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Sokoto State 2023 Pre Health Budget Memorandum

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Sokoto State
2023 Health Budget Memorandum and MTSS 2023-2025 Contribution

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ABBREVIATION

AOPs	Annual Operational Plans
BHCPF	Basic Health Care Provision Fund
Bn	Billion
COVID-19	Corona Virus 2019
CSJ	Centre for Social Justice
CSOs	Civil Society Organisations
DFF	Decentralized Facility Financing
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
HSS	Health and Social Services
IHP	Informal Health Plan
LG	Local Government
LGAs	Local Government Areas
LGCs	Local Government Council
M	Million
MDAs	Ministries, Departments and Agencies of Government
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, New Born and Child Health
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategies
NHA	National Health Act
NDHS	Nigeria Demographic and Health Survey
NGN	Nigerian Naira
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PHP	Private Health Plan
SMOH	State Ministry of Health
SOCHEMA	Sokoto State Contributory Health Care Management Agency
SPHCDA	State Primary Health Care Development Agency
SSFRL	Sokoto State Fiscal Responsibility Law
SSSHDP	Sokoto State Strategic Health Development Plan
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
%	Percentage

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Executive Summary

Section One is the introduction. It affirms that the Sokoto State Fiscal Responsibility Law (SSFRL) requires the State Government to prepare the Medium Term Expenditure Framework (MTEF) every year. This is a three-year rolling plan containing the macroeconomic framework, fiscal strategy paper, expenditure and revenue framework, consolidated debt statement and statement describing the nature and fiscal significance of contingent liabilities. However, after preparing the MTEF, every Ministry, Department and Agency of the State Government (MDA) is expected to submit its Medium Term Sector Strategy (MTSS), which should focus on the medium term goals of their sectors and will feed into the broad goals of the MTEF.

The Section details the objectives of the MTSS exercise and the scheme for ranking priority projects and programs that will be part of the MTSS. It examines the rationale for the exercise, the linkages between MTSS and the annual budget and reviews the sectoral goals, objectives, targets and strategies for the Health MTSS.

Section Two is focused on health indicators and major challenges in Sokoto State related to the minimum core obligation of the State and Primary Health Care (PHC). In maternal, new born and child health, the State's indicators were poorer than the North West regional and national averages in neonatal mortality, post neonatal mortality, infant mortality, under-5 mortality and adolescent birth rates. However, the State performed better than the North West regional average in child mortality rate. Furthermore, the State performed poorer than the national average on percentage of women with unmet need for contraception (spacing, percentage of women without antenatal care, percentage of women who deliver at home and percentage of women with postnatal checks for their newborns - in a facility or at home).

In immunization, the parentage of children aged 1-2years who receive BCG, Hepatitis B, polio vaccine at birth, yellow fever and measles vaccines falls below the national average. In terms of access to improved water supply and open defecation, the State lags behind the national average. The performance is also the same for sanitation while it performed better in persons sleeping under insecticide treated nets. But in prevalence, diagnosis and prompt treatment of children with fever, the performance was below the national average.

Section Three reviews existing budget commitments and emerging issues using the Abuja Declaration (to commit 15% of overall budget resources to health care) and the provisions of the scenarios of the Sokoto State Strategic Health Development Plan II (SSSHDP II) as benchmarks. The benchmarking exercise shows that the State did not meet the Abuja Declaration obligations and there is a funding gap in the demands of the three scenarios of SSSHDP II. The Section reviewed Local Government funding

commitments in the seven focal LGAs (Binji, Yabo, Sokoto North, Sokoto South, Gwadabawa, Tambuwal and Wurno.) while analyzing the whole of government and health in all policies approaches to improving health care, especially PHC.

Section Four is on the Basic Health Care Provision Fund (BHCPF) and it shows that the State has started well in the two gateways of the State Primary Health Care Development Agency (SPHCDA) and the Sokoto State Contributory Health Care Management Agency (SOCHEMA). Steps have been taken to access the fund and provide services to the people.

Section Five discusses the sustainability of healthcare services. It affirms that sustainability is to a great extent dependent on the quantum and sources of healthcare financing. From Section Three on the review of existing budget commitments, the State's public budget allocations do not meet the requirement of the SSSHDP II across all the three scenarios used in costing the health needs of the State. This is compounded by the dwindling fiscal resources and fiscal space available to the State Government. Also, the complimentary funding from the BHCPF is not sufficient to fill the funding gap while the contributions expected from donors, the private sector and other non-state actors have been unable to fill the funding gap. Nigeria's out of pocket expenditure on health is one of the highest in the world and has been stated by the World Bank at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent.

Section Six discussed the possibility of health insurance filling the funding and sustainability gap and draws attention to the SOCHEMA Law and the National Health Insurance Authority Act which provides for compulsory and universal health insurance in Sokoto State and across the Nigerian Federation. It makes a case for awareness creation and sensitization and eventual full enforcement of the Law.

Against the background of the foregoing analysis, the Memorandum recommended as follows.

1. Prepare a Health MTSS: The State Ministry of Health should take steps towards the preparation of a Health MTSS. This is to compliment sections 18 and 20 of the Sokoto State Fiscal Responsibility Law which demands the preparation a Medium Term Expenditure Framework. It is mandatory for the compositional distribution of the annual budget to be in accordance with the priorities of the MTEF.

2. Mainstream the Plan, Policy and Budget Continuum in Health: Plans and policies provide the legal and policy framework for sectoral governance and service delivery while budgets activate plans and policies through providing resources for their

implementation. The disconnect between plans, policies and budgeting has been largely responsible for poor PHC outcomes in most states of Nigeria.

3. Whole-of-Government, Health-in-all Policies Approach: The Ministry of Health should prepare an executive memorandum and seek the approval of the State Executive Council for a whole-of-government and health-in-all policies approach. The whole-of-government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors. For example, the ministry in charge of information should be involved in the critical task of information dissemination as a resource for preventive and promotive health interventions.

Health-in-all-policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people. Health should be made an explicit objective of every policy decision.

4. Stakeholder Engagement and Popular Participation in Preparation of MTSS: In the preparation of the MTSS, formulation and preparation of the annual health budget, there is the need to mobilize all stakeholders in the Health Sector, engage them and ensure popular participation. Most policy and budget failures in Nigeria have been attributed to top-down approach to policy development and implementation. Conscious involvement of all relevant stakeholders in the development and implementation of health sector plans and budgets will be of great benefit to the sector.

5. Whole of Society Approach to Health: Further to the last recommendation, the State should adopt the *whole-of-society* approach involving *the* engagement of all relevant stakeholders in society to address socio-economic and livelihood issues that affect health. This includes public health, education, food security, agriculture, power and energy, communications, environment, employment, industry, and social and economic development.

6. Prepare a New Sokoto State Strategic Health Development 2023-2027 and Other Due Policies: The existing SSSHDP II is expiring by effluxion of time in 2022. The Ministry of Health should take steps towards the preparation and adoption of a new SSSHDP III.

Beyond the SSSHDP II that is due for review, the State Ministry of Health should also come up with a comprehensive list of all policies and plans that are no longer current and ensure they are revised and updated.

7. Declare a State of Emergency in the Health Sector: Considering the State's poor health indicators, it is imperative to declare a state of emergency in the sector especially on maternal, new born and child health. The contours of the state of emergency should include increased funding to the sector, especially primary health care (maternal, newborn and child health, immunization, etc.), promotive and preventive health and ring-fencing health sector allocations in the budget to ensure that they are fully released and utilized.

