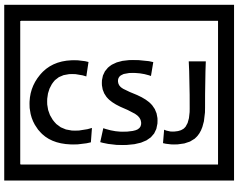
Maternal, New Born and Child Health Standards and Federal Budgets 2010-2015



Centre for Social Justice (CSJ)

(Mainstreaming Social Justice In Public Life)

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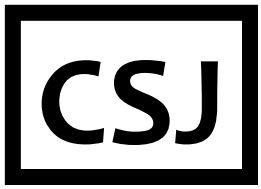

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ACRONYMS

ACHPR	African Charter on Human and Peoples Rights
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral
BMGF	Bill and Melinda Gates Foundation
BOF	Budget Office of the Federation
CCT	Conditional Cash Transfer
CDC	Centre for Disease Control
CHAI	Clinton Health Access Initiative
CHEWs	Community Health Extension Workers
CSJ	Centre for Social Justice
DFATD	Department of Foreign Affairs, Trade and Development
DFID	Department of International Development, United Kingdom
ES	Economic Social
ESR	Economic and Social Rights
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
FRA	Fiscal Responsibility Act
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IMNCH	Integrated Maternal, New Born, Child Health Strategy
ITNs	Insecticide Treated Nets
JICA	Japan International Cooperation Agency
LGA	Local Government Authority
MBB	Marginal Budgeting for Bottlenecks
MDAs	Ministries Department and Agencies
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategies
NACA	National Agency for the Control of AIDS
NBS	National Bureau of Statistics
NHA	National Health Act
NOFIC	National Obstetric Fistula Centre
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
ODA	Overseas Development Assistance

OECD	Organisation for Economic Cooperation and Development
OSSAP	Office of the Senior Special Assistant to the President
PEFA	Public Expenditure and Financial Accountability standard
PHC	Primary Health Care
PLWDs	People living with disabilities
PMTCT	Prevention of Mother to Child Transmission
SDGs	Sustainable Development Goals
SURE-P	Subsidy Reinvestment Empowerment Programme
SWV	Service Wide Votes
TA	Transformation Agenda
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programe on HIV/AIDS
UNFPA	United Nations Population Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
USAID	United State of America International Department
VVF	Vesico Vaginal Fistula
WDC	Ward Development Committee
WHO	World Health Organization
ZBB	Zero Base Budgeting

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EXECUTIVE SUMMARY

Chapter One deals with the introductory issues. Maternal, New Born and Child Health (MNCH) is part of the right to health, which in turn is inextricably tied to the right to life. The right to life is the fulcrum upon which other rights revolve as human rights are only for the living. The easiest way to deny a potential beneficiary of MNCH services of her right to life is to deny her of MNCH services to the point of abrogation. Nigeria is under a minimum core obligation, as stated in national and international standards, to satisfy the minimum core content of the right to health which includes *inter alia,* MNCH rights.

The overall goal of this Study is to present evidence to policy makers, budget designers, implementing MDAs on how best to improve the quantity and quality of MNCH services available from federal level spending. It is part of an engagement strategy that will include the executive, legislature and non state actors for improvements in MNCH. The specific objectives of the Study are to:

- Review the alignment of federal MNCH budgets in the last six years with high level sectoral policy documents and best practices in budgeting.
- Review the implementation mechanisms of Goals 4, 5 and partially No. 6 of the MDGs and identify the reasons why Nigeria was unable to reach the targets in the Goals.
- Review issues of disability, youth and inclusion in the implementation of MNCH policies.
- Review the alignment of federal MNCH budgets with best practices in budgeting
- Identify areas that can be improved upon to make better use of available resources.
- Identify whether the Federal Government of Nigeria is using the maximum of available resources for the progressive realisation of the right to MNCH.
- Conclude and recommend areas that can be improved upon to make better use of available resources.

The Study in Chapter Two reviewed international and national standards on MNCH. The international standards include the standard setting Universal Declaration of Human Rights, the African Charter of Human and Peoples Rights and the International Covenant on Economic, Social and Cultural Rights. It identified the minimum core content of the right to health to include MNCH. It outlined the need for economic, efficient and effective use of available resources, the need to tap new and dormant resources and the forward ever commitment without retrogression. The key provisions of the MDGs and SDGs were reviewed. National standards reviewed include the Constitution of the Federal Republic of Nigeria 1999, the Child Rights Act, National Health Act, Vision 20:2020, Transformation Agenda, National Strategic Health Development Plan and the Integrated Maternal, New Born and Child Health Strategy.

In Chapter Three, the current state of MNCH indicators in Nigeria is reviewed. The 1995 value of neonatal mortality rate stood at 51.4 deaths in every 1,000 live births. This rate continued declining up to 2015 when it reached 34.3 neonatal deaths in every 1,000 live births. Interestingly, given that the 1995 neonatal mortality rate was 51.4 per 1,000 live births and the 2015 neonatal mortality rate was 34.3 per 1,000 live births, it is easy to infer that the values amount to 33.3 percent decline in neonatal mortality rate within the 20 year period of 1995 – 2015. Again, as at 1995, the value of under-five mortality rate stood at 207.8 deaths in every 1,000 live births. This rate continued declining throughout the period under study. As at 2015, under-five mortality rate has declined down to 108.8 under-five deaths in every 1,000 live births. Impressively, going by the two values of under-five mortality rate (i.e. as at 1995 and 2015), it is clear that under-five mortality rate declined by about 47.6 percent within the study period alone.

Further, as at 1995, the value of maternal mortality ratio stood at 1250 deaths in every 100,000 live births. The ratio continuously decreased from that point until it reached a low level of 829 in 2008. However, it started increasing from that point to even as high as 883 in 2009 before oscillating annually to settle at 814 maternal deaths in every 100,000 live births as at 2015. Therefore, going by the 1995 level of maternal mortality ratio of 1,250 per 100,000 live births and the 2015 level of maternal mortality ratio of 883 per 100,000 live births, it shows that there was up to 34.9 percent decline in maternal mortality ratio within the 20 year period of 1995 – 2015.

However, the current level of absolute numbers of infant and maternal deaths is still very alarming. Although, this might be informed by increases in the crude birth rate, there is need to improve healthcare services to be able to curtail this high level of infant and maternal deaths.

