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ADAMAWA STATE 2023 PRE-BUDGET RIGHT TO HEALTH MEMORANDUM

CSJ
Centre for Social Justice

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By

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ASCHMA	Adamawa State Contributory Health Management Agency
CSJ	Centre for Social Justice
CSOs	Civil Society Organizations
EHP	Equity Health Plan
FRL	Fiscal Responsibility Law
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immune Deficiency Virus
ITN	Insecticide Treated Net
MSP	Minimum Service Package
MSPAN	Multi-sectoral Plan of Action on Nutrition
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategy
NGN	Nigeria Naira
NHA	National Health Act
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NHP	National Health Policy 2016
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHCDA	Primary HealthCare Development Agency
SDGs	Sustainable Development Goals
SHIS	State Health Insurance Scheme
SMOH	State Ministry of Health
TB	Tuberculosis
TIHP	Tertiary Institution Health Plan
UHC	Universal Health Coverage
USD	United State Dollars

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EXECUTIVE SUMMARY

This memorandum is divided into seven sections. Section 1 is the background, provides the rationale for the exercise and reviews key sectoral goals, objectives, targets and strategies. Section 2 reviews Adamawa specific health indicators and their implications. Section 3 reviews the health budget commitments of the State including the actuals and their compliance with the Abuja 15% Declaration. It also reviews whether the State has set and costed a Minimum Service Package for PHC and the whole of government and health in all policies approach. Section 4 is on the implementation of the Basic Health Care Provisions Fund in the State while Section 5 reviews the sustainability of the current health care financing model. Section 6 is on the operation of health insurance in Adamawa while Section 7 is on recommendations.

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

- Develop a New Strategic Health Development Plan.
- Prepare a Health MTSS.
- Mainstream the Plan, Policy and Budget Continuum in Health.
- Adopt a Whole-of-Government, Health-in-all Policies Approach.
- Stakeholder Engagement and Popular Participation in Preparation of MTSS.
- Adopt a Whole of Society Approach to Health.
- Increase Funding to the Sector and Invest in Value for Money.
- Moratorium on New Capital Projects.
- Invest in Transparency and Accountability.
- Prepare and publish Annual State of Health Report.
- Ensure Maximum Benefits from BHCPF.
- Full Implementation of Adamawa State Contributory Health Care Management Agency Law and the National Health Authority Act.

SECTION ONE: INTRODUCTION

1.1 Background

The Adamawa State Fiscal Responsibility Law (FRL) requires the State Government to prepare the Medium Term Expenditure Framework (MTEF) and government expenditure must be based on the MTEF[1]. The MTEF is a three-year rolling plan containing the macroeconomic framework, fiscal strategy paper, expenditure and revenue framework, consolidated debt statement and a 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 prepare and 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. If the State neither prepares a MTEF nor the MTSS, it has a constitutional obligation to prepare an annual budget.

Adapting the provisions of the National Health Act (NHA) to Adamawa State, the State Ministry of Health (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]

In the Nigerian context, the Centre for Social Justice (CSJ) articulates the principles of good health budgeting as follows:

- Pursue spending policies that are consistent with strategic and high level health plans and policies and with a reasonable degree of stability and predictability;
- Hinge health spending on a whole of government, health in all policies approach;
- Mainstream primary health care which is the foundation for secondary and tertiary care levels;
- Provide an enabling environment and motivate domestic resource mobilization as a step towards universal health coverage;
- Pursue spending within a definitive macro-economic framework with, at a minimum, medium term horizon and which assures a prudent balance between available resources and planned spending;
- Ensure that the scale and focus of health spending address the prevalent disease conditions found in epidemiological analysis in the State;

[1] S. 6 of the FRL.
[2] S.2(2) of the NHA 2014

- Ensure optimal value for all Government health spending combining the realisation of improved (more) health from already available resources while pushing for more money for health;

- Maintain the integrity of the Health Information Management System;

- Provide full, accurate and timely disclosure of financial information relating to the health activities of the Government and its agencies, that is, ensuring transparency and accountability; and

- Manage health risks faced by the State prudently, having regard to economic, social and other circumstances.