8. Increase Funding to the Sector and Invest in Value for Money: It is imperative to increase health sector funding to ensure that the 15% target is met in actual releases and utilization of the vote. Furthermore, the Ministry of Health should invest in value for money tools and processes to increase economy, efficiency, effectiveness and equity of its investments across the health value chain.

9. Moratorium on New Capital Projects: Considering that the year 2023 will witness a change in the executive and legislative leadership of the State, there should be a moratorium on new capital projects and the focus should be on completing existing and ongoing projects. In this way, the resources of the State will not be spread too thin and project abandonment will be minimized.

10. Invest in Transparency and Accountability: The SMOH should invest in improving the transparency and accountability of its operations through collating and publication of timely and quarterly line item by line-item expenditure details. This will build the confidence of stakeholders and increase contributions and collaborations for improving the standard of health in the State.

11. Annual State of Health Report: To boost transparency and accountability and in accordance with S.2 (2) (d) of the National Health Act, the Commissioner for Health should prepare and present an annual report on the state of health of residents in Sokoto to the Governor and the State House of Assembly and publish same on the State Government's website.

12. Ensure Maximum Benefits from BHCPF: The State should ensure that it derives the maximum benefits available from the BHCPF through guaranteeing the required counterpart funding, accrediting more health institutions especially PHCs, timely and meticulous retirement of disbursed funds from the National Primary Health Care Development Agency and Health Insurance Gateways.

13. Full Implementation of SOCHEMA Law and the National Health Authority Act: SOCHEMA and the National Health Insurance Authority Act envisage a universal and compulsory health insurance regime in Sokoto State and across the Nigeria Federation. SOCHEMA should draw up an action plan that will start from awareness creation and

massive sensitization to enforcement over a period of four years. The first two years should focus on awareness creation and enforcement follows in the second two years.

SECTION ONE: INTRODUCTION

1.1 Background

The Sokoto State Fiscal Responsibility Law (SSFRL) requires the State Government to prepare the Medium Term Expenditure Framework (MTEF) every year.[1] This is a three year rolling plan containing the macroeconomic framework, fiscal strategy paper, expenditure and revenue framework, consolidated debt statement and statement describing the nature and fiscal significance of contingent liabilities. However, after preparing the MTEF, every Ministry, Department and Agency of the State Government (MDA) is expected to submit its Medium Term Sector Strategy (MTSS), which should focus on the medium term goals of their sectors and will feed into the broad goals of the MTEF.

Furthermore, the Sokoto State Strategic Health Development Plan 2018-2022 (SSSHDP II) provides that:

> *It is expected that the health departments of the 23 LGAs, in collaboration with State Primary Health Care Development Agency (SPHCDA) and the State Ministry of Health (SMOH), as well as its agencies, including Development partners in the State would develop their Annual Operational Plans (AOPs) using varying participatory approaches to reflect the local context and prevailing issues. For each of the priority intervention areas, this plan provides uniform guidance on goals, strategic objectives, and recommended interventions. It is recommended that specific activities be derived from the plan, costed, and monitored over time.*

Adapting the provisions of the National Health Act (NHA) to Sokoto State, the SMOH shall prepare strategic, medium-term health and human resource plans annually for the exercise of its powers and performance of its duties and ensure that this plan shall be the basis of the annual budget estimates for health.[2]

The Health Sector MTSS is to be prepared with the Health Sector Envelope contained in the MTEF. It should inform the health component of the budget and is expected to incorporate the following:

- Key programs and projects that the Sokoto State Government shall embark upon within the medium term (three-year period) in order to achieve the health goals and objectives as detailed in high level subnational, national and international standards including the SSHDP II, National Health Policy, National Strategic Health Development Plan, Sustainable Development Goals (SDGs 3, etc.) and ratified treaties and standards, etc.;

[1] Per S.18 of SSFRL
[2] S.2 (2) of the NHA 2014.

- Cost and prioritize the identified key programs and projects in a clear and transparent manner;

- Implementation plan including phased plan for financing the costs of the programs and projects over the period of three years; and

- Definite and measurable outcomes of each of the identified programs and projects;

Accordingly, priority programs and projects are to be ranked in accordance with their contribution to the strategic pillars of SSSHDP II as well as the National Health Policy's theme of "promoting the health of Nigerians to accelerate socioeconomic development". These pillars of the SSSHDP II are as follows:

- *Strategic Pillar 1: Enabled Environment for Attainment of Sectoral Goals*
  - Priority Area 1: Leadership and Governance
  - Priority Area 2: Community Participation
  - Priority Area 3: Partnerships for Health

- *Strategic Pillar 2: Increased Utilization of Essential Package of Health Interventions*
  - Priority Area 4: Reproductive, Maternal, New-born, Child and Adolescent Health plus Nutrition
  - Priority Area 5: Communicable Diseases Prevention and Control
  - Priority Area 6: Non-Communicable Diseases Prevention and Control
  - Priority Area 7: Emergency Medical Services and General Hospital Services
  - Priority Area 8: Health Promotion and Social Determinants of Disease

- *Strategic Pillar 3: Strengthened Health System for Delivery of Package of Essential Health* Services
  - Priority Area 9: Human Resources for Health
  - Priority Area 10: Health Infrastructure
  - Priority Area 11: Medicines, Vaccines and other Health Technologies & Supplies
  - Priority Area 12: Health Information System
  - Priority Area 13: Research for Health

- *Strategic Pillar 4: Protection from Health Emergencies and Risks*
  - Priority Area 14: Protection from Health Risks and Emergencies

- *Strategic Pillar 5: Predictable Financing and Risk Protection*
  - Priority Area 15: Health Financing

Other broad key considerations for project ranking include their contribution to economic growth (output and income), competitiveness of the economy (increased efficiency and cost reduction), employment generation (direct and indirect), access to quality and

affordable education and health care and social welfare improvement and poverty reduction. Other considerations include strong local content (linkages with other sectors), likelihood of completion in the medium term, nature of project (developmental or administrative) and project status (whether ongoing or new).

1.2 Rationale for the Exercise

The SMOH is required to consult with relevant stakeholders including Civil Society Organizations (CSOs) that work in the Health Sector during the preparation of the Health Sector MTSS. Therefore, this memorandum presents the key inputs of CSOs into the Health Sector MTSS 2023 – 2025. This will equally serve as the input of CSOs to the 2023 State Government budget for the health sector. The primary focus is on Primary Health Care (PHC) as an entry point for Universal Health Coverage (UHC).

For MTSS and budgets to be effective, they must be based on empirical evidence and in tandem with the plan, policy and budget continuum. Therefore, this exercise provides the opportunity to use evidence garnered by Centre for Social Justice (CSJ) and other CSO actors and align it with the minimum core content of the right to health in a bid to implement the minimum core obligations of the state for the progressive realization of the right to health within the ambit of available resources. These state obligations reflected as activities, projects and programs should ensure the respect, protection, facilitation and to a great extent, the fulfillment of the right to health and as such should prioritize primary health care including maternal, new born and child health, preventive care, water, sanitation and hygiene, promotional activities and respect the forward ever obligation in health provisioning - backward steps are not acceptable. The MTSS should also be based on a plan for increased domestic resource mobilization and the optimum utilization of all available resources in a more health for the money approach.