Chapter Four seeks to reconcile the budget (2010-2015) with the provisions of national and international standards. Against the background of the Abuja Declaration which dedicates 15 percent of the overall budget to health care, the average allocation for the 6 years (2010-2016) is 5.26 percent. Nigeria did not meet the expenditure projected in the NSHDP nor did it meet the projections of the Integrated Maternal, New Born and Child Health Strategy. The average utilisation rate of the approved capital budget over the study period is 45 percent, which is very low. Allocations to the National Primary Health Care Development Agency averaged 7.40 percent of the Health budget over the study period.

The budgets of 2015 and 2016 ignored the provisions of the National Health Act which mandates the provision of not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provision Fund. The implication of the foregoing is that MNCH and related services (using the minimum floor of 1 percent) lost good sums of money. With a total Consolidated Revenue Fund of N3.419trilion in 2015, one percent amounts to N34.190bn which should have been remitted to the Basic Health Care Provision Fund. With a total Consolidated Revenue Fund of N3.855trilion in 2016, 1 percent amounts to N38.555bn which should have been remitted to the Basic Health Care Provision Fund. Of

these sums, 45% percent of the Basic Health Care Provision Fund would have gone to the National Primary Health Care Development Agency which would have used it for a number of programmes including MNCH. This would amount to N15.385bn and17.350bn in 2015 and 2016 respectively; bringing the total to N32.735bn over the two years. Also, the 50 percent of the Basic Health Care Provision Fund going to basic minimum package of health services to citizens through the National Health Insurance Scheme would have impacted on MNCH.

Chapter Five dealt with matters arising from budgetary and other provisions. These include the challenge of Service Wide Votes; the fact that the contribution of development partners is not captured in the budget; the basic minimum package of health services under the NHA has not been calculated; Nigeria contributes about 40percent of the world's VVF scourge and budgetary provisions for remediation of victims is very low. There were irreconcilable differences in the unit costs for the construction of PHCs; ambiguous nomenclature and description of some MNCH projects in the budget which made these projects very difficult to monitor and follow; the reign of budget frivolities; weak alignment of federal health budgets with policies, plans and best practices; and the mismanagement of the contribution of development partners.

Chapter Six sought to establish the funding gap and reviewed critical issues for consideration in MNCH and health budget funding. There is the expert recommendation that adequate or appropriate amount of health spending in a country like Nigeria, with a malnourished population, facing endemic malaria and other ailments, a high incidence of neoplasms and chronic conditions and an epidemic of HIV/AIDS is likely to be very different from one with limited infectious diseases. This further implies that how much a country should spend on health should be based on the country's epidemiological profile rather than a general ratio or approved recommendation whether by Abuja Declaration or prescription from the WHO. Five different approaches to calculating the adequacy of health expenditure were reviewed. They are the peer review approach; total health spending and national income approaches. Others are the political economy approach, production function approach and the budget approach.

Immunisation is a core component of MNCH and contributes in no small measure to improved MNCH outcomes. According to the Executive Director, National Primary Health Care Development Agency, Dr Ado Mohammed, the full immunisation of a child currently costs N4000 but the introduction of four new vaccines could push the cost up to N14,000 per head. At the current cost, this amounts to a funding need of $274m annually but the new vaccines will push the immunisation cost to $435m annually[1]. For the years 2017 and 2018, the estimated funding gap considering the withdrawal of donors is $181million for routine immunisation vaccines procurement[2].

[1]http://healthreporters.info/2016/04/24/immunization-trust-fund-as-panacea-for-sustainable-immunization-financing-in-nigerian/; 21st Anglophone Africa Peer Review Workshop on Sustainable Immunisation.
[2] Supra.

Ideas have been floated around an Immunisation Trust Fund but the finer details have not been worked out and it is not yet a bill before the legislature to give it legal backing. The NPHCDA has set up the National Immunisation Finance Task Team which envisions a Nigeria where immunisation financing is prioritised by government and backed with a strong legal framework to guarantee sustainability of finance without reliance on donors. Another angle to proper funding of health care including MNCH, beyond budgetary allocations, is compulsory and universal health insurance for all Nigerian citizens. This will pool funds across the federation and population to fund health care over the medium to the long term.

Against the background of the foregoing, the Study makes the recommendations stated below.

Framework Issues

- Adopt a rights framework for the realisation of MNCH instead of the current basic needs approach. This will involve a clear definition of MNCH services as entitlements of persons in need of them; definition of rights holders and duty bearers.

- Guarantee MNCH rights as a fundamental human right in Chapter Four of the Constitution of the Federal Republic of Nigeria, 1999 as amended. The last amendment by the Seventh National Assembly of section 45 (b) to add that: *every citizen of Nigeria is entitled to free primary and maternal health care services* should be considered[3].

- Update the NSHDP and IMNCH Strategy to the post 2015 era including new projections and targets of achievement and costing.

- FGN should operationalise the Basic Health Care Provision Fund in the NHA through the provision of a minimum of 1 percent of the Consolidated Revenue Fund. It is imperative to note that 1 percent is the minimum and not the maximum that could be provided.

- FGN should explore new sources of funding healthcare and by extension MNCH to include universal, compulsory and contributory health insurance, and new incentive based taxes and levies.

- Specifically and further to the above, FGN should expedite action and steps towards a policy and legal framework for sustainable immunization financing.

[3] The entire constitutional amendment was stuck in the Presidency-National Assembly rivalry and did not sail through.

- Female child marriage should be prohibited by law with strong penalties for male offenders.

Budgeting Issues

- The FMoH should articulate the definition of basic minimum package of health services required by the NHA and this should include MNCH. The minimum package should reflect Nigeria's minimum core obligations in health care. The definition is important for costing and funding the minimum package.

- Health and MNCH budgets should be backed by a clear Medium Term Sector Strategy which is linked to high level national and international standards; fully costed and progressively allocates more resources to MNCH based on increased availability of resources.

- Increase health funding to meet the 15 percent of total budget as stipulated in the Abuja Declaration.

- The full and timely release and cash backing of all funds appropriated for the health sector.

- Ring-fencing of all funds appropriated for health including the capital votes which have not been fully released over the years.

- Increase the component of PHC and MNCH funding in the budget to not less than 50 percent of overall health funding.

- Service Wide Votes should be scrapped and the funds allocated to the relevant implementing agencies.

- The full contribution of development partners should be reflected in the budget to enhance transparency and accountability, improve monitoring and evaluation of projects and programmes. This will ensure budget comprehensiveness and strategically invest available resources to high priority areas.

- More resources should be made available for the remediation of VVF patients; sensitisation and awareness creation on the causes of VVF. A three year target date to reduce VVF occurrence to less than 5 percent of the current rate should be set.