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 Adamawa 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 National Health Policy, National Strategic Health Development Plan, Sustainable Development Goals (SDGs 3, etc.) and ratified treaties and standards, etc.;[3]

- 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;

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 annual

[3] The standards containing provisions on the right to health include the standard setting Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, Convention on the Rights of the Child, Convention for the Elimination of all Forms of Discrimination against Women, African Charter on Human and Peoples Rights and the Protocol on the Human Rights of Women in Africa.

budget. Therefore, this memorandum presents the key inputs of CSOs into 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), the Right to Health Cluster 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. It 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.

Thus, this Memorandum seeks to make inputs into the 2023 Adamawa State Health Budget.

1.3 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[4], NHA, etc. The National Health Policy 2016 is made with a vision of Universal Health Coverage for all Nigerians and 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, including the people of Adamawa State by providing clear policy direction and implementing all

[4] 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.

necessary health plans with the participation of relevant stakeholders. This is in tandem with one of the key objectives of the Adamawa State Contributory Health Management Agency.

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[5]. It entitles all Nigerians to a basic minimum package of health services[6]. 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. Adamawa State has a Primary Health Care Development Agency which is established by law and charged with dealing with the PHC challenges in the state.

[5] Section 1 (1) (C) and (e) of the NHA
[6] Section 3 (3) of the NHA

SECTION 2: HEALTH SECTOR INDICATORS AND MAJOR CHALLENGES IN ADAMAWA RELATED TO THE MINIMUM CORE OBLIGATION OF THE STATE AND PRIMARY HEALTH CARE

2.1 Health Indicators

The Adamawa 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. Adamawa State's population was 3,178,950 in 2006. This figure increased to 4,248,436 in 2016[7], representing 33.6% population growth from 2006 to 2016. This scope is 10 years. The above analysis suggests that the Adamawa State population grew by 3.36% per annum. Therefore, Adamawa State's population is estimated to be 4.9 million 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 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 Adamawa 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 Adamawa State

S/N	Health Indicator	National Average	Adamawa State
	Maternal and Child Health		
1	Neonatal Mortality*	39 per 1,000 live births	32 per 1,000 live births
2	Post-neonatal Mortality*	28 per 1,000 live births	36 per 1,000 live births
3	Infant mortality*	67 per 1,000 live births	68 per 1,000 live births
4	Child mortality*	69 per 1,000 live births	39 per 1,000 live births
5	Under-5 Mortality*	132 per 1,000 live births	104 per 1,000 live births

[7] National Population Commission and National Bureau of Statistics Estimates
[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.

6	Adolescent birth rate**	120 per 1,000 population (15 – 19 years)	113 per 1,000 population (15 – 19 years)
7	Percentage of women with unmet need for contraception (spacing)**	18.5%	23.9%
8	Percentage of women without antenatal care**	31.6%	19.0%
9	Percentage of women who deliver at home**	60.2%	57.9%
10	Percentage of women with postnatal checks for their newborns (in a facility or at home)**	32.8%	36.8%
	Immunization		
11	Percentage of children (1-2 yrs) who receive BCG Vaccine**	53.5%	67.4%
12	Percentage of children (1-2 yrs) who receive Hepatitis B Vaccine at birth**	30.2%	35.0%
13	Percentage of children (1-2 yrs) who receive Polio Vaccine at birth**	47.4%	54.5%
14	Percentage of children (1-2 yrs) who receive Yellow Fever Vaccine**	38.8%	44.5%
15	Percentage of children (1-2 yrs) who receive Measles Vaccine (MCV 1)**	41.7%	48.8%
	Adequate Supply of Potable Water		
16	Unimproved Source*	34.7%	48.4%
17	Improved Source*	65.3%	51.6%
	Sanitation		
18	Improved facility usage*	53.4%	76.5%
19	Unimproved facility usage*	23.7%	0.8%
20	Open defecation*	22.9%	22.8%
	Others		

21	HIV/AIDS prevention knowledge* (a) Men: Using condoms and limiting sexual intercourse to one uninfected partner can reduce risk (b) Women: Using condoms and limiting sexual intercourse to one uninfected partner can reduce risk	88.3% 74.1%	57.3% 81.0%
22	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%	43.5% 42.6% 37.8% 27.9%

*Source: * Indicates NDHS 2018: ** Indicates MICS (2016 – 2017)*

Table 1 makes very interesting findings. With respect to maternal and child health indicators, Adamawa State performed better than the national average in neonatal mortality, child mortality and under-5 mortality. However, the State performed poorer than the national average in post neonatal mortality and infant mortality. Furthermore, the State performed better than the national average in percentage of women without antenatal care, percentage of women who deliver at home, percentage of women with postnatal checks for their newborns (in a facility or at home). However, the State performed poorer in percentage of women with unmet need for contraception (spacing).