1.3 Linkages Between MTSS and Annual Budget

This MTSS derives its conceptualization from Section 20 of the SSFRL which stipulates that the MTEF shall be the basis of the annual budget. It provides that:

> *(1) Notwithstanding anything to the contrary contained in this Law or any other Law, the Medium Term Expenditure Framework shall be the basis for the preparation of the estimates of revenue and expenditure required to be prepared and laid before the House of Assembly under section 121 (1) of Constitution.*
>
> (2) *The sectoral and compositional distribution of the estimates of the expenditure referred to in subsection (1) of this section shall be consistent with the medium term developmental priorities set out in the Medium Term Expenditure Framework.*

Thus, this Memorandum aims to make inputs into the 2023-2025 Health MTSS considering that this will form the basis for the preparation of the 2023 State Health Budget.

1.4 Sectoral Goals, Objectives, Targets and Strategies

Health Sector goals and objectives are clearly identified in key high level policy documents such as the National Health Policy 2016 (NHP), SDGs[3], SSSHDP II, NHA, etc. The National Health Policy 2016 is made with a vision of Universal Health Coverage for all Nigerians and specifically states that its goal is to strengthen Nigeria's Health System, particularly the primary health care sub-system so as to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians. This reinforces the mission of the SSHDP II of ensuring the delivery of quality health care services to all people of Sokoto State by providing clear policy direction and implementing all necessary health plans with the participation of relevant stakeholders. The SSSHDP goal is to ensure healthy lives and promote well-being of all citizens of Sokoto State across all ages.

The NHA establishes a National Health System which is mandated inter alia to provide for persons living in Nigeria the best possible health services within the limits of available resources and to protect, promote and fulfill the right of the people of Nigeria to have access to health care services[4]. It entitles all Nigerians to a basic minimum package of health services[5]. The NHA further provides in S.11 for the Basic Health Care Provision Fund (BHCPF) with a government annual grant of not less than one percent of the Consolidated Revenue Fund.

The foregoing goals, objectives, targets and strategies reinforce the core values and principles of the SSSHDP II vis; accountability and transparency; quality of care; ethics and respect for human rights; accessibility, affordability and acceptability; equity and gender sensitivity: community engagement; teamwork and industrial harmony;

[3] Targets include: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births: End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. They further include: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all: Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination, etc.

[4] Section 1 (1) (c) and (e) of the NHA.

[5] Section 3 (3) of the NHA.

alignment and harmonization: and partnership and collaboration. The SSSHDP II seeks to achieve its objectives through the implementation of key essential health care packages in the following areas:

- Reproductive, Maternal, New-born, Child and Adolescent health, plus Nutrition (RMNCAH +N)
- Prevention and control of communicable diseases (prioritizing malaria, HIV/AIDS, tuberculosis, hepatitis and Neglected Tropical Diseases – other high burden of diseases covered under child health – acute respiratory tract infections, diarrheal disease and measles)
- Non-Communicable Diseases Prevention and Control (cancers, cardiovascular diseases, chronic obstructive airways disease, sickle cell disease, oral health, mental health, eye health and care of the elderly)
- Health promotion and social determinants on health (focusing on water supply, food hygiene, medical waste disposal)
- Protection from Health Risks and Emergencies.

Sokoto State has some state specific policies and institutions including Sokoto State Primary Health Care Development Agency under One Roof, Free MCH Policy (RUMCARE, PRUMCARE), State Health Contributory Scheme, Malaria Control and Elimination Agency, State Drugs and Medical Supply Management Logistic Unit, Maternal Death Review, domestication of State Reproductive Health Policy, Human Resource for Health policy, Health Ethics Research policy etc.[6] All these need to be considered in the preparation of the MTSS and annual budget estimates.

SECTION TWO: HEALTH SECTOR INDICATORS AND MAJOR CHALLENGES IN SOKOTO RELATED TO THE MINIMUM CORE OBLIGATION OF THE STATE AND PRIMARY HEALTH CARE

2.1 Health Indicators

The Sokoto State Health Sector is faced with a number of challenges. Some of the challenges include the poor health indicators in the midst of dwindling financial resources. Sokoto State's population was 3.6m in 2006. This figure increased to 5.1m in 2018,[7] representing 42% population growth from 2006 to 2018. This scope is 12 years. The above analysis suggests that the Sokoto State population grew by 3.5% per annum. Therefore, Sokoto State population is estimated to be 5.8m by the year 2022.

The implication of the population figure is that there is increasing pressure on available health facilities in the State. Primary Health Care (PHC) has been identified as a critical

[6] See SSSHDP 11, 2018-2022.
[7] SSSHDP, *supra,* State Profile, Geography and Demographic Structure.

part of the minimum core obligation of the state on the right to health.[8] Table 1 documents major health indicators relating to PHC and other tiers of health in Sokoto State. This will facilitate a proper understanding of the health challenges in the State within the context of programming available public resources towards their resolution.

Table 1: Health Indicators – National Average vs Sokoto Rate

S/N	Health Indicator	National Average	Sokoto
	Maternal and Child Health		
1	Neonatal mortality rate*	46 per 1,000 live births[#]	50 per 1,000 live births
2	Post-neonatal mortality rate*	35 per 1,000 live births[#]	52 per 1,000 live births
3	Infant mortality rate*	80 per 1,000 live births[#]	102 per 1,000 live births
4	Child mortality rate*	117 per 1,000 live births[#]	106 per 1,000 live births
5	Under-five mortality rate*	187 per 1,000 live births[#]	197 per 1,000 live births
6	Adolescent birth rate**	120 per 1000 population (15-19years)	174 per 1000 population (15-19 years)
7	Maternal Mortality Rate	512 per 100,000 live births	Not Given
8	Percentage of women with unmet need for contraception (spacing)**	18.5%	23.6%
9	Percentage of women without antenatal care**	31.6%	63.9%
10	Percentage of women who deliver at home**	60.2%	87.7%
11	Percentage of women with post-natal checks for their newborns (in a facility or at home)**	32.8%	8.1%
	Immunisation		
12	Percentage of children (1-2yrs) who receive BCG Vaccine**	53.5%	16.3%
13	Percentage of children (1-2yrs) who received Hepatitis B vaccine at birth**	30.2%	4.6%
14	Percentage of children (1-2yrs) who received Polio Vaccine at birth**	47.4%	12.6%
15	Percentage of children (1-2yrs) who received Yellow Fever Vaccine**	38.8%	6.4%
16	Percentage of children (1-2yrs) who received Measles Vaccine (MCV1)**	41.7%	9.8%
	Adequate Supply of Potable Water		

[8] United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 3 (Fifth Session, 1990) on the nature of State Parties obligations under article 2 (1) of the International Covenant on Economic, Social and Cultural Rights. Nigeria is a State Party to the ICESCR.