- Good and fit procurement practices should be adopted by FMoH and NPHCDA; with a standard price database to remove price differentials for the same projects, programmes and activities and to enhance value for money in MNCH operations.

- Considering the paucity of resources, frivolous, inappropriate and wasteful expenditure heads should be weeded from the budget and the resources channelled to MNCH and other areas of need. This will involve a scrupulous review of expenditure heads to determine their contribution to economy, efficiency and effectiveness of operations.

- Projects should be clearly and properly described in the budget and repetition of budget heads and items should be avoided.

- All stakeholders in the budgeting process need to commit to ensure that all the bottlenecks that affect the full implementation of MNCH budgets are removed. From appropriation to releases and utilisation, all factors that cause delay and reduce percentage of appropriated budget utilised should be minimised.

- Further to the above, a penalty should be instituted to punish persons or institutions that fail to fulfil their statutory and constitutional roles in budgeting.

- A clear framework, with an inbuilt monitoring and evaluation strategy which can be independently evaluated should be devised to gauge the accessibility of MNCH services to PLWDS and youths.

CHAPTER ONE
Introduction

1.1 BACKGROUND

Maternal, New Born and Child Health (MNCH) is part of the right to health, which in turn is inextricably tied to the right to life. The right to life is the fulcrum upon which other rights revolve as human rights are only for the living. The easiest way to deny a potential beneficiary of MNCH services of her right to life is to deny her of MNCH services to the point of abrogation. Nigeria is under a minimum core obligation, as stated in national and international standards, to satisfy the minimum core content of the right to health which includes *inter alia,* MNCH rights.

Relevant interventions on MNCH would focus on a number of areas for critical action including antenatal care, intrapartum care, emergency obstetric and new born care, routine postnatal care, infant and young child feeding, prevention of malaria, institutionalizing routine immunisation, prevention of mother to child transmission of HIV, strengthening family planning and child spacing, water, sanitation, hygiene, etc[4]. Considering that the health status of a community or population is affected by issues and factors, which *stricto sensu* are not health issues, MNCH service delivery is closely related to and dependent on the realisation of other rights including the rights to food, safe and portable water, housing, work, education, human dignity, non-discrimination and equality, access to information, freedom of assembly and movement, etc.

Against the background of the state obligation to respect, protect and fulfil MNCH rights, the budget and fiscal policy becomes a handy tool. The Federal Government of Nigeria, states and local governments are under a legal obligation to make a budget. The budget is a statement of income and expenditure and an indication of the state's priorities for the year. The budget is both an economic, social, political and human rights process[5]. Budgeting for MNCH provides the basis for breathing life into national and international standards on the subject matter with a view to meeting the basic requirements of functional MNCH services. Ideally, the budget seeks to meet the criteria of availability, accessibility, acceptability and quality of MNCH services. Availability implies that the budget will provide functioning public health and health care facilities as well as programmes made available in sufficient quantity and this will include hospitals, clinics, trained medical personnel, essential drugs, etc[6].

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[4] Integrated Maternal, New Born and Child Health Strategy, Federal Ministry of Health Abuja, 2007.
[5] Eze Onyekpere in Civil Society and the Budget- A Reader,(page 3), Socio Economic Rights Initiative, 2004.
[6] Adapted from General comment No.14 of the United Nations Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights).

Accessibility in MNCH has four components. The first is non-discrimination, meaning that MNCH facilities and services have to be available to everyone (including the vulnerable) who needs it without discrimination in law or in fact. The second is physical accessibility of MNCH facilities to those who need them[7]. The third is economic accessibility meaning that it must be affordable for all; payments if any have to be based on equity thereby ensuring that public or private services are affordable to all, especially the disadvantaged and poorer households. It also implies that no one is left behind who cannot afford the services. The fourth is information accessibility implying that those receiving MNCH services receive and impart MNCH information relevant to their health. MNCH services also need to be acceptable to the community where it is delivered - it needs to be respectful of medical ethics and culturally appropriate. Finally, the budget must provide for quality services which are scientifically and medically appropriate[8]. The budget will facilitate the achievement of these standards within the context of using the maximum of available resources for the progressive realisation of MNCH rights.

MNCH budgets, like other estimates, taken on the basis of projections without ascertaining the actual expenditures, usually convey a good picture. However, the details in terms of the actual expenditure, usually reveals a different picture. Also, budgets are supposed to be in tandem with sectoral development policies and standards and should seek to fulfil them. This has been a perennial challenge for budgeting in Nigeria and the poor MNCH indicators seem to suggest a discord between MNCH standards and the provisions of successive budgets. The accountability dimension of value for money in MNCH spending seems to be missing in traditional studies and discourse. Accountability could be engaged in the sense of using resources, in recognition of the functional parameters of economy, efficiency and effectiveness whilst it could also be discussed within the theme of accountability for human rights obligations under the MNCH umbrella. The study will engage both subthemes of accountability.

1.2 OBJECTIVES AND TERMS OF REFERENCE

The overall goal of this Study is to present evidence to policy makers, budget designers, implementing MDAs on how best to improve the quantity and quality of MNCH services available from federal level spending. It is part of an engagement strategy that will include the executive, legislature and non state actors for improvements in MNCH.

The specific objectives of the Study are to:

- Review the alignment of federal MNCH budgets in the last six years with high level sectoral policy documents and best practices in budgeting.
- Review the implementation mechanisms of Goals 4, 5 and partially No. 6 of the MDGs and identify the reasons why Nigeria was unable to reach the targets in the Goals.

[7] General Comment No.14, supra.
[8] General Comment No. 14, supra.

- Review issues of disability, youth and inclusion in the implementation of MNCH policies.
- Review the alignment of federal MNCH budgets with best practices in budgeting
- Identify areas that can be improved upon to make better use of available resources.
- Identify whether the Federal Government of Nigeria is using the maximum of available resources for the progressive realisation of the right to MNCH.
- Conclude and recommend areas that can be improved upon to make better use of available resources.

