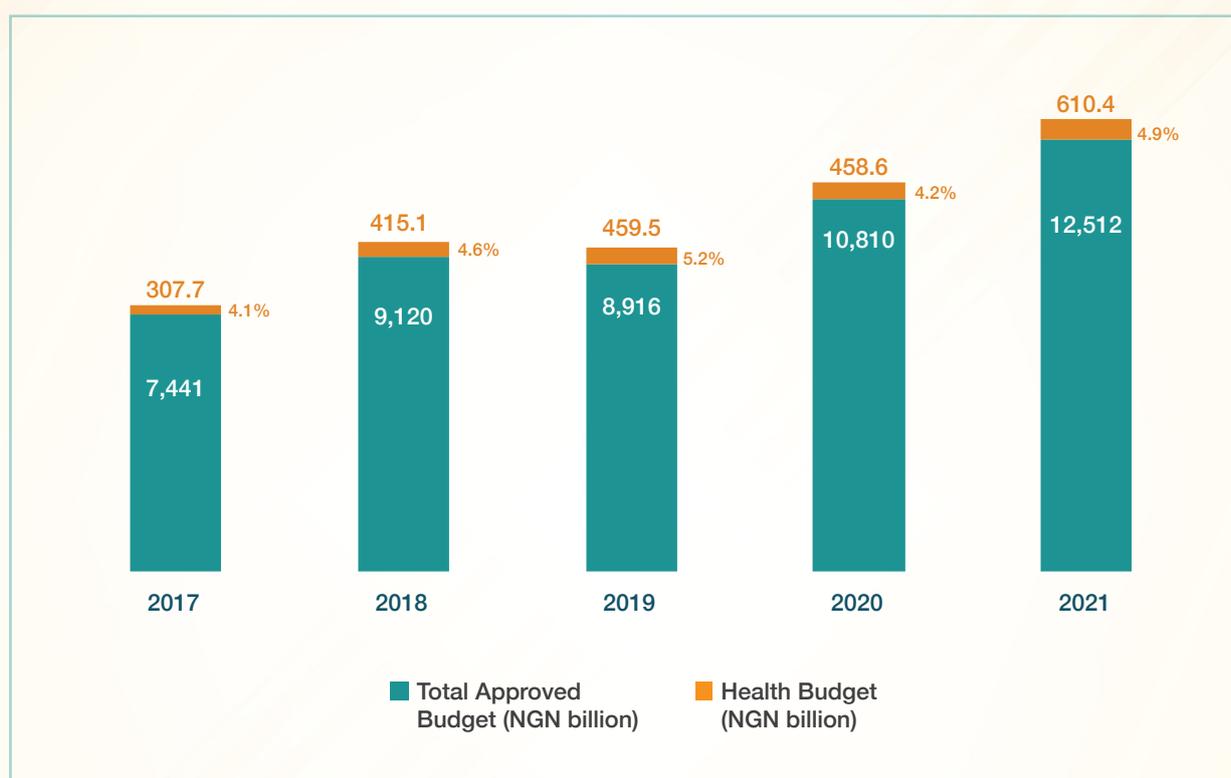
<sup>4</sup> The participants for the Key Informant Interviews (KIIs) included: SPARK partners for the Primary Health Care entry point (JDPC Nnewi and their CSO/technical partners), the Director-General of the Budget Office in focus states, the Head of State Bureau of Public Procurement, Director in State Ministry of Finance or Office of the Accountant General, and the Executive Secretary of Primary Healthcare Development Agencies in focus States.

**Budget Credibility  
Trends at the Federal  
Government Level,  
Anambra and Oyo State**



# Federal Government

Figure 1: Federal Government Allocation to Health



In April 2001, Africa Union member states met in Abuja and agreed to allocate 15 percent of their budgets to health<sup>5</sup>. 21 years later, Nigeria is yet to meet the 15 percent threshold both at the federal and subnational level. Figure 1 shows that between 2017 and 2021, Nigeria has consistently allocated less than 6 percent of its annual budget to its health sector.

5 See "Public financing for health in Africa: 15% of an elephant is not 15% of a chicken" by Dr. Nkechi Ojalere and Ms. Agnes Gatome-Munyua, on October 13 2022, in Africa Renewal (Online) Magazine, United Nations. Available at: <https://www.un.org/africarenewal/magazine/october-2020/public-financing-health-africa-when-15-elephant-not-15-chicken>

**Figure 2:** Total Budget Execution Rate Trends

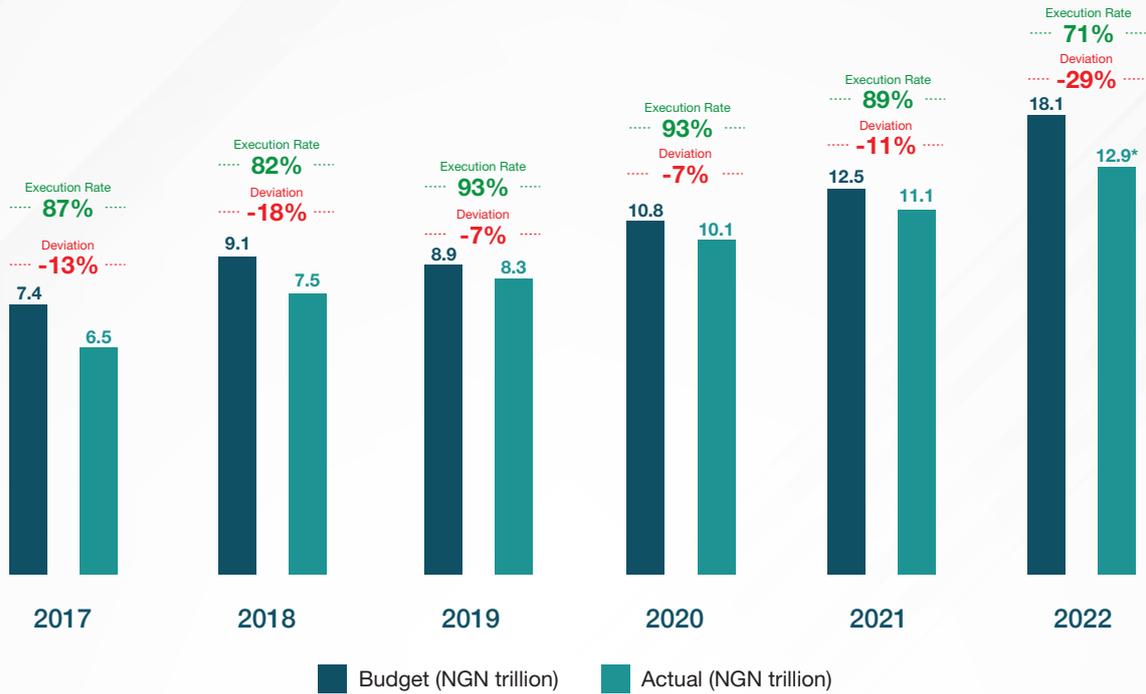
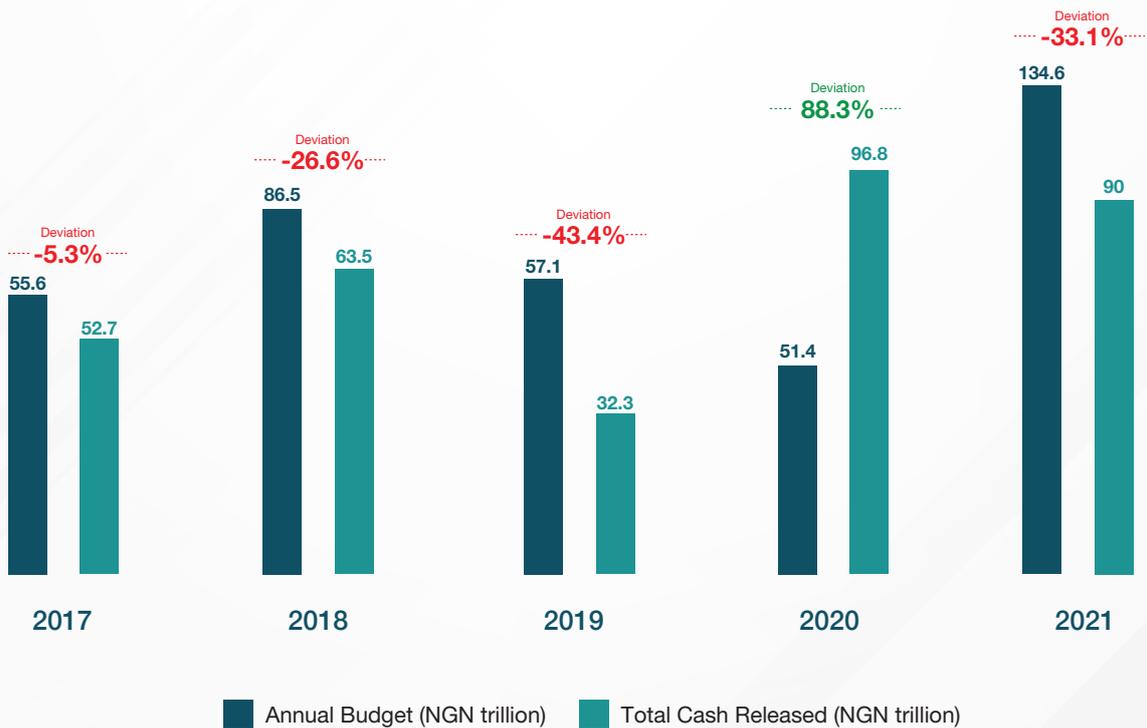


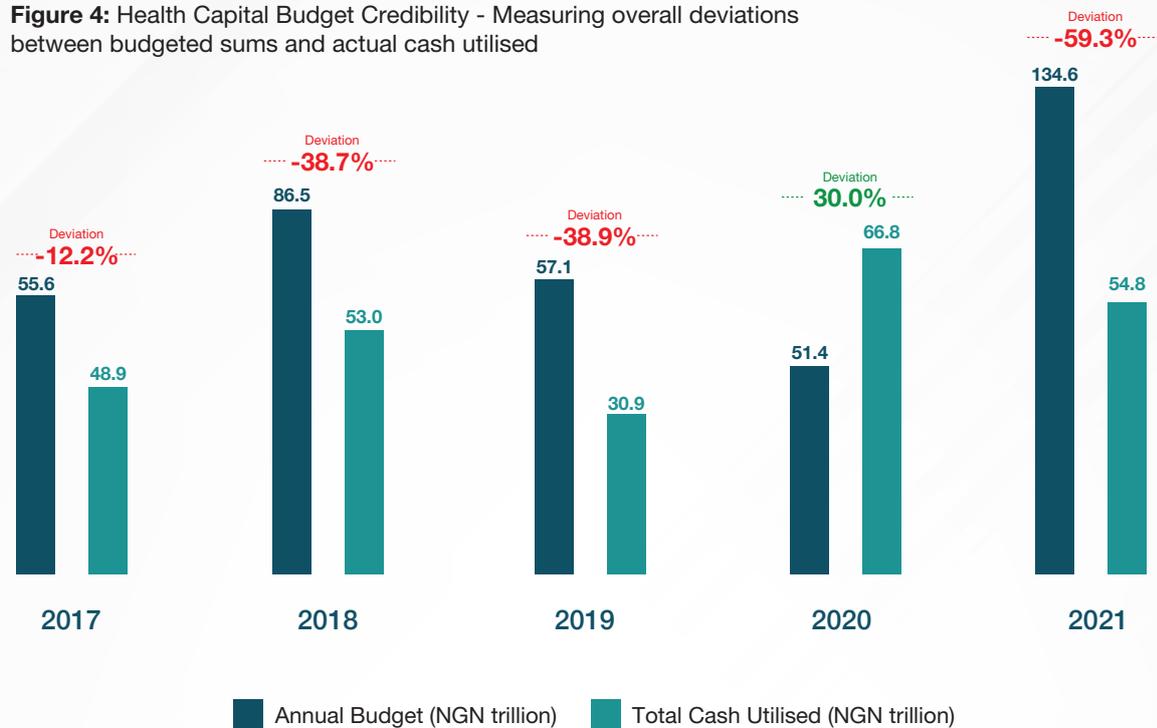
Figure 2 shows that between 2017 and 2022, the federal government under-implemented its budget, leading to deviations as high as 29.05 percent in the first eleven months of 2022. Budget deviation rose from -13 percent in 2017 to -18 percent in 2018 but declined to -7 percent in 2019 and increased marginally to -7 percent in 2020, the year COVID-19 struck.