17	Unimproved Source*	34.7%	65.6%
18	Improved Source*	65.3%	34.4%
	Sanitation		
19	Improved Facility Usage*	53.4%	43.5%
20	Unimproved Facility Usage*	23.7%	31.0%
21	Open Defecation*	22.9%	25.5%
	Others		
22	Tuberculosis	-	-
23	HIV/AIDS** – (a) Men: Using condoms and limiting sexual intercourse to one uninfected partner (b) Women: Using condoms and limiting sexual intercourse to one uninfected partner	 73.3%[#] 74.0%[#]	 65.8% 53.7%
24	Malaria* (a) Percentage who slept under any mosquito net last night (b) Percentage who slept under ITN by persons in the household the previous night (c) Percentage of pregnant women who slept under an ITN last night (d) Prevalence, diagnosis and prompt treatment of children with fever	 43.9% 43.2% 58.0% 24.2%	 54.2% 52.6% 78% 32.7%

*Source: * Indicates NDHS 2018*

*** Indicates MICS (2016-17)*

[#] Indicates that the value is the North Western geopolitical zone average

Table 1 makes very interesting findings. In maternal, new born and child health, the State's indicators were poorer than the North West regional and national averages in neonatal mortality, post neonatal mortality, infant mortality, under-5 mortality and adolescent birth rates. However, the State performed better than the North West regional average in child mortality rate. Furthermore, the State performed poorer than the national average on percentage of women with unmet need for contraception (spacing, percentage of women without antenatal care, percentage of women who deliver at home and percentage of women with postnatal checks for their newborns (in a facility or at home).

In immunization, the parentage of children aged 1-2years who receive BCG, Hepatitis B, polio vaccine at birth, yellow fever and measles vaccines falls below the national average. In terms of access to improved water supply and open defecation, the State lags behind the national average. The performance is also the same for sanitation while it performed better in persons sleeping under insecticide treated nets. But in prevalence, diagnosis and prompt treatment of children with fever, the performance was below the national average.

2.2 Implications of the Indicators

The first major implication of the indicators listed in Table 1 is the urgency of taking deliberate and targeted steps within the context of available resources to begin to reverse the trend. The second implication is the need to increase the resource outlay through domestic resource mobilization for the task of promoting improvements in health indicators and the third is the need to improve value for money and resource optimization in the deployment and expenditure of the available resources.

Improving the standard of health in the State in a constrained fiscal environment will require the mainstreaming of health in governance through the whole of government and health in all policies approach to the realization of the right to the highest attainable standard of physical and mental health using PHC as the entry point towards UHC.

2.3 Some National Targets for Improvement of Key and Critical Indicators

This subsection reviews some national targets in respect of improving key and critical health indicators listed above.

The National Primary Health Care Development Agency of Nigeria had set targets for improving ***immunization coverage*** within a medium-term plan that expired in 2020. By 2020, Penta-3, BCG, OPVO and IPV were supposed to have reached 95%, 94%, 95% and 95% of the eligible population. Furthermore, PCV-13, Rota, Measles 1, Tetanus Toxoid, Fully Immunized Children and Dropout Rate were supposed to be at the level of 95%, 95%, 95%, 100%, 80% and 10% respectively.[9]

The plan acknowledged the magnitude of the challenges while setting the targets. There is the need to take action to sustain routine immunization coverage for all antigens including the available bundled vaccines at service delivery sites and the eradication of polio in Nigeria. It will also entail increased routine immunization coverage to ensure it reaches all including the hard-to- reach LGAs/communities.

[9] See the source: *Comprehensive EPI Multi-Year Plan 2016 – 2020 (2015 Edition)*

Nigeria's National Malaria Strategic Plan of 2014 – 2020 outlined the targets of the Federal Government of Nigeria towards the elimination of malaria from Nigeria by the end of the year 2020. Nigeria is a major contributor to the global malaria deaths of about 95,802 in 2020. [10] Nigeria's contribution to global malaria cases is 27% while our contribution to global malaria deaths is 23%.[11] On the basis of this, the Strategic Plan posited the following objectives:

- At least 80% of targeted population utilizes appropriate preventive measures by 2020: To test all care-seeking persons with suspected malaria using RDT or microscopy by 2020 and to treat all individuals with confirmed malaria seen in private or public facilities with effective anti-malarial drugs by 2020.

- To provide adequate information to all Nigerians such that at least 80% of the population habitually takes appropriate malaria preventive and treatment measures as necessary by 2020.

- To ensure the timely availability of appropriate anti-malarial medicine and commodities required for prevention and treatment of malaria in Nigeria wherever they are needed by 2018: At least 80% of health facilities in all LGAs report routinely on malaria by 2020, progress is measured, and evidence is used for program improvement.

- To strengthen governance and coordination of all stakeholders for effective program implementation towards an 'A' rating by 2017 sustained through to 2020 on a standardized scorecard.

Evidently, these targets were not met by 2020 and have not still been met as at now.

SECTION THREE: REVIEW OF EXISTING BUDGET COMMITMENTS AND EMERGING ISSUES

There is a state obligation to take concrete and targeted steps and to use the maximum of available resources for the progressive realization of the right to health including PHC.[12] This is to be done with a view to the realization of UHC. Resource includes financial resources appropriated through the budget and other finances leveraged through collaboration with state and non-state actors. Resources also include information, environment, technology and human resources. There are standards used to benchmark state financial resources dedicated to health. Two of the standards vis,

[10] World Malaria Report of the World Health Organization, 2020.
[11] World Malaria Report of the World Health Organization, 2020.
[12] Article 2 (1) of the ICESCR ratified and binding on Nigeria.

the Abuja Declaration and the Sokoto State Strategic Health Development Plan II will be used to benchmark Sokoto State's health budget allocations in recent years.

3.1 Abuja Declaration

Under the Abuja Declaration, Nigeria (and this is binding on Sokoto State being a component of the Federation of Nigeria) made a commitment to dedicate not less than 15% of its overall budget to funding the health sector. Table 2 shows the trend of Sokoto State Allocation to Health Sector as a percentage of total State budget over a nine-year period of 2014 – 2022.

Table 2: Trend of Sokoto State Allocation to Health Sector as % of Total State Budget (2014 - 2022)

TREND OF SOKOTO STATE ALLOCATION TO HEALTH SECTOR AS % OF STATE TOTAL BUDGET (2014 - 2021)					
Years	**Total Budget (NGN)**	**Health Budget (NGN)**	**% of Health Budget to Total Budget**	**15% of Total Budget (NGN; Benchmark)**	**Variance from 15% Benchmark (NGN)**
2014	125,872,202,000.00	5,933,835,768.00	4.7%	18,880,830,300.00	12,946,994,532.00
2015	112,541,452,000.00	4,659,790,505.00	4.1%	16,881,217,800.00	12,221,427,295.00
2016	174,391,603,308.00	6,678,700,014.00	3.8%	26,158,740,496.20	19,480,040,482.20
2017	204,288,364,741.00	9,121,224,332.00	4.5%	30,643,254,711.15	21,522,030,379.15
2018	220,500,264,565.00	17,509,501,994.00	7.9%	33,075,039,684.75	15,565,537,690.75
2019	169,652,771,486.00	10,996,819,565.00	6.5%	25,447,915,722.90	14,451,096,157.90
2020	164,394,397,817.90	13,523,667,836.80	8.2%	24,659,159,672.69	11,135,491,835.89
2021	176,685,535,633.47	20,826,832,913.39	11.8%	26,502,830,345.02	5,675,997,431.63
2022	188,429,495,847.63	29,617,906,608.45	15.7%	28,264,424,377.14	-1,353,482,231.31
	TOTAL		**7.5%#**	**230,513,413,109.85**	**111,645,133,573.21**

Source: Sokoto State Budgets and Author's Calculation. *# This is the average percentage over the nine years.*

From Table 2 above, the year 2014 had a 4.7% vote and it depreciated to 4.1% in 2015 and 3.8% in 2016 and moved up to 4.5% in 2017. In 2018, it moved to 7.9% and increased thereafter except in the year 2019 when it declined to 6.5%. The year 2021 recorded a vote of 11.8% while 2022 recorded the highest vote of 15.7%. However, the average vote over the eight years was 7.5% - being 50% of the Abuja Declaration. The variance in terms of shortfall between the expected 15% in the Abuja Declaration and allocated resources amounts to N111.645 billion. The implication of Table 2 is that the State is not meeting the demands and commitments of the Abuja Declaration.