1.3 METHODOLOGY

Given the nature of the objectives of the Study which is more of reviews and analysis, the methodology involves broadly, reviewing development plans, policy documents and budgets as well as identifying where gaps exist between policy and practice and making recommendations for correcting gaps. Specifically, it involves:

- Collation of relevant materials from MDAs including Federal Ministry of Health (FMoH), National Primary Health Care Development Agency (NPHCDA), Budget Office of the Federation (BOF), National Planning Commission; and development partners. The documents so collated include the Transformation Agenda which contained the vision that guided government actions within the period that the research covers; the NSHDP because it contains the health indicators such as infant and maternal mortality rates and the targets set for measuring progress over time on those indicators; annual budgets because they show health sector allocations and MNCH allocations within the sector; budget implementation reports as they show the extent of capital budget implementation. It also relied on various papers presented during CSJ's MNCH workshops which provided civil society perspectives; and MNCH performance reports developed by international agencies showing Nigeria's performance and ranking on the indicators.

- A review of the documents collated for in-depth analysis of the situation and reasons for the situation. During the review, the following issues were considered: the content and scope of MNCH services; the performance level of Nigeria against the targets; budgetary gaps in terms of what is recommended or planned for use in achieving the targets and actual expenditures; whether the approved budgets were released and spent according to plans or otherwise; the issue of value for money, inefficiency or ineffectiveness in the management of MNCH federal budgets in the years that the Study focused on. In addition, the Study employs descriptive analysis using simple tables and charts to highlight relevant sections of development plans, budgets and also to illustrate its points and arguments.

- Consultation of relevant stakeholders to clarify grey areas and provide explanations where documentation on its face is susceptible to multiple interpretations.

- Making recommendations following the review of documents. Such recommendations were evidenced based and flowed from the analysis of issues.

1.4 LIMITATIONS OF THE STUDY

The Study is limited by the quality of information and data on budgets, budget implementation and results of MNCH interventions available to it. For instance, there is no special section of the budget of the FMoH on MNCH. Even though a good number of issues under the vote of the NPHCDA are related to MNCH, not all are for MNCH. Thus, the Study needed to go across many sectors to fish out allocations to MNCH. Some of the allocations were found in the budget of the Federal Ministry of Women Affairs, National Agency for the Control of HIV/AIDS, Service Wide Votes (SWV), etc. There were also issues of services that were on the borderline between MNCH and other subthemes of health.

Some of the provisions of Service Wide Votes were not disaggregated or stated for particular activities. Some were for MDSs generally; beyond MNCH, there were other issues included in the MDGs. Thus, it is difficult to know what portion (if any) of such allocations went to MNCH. Also, budget implementation reports contained nothing on the implementation of SWVs. Further, many of the national standards made no provisions on the specific funding of MNCH. Rather, they had general prescriptions for the funding of the health sector.

CHAPTER TWO

Review of International and National Standards on MNCH

2.1 INTERNATIONAL STANDARDS

Nigeria is a member of the United Nations and signatory to a plethora of international standards that mandate States Parties to be more responsive to the bundle of rights encapsulated in MNCH. These standards include the following.

2.1.1 Universal Declaration of Human Rights (UDHR)

In Article 25, the UDHR states:

> (1) *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*.
>
> (2) *Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection*.

The UDHR shows that State Parties are obligated to provide a standard of living adequate for the health and well-being of families. It specifically emphasizes special care and assistance for motherhood and childhood.

2.1.2 The African Charter on Human and Peoples' Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR)

Nigeria is a signatory to the African Charter on Human and Peoples Rights (ACHPR) which states in article 16:

> (1) *Every individual shall have the right to enjoy the best attainable state of physical and mental health.*
>
> *(2) State Parties to the present Charter shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.*

In article 1 of the African Charter, it is stated that:

> *The Member States of the Organization of African Unity parties to the Charter shall recognize the rights, duties and freedoms enshrined in this Charter and shall undertake to adopt legislative or other measures to give effect to them"*

Just like the UDHR considered above, the ICESCR has a human rights centred approach. In Part II, article 2 states:

> (1) E*ach State Party to the Present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.*

In article 12, it further states:

> *1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:*
>
> *a. The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;*
> *…….*
> *d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

Article 2 (1) emphasises the progressive realisation approach. The progressive realisation approach is underpinned by the understanding that all states members do not have all the required resources to address all MNCH challenges at the same time. However, it implies that efforts should be made towards realising MNCH service users' rights. Considering the paucity of resources, such efforts should be done with a great sense of economy, efficiency and effectiveness especially, in the deployment of budgetary resources. So in the light of the ICESCR, it is not enough to plead resource insufficiency as an excuse for not realising MNCH targets or taking concrete steps towards their realisation, rather a proof that available resources have been applied economically, efficiently and effectively towards meeting MNCH targets will be more convincing.

The interpretation of the provisions of the ICESCR is provided *inter alia* through a number of General Comments, Guidelines[9] and Principles including the Limburg Principles on the Implementation of the ICESCR[10]. The Interpretative Principles relating to Part II of the Covenant provides an anchor for the direction and focus of this Study.

(i). MNCH as Minimum Core Content of the Right to Health and State Obligation to Fulfil the Right

The Economic, Social and Cultural Rights Committee of the UN identified the minimum obligation(s) of the States Parties to the ICESCR's to mean a commitment to guarantee

[9] The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights 1997.
[10] UN Document E/CN.4/1987/17

the satisfaction of, at the very least, minimum essential levels of each of the rights contained in the Covenant[11]. Thus, the minimum core obligation on the right to health is the minimum level below which Nigeria and other States Parties will not be allowed to descend. It is the level below which conditions should not be permitted to fall. States Parties including Nigeria have an obligation to meet this threshold regardless of resources available to them. Below this level, Nigeria will be deemed to be in violation of its right to health obligations. In determining the core content of the right to health, the prevalent disease conditions as demonstrated by epidemiological data, analysis and health indicators in the Nigerian society will be taken into consideration[12]. Nigeria's MNCH statistics and indicators as would be shown in the later part of this Study are so dire and demands immediate action to stem the loss of lives.

Primary Health Care (PHC) and MNCH will be automatic candidates for recognition as minimum core obligations of Nigeria especially considering their link to the right to life. The right to life is the fulcrum upon which other rights revolve; fundamental rights can only be enjoyed by the living. The easiest way to deprive a mother or child of her right to life would be to deny her of MNCH supporting services to the point of abrogation. This appears to be the thinking when the National Assembly sought to amend the 1999 Constitution by introducing a new section 45 (b) which states that[13]:

Every citizen of Nigeria is entitled to free primary and maternal health care services.