**Figure 3:** Health Federal Capital Budget Credibility-Measuring deviations between cash released and budgeted sums only

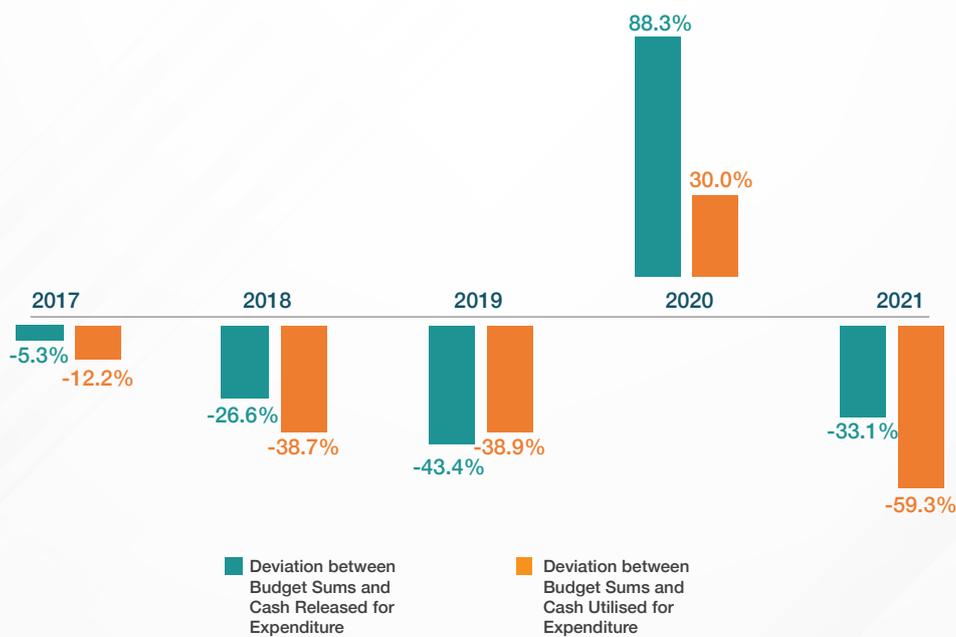


In addition to the comparatively low allocation to the health sector in years under review, cash releases for budget execution have been suboptimal, leading to relatively low budget credibility. As seen in Figure 3, capital budget execution worsened year-on-year between 2017 and 2021, except for 2020, when COVID-19 occurred, and the government had to embark on emergency spending to contain and respond to the disease outbreak.

**Figure 4: Health Capital Budget Credibility - Measuring overall deviations between budgeted sums and actual cash utilised**



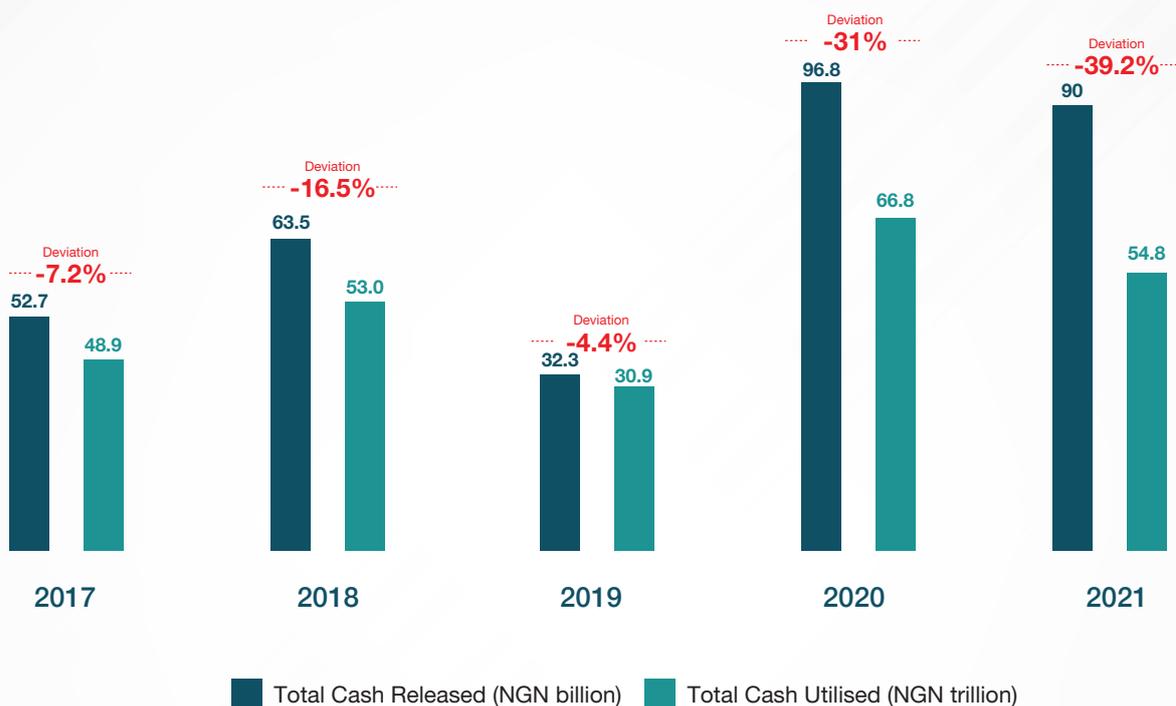
**Figure 5: Health Federal Capital Budget Credibility - Comparing the different levels of budget deviation at two points in the budget cycle**

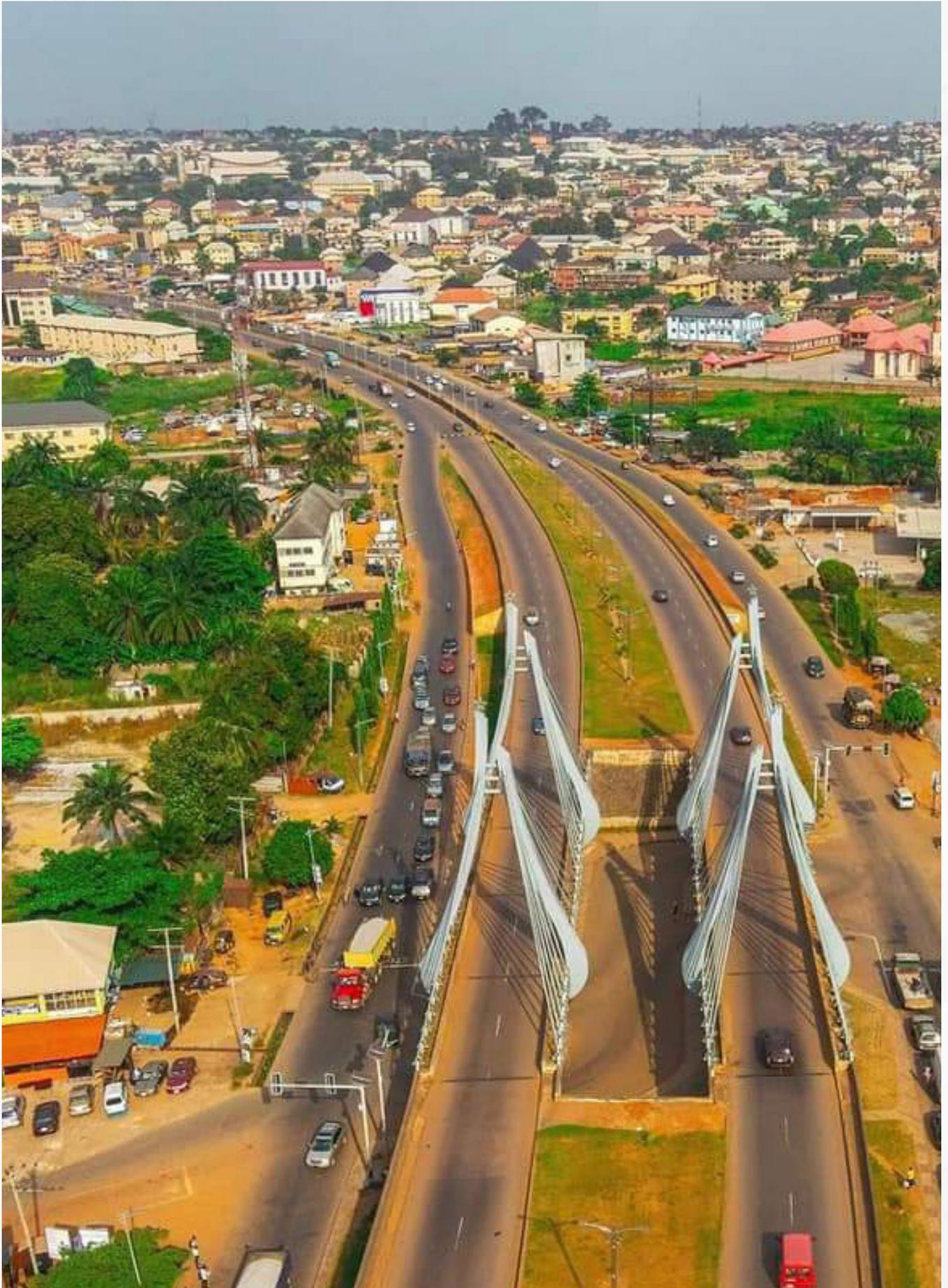


*Note: Total cash released includes amounts captured under Authority to Incur Expenditure (AIE)*

As depicted in Figure 5, the health sector in the years under review has been unable to utilise releases made to it for capital expenditure. This is quite worrisome, considering the fact that several accountability actors have increasingly geared advocacy efforts towards the improved budgetary allocation to the health sector to meet the Abuja declaration threshold of 15 percent. The health sector’s capacity to optimally utilise budget releases within the fiscal year must be enhanced if the advocacy for improved allocation will yield any result.

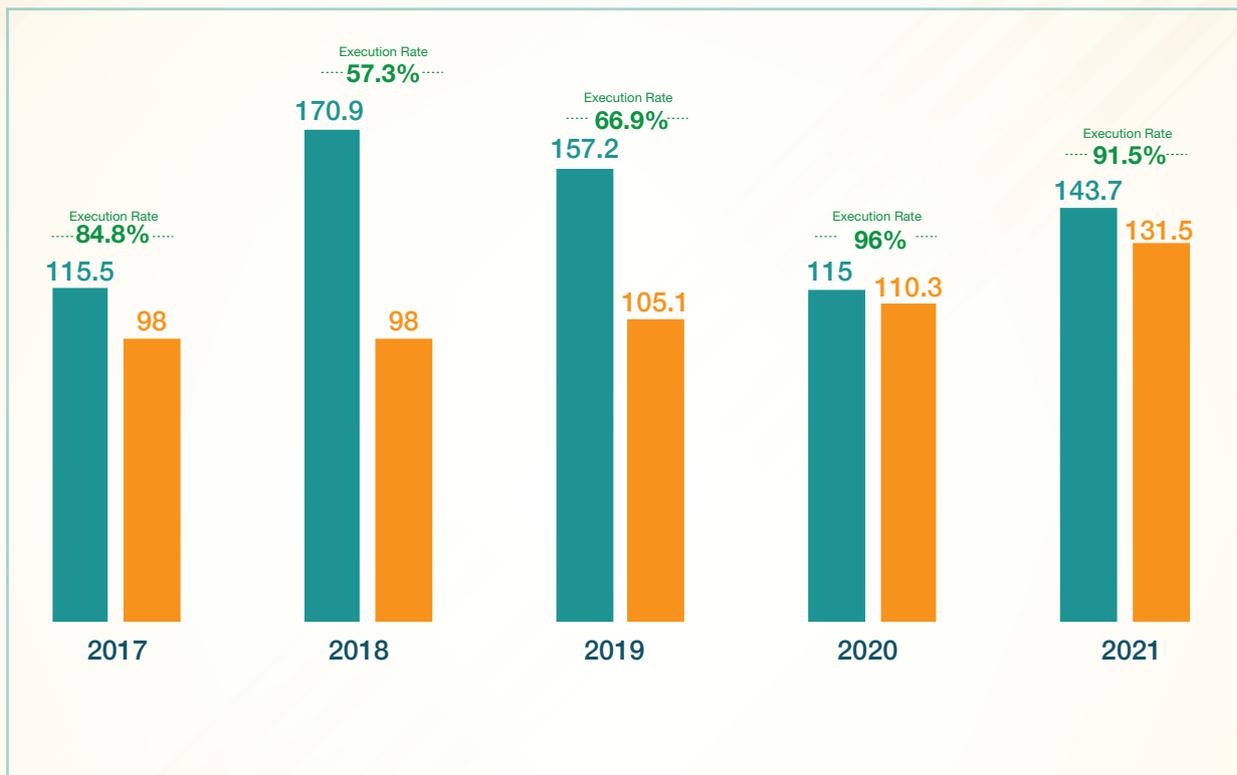
**Figure 6:** Health Federal Capital Budget Credibility - measuring deviations between actual cash released and actual cash utilised only