In Table 3, the disaggregation between appropriated capital and recurrent expenditure over the years is shown.

Table 3: Trend Analysis of Sokoto Health Budget (2014 - 2022): Recurrent and Capital Expenditure

Trend Analysis of Sokoto Health Budget (2014 - 2022)					
Year	**Health Budget (NGN)**	**Capital Expenditure (NGN)**	**Recurrent Expenditure (NGN)**	**% of Capital Exp to Total Health Budget**	**% of Recurrent Exp to Total Health Budget**
2014	5,933,835,768.00	4,845,000,000.00	1,088,835,768.00	81.7%	18.3%
2015	4,659,790,505.00	3,516,029,064.00	1,143,761,441.00	75.5%	24.5%
2016	6,678,700,014.00	5,580,000,000.00	1,098,700,014.00	83.5%	16.5%
2017	9,121,224,332.00	7,827,500,000.00	1,293,724,332.00	85.8%	14.2%
2018	17,509,501,994.00	15,991,497,000.00	1,518,004,994	91.3%	8.7%
2019	10,996,819,565.00	8,649,137,000.00	2,347,682,565	78.7%	21.3%
2020	13,523,667,836.80	11,046,197,014.80	2,477,470,822.00	81.7%	18.3%
2021	20,826,832,913.39	8,693,568,160.00	12,133,264,753.39	41.7%	58.3%
2022	29,617,906,608.45	17,410,949,929.46	12,206,956,678.99	58.8%	41.2%

Source: Sokoto State Budget 2014-2022

Table 3 clearly shows that capital expenditure received more votes than recurrent expenditure. Capital expenditure over the nine years averaged 75.4% while recurrent expenditure averaged 24.6%. It is imperative to present information on the actual expenditure especially where there are variances between appropriation and actual releases and implementation. Tables 4A and 4B show the actual expenditure between the years 2019-2021 being the years in which implementation reports are available.

Table 4A: Trend Analysis of Approved and Actual Sokoto State Health Sector Budget 2019-2021

Trend Analysis of Approved and Actual Sokoto State Health Sector Budget (2019-2021)			
Year	Approved/Revised Health Budget (NGN)	Released Health Budget (NGN)	% of Released Health Budget to Approved Heath Budget
2019	10,996,819,565	9,564,999,237	86.98%
2020	13,523,667,837	12,111,047,195	89.55%
2021	29,956,071,571**	27,029,413,581	90.23%

Source: Sokoto State 2022 Approved Budget for the 2020 Figures and 2019 and 2021 Quarter 4 Budget Performance Reports. ** 2021 Revised Health Budget, while the approved figure is 20,826,832,913.39.

Table 4A shows that 86.98%, 89.55% and 90.23% of the health budget were released and utilized in the years 2019, 2020 and 2021 respectively. Although there is room for

improvement, the above statistics show that the Sokoto State Government is inching towards budget credibility in the health sector.

Table 4B below shows the breakdown of the ratios between recurrent and capital expenditure in 2019 - 2021.

Table 4B: Trend of Actual Health Expenditure- Capital and Recurrent 2019-2021

Trend Analysis of Actual Sokoto State Health Sector Budget (2019-2021)					
Year	**Released Health Budget (NGN)**	**Actual Recurrent Expenditure (NGN)**	**Actual Capital Expenditure (NGN)**	**% of Recurrent Exp. to Total Health Budget**	**% of Capital Exp. to Total Health Budget**
2019	9,564,999,237	1,130,466,708	8,434,532,529	11.8%	88.2%
2020	12,111,047,195	9,318,868,828	2,792,178,367	76.9%	23.1%
2021	27,029,413,581	10,728,909,153	16,300,504,427	39.7%	60.3%

Source: Sokoto State 2022 Approved Budget for the 2020 Figures and 2019 and 2021 Quarter 4 Budget Performance Reports

From Table 4B, in 2019, the ratio of recurrent to capital expenditure was 11.8% to 88.2%; 2020 was 76.9% to 23.1% while 2021 was 39.7% to 60.3% respectively. It is imperative to note that this trend deviates from the trend observed at the Federal level and in many States of the Federation where recurrent expenditure is usually more.

3.2 Sokoto State Strategic Health Development Plan II

Under the SSSHDP II, Sokoto State proposed three financing scenarios for the improvement of the standard of health. They are:

- Baseline – with no coverage scale up and no significant change in HSS investment across the horizon of the plan.

- Essential Service Moderate Scenario – scale-up of essential services and HSS investments required for implementation of the Primary Health Revitalization Agenda.

- Essential Service Aggressive Scenario – Scale-up of Health Service and HSS investments aimed at to achieving universal health coverage while implementing components of the primary health care revitalization agenda contained in Moderate Scenario.

Table 5 shows the details of the costing across the three scenarios.

Table 5: Total Cost of SSSHDP II 2018 – 2022 by Scenarios, in Million (₦)

Total Cost of Sokoto SHDP II 2017- 2021 by Scenarios, in Million (₦)							Mean Cost Per Capita
NSHDP II Policy Scenarios	2018	2019	2020	2021	2022	Total	
N/SHDP II Essential Package Aggressive Scale-up Scenario	₦89,565M	₦ 78,823M	₦ 61,601M	₦39,802M	₦52,202M	₦321,993M	$63
N/SHDP II Essential Package Moderate Scale-up Scenario	₦24,747M	₦28,585M	₦32, 370M	₦34,952M	₦39,193M	₦159,846M	$31
N/SHDP II Baseline Scale Scenario	₦18,489M	₦18,489M	₦19,307M	₦19,086M	₦19,636M	₦94,500M	$18

Source: Sokoto State Health Development Plan II, 2018-2022

From Table 5, ₦322 Billion, ₦160 Billion and ₦95 Billion is required across the three scenarios of Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up Scenario and Baseline respectively over the five-year period of the plan. The mean cost per capita for each scenario was estimated at $ 63, $ 31 and $ 18 for Essential Package Aggressive Scale-up, Essential Package Moderate Scale-up Scenario and Baseline respectively. It is pertinent to mention that the SSSHDP II acknowledges that the above funding requirement will not be met through government budgeted funds alone. It seeks collaboration from stakeholders including donors and the private sector to meet public sector funding gaps.

Table 6 shows the funding requirements of the SSHDP II and the health sector allocations over the five years and the financing gap.