In immunization, Adamawa State performed better than the national average in percentage of children (1-2 yrs) who receive BCG Vaccine, percentage of children (1-2 yrs) who receive Hepatitis B Vaccine at birth, percentage of children (1-2 yrs) who receive

Polio Vaccine at birth, percentage of children (1-2 yrs) who receive Yellow Fever Vaccine, percentage of children (1-2 yrs) who receive Measles Vaccine (MCV 1).

The State performed poorer than the national average in improved source of potable water and open defecation. For malaria, the State performed poorer than the national average in percentage of people sleeping under any mosquito net, percentage of people sleeping under insecticide treated net (ITN), and percentage of pregnant women sleeping under an ITN. However, the State performed better than the national average in prevalence, diagnosis and prompt treatment of children with fever.

But these above the national average performances still leaves a long way to attaining SDG 3. For instance, the under-5 mortality of 104 per 1,000 live births is so far off the SDG target mark of 25 per 1,000 live births. The indicators are also below the expectations and targets set in other SDGs (beyond SDG3), National Health Policy, other relevant policies and ratified international standards on the best attainable state of physical and mental health.

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 negative trends as well as sustaining and improving on the relatively positive trends. 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.

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[9]. 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. To set the context for the state health budget review, the overall Adamawa State Budget per capita was N41,893.46, N57,603.20, N33,118.07, N32,961.68 and N38,515.66 for the years 2018, 2019, 2020, 2021 and 2022 respectively.

There are standards used to benchmark state financial resources dedicated to health. Two of the standards vis, the Abuja Declaration and the utilization of appropriated funds will be used to benchmark Adamawa State's health budget allocations in recent years.

3.1 Abuja Declaration

Under the Abuja Declaration, Nigeria (and this is binding on Adamawa 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 Adamawa State Allocation to Health Sector as a percentage of total State budget over a five-year period of 2018 – 2022.

Table 2: Trend of Adamawa State Allocation to Health Sector as % of Total State Budget (2018 - 2022)

TREND OF ADAMAWA STATE ALLOCATION TO HEALTH SECTOR AS % OF FG TOTAL BUDGET (2018 - 2022)					
Years	Total Budget (NGN)	Health Budget (NGN)	% of Health Budget to Total Budget	15% of Total Budget (NGN; Benchmark)	Variance from 15% Benchmark (NGN)
2018	177,980,163,124.00	11,970,637,011.00	6.7%	26,697,024,468.60	14,726,387,457.60
2019	244,721,447,175.00	21,171,310,673.00	8.7%	36,708,217,076.25	15,536,906,403.25
2020	140,698,801,626.00	19,391,412,175.00	13.8%	21,104,820,243.90	1,713,408,068.90
2021	140,034,409,440.00	11,015,130,000.00	7.9%	21,005,161,416.00	9,990,031,416.00
2022	163,629,910,040.00	12,175,110,000.00	7.4%	24,544,486,506.00	12,369,376,506.00
Total	**867,064,731,405.00**	**75,723,599,859.00**	**8.9%**	**130,059,709,710.75**	**54,336,109,851.75**

Source: Adamawa State Approved Budgets 2018-2022 and Author's Calculation

[9] Article 2 (1) of the ICESCR ratified and binding on Nigeria.