MDGs 4, 5 and 6 (reduce child mortality; improve maternal health; and combat HIV/AIDS, malaria, and other diseases) also come in as part of the core obligations since they are part of a worldwide consensus on targets to be met on or before 2015[14]. Being minimum core obligations of Nigeria by virtue of being part of the minimum core content of the right to health, MNCH and MDGs related to them ought to be realized in Nigeria. No excuses are tenable for not doing so; not even the paucity of resources. But given the reality of paucity of resources in relation to competing demands, the only approach recommendable is prioritisation of MNCH and strict economy, efficiency and effectiveness in the use of available funds to realise them.

Some contextual clarification is necessary at this point. A basic problem for Economic Social (ES) Rights including the bundle of rights encapsulated in MNCH is the attempt to force the basic needs[15] approach on issues of ESR in situations where the only feasible alternative is the human rights paradigm. This seems to be the justification for the

[11] See Maastricht Guidelines, supra, Paragraph 9 reaffirming General Comment No.3 (Fifth Session 1990) of the UN CESCR; UN Document E/1991/23, Annex 111, Paragraph 10.
[12] Constitutionalising the Right to Health: memorandum submitted by Centre for Social Justice and Health Reform Foundation to the Constitution Amendment Committee of the National Assembly in 2014.
[13] The amendment was approved by over 24 state legislatures being the 2/3rds majority required to amend the Constitution. However, the entire constitution amendment exercise was stopped by the refusal of former President Jonathan to assent to the bill containing a number of other amendments, over the contentious clause that stripped the President of powers to assent to a bill amending the Constitution..
[14] Constitutionalising the Right to Health, supra.
[15] The basic needs were identified as food, clothing and shelter.

international interest and rush to designate many ESR as Millennium Development Goals or Sustainable Development Goals. For purposes of clarity, the basic needs approach and the human rights paradigm differs in a number of ways. A human rights approach to ESR introduces a normative basis, which binds the state implying that beneficiaries of development are active "subjects" and "claim holders" and stipulates the duties and obligations of those against whom such claims can be made. Such approach introduces the accountability dimension not present in the basic needs approach[16]. Further, not all human needs are recognized as rights; rights are indivisible, equal rights necessitate the elimination of inequalities and all human rights embody individual freedom. The human rights approach moves away from human development indicators premised on or oriented towards goals, not towards rights. Goals are something you reach for while human rights are inalienable and intrinsic. In short, they are our birth rights[17]. Thus, the language of human rights and its demand should supersede goals and targets.

(ii). Resource Adequacy

In accordance with the Limburg Principles, Nigeria has an obligation, regardless of its economic development and resource status, to ensure respect for minimum subsistence rights for all[18]. Resources include what can be sourced locally, from aid and general international cooperation[19]. They also include already available resources and potentials which could be tapped to improve healthcare. Thus, resources for guaranteeing access to healthcare and MNCH go beyond budgetary resources. In recognition of the fact that States Parties to the ICESCR are supposed to take steps including the adoption of legislative measures; using legislation and policy to provide universal health care, health insurance, special funds for MNCH, tax holidays for companies and individuals for specific MNCH supporting actions, trade tariffs and non tariff measures, etc, ought to be explored for the full realisation of MNCH rights.

For Nigeria to rely on lack of resources as an excuse for failing to meet its obligations, it must show that every effort has been made to use all the resources at its disposal to satisfy the minimum core obligation[20]. It is popularly known and said that corruption absorbs a lot of resources that could have been invested in social service provision of which MNCH is a crucial part. To fail to plug the leakages of corruption and plead resource inadequacy as a reason for not fulfilling the basic right of mothers, infants and children to MNCH is unacceptable.

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[16] Adapted from *the Right to Food in Theory and in Practice*, Food and Agricultural Organization of the United Nations, Rome 1998; Introduction by Mary Robinson (p.vii), Former United Nations High Commissioner for Human Rights.

[17] See Professor Virginia Dandan, former chairperson of the United Nations ESCR Committee in *Monitoring ESCR, the Phillipine Experience*, Philippine Human Rights Information Centre, Manila, Philippines 1997, p.10.

[18] Limburg Principles, paragraph 25.

[19] Resources have been classified into human, technological, information, natural and financial resources; see Roberts E. Robertson *"Measuring State Compliance with the Obligation to Devote the Maximum of Available Resources to Realising Economic, Social and Cultural Rights* (1994) 16 HUM RTS.Q 693, 695-697.

[20] See General Comment No. 3 of the UN Committee on ESCR, adopted at the Fifth Session of the ESCR Committee in 1990, UN Doc E/199/123, Annex 111, para 10.

(iii). Towards Economy

According to Part B (17) of the Limburg Principles:

> *At the national level, States Parties shall use all appropriate means, including legislative, administrative, judicial, economic, social and educational measures, consistent with the nature of the rights in order to fulfil their obligations under the Covenant"*[21].

Economic measures could possibly be applied in the pursuit of the fulfilment of obligations under the Covenant, meaning that Nigeria could be thrifty and frugal in the expenditure of budgetary and other resources. So in the light of the obligation, it behoves MDAs associated with budget planning and management to deploy economy and ensure that resources that guarantee the progressive realization of MNCH rights are allocated and efficiently applied. In the later parts of this Study, the extent to which the Federal Government has been economical with resources in the overall economy, the health sector and specifically the MNCH sub-sector will be reviewed in the light of its impact on the achievement of MNCH. Bloated and over-invoiced votes for MNCH items beyond the normal market value would definitely be a contradiction of the need for economy in MNCH procurement and would be antithetical to the duty to use the maximum of available resources for the progressive realisation of MNCH.

(iv). Towards Efficiency

In line with paragraph 17 of the Limburg Principles, Nigeria is allowed to apply various measures including administrative, judicial, economic, social and educational measures to ensure that MNCH rights are realized. In the context of this Study, we shall examine the extent to which the MNCH MDAs have made efficient use of resources or measures. Efficiency helps to ensure that projects such as PHCs construction and equipping, immunisation and training of personnel are carried out without 'wasting' materials, time or energy. It implies that the government is deriving the maximum use from available resources and this can help to reach more underserved, vulnerable and poor communities with MNCH services. Also, budgeting for wasteful and frivolous projects and items would be an inefficient way to deploy scarce resources and such would contradict the government's obligation to use the maximum of available resources for the realisation of MNCH. A commentator has stated of efficiency as follows[22]:

> *This is making sure that the maximum useful output is gained from the resources devoted to each activity, or alternatively that only the minimum level of resources are devoted to achieving a given level of output. An operation could be said to have increased in efficiency if either lower costs were used to produce a given amount of output or a given level of cost resulted in increased output. Inefficiency would be revealed by identifying the performance of work with no useful purpose or the accumulation of surplus materials that are not needed to support operations.*

[21] Underlining supplied for emphasis.
[22] *The Pursuit of Value for Money*, Samuel Afemike, Spectrum Books 2003, pages 6-9.