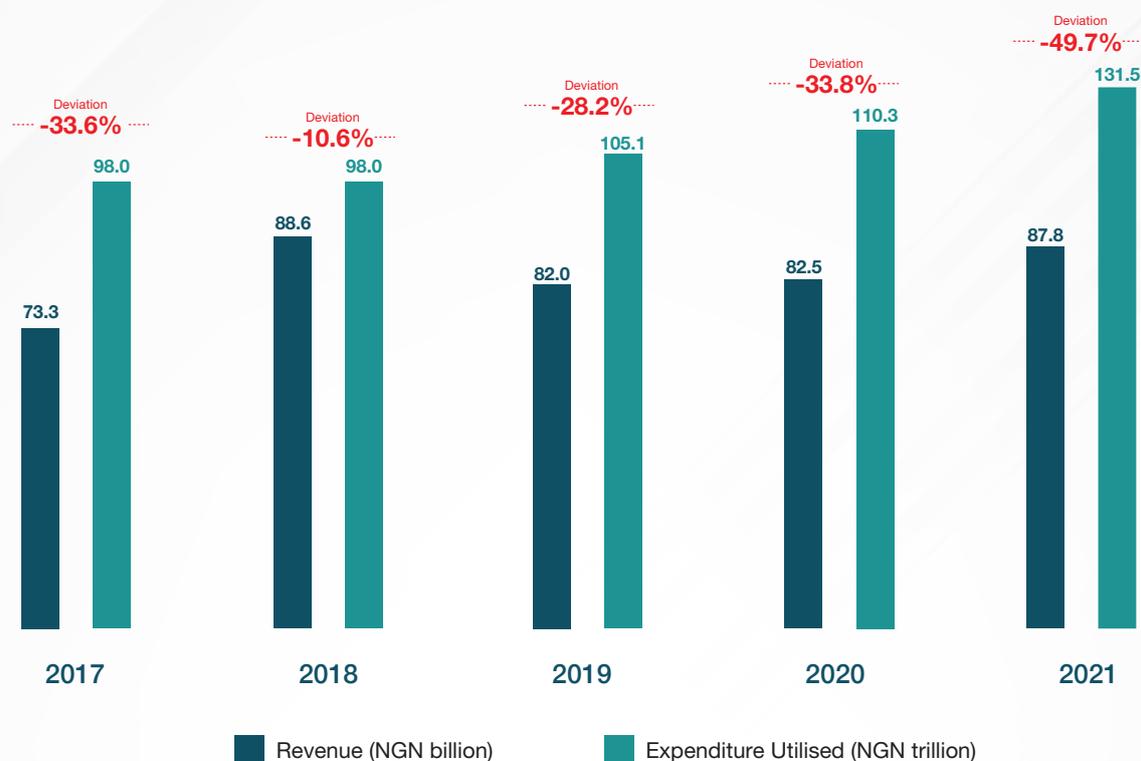
# Anambra State

**Figure 7: Anambra Budget Execution Trend (2017-2021)**



A look at Anambra's budget execution rate as articulated in figure 7, shows that between 2017 and 2021 Anambra had the worst budget execution in 2018, where it implemented just 57.3 percent of its budget. Expectedly, in a bid to respond to the socio-economic impact of the COVID-19 pandemic that occurred in 2020, Anambra implemented 96.0 percent of its approved budget in 2020.

**Figure 8: Anambra Actual Budget Trend (2017-2021)<sup>6</sup>**



Although Anambra has had a comparatively low actual budget deficit in the years under review, it has failed to prioritise spending on its health sector duly. Figure 8 shows that there has been a constant increase in the revenue accruing to the state from 73.3 billion naira in 2017 to 87.8 billion naira in 2021. However, implementing key budget lines in the health sector has been below par.

<sup>6</sup> See Anambra State Government, (2022), The Report of the Accountant General, Anambra State, at page 15. Available at: <https://www.anambrastate.gov.ng/storage/Anambra-State-2021-Report-of-the-Accountant-General.pdf>

**Table 1: Anambra Budget Prioritization Trend (2019-2021)**

Programme Description	2019		2020		2021	
	Budget as a percentage of Total Budgeted	Actual as a percentage of Total Actual Expenditure	Budget as a percentage of Total Budgeted	Actual as a percentage of Total Actual Expenditure	Budget as a percentage of Total Budgeted	Actual as a percentage of Total Actual Expenditure
	Improvement to Human Health	10.0%	3.0%	8.0%	3.0%	6.0%
Enhancing Skills and Knowledge	10.0%	7.0%	9.0%	5.0%	6.0%	5.0%
Water Resources and Rural Development	1.0%	0.0%	1.0%	0.0%	1.0%	0.0%
Road	24.0%	42.0%	21.0%	26.0%	24.0%	27.0%
Airways	3.0%	0.0%	8.0%	36.0%	20.0%	24.0%

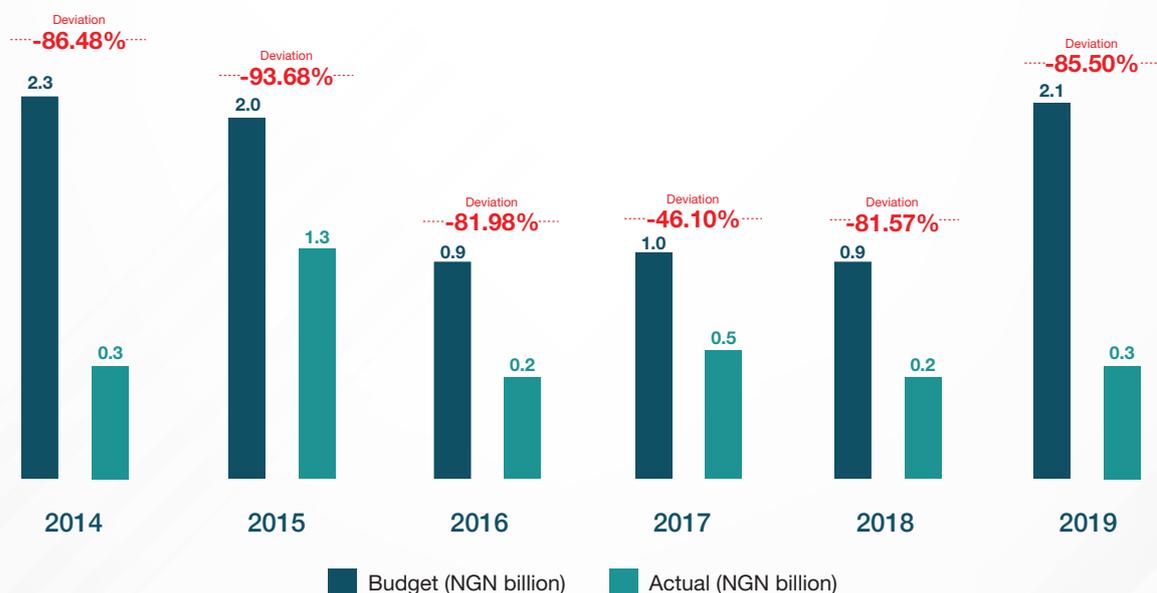
**Table 2: Anambra Budget Prioritization (2017-2018)**

Expenditure by Function	2017		2018	
	Budget as a percentage of Total Budgeted	Actual as a percentage of Total Actual Expenditure	Budget as a percentage of Total Budgeted	Actual as a percentage of Total Actual Expenditure
	Health	3.7%	5.0%	7.0%
Education	9.9%	11.0%	11.0%	10.0%
Social Protection	0.2%	1.0%	1.0%	1.0%
General Public Services	41.3%	45.0%	42.0%	42.0%
Public Order and Safety	2.3%	3.0%	2.0%	3.0%

According to Tables 1 and 2, Anambra, between 2017 and 2021, failed to meet the 15 percent budget allocation to health. While the State improved its health allocation from 7 percent in 2017 to 10 percent in 2019, its health budget allocation declined to 6 percent in 2021. A more critical look at Anambra's actual spending between 2019 and 2021 reveals that the state prioritised spending on airways and roads over critical social sectors, including health. While the state spent 27 percent and 24 percent of its resources on roads and airways in 2021, a paltry 4 percent of total expenditure was geared toward the health sector.

Interestingly, while 8 percent of the 2020 budget of Anambra was allocated to health and airways, respectively, 36 percent of the state's expenditure in 2020 was eventually spent on airways, while the state disappointingly spent just 3 percent of its total budget on health. The aforementioned speaks to a bigger prioritisation problem than it does to the paucity of funds, which the government frequently posits as the reason for the poor budgetary allocation and implementation of its social sector budget, including health. During a stakeholder engagement meeting, a government official confirmed that due to the deplorable state of some roads essential to the state's economy, the improvement of road infrastructure was a key priority of the state government, hence the government shifting funding in that regard.