From Table 2, the Adamawa State health budget per capita was N2,817.68, N4,983.36, N4,564.40, N2,592.77 and N2,865.81 for the years 2018, 2019, 2020, 2021 and 2022 respectively. Furthermore, Table 2 shows that the year 2018 had a 6.7% vote to health. It appreciated to 8.7% in 2019 and appreciated even further to 13.8% in 2020. It then depreciated to 7.9% in 2021 and depreciated further to 7.4% in 2022. The highest vote of 13.8% was recorded in 2020 while the lowest vote of 6.7% was recorded in 2018. The average vote of the period was 8.9% which represents 59% of the Abuja Declaration. The variance in terms of shortfall between the expected 15% in the Abuja Declaration and allocated resources amounts to N54.336 billion. The implication of Table 2 is that the State has not met the demands and commitments of the Abuja Declaration. The 59% mark should be scaled up progressively towards the Abuja Declaration target.

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

Table 3: Trend Analysis of Adamawa State Health Budget (2018 - 2022): Recurrent and Capital Expenditure

Trend Analysis of Adamawa Health Budget (2018 - 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**
2018	11,970,637,011.00	7,416,293,011.00	4,554,344,000.00	62.0%	38.0%
2019	21,171,310,673.00	14,952,518,011	6,218,792,662.00	70.6%	29.4%
2020	19,391,412,175.00	13,243,417,075.00	6,147,995,100.00	68.3%	31.7%
2021	11,015,130,000.00	6,276,240,000.00	4,738,890,000.00	57.0%	43.0%
2022	12,175,110,000.00	6,400,000,000.00	5,775,110,000.00	52.6%	47.4%

Source: Adamawa State Approved Budgets and Author's Calculation

Table 3 clearly shows that capital expenditure received more votes than recurrent expenditure. The highest capital vote was in 2019 while the lowest was in 2022. Capital expenditure over the five years averaged 62.10% while recurrent expenditure averaged 37.90%.

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 for the years 2019 and 2021 being the years in which implementation reports are available.

Table 4A: Trend Analysis of Approved and Actual Adamawa State Health Sector Budget (2019 and 2021)

TRENDANALYSIS OF APPROVED AND ACTUAL ADAMAWA STATE HEALTH SECTOR BUDGET (2019 AND 2021)			
Year	Approved/Revised Health Budget (NGN)	Actual Health Budget (NGN)	% of Actual Health Budget to Approved Heath Budget
2019	21,171,310,673.00	6,184,870,963.00	29.21%
2020	19,391,412,175.00	4,126,091,517.59	21.28%
2021	11,015,130,000.00	5,855,347,974.32	53.16%

Source: Adamawa State Budgets and Author's Calculation

Table 4A shows that 29.21%, 21.28% and 53.16% respectively were utilized in the years 2019 and 2021. This is an average budget utilization of 34.55% over the three years. This shows that the Adamawa State budget requires more credibility to reduce the gap between appropriation, releases and utilized budget sums.

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

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

TREND OF ACTUAL HEALTH EXPENDITURE - CAPITAL & RECURRENT BUDGET (2019 AND 2021)					
Year	Actual 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	6,184,870,963.00	3,736,152,427.00	2,448,718,536.00	60.4%	39.6%
2020	19,391,412,175.00	2,568,378,218.13	1,557,713,299.46	62.2%	37.8%
2021	5,855,347,974.32	3,994,344,396.84	1,861,003,577.48	68.2%	31.8%

Source: Adamawa State Budgets and Author's Calculation

From Table 4B, in 2019, the ratio of recurrent to capital expenditure was 60.4% to 39.6%; 62.2% to 37.8% and in 2021 it was 68.2% to 31.8%. Despite capital votes being more than recurrent votes (as shown in Table 3), there was more actual recurrent than capital expenditure.

3.2 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[10]. 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 and overall budget over the years. Table 5 tells the story.

Table 5: Trends of Adamawa State Allocation to Health Sector in USSD as % of State's Total Budget (2018 - 2022)

TREND OF ADAMAWA STATE ALLOCATION TO HEALTH SECTOR AS % OF FG TOTAL BUDGET (2018 - 2022)					
Years	**Total Budget (NGN)**	**Health Budget (NGN)**	**Exchange Rate (1$=NGN)**	**Total Budget (USD)**	**Health Budget (USD)**
2018	177,980,163,124.00	11,970,637,011.00	307	579,739,945.03	38,992,302.97
2019	244,721,447,175.00	21,171,310,673.00	307	797,138,264.41	68,961,924.02
2020	140,698,801,626.00	19,391,412,175.00	380	370,260,004.28	51,030,032.04
2021	140,034,409,440.00	11,015,130,000.00	413.49	338,664,561.27	26,639,410.87
2022	163,629,910,040.00	12,175,110,000.00	415.63	393,691,288.02	29,293,145.35
TOTAL	**867,064,731,405.00**	**75,723,599,859.00**		**2,479,494,063.01**	**214,916,815.24**