(v). Towards Effectiveness

Under the Covenant, Nigeria is required to move immediately and as expeditiously as possible towards the realisation of the right to health including MNCH. The obligation exists independently of increase or decrease in resources; requiring effective use of available resources and developing societal resources for the realisation of the right to health[23]. In the context of this Study, we shall examine whether the NPHCDA and other relevant MDAs have applied available resources to increase greater realization of the rights proportionately. For instance, the Study will seek a resolution of posers such as the following: Has primary healthcare projects been made to work and increase access to MNCH for service users? Are the medical supplies reaching the desired PHCs and users? How will the projects become more effective in the face of existing gaps?

(vi). No Retrogressive Steps

Progressive realisation of ESC rights including MNCH implies a forward ever motion. Deliberate retrogressive steps that diminish the enjoyment of MNCH rights are outlawed. Considering that the budget is a key instrument in realising MNCH rights, the government has to strictly justify any cut in the budget for MNCH and the resultant reduction in MNCH goods and services, especially if there are no accompanying compensatory mechanisms. Compensatory mechanisms would include other sources of funding that do not task the poor and vulnerable groups or efficiencies in spending that neutralises budget cuts.

2.1.3 Other Standards

These include the African Charter on the Rights and Welfare of the Child which places an obligation on the state to guarantee the survival, protection and development of the child[24]; reduce infant and child mortality rates; ensure appropriate health care to expectant and nursing mothers; combat disease and malnutrition within the framework of primary health care through the application of appropriate technology[25]. The Convention on the Rights of the Child makes similar provisions. The Convention on the Elimination of all forms of Discrimination against Women mandates the state to provide appropriate services in connection with pregnancy, confinement and the post natal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation[26].

The MDGs are agreed development goals that Nigeria, alongside other 188 countries signed up to in 2000. Of the 8 goals, three relate closely to the issues of MNCH: Goal 4- reduce child mortality; Goal 5: Improve maternal health; and Goal 6: Combat HIV/AIDS, Malaria and other diseases. The specific targets are reducing by two-thirds between 1990 and 2015, the under-five mortality rate; reducing by three-quarters, between 1990 and 2015, maternal mortality ratio and achieving by 2015, universal access to reproductive health; and for Goal 6: Have halted by 2015 and begun to reverse the

[23] See Principles 21-24 of the Limburg Principles
[24] Article 5 of the ACRWC on survival and development.
[25] Article 14 of the ACRWC on health and health services.
[26] Article 12 (2) of CEDAW.

spread of HIV/AIDS; achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it; have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. The MDGs were replaced by the Sustainable Development Goals (SDGs) which has a terminal date of 2030. Goal 3 is to ensure healthy lives and promote well-being for all at all ages. The 2030 targets related to MNCH include:

- *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.*
- *By 2030, 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, 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 programmes.*
- *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 increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.*

2.2 NATIONAL STANDARDS

This subsection of the Study will review national standards applicable to the period of the Study between 2010 and 2015

2.2.1 Constitution of the Federal Republic of Nigeria 1999

The Constitution of the Federal Republic of Nigeria 1999 is the fundamental law. It provides in Chapter 2 under the Fundamental Objectives and Directive Principles of State Policy - section 17 (3) (c) and (d), that:

> *The State shall direct its policy towards ensuring that-*
>
> > *(c) The health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;*
> >
> > *(d) There are adequate medical and health facilities for all persons;*

However, these provisions under the non-justiciable Chapter 2 of the Constitution seem like constitutional ropes of sand which bind no one. But the state can enact a law which gives specific rights and duties to right holders and duty bearers respectively, and this will make effective, the right to health or specific aspects of it including MNCH. This is the

context that gave rise to the National Health Act of 2014. This position has been very well captured by the Supreme Court as follows[27]:

> *The Constitution itself has placed the entire Chapter 11 under the Exclusive Legislative List. By this, it simply means that all Directive Principles need not remain mere or pious declarations. It is for the Executive and the National Assembly, working together, to give expression to anyone of them through appropriate enactment as occasion may demand.*

2.2.2 Child Rights Act

The Child Rights Act makes extensive provisions for the rights and welfare of the Nigerian child including her health. The most relevant section is section 13 which as follows.

> *13.—(1) Every child is entitled to enjoy the best attainable state of physical, mental and spiritual health.*
>
> *(2) Every Government, parent, guardian, institution, service, agency, organisation or body responsible for the care of a child shall endeavour to provide for the child the best attainable state of health.*
>
> *(3) Every Government in Nigeria shall—*
>
> > *(a) endeavour to reduce infant and child mortality rate;*
> > *(b) ensure the provision of necessary medical assistance and health care services to all children with emphasis on the development of primary health care;*
> > *(c) ensure the provision of adequate nutrition and safe drinking water;*
> > *(d) ensure the provision of good hygiene and environmental sanitation;*
> > *(e) combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;*
> > *(f) ensure appropriate health care for expectant and nursing mothers; and*
> > *(g) support, through technical and financial means, the mobilisation of national and local community resources in the development of primary health care for children.*
>
> *(4) Every parent, guardian or person having the care and custody of a child under the age of two years shall ensure that the child is provided with full immunization.*
>
> *(5) Every parent, guardian or person having the care of a child who fails in the duty imposed on him under Subsection (4) of this section commits an offence and is liable on conviction for—*
> > *(a) a first offence, to a fine not exceeding five thousand Naira; and*
> > *(b) a second or any subsequent offence, whether in respect of that child or any other child, to imprisonment for a term not exceeding one month.*

[27] Per Uwaifo J.S.C. in *Attorney General Ondo State v Attorney General Federation* (2002) 9 N.W.L.R. (Pt.772) 222 at 391.

(6) The court may make, in substitution for or addition to any penalty stipulated under Subsection (5) of this section, an order compelling the parent or guardian of a child to get the child immunized.

Indeed, the Act creates positive obligations for the state to ensure the protection of the rights of the child to MNCH services.