Table 6: Sokoto Strategic Health Development Plan II (SSSHDP) and the State Budget

Year	SSHPD II Policy Scenario (N)		Health Budget (N)	Financing Gap
2018	N/SHDP II Essential Package Aggressive Scale-up Scenario	N89.565bn	N17.509bn	N72.056bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N24.747bn		N7.238bn
	N/SHDP II Baseline Scale Scenario	N18.489bn		N0.98bn
2019	N/SHDP II Essential Package Aggressive Scale-up Scenario	N78.823bn	N10.897bn	N67.926bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N28.585bn		N17.688bn

	N/SHDP II Baseline Scale-up Scenario	N18.489bn		N7.592bn
2020	N/SHDP II Essential Package Aggressive Scale-up Scenario	N61.601bn	N14.224bn	N47.377bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N32.370bn		N18.146bn
	N/SHDP II Baseline Scale Scenario	N19.086bn		N4.862bn
2021	N/SHDP II Essential Package Aggressive Scale-up Scenario	N39.802bn	N20.827bn	N18.975bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N34.952bn		N14.125bn
	N/SHDP II Baseline Scale Scenario	N19.086bn		-N1.741bn
2022	N/SHDP II Essential Package Aggressive Scale-up Scenario	N52.202bn	N29.618bn	N22.584bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N39.193bn		N9.575bn
	N/SHDP II Baseline Scale Scenario	N19.636bn		-N9.982bn

Source: Sokoto State Strategic Health Development Plan II (2018-2022) & the Authors Calculation

Note: Funding gap values in negative indicate that the state budget met and surpassed the costed plan in that instance, while values in positive indicate by what sums the budgets were yet to match the costed plan.

Table 6 clearly shows funding gaps. In the Aggressive Scale up Scenario, a total funding gap of N228.918bn is established. The Moderate Scale Up Scenario establishes a total funding gap of N66.772bn while the Baseline Scenario established a total funding gap of N1.711bn over the review period. Considering that most collaborating donor and private sector funds are reflected in the budget, the development of a strategy for plugging the gaps is imperative.

The SSSHDP II provided a cost for specific program areas in the Essential Moderate Scale Up Scenario. This is as shown in Table 7.

Table 7: Summary Costs by Program Area of Sokoto SSSHDP II 2018-2022 Essential Package Moderate Scale Up Scenario in Millions (N)

SHDPII 2017-2021 Program Areas	2018	2019	2020	2021	2022	total	% Of total cost

Maternal, Newborn and Reproductive Health	₦511m	₦592M	₦591M	₦624M	₦710M	₦3,028M	18.9%
Child Health	₦345M	₦340M	₦334M	₦328M	₦322M	₦1,669M	10.4%
Immunization	₦108M	₦137M	₦165M	₦192M	₦219M	₦821M	5.1%
Malaria	₦64M	₦49M	₦108M	₦93M	₦83M	₦396M	2.5%
TB	₦365M	₦471M	₦ 569M	₦662M	₦758M	₦2,825M	17.7%
HIV/AIDS	₦179M	₦177M	₦ 179M	₦179M	₦183M	₦897M	5.6%
Nutrition	₦283M	₦338M	₦391M	₦445M	₦500M	₦1,957M	12.2%
WASH	₦73M	₦74M	₦75M	₦77M	₦80M	₦380M	2.4%
Non-Communicable Disease	₦327M	₦414M	₦496M	₦579M	₦672M	₦2,488M	15.6%
Mental, Neurological, and Substance Use Disorders	₦49M	₦56M	₦108M	₦72M	₦95M	₦379M	2.4%
Adolescent Health	₦51M	₦75M	₦100M	₦128M	₦159M	₦512M	3.2%
Neglected Tropical Diseases	₦12M	₦11M	₦13M	₦11M	₦12M	₦58M	0.4%
Health Promotions and Social Determinant	₦28.10M	₦28M	₦28M	₦27M	₦28M	₦139M	0.9%
General and Emergency Hospital Services	₦71.90M	₦87M	₦70M	₦68M	₦90M	₦387M	2.4%
Public Health Emergencies, Preparedness and Response	₦9.8M	₦9.6M	₦10.2M	₦9.6M	₦9.7M	₦48.9M	0.3%
SHDP II TOTAL COST	**₦24,747M**	**₦28,585M**	**₦32,370M**	**₦34,952M**	**₦39,193M**	**₦159,846M**	

Source: SSSHDP 2018-2021

A good number of the issues in Table 7 above are relevant to the maintenance of an effective, functional and efficient PHC system. These include maternal, newborn and reproductive health; child health, immunization, malaria, TB, nutrition; WASH; health promotion and social determinants of health, etc.

3.4 Forward Ever, Backward Never Commitment

The right to health, which is to be realized progressively, under the jurisprudence of economic, social and cultural rights is a "forward ever, backward never" right. Deliberate retrogressive measures are not permitted and if any such measure is to be undertaken by the State, it requires the most careful consideration and justification by reference to other compelling rights and in the context of the full use of the maximum of available resources.[13]

Considering that the Naira has been depreciating over the years, the health allocations have been converted to a more stable international currency being the United States Dollar to bring out the real value of the votes over the years. Table 8 tells the story.

Table 8: Trends of Sokoto State Allocation to Health Sector in USSD as % of State's Total Budget (2014 - 2022)

TREND OF SOKOTO STATE ALLOCATION TO HEALTH SECTOR AS % OF STATE GOVERNMENT'S TOTAL BUDGET (2014 - 2022)					
Years	**Total Budget (NGN)**	**Health Budget (NGN)**	**Exchange Rate (1$=NGN)**	**Total Budget (USD)**	**Health Budget (USD)**
2014	125,872,202,000.00	5,933,835,768.00	168	749,239,297.62	35,320,451.00
2015	112,541,452,000.00	4,659,790,505.00	197	571,276,406.09	23,653,758.91
2016	174,391,603,308.00	6,678,700,014.00	305	571,775,748.55	21,897,377.10
2017	204,288,364,741.00	9,121,224,332.00	306	667,609,035.10	29,807,922.65
2018	220,500,264,565.00	17,509,501,994.00	307	718,241,904.12	57,034,208.45
2019	169,652,771,486.00	10,996,819,565.00	307	552,614,890.83	35,820,259.17
2020	164,394,397,817.90	13,523,667,836.80	380	432,616,836.36	35,588,599.57
2021	176,685,535,633.47	20,826,832,913.39	413.49	427,303,043.93	50,368,407.73
2022	188,429,495,847.63	29,617,906,608.45	4.15.63	453,358,746.6	71,260,271.42

Source: Sokoto State Budgets, Central Bank of Nigeria Website https://www.cbn.gov.ng/rates/exchratebycurrency.asp and Author's Calculations

The overall available resources being the total budget figures have been diminishing in real terms between 2014 and 2022. It diminished from $749.239 million in 2014 to the 2022 figure of $453.358 million. The health allocations started with $35.320 million in 2014, reducing to $23.653 million in 2015 and further down to $21.897 million in 2016. It increased to $29.897million in 2017. It took a big leap to $57.034 million in 2018 and nosedived to $35.820 million and $35.588 million in 2019 and 2020 respectively. Further, it increased to $50.368 million in 2021 and $71.260 million in 2022. Essentially,

[13] General Comment No.3 (Fifth Session, 1990) on the nature of State Parties obligations under the ICESCR, paragraph 9.

the funding for health has been undulating but has been increasing in the last two years. So, the State Government in the Appropriation Laws has recently been in compliance with the forward ever, backward never commitment.