Source: Adamawa 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 2018 and 2022. However, it has taken the shape of an undulating framework - rising and falling. It initially increased between 2018 and 2019 (from $579.739 million to $797.138million); diminished to $370.260 million in 2020 and diminished again to $338.664 million in 2021 and increased to $393.691 million in 2022. The health allocations started with $38.992 million in 2018, increasing to $68.961 million in 2019 and reducing to $51.030 million in 2020. It reduced further to $26.639 million in 2021 and increased to $29.293 million in 2022. Essentially, the funding for health has decreased from $38.992 million in 2018 to $29.293 million in 2022. The resources available to the health sector has decreased at a percentage lower than the overall decrease in the overall budget envelope. While the overall budget of 2022 is a 32.09% reduction of the 2018 overall budget, the health allocation of 2018 as a percentage of the overall budget is 6.7% while that of 2022 is 7.4%. This is actually a marginal increase. However, the State Government in the Appropriation Laws has not complied with the forward ever, backward never commitment, because of the decrease in 2021 and 2022

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

3.3 Minimum Service Package

Adamawa State has not developed a Minimum Service Package (MSP) for the PHC facilities identified for the one PHC per political ward strategy.[11] MSP is the minimum core content of PHC, being the minimum package of health services to be delivered at the primary and secondary levels of care funded by the state. This is to ensure the best health/value for money in government expenditure so that scarce resources are deployed for the areas of greatest need and impact. This will ensure the provision of the best possible health services to citizens within the limits of available resources.

3.4 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.

[11] Page 62 of the State of Primary Health Care Service Delivery in Nigeria 2019-2021 by One Campaign.

SECTION FOUR: THE BASIC HEALTH CARE PROVISIONS FUND (BHCPF)

According to the State of Primary Health Care Delivery in Nigeria, 2019-2021;[12]

> *Adamawa State has attained full capacity to utilize BHCPF disbursements from the NPHCDA Gateway. However, enrollees on the NHIS Gateway have not started accessing care and provider payments have not commenced. The State has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state does not have any formal sector health insurance scheme to support risk and financial pooling.*

According to the summary of key steps to improvement, the following is recommended:[13]

- Provide equity funds for the NHIS gateway of the BHCPF;
- Develop an Electronic Workforce Registry in the State to support management of human resources for health;
- Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF;
- Commission a legal assessment and provide political leadership for the drafting and passage of a Comprehensive State Health Law;
- Develop a Health System Wide Accountability and Performance Management Framework, and engage technical assistance to support its implementation;
- Create a pipeline for private sector partnerships, especially to support the production and training of human resources for health;
- Develop a State MSPAN, a costed MSP, and an investment plan to accompany the fully costed MSP and ensure that both plans fit into the State and Strategic Health and Development Plan III and forms the basis of state budgeting for health;
- The State needs to take a multisectoral approach to investments in health by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health.

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[12] State of Primary Health Care Delivery in Nigeria, supra at page 61.
[13] State of Primary Health Care delivery in Nigeria, supra.

SECTION FIVE: SUSTAINABILITY OF CURRENT HEALTHCARE FINANCING MODEL IN ADAMAWA 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 funding needed to achieve UHC. 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[14]. Adamawa State, as a part of the Nigerian Federation falls under this umbrella of high out of pocket health 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, education, etc.

To fulfil the vision of UHC where all Adamawa 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 Adamawa State Health Financing Model is not sustainable and needs to be improved upon.