2.2.3 The National Health Act, 2014

The National Health Act was made as an Act to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services in the Federation and for related matters. The Act made a number of provisions which potentially will improve MNCH. These include the mandate of the Federal Ministry of Health to: Prepare strategic medium term health and human resources plans annually for the exercise of its powers and the performance of its duties under this Act.[28] The Ministry is to ensure that the national health plan forms the basis for budget preparation and other government planning exercise as may be required by law[29]. The National Council established by the Act has a mandate *inter alia* to ensure that children between the ages of zero and five years and pregnant women are immunized with vaccines against infectious diseases.

The Act establishes a Basic Health Care Provision Fund with a government annual grant of not less than one percent of the Consolidated Revenue Fund which is to be used *inter alia*; 20 per cent for essential drugs, vaccines, and consumables for eligible primary health care facilities; 15 per cent for the provision and maintenance of facilities, equipment and transport for eligible primary health care facilities whilst 10 per cent is to be used for the development of human resources for primary health care. It also makes provisions for grants to states and local governments who will be required to provide counterpart funding of 25 per cent of the total cost of the project. It strengthens the authority of the National Primary Health Care Development Agency over Local Government Health Authority as it can withhold funds due to the later, if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of the Act.

2.2.4 Vision 20:2020

This documents the country's vision of becoming one of the worlds' 20 largest economies by the year 2020. The First Pillar of Vision 20:2020 is *Guaranteeing the Productivity and Wellbeing of the People* and one of its strategic objectives is focused on health - *enhance access to quality and affordable healthcare.* Specifically, the Vision contends that a holistic government led effort to revive the health sector would be required to support its aspirations. It targets improvements in the health indicators to achieve remarkable drop in maternal, new-born and under-5 mortality rates. It also targets reduction by half of the HIV prevalence rate of 4.4% by 2015 and increasing

[28] See section 2 (2) of the Act.
[29] Supra.

immunisation coverage from 27% at the base year (2009/10) to 95% in 2015. These goals are well aligned to the MDGs for health: reduction in the maternal mortality, reduction in under-5 mortality, and reduction in HIV/AIDs prevalence amongst others. The relevance of Vision 20:2020 lies in the fact that the year 2020 is still some four years away.

In its First National Implementation Plan (2010-2013), the Vision provided financial estimates relevant to MNCH as shown in Table 1.

Table 1: Vision 20:2020 Estimates for MNCH

Health	**Millions of Naira**			
Priority Projects	2011	2012	2013	Total
Expanded immunisation programme	3,166.37	3,588.55	3,799.64	10,554.56
Integrated management of maternal, newborn and child health programme	16,907.74	28,828.77	22,289.29	68,025.80

Source: First National Implementation Plan (2010-2013)

2.2.5 The Transformation Agenda (TA)

The Transformation Agenda (TA) was the blueprint for Nigeria's development during the period 2011-2015, and it recognized health as wealth, implying that the nation's wealth comprises not only the physical capital, but also human capital which, was rightly pointed out as one of the factors of production required to achieve high and sustainable economic growth. Given this recognition, government was expected to commit resources to the achievement of its goals. The commitment demands that the Executive and Legislative Arms of Governments at all levels, health professionals, journalists, community and non-governmental organisations, and parents unite to introduce policy and legislation, improve funding, maintain low duty rates on Insecticide Treated Nets (ITNs) and other materials; immunize new-borns and children as well as popularize the IMNCH Strategy[30].

2.2.6 The National Strategic Health Development Plan (NSHDP)

The Plan details strategies for developing the overall health sector of the country, setting periodic targets and the improvement of MNCH indicators. The NSHDP seeks to achieve the following:

- *Implement good governance at all levels of health system through the application of a National Heath Law, thereby creating a system where regulatory responsibilities are shared between the three tiers of government;*
- *Foster integrated service delivery by clarifying technical responsibilities of federal institutions;*
- *Improve the efficiency of the federal health workforce by implementing a comprehensive human resources for health agenda;*

[30] Integrated Maternal, New Born and Child Health Strategy.

- *Ensure increase in availability of and access to financial resources for health including appropriate risk pooling and exemption mechanisms;*
- *Strengthen the National Health Management Information System (NHMIS) to improve the use of routine health information for programmes/service performance monitoring and evaluation;*
- *Improve community ownership and participation during implementation of the National Health Agenda through a purposeful engagement of Community Service Organizations; and*
- *Embed appropriate solutions to health equity issue, including service provision, access to finance, financial risk protection for vulnerable, low and middle income groups*

2.2.7 The Integrated Maternal, New Born and Child Health Strategy (IMNCH)

MNCH issues include life expectancy at birth, neonatal mortality rate, infant and under five mortality rate, immunisation of children and pregnant women against some diseases, feeding and nutrition, underweight children, use of ITNs and malaria prevention, maternal mortality, adolescents birth, HIV prevalence among 15-24 year olds, etc. Before the IMNCH, MNCH interventions have been implemented as separate and individual interventions, leading to poorly coordinated and ineffective services. But in line with the World Health Assembly Resolution 58.31 which urges member-states to, among other things, speed up actions to ensure that MNCH interventions are available everywhere[31], the IMNCH Strategy was developed in 2007. The IMNCH sets out to weave together all interventions to ultimately improve MNCH implementation.

The major causes of maternal deaths as identified in the IMNCH include haemorrhage 23 percent; infections 17 percent; toxaemia/eclampsia/hypertension 11 percent; unsafe abortion 11 percent; obstructed labour 11 per cent; malaria 11 per cent and anaemia 11 per cent; HIV and others contribute about 5 per cent[32]. For under-five mortality, the causes are malaria 24 percent; pneumonia 20 percent; diarrhoea 16 percent; measles 6 percent; HIV 5 percent; 26 percent for neonatal conditions.

The overall objective of the IMNCH is to reduce maternal, new-born and child morbidity and mortality in line with MDGs 4 and 5. The vision is of a Nigeria where pregnancy and delivery do not pose a threat to the lives of mothers and the newborn; where children are healthy and able to grow and develop to their full potential, thereby contributing to the nation's socio-economic development. The IMNCH is designed with a costed implementation plan detailing estimates of funding from FGN, the private sector, international development partners, additional funding needs per capita, etc. Its specific objectives are to:

- *Improve access to good quality health services; ensure adequate provision of medical and laboratory supplies, drugs, bundled vaccines, reproductive health (RH) commodities, insecticide treated nets, and the provision and maintenance of basic equipment;*

[31] MNCH Flyer
[32] See page 15, Column 1 of the Strategy.