**Figure 9: Anambra Budget for the Rehabilitation of Primary Healthcare Centres & General Hospitals**

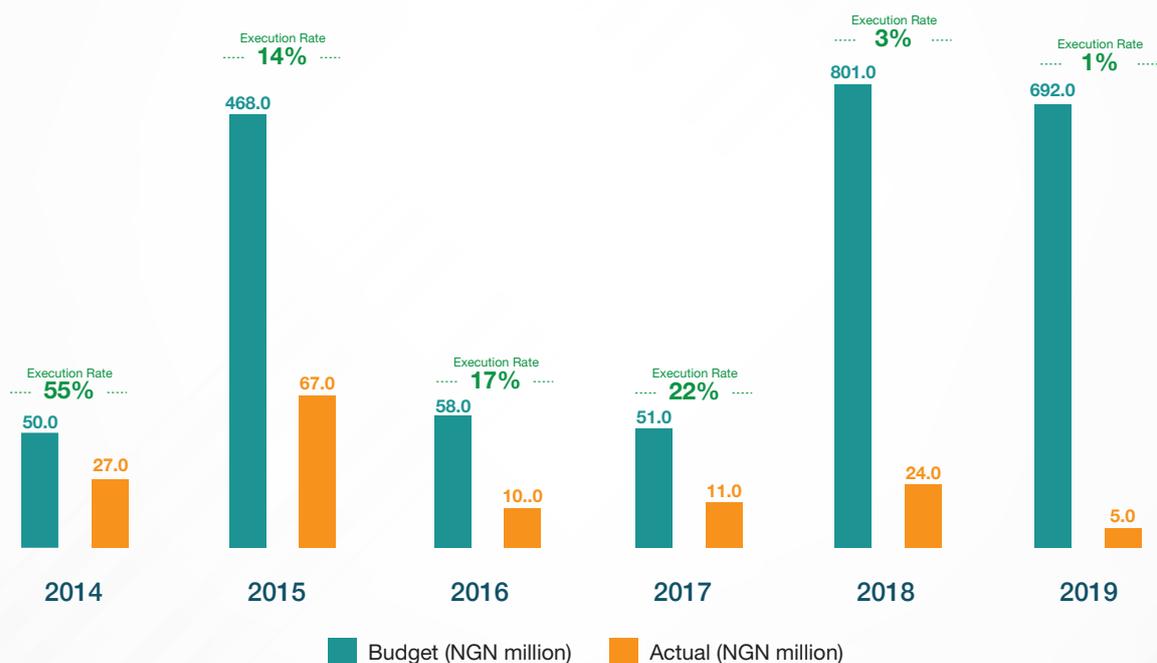


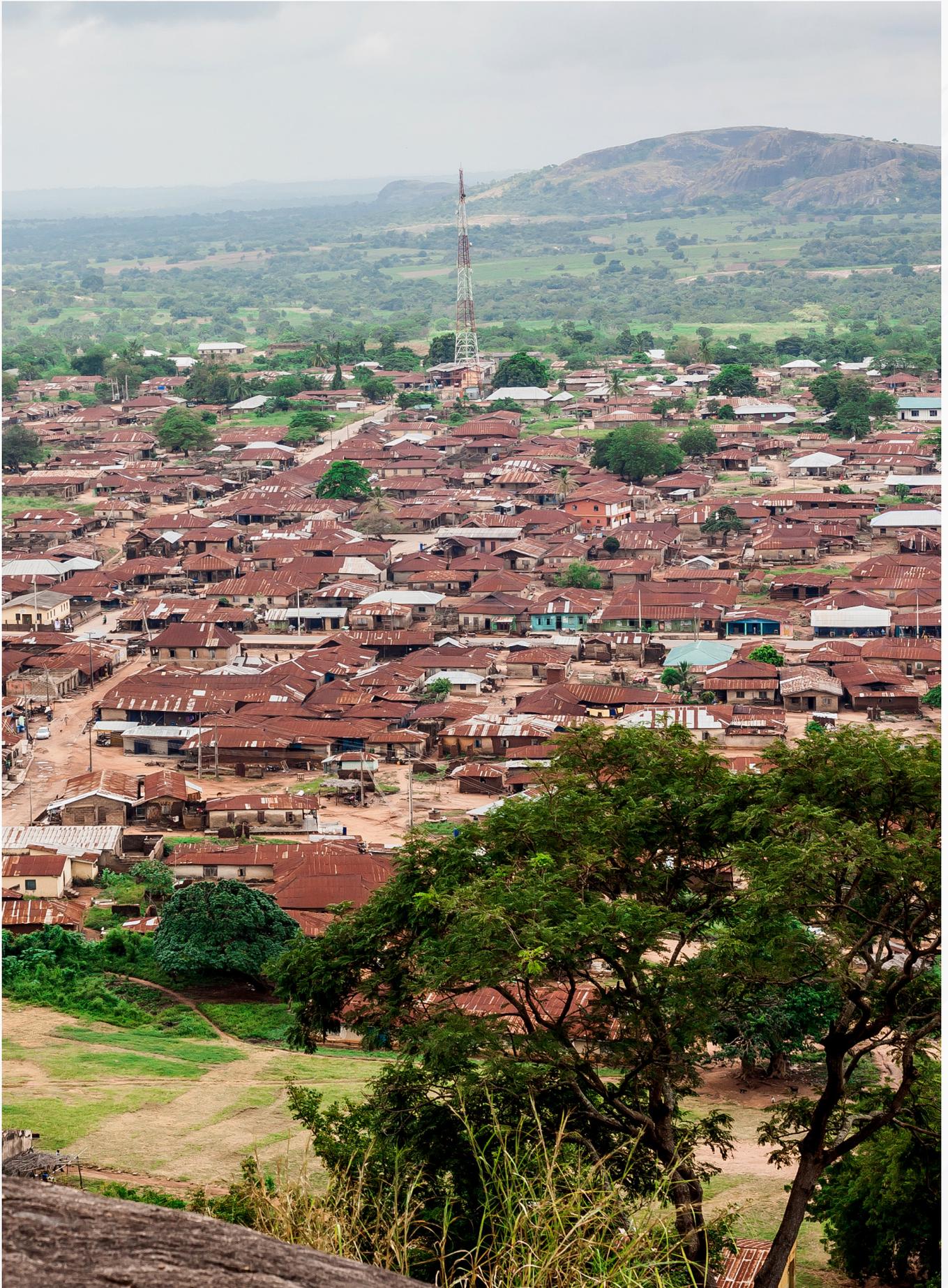
Source: Computed from Anambra State Government Approved Budget 2014 - 2020

Anambra state government developed a plan for rehabilitating 10 Primary Health Care Centres and two General Hospitals yearly between 2014 and 2019. However, the budget of this program had abysmal budget execution rates during the period under review. According to civil society actors in a Health Dialogue held in Awka, Anambra, in June 2022, 63 Primary Health Care Centres (3 per local government) were rehabilitated between 2014 and 2015. Figure 9 shows that as much as 93.68 percent of the budgeted funds were not spent (2015), while an average of 77 percent of all budgeted sums between 2014 and 2019 were not expended. A similar trend was also observed in the budget for the purchase of medical supplies for selected hospitals, as shown in Figure 10.

It is important to understand the drivers of this poor budget execution and what has been attempted to resolve this problem.

**Figure 10:** Budgetary Provision for Medical Supplies





# Oyo State

**Table 3:** Oyo State Health Budget Trend (2018-2021)

Year	Health Budget (NGN Billion)	Health Actual Spend (NGN Billion)	Execution Rate (%)	Total Approved Budget (NGN Billion)	Total Actual Expenditure (NGN Billion)	Health Budget as a percentage of Total Budget	Health Spend as a percentage of total actual expenditure
2018	12.9	7.3	57%	271.7	121.5	5%	6%
2019	12.2	8.4	69%	285.2	122.6	4%	7%
2020	10.9	8.4	78%	174.1	114.4	6%	7%
2021	13.8	9.8	71%	268.8	178.1	5%	6%

Table 3 shows that a 46.6 percent growth in the actual expenditure of Oyo State from 121.5 billion naira in 2018 to 178.1 billion naira in 2021 was accompanied by a 33.88 percent increase in its actual total health spend from 7.3 billion naira in 2018 to 9.8 billion naira in 2021. However, the health budget and actual expenditure on health have been below 10 percent within the period under review. Like the federal government and Anambra State, Oyo’s budget allocation to its health sector between 2018 and 2021 did not meet the 15 percent threshold the AU member states agreed on in Abuja in 2001.

**Figure 11:** Oyo Actual Budget Trend (2018-2021)

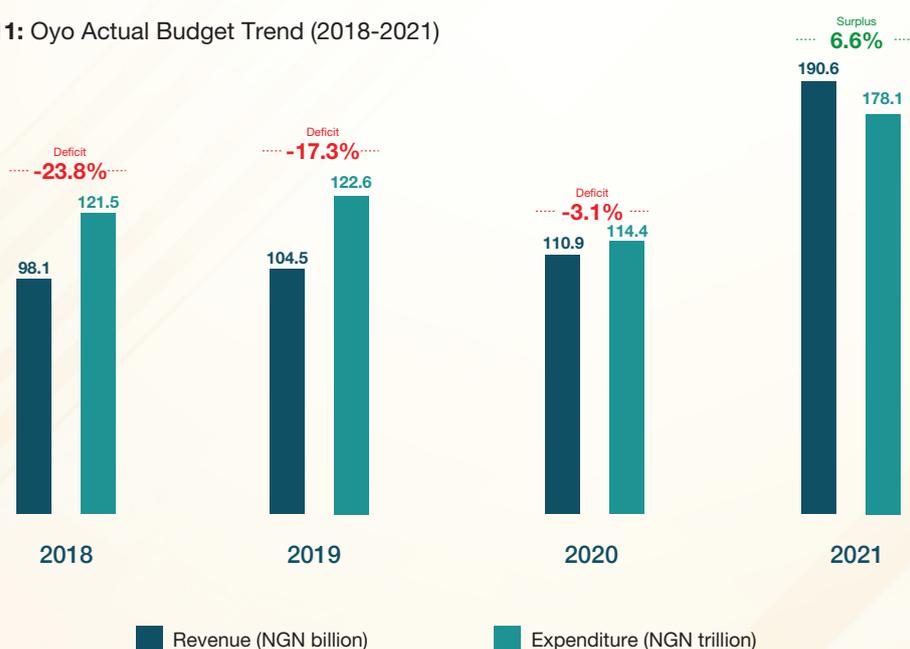


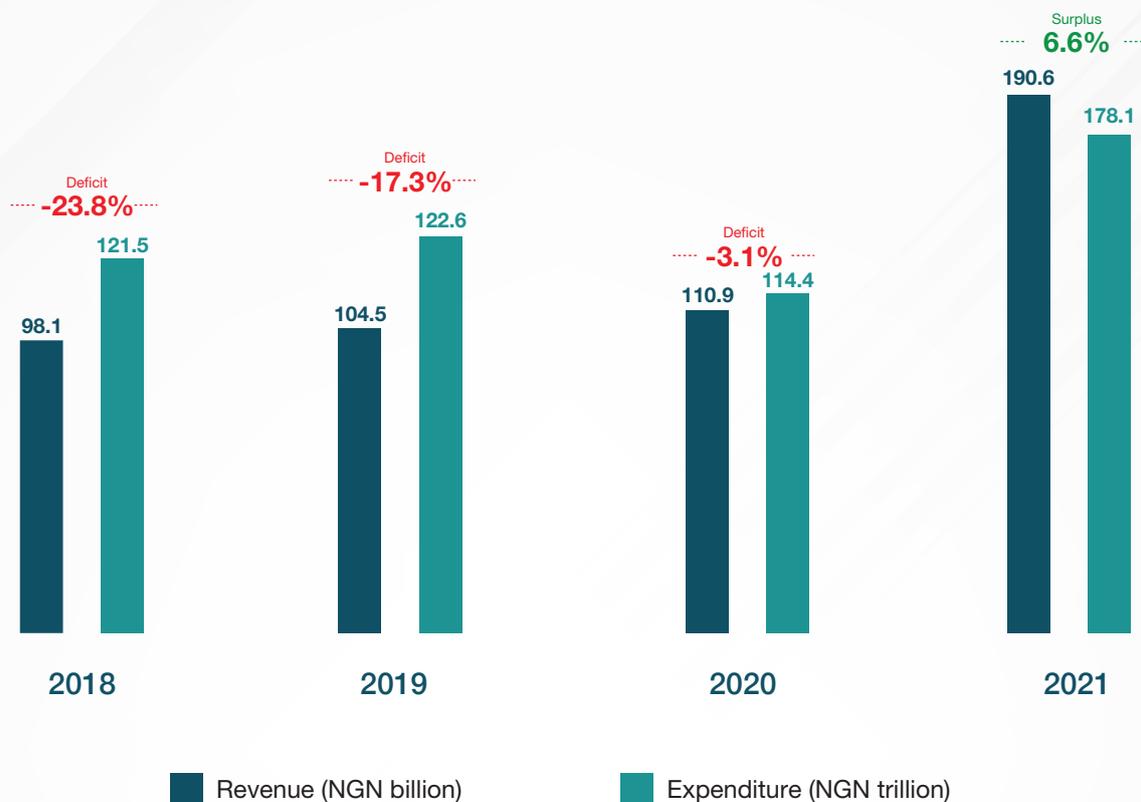
Figure 11 shows that Oyo State has consistently grown its revenue from 98.1 billion naira earned in 2018 to 190.6 billion naira in 2021. In the aforementioned period under review, the state had a budget deficit in 2018, 2019, and 2020 but a surplus in 2021. An official of the Oyo State Government revealed that a tax refund of about 10 billion naira, which likely came in later in the year, may have been responsible for the budget surplus recorded in 2021. The budget trend in Table 14 shows that the state creditably reduced its budget deficit year-on-year from 2018 to 2021.

**Table 4: Oyo State 2021 Budget Execution Rates**

MDA	2021 Approved Budget (NGN Billion)	2021 Actual Expenditure (NGN Billion)	Execution Rate (percentage)	MDA Approved Budget As a percentage of Total Budget	MDA Actual as a percentage of Total Actual Expenditure
Health	13.8	9.8	71.0%	5.0%	5.5%
Education	53.0	41.2	78.0%	19.7%	23.1%
Social Protection	0.5	0.3	54.0%	0.2%	0.1%
Construction	30.5	42.6	140.0%	11.3%	23.9%
Executive Organs & Legislative Organs	41.3	27.6	67.0%	15.4%	15.5%

As depicted in Table 4, while 19.7 percent, 11.3 percent, and 15.4 percent of its 2021 budget were allocated respectively to education, construction, and the executive and legislative organs of government, a paltry 5 percent was allocated to health. In terms of budget execution rates, 5.5 percent of the actual expenditure of Oyo State was geared towards its health sector. Despite a 6.6 percent actual budget surplus in 2021, not only was the state's health budget under-implemented, the implementation of its Primary Health Care Board budget was abysmal, with only 15.0 percent of the approved budget actually spent.