3.5 Local Government Funding

The Constitution of the Federal Republic of Nigeria 1999 (as amended) schedules Local Governments against their States in First Schedule, Part 1 of the Constitution. However, it provides in S.7 (1) as follows:

> "*The system of local government by democratically elected local government councils is under this Constitution guaranteed; and accordingly, the Government of every State shall, subject to section 8 of this Constitution, ensure their existence under a Law which provides for the establishment, structure, composition, finance and functions of such councils"*

However, in the Fourth Schedule, the Constitution provides that the functions of a Local Government Council shall include the provision and maintenance of health facilities. This is understood to be a reference to Primary Health Care facilities. The budgetary provisions of the seven LGCs in focus in this Memorandum in respect of PHC is reproduced in Table 9 below.

Table 9: Key Budget Provisions of Local Government Areas Related to PHC 2019-2021

Summary of Local Government PHC Budget Funding (2019 - 2021)						
S/N	Local Govt Areas	PHC Construction, Renovation and Purchase of Equipment	Social Protection Allocation	Water Supply	Immunization, Drugs etc.	Provision for the Control of Disease Outbreak
1	Binji	49,122,720	48,268,000	465,731,090	12,502,230	-
2	Yabo	12,236,960	48,268,000	237,031,282	12,502,230	-
3	Sokoto North	6,648,090	48,268,000	675,415,830	12,502,230	-
4	Sokoto South	35,000,000	48,268,000	519,545,090	52,502,230	15,000,000
5	Gwadabawa	52,773,990	48,268,000	582,464,540	155,502,230	-
6	Tambuwal	25,713,180	48,268,000	469,545,090	-	-
7	Wurno	41,473,990	48,268,000	437,132,480	17,798,934	-
	TOTAL	**222,968,930**	**337,876,000**	**3,386,865,402**	**263,310,084**	**15,000,000**

Source: Budgets of the Seven Local Government Councils

From Table 9, the single most invested line-item across the seven LGCs is water supply followed by social protection which was in respect of the COVID-19 period. Allocations to immunization and drugs was the next priority and the fourth was construction and renovation of PHCs while provisions for the outbreak of diseases came last in the priority. The budgets seem not to have paid attention to addressing key maternal and child health indicators as well as investments in preventive and promotive health. A good number of the projects in water supply were pooled projects for which each LG made a contribution and apparently being coordinated by the State Government.

3.6 Whole-of-Government and Health-in-all-Policies Approach

Although there are indications of collaboration across Ministries, Departments and Agencies of Government in the State, there is no policy mandating the whole of government and health in all policies approach. For example, there is little in the budget to show the involvement of the ministry in charge of information in the critical task of information dissemination as a resource for preventive and promotive health interventions.

The whole-of-government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors. Health is made an explicit objective of every policy decision. Health in all policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people.

SECTION FOUR: THE BASIC HEALTH CARE PROVISIONS FUND

According to the Sokoto State Primary Health Care Development Agency, Sokoto State Government has met all the criteria for the operationalization of BHCPF and has received funds in year 2021 and 2022 respectively. The State Government committed over N100 million for pre-implementation activities. The total sum that has accrued to the BHCPF from the Federal Government through the SSPHCDA gateway in the State is the sum of N466.732m. 193 PHCs were cleared by NPHCDA to receive funds through Decentralized Facility Financing (DFF) for two quarters. Disbursement to facilities per quarter is N300,750.00 (N100,250.00 per month). The Scheme has recruited 118 midwives. The State's 25% contribution to the fund's basket is done through the SSPHCDA and SOCHEMA's budget starting from the 2021 fiscal year onwards.[14]

[14] *Basic Health Care Provision Fund and the Sokoto State Primary Health Care Development Agency Gateway*, presented by Dr. Tijjani Ahmad Faruk, being a paper presentation by SSPHCDA at the 3-day

Furthermore, according to SOCHEMA, it has enrolled 39,822 beneficiaries in 12 Local Government Areas out of 43,934 allocated to Sokoto State by NHIS.[15]

From available information, the State is on the right path in terms of accessing resources from the BHCPF and needs to deepen the engagement with the Fund through transparency, accountability, value for money and citizens' engagement.

SECTION FIVE: SUSTAINABILITY OF CURRENT HEALTHCARE FINANCING MODEL IN SOKOTO STATE

The sustainability of healthcare services is to a great extent dependent on the quantum and sources of healthcare financing. From section 3 on the review of existing budget commitments, it is clear that the State's public budget allocations do not meet the requirement of the SSHDP II across all the three scenarios used in costing the health needs of the State. This is compounded by the dwindling fiscal resources and fiscal space available to the State Government. Also, the complimentary funding from the BHCPF is not sufficient to fill the funding gap while the contributions expected from donors, the private sector and other non-state actors have been unable to fill the funding gap.

Nigeria's out of pocket expenditure on health is one of the highest in the world and has been stated by the World Bank at 70.52 percent. This is in contrast to the Sub-Saharan Africa average of 29.98 percent. [16] Sokoto State, as a part of the Nigerian Federation falls under this umbrella of high out of pocket heath expenditure. Out of pocket health expenditure is a reference to direct expenses on health care which is not covered by any prepayments for health services. It is paid from an individual's cash reserves. It forces people, especially the poor to make unnecessary choices between their health and expenditure on other basic rights such as food, housing and education.

To fulfil the vision of UHC where all Sokoto residents can have access to the health care services they need at any time without being constrained by the depth of their pocket and personally available resources will require optimum health financing from a plethora of sources which minimizes the need for out-of-pocket health expenditure. The current Sokoto State Health Financing Model is not sustainable and needs to be improved upon.

SECTION SIX: HEALTH INSURANCE TO THE RESCUE

Stakeholders Capacity Building on Funding for Primary Health Care, Universal Health Coverage and the Right to Health, held by CSJ on the 10th to 12th May, 2022 in Sokoto.

[15] The numbers are as follows: Aged at 6,546; children under 5 at 18,847; pregnant women at 4,393; disabled at 1,467 and the poor at 8,860 respectively. This is from a paper presented by SOCHEMA at the workshop referred to in Footnote 14 above.

[16] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG, 2019.

The enrolment numbers into the various plans of the National Health Insurance Scheme (NHIS) and various private health insurance schemes across the Federation is reported at 10million, about 5% of the population.[17] However, there is no disaggregation of this overall national figure according to States. On the other hand, the Sokoto State Contributory Health Care Management Scheme (SOCHEMA) states that Sokoto, with an estimated population of 5.3 million people has about 4.5 million without health insurance.[18] This implies that not less than 800,000 Sokoto residents have access to health insurance. This SOCHEMA number is on the very high side considering the national estimates of persons who have health insurance. Generally, the contribution of health insurance to overall healthcare financing is still very low. The majority of health insurance enrollees seem to be in the NHIS schemes which have been generally rated not to be very impactful. A health scholar has posited of the low enrolment numbers as follows:[19]

> "*A number of reasons could be attributed to the small proportion of this veritable source of healthcare financing. One of the major reasons is the administrative bottlenecks within the National Health Insurance Scheme in Nigeria. Another important reason is the non-comprehensiveness and non-inclusiveness of the Scheme. A number of those that have NHIS accounts are deprived of some services with the flimsy reason that the Scheme does not all the healthcare services they may have need of. Certain healthcare services have been deliberately excluded under the scheme. This does not encourage more take-up of the Scheme. This is compounded by the fact that the Scheme has not been made marketed to non-government workers. An all-inclusive Scheme will do Nigeria a greater and better deal than the current state of the National Health Insurance Scheme".*

Considering the beautiful provisions of the Sokoto State Contributory Health Care Management Agency Law and its plans, the Agency should take steps to popularize the available schemes as well as enforce the mandatory provisions of S.11(2) of the Law vis:

> *All residents in the formal or informal sector must possess evidence of being covered by the Scheme.*

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[17] See the Guardian Newspaper of 25th September 2020: https://guardian.ng/features/Over 170 million Nigerians without health insurance — Features — The Guardian Nigeria News – Nigeria and World News quoting Head, Media and Public Relations of NHIS, Mr. Ayo Osinlu who stated: "There are over 10 million Nigerians currently covered by health insurance under various programs by NHIS, State health insurance agencies and private plans by HMOs". It also cited with approval a study published in The Lancet, a medical journal, where it was noted that more than ''90 per cent of the Nigerian population were uninsured, despite the NHIS that was established in 2006. Less than five per cent of Nigerians in the formal sector are covered by the NHIS. Only three per cent of people in the informal sector are covered by voluntary private health insurance. Uninsured patients are at the mercy of a non-performing health system."