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

SECTION SIX: HEALTH INSURANCE TO THE RESCUE

The enrolment numbers into the various plans of the former NHIS, now NHIA and various private health insurance schemes across the Federation is reported at 10million, about 5% of the population[15]. However, there is no disaggregation of this overall national figure according to States. On the other hand, the Adamawa State Contributory Health Care Management Scheme is relatively new and may not have covered majority of the population. 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/NHIA schemes which have been generally rated not to be very impactful. A health scholar has posited of the low enrolment numbers as follows:[16]

> *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 cover 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 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.*

The Adamawa State Contributory Health Management Agency (ASCHMA) is established with a goal of ensuring that all residents of Adamawa State have equitable access to quality and affordable healthcare services without suffering from financial hardship. The vision of ASCHMA is securing universal health access and coverage for all residents of Adamawa State. The mission of ASCHMA is to provide financial risk protection against huge medical bills through sustainable prepayment mechanisms. The core values adopted by ASCHMA include: integrity, excellence, quality and efficiency. The objectives of the Agency include:

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[15] 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."

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

- Ensure that all residents of Adamawa State have access to effective, quality and affordable healthcare services.
- Protect families from financial hardship of huge medical bills.
- Limit the inflationary rise in the cost of healthcare services.
- Ensure equitable distribution of healthcare costs across different income groups.
- Maintain high standard of healthcare service delivery within the health sector.
- Ensure efficiency in healthcare service delivery.
- Improve and harness private sector participation in the provision of healthcare services.
- Ensure adequate distribution of health facilities within the state.
- Ensure appropriate patronage at all levels of healthcare.

Considering the beautiful provisions of the Adamawa State Contributory Health Management Agency Law and its plans, the Agency should take steps to popularize the available plans. The provisions of the law are further supported by the National Health Insurance Authority Act which makes health insurance compulsory and universal. The available plans under the Adamawa State Contributory Health Management Agency Law include (a) Formal Sector Health Plan (b) Informal Sector Health Plan (c) Equity Health Plan (d) Retirees Health Plan (e) Basic Health Care Provision Fund (f) Tertiary Students Health Plan[17]

Table 6 shows the amount appropriated for the Adamawa State Contributory Health Management Agency (2021 and 2022) or the Adamawa State Health Insurance Scheme (2019 and 2020). The Scheme changed its name in 2021.

Table 6: Votes to the Contributory Health Management Agency 2019-2022

YEAR	RECURRENT	CAPITAL	TOTAL
2022	41,213,000.00	50,000,000.00	91,213,000.00
2021	44,080,000.00	750,000,000.00	794,080,000.00
2020 (Revised)	8,449,500.00	50,000,000	58,449,500.00
2019	13,038,000.00	600,000,000	613,038,000.00

[17] Adamawa State Contributory Health Care Management Agency Website https://aschma.org/

TOTAL	106,780,500.00	1,450,000,000.00	1,556,780,500.00

Source: Adamawa State Approved Budgets

Available information indicates that in 2019, not votes were released; in 2021, N1.523 million was spent and the full details of 2020 is not immediately available. But following the trend in health budget actual expenditure, the actuals will definitely be less than appropriated.

SECTION SEVEN: RECOMMENDATIONS

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

7.1 A New Strategic Health Development Plan: Considering the expiry by the effluxion of time of the Adamawa State Strategic Health Development Plans, prepare a new Adamawa State Strategic Health Development Plan 2023-2027 to provide a framework, guide and policy basis for state level health budgeting.

7.2 Prepare a Health MTSS: The State Ministry of Health should take steps towards the preparation of a Health MTSS. This is to compliment section 20 of the Adamawa 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.

7.3 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 and health outcomes in most states of Nigeria.

7.4 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.

7.5 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.

7.6 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.

7.7 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 State Government should ensure the full release of appropriated votes and possibly ringfence the votes of the Health Sector. 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.

7.8 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. Project continuity is recommended even after change of government.

7.9 Invest in Transparency and Accountability: The SMOH should invest in improving the transparency and accountability of its operations through publication of all policies, plans, MTSS, etc. It should also collate and publish 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.

7.10 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 Adamawa to the Governor and the State House of Assembly and publish same on the State Government's website.

7.11 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, equity funds, 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.

7.12 Full Implementation of Adamawa State Contributory Health Care Management Agency Law and the National Health Authority Act: ASCHMA and the National Health Insurance Authority Act envisage a universal and compulsory health insurance regime in Adamawa State and across the Nigeria Federation. ASCHMA 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.