**Figure 12:** Budget Execution Rate of Oyo State Primary Health Care Board (2018-2021)



The Oyo State Primary Health Care Board is saddled with the responsibility of coordinating resources and stakeholders to achieve the optimum Primary Health Care (PHC) System for the people of the State. Furthermore, the Board coordinates the activities of all the Primary Health Care Facilities in all the 33 LGAs of the State under one roof for effective planning, budgeting, monitoring, and evaluation. Its key intervention areas include Immunization and Disease Control, Nutrition and Health Promotion, and Reproductive Health/Family Planning<sup>7</sup>.

As seen in Figure 12, except in 2019, the implementation of the budget for the Oyo State Primary Health Care Board has been extremely poor. In 2018, 2020, and 2021, less than 30% of the funds allocated to the board were disbursed and spent. This is indicative of the quality of healthcare at the PHC facilities. Despite the poor allocation and a 15.4 percent implementation of the Oyo State Primary Health Care Board in 2021, the State reported that it completed the rehabilitation and upgrade of 40 Primary health care facilities in 2021<sup>8</sup>. According to a ranking official of the Oyo State Government, 290 PHCs had been rehabilitated during 2018-2021. The official also reported that a couple of donor-funded programs/projects were implemented by the state government but not mentioned in this study.

7 See "The Ministry" (Online). Oyo State Government. Available at: <http://oyophcb.oyostate.gov.ng/about-ministry/>

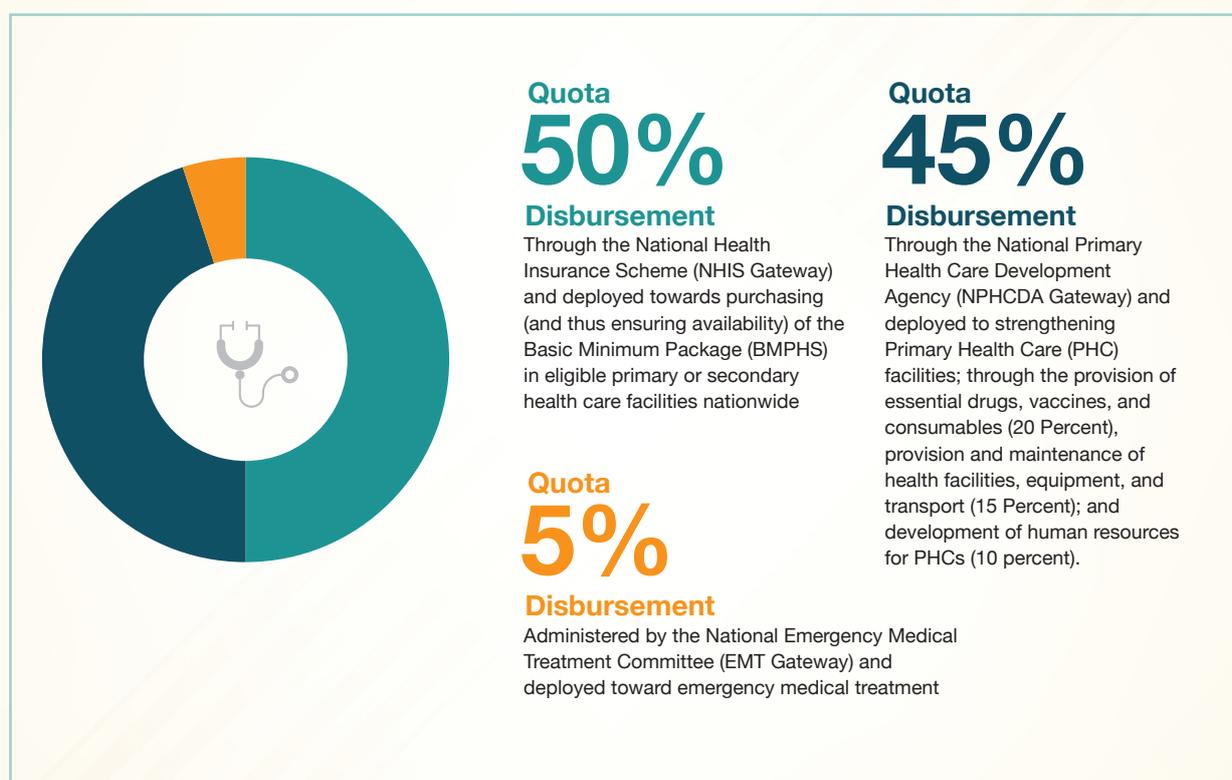
8 See the Government of Oyo State. Budget Performance Report for Year 2021 Quarter 4 (October - December). Available at: <https://budget.oyostate.gov.ng/wp-content/uploads/2022/01/OYO-STATE-BPR-Q4-27-CR.pdf>



# The Basic Healthcare Provision Fund

The Basic Health Care Provision Fund (BHCPF) was established under section 11 of the National Health Act enacted in 2014. The BHCPF is a special-purpose vehicle set up to increase the fiscal space for health, strengthen the national health system, particularly at the primary health care (PHC) level, and ensure universal health coverage<sup>9</sup>. The funding sources for the BHCPF include an annual grant from the Federal Government of at least one percent of the Consolidated Revenue Fund (CRF), grants by international donor partners, and funds from any other source, including the private sector.

**Table 13: BHCPF Payment and Implementation Gateways<sup>10</sup>**



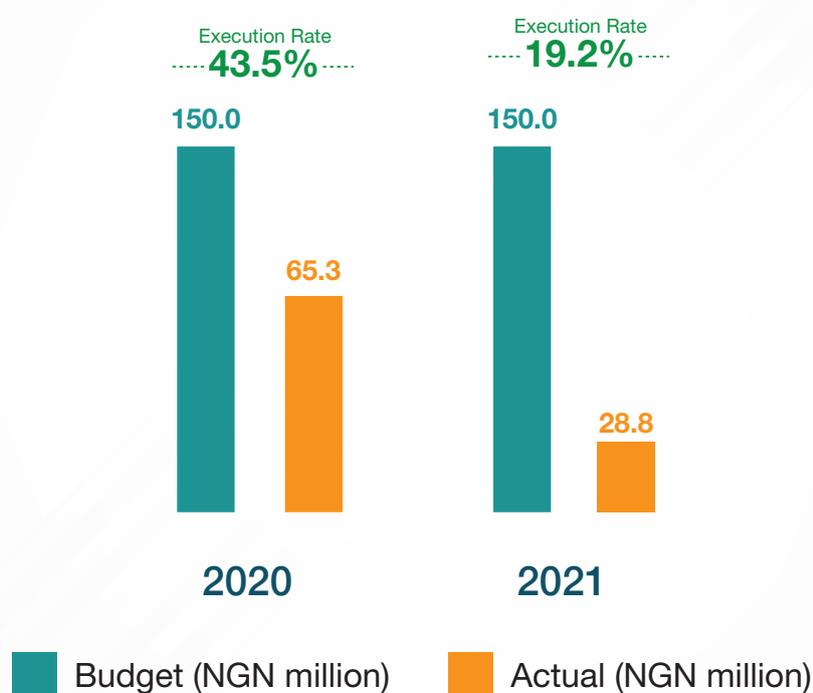
According to an official of the Anambra State Primary Health Care Development Agency, the Primary Health Care facilities access BHCPF funding directly to their accounts through Remita from the Central Bank of Nigeria. The two signatories to the account are the Ward Development Chairman (WDC) of the ward where the PHC is situated and the Officer-in-Charge (OIC) facility. According to the Executive Secretary, 332 PHCs out of the 638 PHCs in Anambra were, as of June 2023, accessing the BHCPF.

<sup>9</sup> See the Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (September, 2020). Developed by the National Primary Health Care Development Agency (NPHCDA), National Health Insurance Scheme (NHIS), and the National Emergency Medical Treatment Committee (NEMTC). Federal Government of Nigeria. Available at: <https://www.health.gov.ng/doc/BHCPF-2020-Guidelines.pdf>

<sup>10</sup> See the Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (September, 2020), op.cit.

In 2020, the Anambra State Government approved a 100 million naira counterpart fund for the take-off of the BHCPF. As revealed by a Ward Development Chairman (WDC) in Health Dialogue held in Awka, Anambra, in June 2021, the first tranche of 6 months was paid to the beneficiary facilities in 2021, which was utilised in giving the beneficiary facilities a facelift and procuring equipment like fire extinguishers, refuse disposal systems and water supply systems. According to the WDC, each facility prepares a work plan approved by the State Primary Healthcare Development Agency (SPHCDA). Furthermore, each PHC gets 103 thousand naira monthly from the BHCPF after approval is given by the SPHCDA. The facilities must properly retire the funds accessed as a prerequisite for accessing future funds from the BHCPF. An official of the Anambra PHCDA revealed that since routine immunisation is executed by the PHC facilities, inaccessibility to BHCPF by PHC facilities compromises the effectiveness of routine immunisation.

**Figure 14: Oyo State Counterpart Funding for the Basic Health Care Provision Fund**



One of the eligibility criteria for accessing the BHCPF is that State Governments must commit a counterpart funding of 25 percent of the total funds expected from the BHCPF<sup>11</sup>. PHC facilities cannot draw funding from the BHCPF if their state governments don't meet up with their counter-fund. Figure 14 shows that the contribution of Oyo State to the Basic Health Care Provision Fund dropped from 65.26 million naira in 2020 to 28.75 million naira in 2021, representing 43.5 percent and 19.16 percent budget execution, respectively. The inability of Oyo State to meet up with their counterpart fund in 2020 and 2021 compromises the quality of health care in PHC facilities in Oyo State.

11 See Federal Ministry of Health (2020). Guideline For the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF). Available online: <https://www.health.gov.ng/doc/BHCPF-2020-Guidelines.pdf>

### Identified Challenges with Accessing and Administering the BHC PF

- Adequate budgeting for counterpart funds provided by the state governments.
- Capacity to properly account for and retire disbursed funds by PHCs.
- Delayed funds transfer.
- Mismanagement and diversion of funds.
- The capacity of PHCs to manage the disbursed funds



# Root cause analysis of budget deviations

All budgets are merely revenue and expenditure projections in a specific fiscal year. Governments plan their expenditures based on what they intend to raise as revenues. Without perfect information, budgets are, by nature, an incomplete forecast of the future<sup>12</sup>. When government revenues fall short of projections, its expenditure plans are equally affected. Deviations between planned and actual expenditures often have implications for the smooth running of government, provision of infrastructure, improvement in human capital development, and service delivery. This section outlines the identified drivers/causes of budget credibility at the federal and subnational levels of government.



**The TSA policy was introduced for two principal reasons: firstly, to create central control over governments' cash resources, and secondly, to eliminate the instances of government resources idling away in several bank accounts operated by the MDAs, whilst the government resorted to massive borrowing to fund its budget deficit.**

## 1 Revenue leakages

Within the Nigerian context, several loopholes for corruption pose a major

problem and appear to affect the implementation of government budgets significantly. The result is that before resources are allocated in the budget, inaccurate/compromised revenue projections will ab initio cause inaccurate/compromised expenditure outturn. At the federal level, before the implementation of the Treasury Single Account (TSA)—“a unified government account or set of accounts, through which all the receipts and payments of a specific government are transacted”—MDAs maintained about 20,000 accounts spread across different Deposit Money Banks (DMBs) across the federation<sup>13</sup>. The TSA policy was introduced for two principal reasons: firstly, to create central control over governments' cash resources, and secondly, to eliminate the instances of government resources idling away in several bank accounts operated by the MDAs, whilst the government resorted to massive borrowing to fund its budget deficit. Hitherto, implementing the TSA policy, multiple bank accounts were run by MDAs and Government Owned Enterprises (GOEs): constituting a major source of revenue leakages. Although the implementation of the TSA policy, to a considerable extent, has yielded positive results, the exemption of some key GOEs, like the Nigerian National Petroleum Corporation (NNPC), has prevented the federal government from maximising the gains of a fully operational TSA.

Another instance of revenue leakage emanates from MDAs and GOEs breaching Section 22(2) of the Fiscal Responsibility Act, which mandates all MDAs and GOEs to remit 80 percent of their operating surpluses to the Consolidated Revenue Fund (CRF) account.

<sup>12</sup> See generally Simson, R and Welham, B. (July, 2014). Incredible Budgets: Budget Credibility in Theory and Practise. Working Paper 400. Overseas Development Institute (ODI). Available at: <https://cdn.odi.org/media/documents/9103.pdf>

<sup>13</sup> See generally, Omolehinwa, E., and Naiyeju, J. (2015). Government Accounting in Nigeria: An IPSAS Approach.