[18] The Sokoto State Contributory Healthcare Management Scheme (SOCHEMA) becomes law | HFG (hfgproject.org)

[19] David Agu in Contributions to Health Sector MTEF 2019-2021.

The mandatory provisions of SOCHEMA are further supported by the National Health Insurance Authority Act which makes health insurance compulsory and universal. The available plans under SOCHEMA include (a) the Sokoto State Health Plan (SKSHP); (b) the Formal Health Plan; (c) the Informal Health Plan (IHP); (d) the Sokoto State Private Health Plan (PHP); (e) the Equity Health Plan and (f) any other component as maybe developed by the Agency with the approval of the Board.[20]

SECTION SEVEN: RECOMMENDATIONS

The following recommendations flow from the review and analysis in this Memorandum.

7.1 Prepare a Health MTSS: The State Ministry of Health should take steps towards the preparation of a Health MTSS. This is to compliment sections 18 and 20 of the Sokoto State Fiscal Responsibility Law which demands the preparation a Medium Term Expenditure Framework. It is mandatory for the compositional distribution of the annual budget to be in accordance with the priorities of the MTEF.

7.2 Mainstream the Plan, Policy and Budget Continuum in Health: Plans and policies provide the legal and policy framework for sectoral governance and service delivery while budgets activate plans and policies through providing resources for their implementation. The disconnect between plans, policies and budgeting has been largely responsible for poor PHC outcomes in most states of Nigeria.

7.3 Whole-of-Government, Health-in-all Policies Approach: The Ministry of Health should prepare an executive memorandum and seek the approval of the State Executive Council for a whole-of-government and health-in-all policies approach. The whole-of-government approach is an understanding that securing the health of the population cannot be achieved by the Ministry of Health and its departments and agencies alone. It requires inter-ministerial/agency collaboration and mainstreaming health in other sectors. For example, the ministry in charge of information should be

[20] (a) The Sokoto State Health Plan (SKSHP) - the plan shall consist of a basic, defined Minimum Benefit Package of healthcare services for Primary Care as well as an affordable Supplementary Benefit Package of healthcare services for Secondary and Tertiary Care and will be accessible from both Public and Private Primary Health Care Facilities who shall refer if necessary to designated secondary and tertiary health facilities. (b) the Formal Health Plan - this shall be a contributory plan for all Students of educational institutions, public and private formal sector employees wherein the employer and employees shall make contributions as determined by the Board; (c) the Informal Health Plan (IHP) - this shall be an affordable program providing access of health services at uniform contribution accessible at grassroots; (d) the Sokoto State Private Health Plan (PHP) - this shall consist of a variety of packages providing healthcare services in direct proportion to the contribution; (e) the Equity Health Plan - this shall be a package providing health care services for the vulnerable groups and shall be funded from the Equity Fund; and (f) any other component as maybe developed by the Agency with the approval of the Board.

involved in the critical task of information dissemination as a resource for preventive and promotive health interventions.

Health-in-all-policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all communities and people. Health should be made an explicit objective of every policy decision.

7.4 Stakeholder Engagement and Popular Participation in Preparation of MTSS: In the preparation of the MTSS, formulation and preparation of the annual health budget, there is the need to mobilize all stakeholders in the Health Sector, engage them and ensure popular participation. Most policy and budget failures in Nigeria have been attributed to top-down approach to policy development and implementation. Conscious involvement of all relevant stakeholders in the development and implementation of health sector plans and budgets will be of great benefit to the sector.

7.5 Whole of Society Approach to Health: Further to the last recommendation, the State should adopt the *whole-of-society* approach involving *the* engagement of all relevant stakeholders in society to address socio-economic and livelihood issues that affect health. This includes public health, education, food security, agriculture, power and energy, communications, environment, employment, industry, and social and economic development.

7.6 Prepare a New Sokoto State Strategic Health Development 2023-2027 and Other Due Policies: The existing SSSHDP II is expiring by effluxion of time in 2022. The Ministry of Health should take steps towards the preparation and adoption of a new SSSHDP III.

Beyond the SSSHDP II that is due for review, the State Ministry of Health should also come up with a comprehensive list of all policies and plans that are no longer current and ensure they are revised and updated.

7.7 Declare a State of Emergency in the Health Sector: Considering the State's poor health indicators, it is imperative to declare a state of emergency in the sector especially on maternal, new born and child health. The contours of the state of emergency should include increased funding to the sector, especially primary health care (maternal, newborn and child health, immunization, etc.), promotive and preventive health and ring-fencing health sector allocations in the budget to ensure that they are fully released and utilized.

7.8 Increase Funding to the Sector and Invest in Value for Money: It is imperative to increase health sector funding to ensure that the 15% target is met in actual releases

and utilization of the vote. Furthermore, the Ministry of Health should invest in value for money tools and processes to increase economy, efficiency, effectiveness and equity of its investments across the health value chain.

7.9 Moratorium on New Capital Projects: Considering that the year 2023 will witness a change in the executive and legislative leadership of the State, there should be a moratorium on new capital projects and the focus should be on completing existing and ongoing projects. In this way, the resources of the State will not be spread too thin and project abandonment will be minimized.

7.10 Invest in Transparency and Accountability: The SMOH should invest in improving the transparency and accountability of its operations through collating and publication of timely and quarterly line item by line-item expenditure details. This will build the confidence of stakeholders and increase contributions and collaborations for improving the standard of health in the State.

7.11 Annual State of Health Report: To boost transparency and accountability and in accordance with S.2 (2) (d) of the National Health Act, the Commissioner for Health should prepare and present an annual report on the state of health of residents in Sokoto to the Governor and the State House of Assembly and publish same on the State Government's website.

7.12 Ensure Maximum Benefits from BHCPF: The State should ensure that it derives the maximum benefits available from the BHCPF through guaranteeing the required counterpart funding, accrediting more health institutions especially PHCs, timely and meticulous retirement of disbursed funds from the National Primary Health Care Development Agency and Health Insurance Gateways.

7.13 Full Implementation of SOCHEMA Law and the National Health Authority Act: SOCHEMA and the National Health Insurance Authority Act envisage a universal and compulsory health insurance regime in Sokoto State and across the Nigeria Federation. SOCHEMA should draw up an action plan that will start from awareness creation and massive sensitization to enforcement over a period of four years. The first two years should focus on awareness creation and enforcement follows in the second two years.


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