According to the Fiscal Responsibility Commission, MDAs were yet to remit 1.7 trillion naira in operating surpluses as of September 2020<sup>14</sup>. To put this in proper context, the value of operating surpluses not remitted to the CRF is 40.68 percent of the country's fiscal deficit in 2019. In addition to the non-remittance of operating surpluses, the Fiscal Responsibility Commission posits that Nigeria loses 1 trillion naira yearly in operating surpluses as a result of "wrong computations by agencies of government, direct diversion of funds, application of wrong accounting standards and the non-inclusive listing of all government corporations."<sup>15</sup>

At the sub-national level, many states are yet to operationalize their TSA fully. The World Bank initiated a State Fiscal Transparency Accountability and



## According to the Fiscal Responsibility Commission, MDAs were yet to remit 1.7 trillion naira in operating surpluses as of September 2020.

Sustainability (SFTAS) Program for Results in 2018 to incentivize states to increase fiscal transparency and accountability, strengthen their domestic revenue mobilisation capacity, strengthen their efficiency in public expenditure, and strengthen their debt sustainability.<sup>16</sup> The program has several Disbursement-Linked Indicators (DLIs); one is to help states improve cash management and reduce revenue leakages by implementing State TSA. The goal of this indicator was to

ensure that by the end of 2021, states have an established and functional TSA, covering a minimum of 80 percent of the state government's finances. Despite the opportunity of earning an aggregate incentive of \$6 million (from 2018 to 2021) for achieving the DLI on implementing the TSA, Oyo and Anambra (the two focus states for this report) failed to operationalize their TSA sufficiently. The implication of not having a fully functional TSA is that MDAs continue to run several bank accounts that are not under the purview of the state government, leading to massive revenue leakages. The IMF posits that implementing a TSA improves appropriation and operational control during budget execution.<sup>17</sup> The aforesaid revenue leakages, resulting from the non-implementation of a TSA, often lead to lower-than-projected revenues, compromising the government's capacity to fund its budget fully.

Engagements with state and non-state actors in Oyo and Anambra revealed that revenue leakages at the PHC facility level occur due to several reasons ranging from cash-based transactions, to lack of funds, to inducement of staff by patients, to poor internet coverage required for electronic transactions, to the prevalence of multiple cash collection points. In rural areas where technology penetration and internet data coverage are limited, cash becomes the primary payment medium. This situation increases the risk of inflation of the cost of care, issuing of wrong receipts, and the diversion of revenues realised from patients. It was also revealed that inadequate provision of funds through the budget for maintaining services at the facility level leads to mismanagement, as staff members seek alternative ways to sustain operations.

14 See "MDAs yet to remit over N1.7trn operating surplus, says Muruako", by Anthony Otaru, on 9th September 2020, in the Guardian-Business News (Online) Newspapers. Available at: <https://guardian.ng/business-services/mdas-yet-to-rem-it-over-n1-7trn-operating-surplus-says-muruako/>

15 See "Nigeria loses N11m to Non-remittance of Operating Surplus", by Chijioke Nelson and Anthony Otaru, on 15th May 2016, in Sweet Crude (Online) Reports. Available at: <https://sweetcrudereports.com/nigeria-loses-n11m-to-non-remittance-of-operating-surplus/>

16 See SFTAS (Online) Homepage. Available at: <https://www.sftas.org.ng/>

17 See generally, Pattanayak, S and Fainboim, I. (2010). Treasury Single Account: Concept, Design and Implementation Issues. International Monetary Fund Working Paper. Fiscal Affairs Department. Available at: <https://www.imf.org/external/pubs/ft/wp/2010/wp10143.pdf>.

In the same vein, it has been observed that at the PHC facility level, some patients often induce facility staff to collect cash for services when the digital points of sale are faulty. This system failure at the point of collection results in additional payments and compromises the revenue collection processes. Multiple payment points at the facility level create loopholes for revenue leakages: To resolve the aforementioned, consolidating payment points within a facility reduces the risk of revenue leakages and enhances transparency in the revenue collection process.

## 2 Unrealistic revenue projections

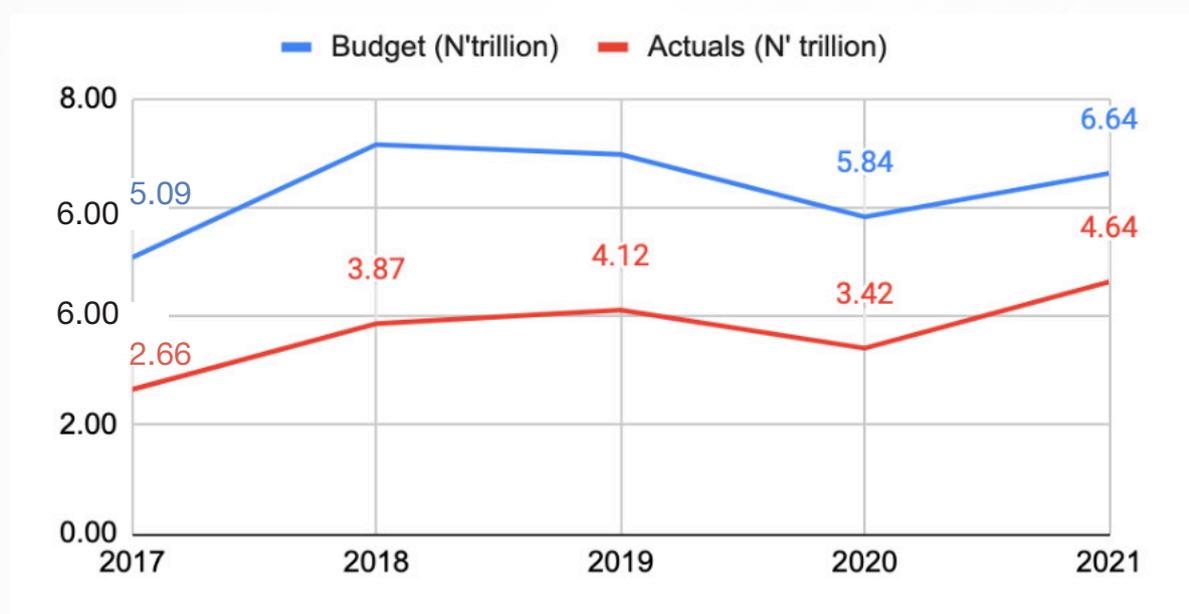
At the federal and subnational levels, governments in Nigeria have historically set annual revenue targets that have never been actualised, leading to increased fiscal deficits. Incessant shortfalls in Nigeria's revenue targets over the last five years have resulted in rising fiscal deficits. There exists a positive relationship between fiscal deficit and public debt. As seen in Table 18, as Nigeria's fiscal deficit increased from 3.64 trillion naira in 2018 to 7.05 trillion naira in 2021, its public

**Table 5: Federal Government Revenue Profile (2018-2022)**

Year	Revenue			Fiscal Deficit	
	Budget (NGN trillion)	Actuals (NGN trillion)	Execution Rate (Percentage)	Projected (NGN trillion)	Actual (NGN trillion)
2017	5.1	2.7	52.3%	2.4	3.8
2018	7.2	3.9	54.0%	2.0	3.6
2019	7.0	4.1	58.9%	1.9	4.2
2020	5.8	3.4	58.6%	5.0	6.6
2021	6.6	4.6	69.9%	5.9	6.4

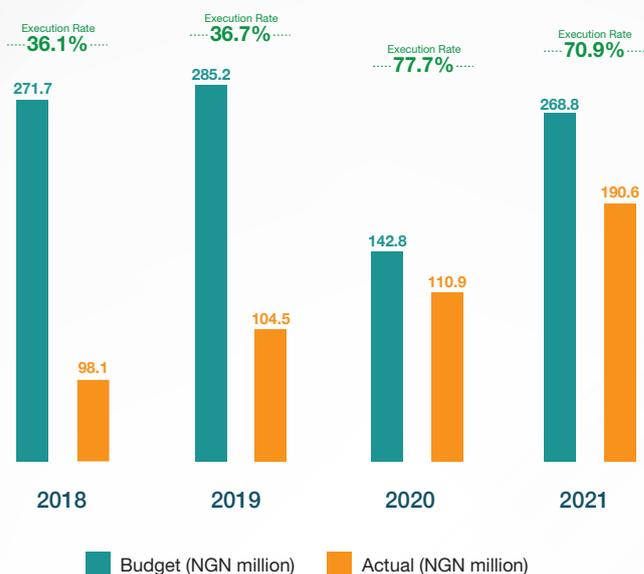
As seen in Table 18, the country could only realise 54 percent of its projected revenue in 2018, 58.9 percent in 2019, 58.6 percent in 2020, and 67.8 percent in 2021. Between 2018 and 2021, more than 30 percent of the federal government’s revenue projections were not actualized. Even though Nigeria has never reached the 6 trillion naira mark in actualized revenue since its creation, the federal government still went ahead with an ambitious revenue projection of 10.7 trillion naira in the 2022 fiscal year. The credibility of the 2022 budget is at risk, considering Nigeria’s historical revenue collection and vast petroleum subsidy cost. The implication of the government being unable to actualise a sizable portion of its projected revenue is that it will have to acquire more debt to finance its budget. Thereby, it would increase its debt stock and debt service obligations, which often crowd out spending on core sectors of the economy, in the following years.

### Federal Government Revenue Trend



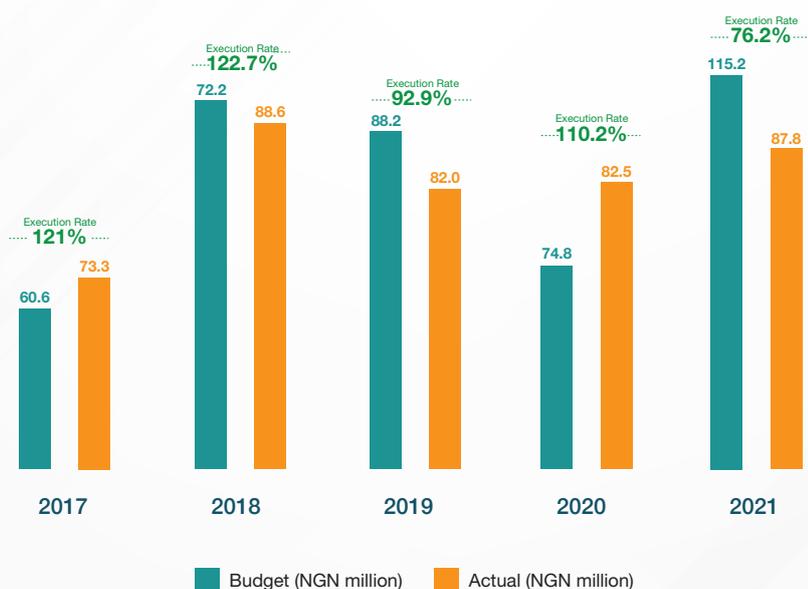
The federal government’s revenue projection is usually predicated on some macroeconomic assumptions, including the oil price, oil production, foreign exchange rate, and interest rate. The subnational governments use the macroeconomic assumptions of the federal government to prepare their budgets. Although the federal government is usually conservative in its annual oil price forecast, there are some years when actual oil revenues often fall short of the projections due to other factors, including but not limited to the volume of oil produced.

**Figure 15: Oyo State Revenue Profile (2018-2021)**



Oyo State has historically underperformed in realising its projected revenue, as seen in Table 19. The state earned only 36.1 percent of its projected earnings in 2018. Although Oyo State’s revenue rose by 94.3 percent from 98.1 billion naira in 2018 to 190.6 billion naira in 2021, it was only able to realise 70.9 percent of what it had planned to earn in 2021. Several reasons were revealed by a senior official in the Oyo State Government as drivers of deviations of actual revenues from projections, and they include the following: Weak domestic resource mobilisation capacity; overdependence on federal transfers/allocations; external shocks like Covid-19, and security challenges affecting the real sector (SMEs, service providers, transportation, etc.).

**Figure 16: Anambra State Revenue Profile (2018-2021)**



As shown in Figure 16, Anambra surpassed its revenue projections in 2017, 2018, and 2020. The state grew its revenue by 19.7 percent from 73.3 billion naira in 2017 to 87.8 billion naira in 2021. Despite Anambra's stellar revenue collection, on average surpassing its revenue projections in the period under review, the state has relatively under-implemented its health budget in the period under review. An official of the government of Anambra State averred that the excess of revenue projected is often recorded as part of the opening balance in the following fiscal year.



**Before 2007, Nigeria had no existing legislation guiding the procurement of goods, services, and works by MDAs and government-owned enterprises (GOEs), leading to massive revenue loss from procurement fraud.**

### **3 Procedural, Regulatory, and Contextual Issues**

Beyond acts of parliament establishing government MDAs, other laws, regulations, and guidelines regulate the operational and financial conduct of government MDAs.

The performance of government budgets is largely influenced by the quality of established public procurement processes. Before 2007, Nigeria had

no existing legislation guiding the procurement of goods, services, and works by MDAs and government-owned enterprises (GOEs), leading to massive revenue loss from procurement fraud. A World Bank Country Assessment survey conducted in 2000 revealed that Nigeria, at the time, lost 60 percent of its spending to procurement fraud<sup>18</sup>.

To solve this behemoth problem confronting the country, Nigeria enacted its Public Procurement Law (PPL) in 2007. This law was established to ensure transparency, probity, accountability, competitiveness, cost-effectiveness, value for money, and professionalism in Nigeria's public sector procurement system<sup>19</sup>. While the purpose of the PPL, 2007 is to ensure that procurement of goods, services, and works are conducted in a manner that is transparent, just, and based on established guidelines and thresholds, there are extrinsic factors that are causing well-intended provisions of the law to inhibit the implementation of government budgets. One such extrinsic factor has, up until 2020, been the late passage of the annual budget.

Before 2020, Nigeria's federal budgets were often signed into law months after the budget implementation was supposed to have commenced. For emphasis, while the federal government budget for 2017 was signed into law on the 12th of June, 2017, those for 2018 and 2019 were granted presidential assent, respectively, on the 20th of June, 2018, and the 20th of May, 2019. The inference of the aforementioned example is that the budgets of 2017, 2018, and 2019 were passed into law approximately six months into the fiscal year. Late passage of the budget often has adverse implications for the implementation of the budget.

18 See generally, Abah, J. (2020). Development for Sale: Public procurement in Nigeria is stuck in a quagmire. Issue 1, 2020. Available at: <https://digitalmailblobstorage.blob.core.windows.net/wp-content/2020/10/NGI-1-Development-for-Sale.pdf>

19 See Olatunji, S., Olawumi, T., and Odeyinka, H. (2016). Nigeria's Public Procurement Law- Puissant Issues and Projected Amendments. In the Journal of Public Policy and Administration Research, Vol.6, No.6, 2016. Available at: <https://core.ac.uk/download/pdf/234669931.pdf>

Late passage of the annual budget distorts the annual operational plan of MDAs, leading to the late commencement of procurement activities by MDAs. Section 16 (1b) of the PPL, 2007 stipulates that “... no procurement proceedings shall be formalised until the procuring entity has ensured that funds are available to meet the obligations and subject to the threshold in the regulations made by the Bureau...”: The import of this provision, vis-a-vis the late passage of the annual budget, is that MDAs are constrained in allocating resources to a planned program of activities and projects early in the fiscal year.

Similarly, section 2(a) of the PPL, 2007 empowers a National Council on Public Procurement to establish monetary thresholds for procuring entities (MDAs). However, 15 years after the enactment of the Act, the National Council on Public Procurement has not been constituted, thus contravening section 1 of the Act. Despite this flagrant violation of section 1, the Bureau of Public Procurement set monetary thresholds for procuring entities (MDAs).

**Table 6:** Bureau of Public Procurement (BPP) Approved Thresholds and Composition of Tenders Board<sup>20</sup>.

Approving Authority/ “No Objection” to award	Goods	Works	Non-Consultant Services	Consultant Services
BPP issues “No Objection” to award/ FEC approves	100 million naira and above	500 million naira and above	100 million naira and above	100 million naira and above
Ministerial Tenders Board	5 million naira and above but less than 100 million naira	10 million naira and above but less than 500 million naira	5 million naira and above but less than 100 million naira	5 million naira and above but less than 100 million naira
Parastatal Tenders Board	2.50 million naira and above but less than 50 million naira	5 million naira and above but less than 250 million naira	2.50 million naira and above but less than 50 million naira	2.50 million naira and above but less than 50 million naira
Accounting Officer: Permanent Secretary	Less than 5 million naira	Less than 10 million naira	Less than 5 million naira	Less than 5 million naira
Accounting Officer: Director General/CEO	Less than 2.50 million naira	Less than 5 million naira	Less than 2.50 million naira	Less than 2.50 million naira

<sup>20</sup> See the Federal Republic of Nigeria, Bureau of Public Procurement (BPP), Approved Revised Thresholds For Service-Wide Application. Available at: [https://www.bpp.gov.ng/wp-content/uploads/2019/02/Approved\\_Revised\\_Thresholds\\_for\\_Service-Wide\\_Application-updated.pdf](https://www.bpp.gov.ng/wp-content/uploads/2019/02/Approved_Revised_Thresholds_for_Service-Wide_Application-updated.pdf)

In light of the current fiscal realities, while monetary thresholds were established to ensure probity in the public procurement process, these thresholds seem to now constitute a major spanner in the wheel of progress by creating a lag and frustrating the procurement process. As seen in Table 6, MDAs require the approval of the Federal Executive Council (FEC) to award contracts for the procurement of goods valued at 100 million naira and above, works valued at 500 million naira and above, and consultant and non-consultant services valued at 100 million naira and above. To put it in proper context, there were 4,681 capital projects valued at 100



**There were 4,681 capital projects valued at 100 million naira and above in the 2021 federal government-approved budget.**

million naira and above in the 2021 federal government-approved budget<sup>21</sup>. Going by the aforementioned, 83.6 percent (2.6 trillion naira) of the funds allocated to capital expenditure in the 2021 budget required the approval of the Federal Executive Council (FEC) for the award of contracts—a function assigned to the National Council of Public Procurement by the PPL, 2007. A similar review of the 2022 federal government budget revealed that there are 5095 capital projects valued at 100 million naira and above in the 2022 federal government-approved budget, representing 67.1 percent (2.9 trillion naira) of the funds allocated to capital projects. The implication of having the FEC award contracts for projects that

take the bulk of capital budget allocations is that procurement activities get buried in a web of bureaucracy, decelerating the speed at which projects must be executed. Ultimately, MDAs return some disbursements to the treasury at the end of the fiscal year because approvals for awards and disbursements to MDAs often come very late in the year.

The procurement process at the subnational level is slightly different from what is obtainable at the federal level. In most states, before MDAs can execute a capital project, the MDAs have to send a memo to the state governor requesting approval. Thereafter, the governor directs the State's Accountant General to release funds for the projects subject to the availability of funds, after which the procurement process commences. In the case of Oyo State, all expenditures above the 100 million naira threshold require the approval of the state governor/the State Executive Council before contract award. Similarly, all expenditures above 10 million naira but below 100 million naira require the approval of the governor. According to an official of the Oyo State Government, the threshold of the state tenders board has been reviewed from 5 million naira to 99 million naira, with final approval from the governor. While these thresholds are established to ensure that projects are executed by the most qualified contractors in the most cost-effective manner, the existing layers of bureaucracy sometimes delay and frustrate the funds request memo approval process. This will then lead to excessive delays in the implementation of budgets.

**Table 7:** Threshold for consideration and award of contracts in Oyo State<sup>22</sup>

Approving Authority	Current Thresholds	Thresholds for Goods	Thresholds for Works	Thresholds for Consultant Services	Thresholds for Consultant Services
Executive Governor/ State Executive Council	50 Million naira and above	100 Million naira and above	100 Million naira and above	100 million naira and above	100 million naira and above
Executive Governor/ State Tenders Board	5 million naira - 50 million naira	10 million naira - 50 million naira	10 million naira to 50 million naira	10 million naira to 50 Million naira	10 million naira to 50 million naira
Ministerial/ Parastatal Tenders Board	1million naira -4,999,999 million naira	5 million naira - 10 million naira	5 million naira to 10 million naira	5 million naira to 10Million naira	5 million naira to 10 million naira
Deputy Governor	250,000 thousand naira	1 million naira - 4,999,999 naira	1 million naira to N4,999,999 naira	1 million naira to 4,999,999 naira	1 million naira to 4,999,999 naira
Secretary to State Government	200,000 thousand naira	1 million naira	1 million naira	1 million naira	1 million naira
Head of Service	200,000 thousand naira	1 million naira	1 million naira	1 million naira	1 million naira

#### 4 Political interference in Public Finance Management mechanisms, overspending by ministries

A State's expenditure priority is largely influenced by the political agenda of the state Governor, disregarding budgetary realities and compromising fiscal discipline. For example, if physical infrastructure like roads, airports, and international conference centres are top on the agenda of the Governor, resources will be deployed heavily to those areas at the expense of social sectors like health and education, regardless of whether these infrastructures align with the development plan.

Political interference can often lead to an increase in the expenditure allocated to other Ministries, Departments, and Agencies in the budget or lead to either overspending or completely extrabudgetary expenses. Also, political interference can lead to overspending by certain influential MDAs that render non-essential services or extrabudgetary expenses, thus making less money available for critical issues like the procurement of medical supplies.

<sup>22</sup> See the Oyo State Government of Nigeria: Bureau of Public Procurement, (May, 2020), Procurement Procedures Guidelines For Public Procurement In Oyo State, Second Edition. <https://old.oyostate.gov.ng/wp-content/uploads/2020/02/Oyo-State-Guidelines-on-Public-Procurement.pdf>

A critical look at the sector prioritisation of Anambra between 2017 and 2021 reveals that although 6 billion naira was approved for the construction of the airport in the 2020 budget, 22.6 billion naira was eventually spent. This sort of expenditure pattern often crowds out disbursements to other critical sectors of the economy. Although the Anambra State government realised an average of 99.9 percent of its revenue between 2015 and 2019, an average of 22 percent of funds budgeted for the rehabilitation of about 10 PHCs were released, almost crippling service delivery in the affected PHCs. This scenario typically happens when



**Although the Anambra State government realised an average of 99.9 percent of its revenue between 2015 and 2019, an average of 22 percent of funds budgeted for the rehabilitation of about 10 PHCs were released, almost crippling service delivery in the affected PHCs.**

subtle political priorities interfere with PFM systems to influence disbursements away from otherwise critical areas already budgeted for.

The appropriation of funds and disbursement process is frequently subject to political interference. Political actors exert influence over the allocation of funds, leading to a deviation from transparent and merit-based decision-making. This interference undermines

the efficiency and effectiveness of public financial management. A critical example of the aforementioned is the influence the legislature wields on how resources are allocated, distributed, and disbursed. Of a truth, the legislature ideally should play a crucial role in appropriating funds through the budget, overseeing the disbursement of those funds, and ensuring financial accountability. However, there is evidence of political interference in this process, which hampers the efficient deployment of resources to address society's problems and effective financial management.

## **5 Late cash release**

Late cash releases towards the year's end often mean that Primary Health Care facilities are not able to fulfill the requirements of procurement processes needed to spend the cash released before the last day of the year. The result is that such unutilized funds - irrespective of the reason - would usually be refunded to the treasury even though the public projects they were meant to finance are still pending. According to an official of the Budget Office of the Federation, Nigeria runs a deficit budget, leading to sourcing for budget loans through borrowing, which could often drag on longer depending on the approval process by the National Assembly. The official revealed that the borrowed funds often become available in the last quarter of the fiscal year, resulting in the late release of funds to MDAs for budget execution.

At the sub-national level, 33 states relied on federal transfers for at least 50 percent of their revenues, while 13 states relied on federal transfers for at least 70% of their revenues in 2021. A high-ranking official in the Oyo State Budget Ministry revealed that fiscal shocks affecting the net distributable revenue significantly impact their revenue projections, and the state often resorts to borrowing and seeking bailouts from the federal government. If the aforementioned support becomes available late into the fiscal year, it will lead to late cash releases to the implementing MDAs.



The BHCPF was set up so that a facility can not access new funding unless it has properly accounted for the funds previously disbursed to it.

to unexpected budget deviations. For example, with the administration of the BHCPF at the facility level, it was revealed that facilities often experience delays in accessing funds because the fund managers at the facility level often lack the capacity to properly retire the previously disbursed funds. The BHCPF was set up so that a facility can not access new funding unless it has properly accounted for the funds previously disbursed to it. The inability to properly retire the funds has been adjudged to result from either the absence of accounting know-how or corruption. Some users of PHCs contacted disclosed that they have had to buy medical supplies that the BHCPF was supposed to cater to at the facility.

## 6 Capacity gap for planning, program costing, and cash management

A study of PHCs in the South West, including Oyo State, revealed that mid-level managers had poor quantitative-related skills necessary<sup>23</sup> for administrative and technical roles to implement the BHCPFP financing scheme. These capacity gaps foster inherent weakness in Public Finance Management systems within the state, often leading to poor planning, poor program costing, weak funds management, and other budget-related challenges that inevitably lead

23

See Adewole, D. A., Bello, S., Okunola, O.O and Owoaje, E.T (2021). Basic health care provision fund project implementation: An assessment of a selected technical skill among mid-level managers of a performance-based financing scheme in Southwest Nigeria. Niger Journal of Medicine. 2021; Vol. 30:470-5.

# Effects of budget deviations on service delivery

## 1 Compromised Immunisation Program

Immunisation is an efficient strategy for reducing infectious disease-induced morbidity and mortality. Lack of access to basic health services—which include the prevention and treatment of communicable diseases, immunisation, maternal and child health services, family planning, public health education, etc.—increases the vulnerability of poor and rural households to diseases. Reduced funding for PHCs, therefore, threatens routine immunisation, which results in unvaccinated children who, in the end, become susceptible to vaccine-preventable diseases like polio. Huge budget deviation/low budget credibility



Poor allocation and disbursements to activities geared towards improving the epidemic preparedness capacity of a state often result in catastrophic responses to disease outbreaks, leading to loss of lives.

negatively affects access to PHC facilities, vaccine availability, and vaccinator availability which is instrumental to an effective and essential routine immunisation regime<sup>24</sup>.

## 2 Threatened Health Security

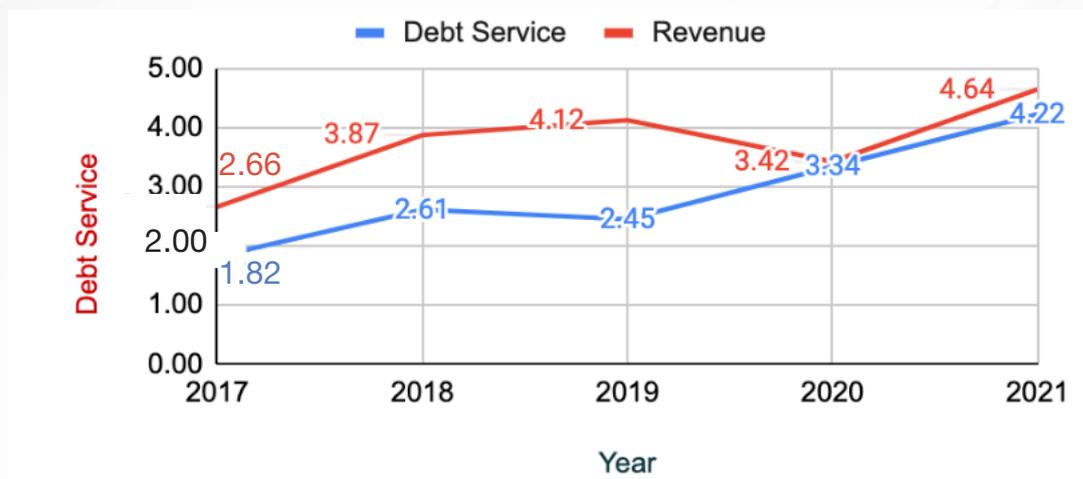
The capacity of a country and its subnational units to prevent, detect, and respond to disease outbreaks depends on the quantity and quality of investments in its health sector over time. The prevalence of infectious diseases like cholera, Lassa fever, and poliovirus that have ravaged communities in Nigeria on multiple occasions is a testament to the fact that Nigeria has a very weak health security system. Poor allocation and disbursements to activities geared towards improving the epidemic preparedness capacity of a state often result in catastrophic responses to disease outbreaks, leading to loss of lives. First responders to disease outbreaks like cholera and Lassa fever are often PHC health workers. Inaccessibility to the BHCPF compromises the capacity of the aforementioned first responders to provide adequate care to victims and limit the spread of infectious diseases.

## 3 Future spending on service delivery, compromised:

Weak budget credibility on the revenue component of public finance poses a severe risk to future service delivery. Less public revenue, even when agreements have been entered into with contractors based on high revenue projections, often means there are two things - for one, either contractors will be owed, exposing public projects to the risk of abandonment, or the government would have to take on more loans than anticipated to meet up with financial obligations. More loans tend to mean more future debt servicing costs, which would ultimately crowd out funds needed for service delivery.

In Nigeria, unrealistic revenue projections over the years have led to wider deficits and debts than anticipated. The result has been increased debt servicing costs, which leaves less money available for financing service delivery and infrastructure. In 2020 and 2021, debt servicing wiped off over 90 percent of federal government revenue, leaving only 10% of all revenues.

#### FG Debt Service vs Revenue



The government often over-projects revenues and underestimates debt service costs. This often results in borrowings not being enough to finance deficits since the deficits were, in the first place, underestimated. Secondly, the government's capacity to borrow has drastically decreased due to the low credit ratings. Thirdly, extrabudgetary expenditures, which involve ad-hoc responses to disasters like flooding, etc., crowd out budget items. Fourthly, overspending on petroleum, electricity, and foreign exchange subsidies also crowds out spending on core govt programs.

#### 4 Substandard Service Delivery

Budget deviations often mean that Primary Health Care facilities needing essential supplies like essential drugs, vaccines, and consumables will not get the required funding, which impedes the accessibility of would-be beneficiaries to quality healthcare. Similarly, low budget credibility threatens the provision and maintenance of health facilities and equipment, jeopardises the development of human resources for PHC facilities, and compromises the welfare of healthcare workers. Low budget credibility means contractors may not have the financial resources to render services to PHCs meant for routine care or provide immunisation to the quality and timeliness required. Furthermore, contractor payment delays distort those contracting companies' cash flow. This further means they may default on bank debt and have limited financial capacity to retain high-quality staff to deliver value. This could have a cascading effect on other contracts the contractor is handling, leading to the delivery of substandard jobs for citizens in a bid for those companies to survive and cut costs.

The Oyo State Primary Health Care Board revealed that although the state government had made it free for all residents of the state to access healthcare at the primary healthcare facilities, there had been reports of hospital officials illegally charging patients for using the health facilities. The Board also stated that the government has taken measures to identify and eliminate the exploitation of patients by healthcare workers at the PHC facilities. One of the measures taken by the government is introducing an e-payment system to reduce exploitation at PHCs and address cash management.

## 5 Compromised workforce, income taxes for Anambra and Oyo states

The inability of PHCs to deliver adequate immunisation and other life-saving health services means that fewer workers are going to be healthy enough in the future (to work and earn enough) to pay sizeable sums in income taxes to the government, which ordinarily is the biggest source of Internally Generated Revenue (IGR) for both Oyo and Anambra state. Higher IGR for states depends on economic prosperity, amongst other factors; economic prosperity, in turn, depends on having a quality workforce and a healthy one.



# Recommendations

## 1 Firstline charge for BHCPF Counterpart Funding

Anambra and Oyo state governments need to set aside 25 percent of the total funds expected from BHCPF in any fiscal year as required by Section 11(5)(a,b) of the NHAAct, 2014. Preferably, this should be done as a first-line charge, as part of their annual budgetary provision to reduce the risk that available funds will not be released to PHCs in the respective states from the federal government.



CSOs in Anambra and Oyo States should develop PHCs and BHCPF compliance checklists required to access BHCPF funding.

## 2 Compliance Checklists for Budget Credibility Advocacy:

CSOs in Anambra and Oyo States should develop PHCs and BHCPF compliance checklists required to access BHCPF funding. This would become a rallying point for advocacy to ensure PHCs in their states can access funding as and when due. A sample checklist is attached in Appendix I for further development.

## 3 Strengthen PFM Systems in PHCs:

Stakeholders need to work hard to strengthen accounting and reporting mechanisms, budget execution mechanisms in states -- including public procurement systems, virement, and other relevant policies and the capacity of personnel to utilise these systems. More specifically, the capacities of fund managers at the PHC facility level need to be further improved to aid them in properly accounting for the funds disbursed to the facilities either through the Budget or the BHCPF. This will aid accountability and improve access to future BHCPF funds.

## 4 Constitution of National Council on Public Procurement:

The federal government must abide by Section 1 of the Public Procurement Act 2007, mandating it to set up the National Council on Public Procurement. The Public Procurement Law 2007 empowers the National Council on Public Procurement to approve and amend monetary and prior review thresholds, consider and approve policies on public procurement, and approve changes in the procurement process to adapt to improvements in modern technology. If allowed, the establishment and operationalisation of the National Council on Public Procurement can lead to an improvement in the speed of contract approvals and enhancement of the efficiency and effectiveness of Nigeria's public procurement process.

## 5 Full Operationalisation of the Treasury Single Account:

The governments of both Oyo and Anambra State need to fully operationalize their treasury single account to ensure that it covers 100% of the state government's financing. This will plug the leakages of state revenue lost to the existence of multiple government accounts and enable the government to have a full view of the revenues that accrue to the state for effective deployment to service delivery areas.



To ensure proper enforcement and accountability, unauthorised payment points at the health facilities should be replaced with authorised and regulated channels.

## 6 Automation of Cash Transactions:

Replacing cash transactions with automated systems is recommended to streamline processes and improve accuracy. By digitising financial transactions, the organisation can minimise the risk of errors, fraud, and misappropriation of funds. This transition should be supported by robust technology infrastructure and appropriate training for staff to ensure the smooth adoption and operation of the automated systems.

## 7 Replacement of Unauthorised Payment Points:

To ensure proper enforcement and accountability, unauthorised payment points at the health facilities should be replaced with authorised and regulated channels. The facilities can mitigate the risk of revenue leakages by establishing a robust system that oversees payment processes. This measure should be complemented by regular monitoring, audits, and sanctions for non-compliance.

## 8 Peer Review Mechanism:

Establishing a peer review mechanism like the Nigerian Governors' Forum can facilitate inter-state comparisons and encourage healthy competition. By regularly assessing and benchmarking the performance of governors, governments can promote accountability, knowledge sharing, and best practices. This mechanism should be designed to encourage constructive feedback and drive continuous improvement among participating states.

## 9 Proactive Disclosure and Support for Partners:

Since state governments under-report the support they get from donor agencies and multilateral agencies, it is imperative that donor and multilateral agencies proactively disclose the support given to states to empower accountability actors to hold their governments to account. This approach fosters transparency, trust, and collaboration with the government.

# Appendix I:

## Compliance checklist to improve budget credibility of BHCPF funding in Anambra and Oyo State.

This check list is developed based on the criteria for States to access funds as stipulated in the provision of the Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF).

State Name: Utopia State

Date Assessed: \_\_\_\_\_

CSOs conducting assessment: BudgIT, JDPC

	Criteria	State's Status	Comment
1	Has the state identified at least 1 (one) functional health facility in each ward, for assessment and subsequent accreditation to qualify for award of a Certificate of Standards and BHCPF participation?		
2	Are the Disbursement Linked Indicators (DLIs) for quarterly disbursements of NPHCDA Gateway funds through the SPHCDA or SPHCBs to PHCs published on the state website and clearly known by all stakeholders at the PHCs and in the ministry of health?		
3	Is there evidence of contribution of the state and LGHA 25% counterpart funding from the previous year?		
4	Is there evidence of a firstline charge for the provision of 25% counterpart funding of funds expected from the federal government?		
5	If Certificate of Standards has been issued to selected PHCs, is there adequate disbursement from the state's budget outside the 25% counterpart funding to ensure selected facilities maintain the minimum standards for PHC in terms of human resources, infrastructure, and equipment?		
6	Has the state opened a TSA account with the Central Bank titled 'SPHCDA BHCPF or SPHCB BHCPF' and are their difficulties in accessing that account?		
7	Does the state have a functioning State Primary Health Care Board or Agency and LGHAs in accordance with the Primary Health Care Under One Roof (PHCUOR) policy?		
8	Has the state updated the compliance checklist with the latest guidelines from NPHCDA?		

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