- *Strengthen the capacity of individuals, families and the community to take necessary MNCH actions at home and to recognize when to seek appropriate health care solutions;*
- *Improve capacity for organization and management of MNCH services;*
- *Establish a financing mechanism that ensures adequate funding, affordability, equity, and the efficient use of funds from various sources;*
- *Strengthen supervision, monitoring and evaluation systems, to assess the progress towards achieving the maternal and child health MDGs;*
- *Establish and sustain partnerships to support the implementation of the IMNCH strategy.*

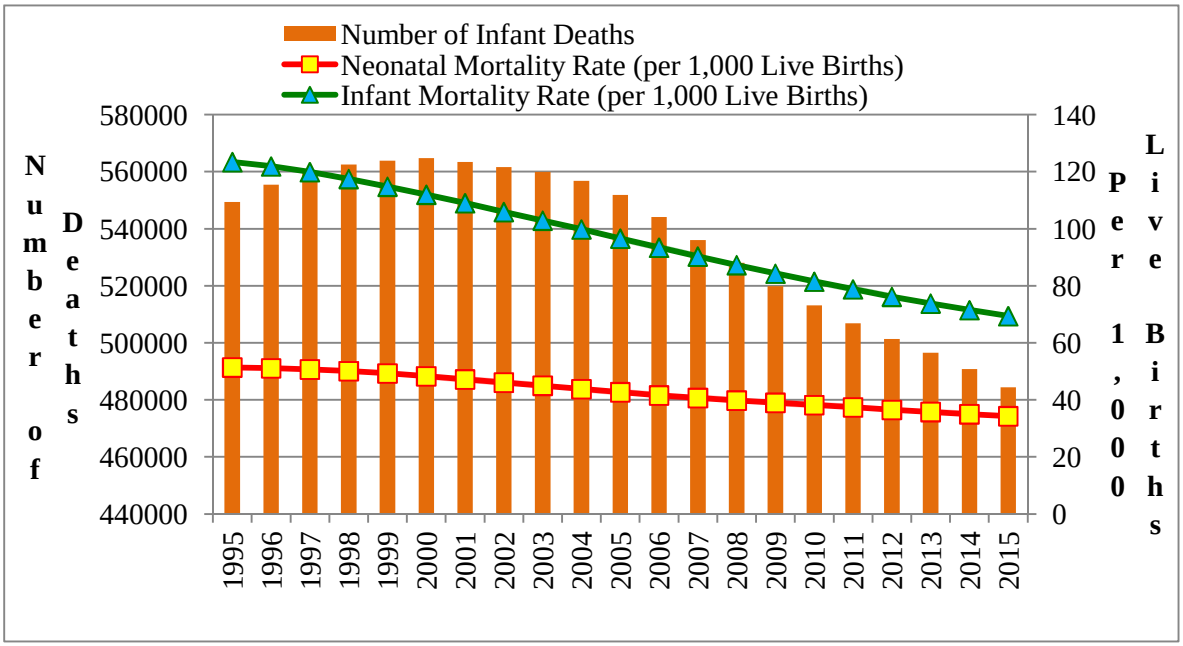
CHAPTER THREE

Current State of Maternal, New Born and Child Health Indicators in Nigeria

3.1 NEO-NATAL AND CHILD MORTALITY RATE

The state of MNCH in any particular country goes a long way in determining the future of the population of the same country in terms of replacing the ageing population. To emphasise the importance of MNCH in the general healthcare of any country, two out of the three health related goals in the MDGs of 2000 – 2015 focused on maternal and child healthcare[33]. In the same way, the first two targets of Goal 3 of the current 2030 SDGs focus on MNCH. All the above go a long way in showing how important maternal, neonatal and child healthcare is to the overall health of any country. Some indicators for monitoring the extent of actualisation of the goals have remained veritable tools for evaluating the current state of maternal, new born and child health in Nigeria. Therefore, adopting some of the indicators of health-related goals in both the MDGs and SDGs, we can understand how well Nigeria has fared in terms of MNCH over time. Based on that, Figure 1 below graphically presents the extent of improvements in the indicators.

Figure 1: Number of Infant Deaths, Neonatal Mortality & Infant Mortality Rates in Nigeria



Source: *World Bank (2016) World Development Indicators*

Infant mortality rate is usually calculated as the total number of infant deaths in every 1,000 live births. In like manner, neonatal mortality rate is also calculated as the total

[33] Office of the Senior Special Assistant to the President on Millennium Development Goals – OSSAP-MDGs (2010) "Countdown Strategy 2010 to 2015: Achieving the MDGs". Abuja: OSSAP-MDGs Publications. Also available at: http://mdgs.gov.ng/index.php/downloads/category/1-mdgs-general?download=10:mdgs-countdown-strategy

number of newborn deaths in every 1,000 live births. Figure 1 above shows that there has been significant reduction in infant mortality ratio in Nigeria. The 1999 value of infant mortality rate stood at 114.8 deaths in every 1,000 live births. This rate continued moving on a decreasing trend until 2015 when it had reached 69.4 infant deaths in every 1,000 live births. Impressively, going by the 1995 infant mortality rate of 123.4 per 1,000 live births and the 2015 infant mortality rate of 69.4 per 1,000 live births, we can easily infer that there was up to 43.8 percent decline in infant mortality rate within the 20 year period of 1995 – 2015.

In the same way, Figure 1 above shows that there has also been significant reduction in neonatal mortality rate in Nigeria. The 1995 value of neonatal mortality rate stood at 51.4 deaths in every 1,000 live births. This rate continued declining up to 2015 when it reached 34.3 neonatal deaths in every 1,000 live births. Interestingly, given that the 1995 neonatal mortality rate was 51.4 per 1,000 live births and the 2015 neonatal mortality rate was 34.3 per 1,000 live births, it is easy to infer that the values amount to 33.3 percent decline in neonatal mortality rate within the 20 year period of 1995 – 2015.

However, when the absolute number of infant deaths is considered as an indicator for measuring progress in newborn and child healthcare, we find an entirely different scenario. Figure 1 above shows that there has been reduction in the absolute number of infant deaths in Nigeria over the period of 1995 and 2015. But the decline is not really significant when compared with the observed declines in infant and neonatal mortality rates discussed above. As at 1995, the total number of infant deaths stood at 549,367 infants. The number increased consistently from 1995 till 2000 when it reached the climax of 564,728 infant deaths. After this point, the number of infant deaths started declining gradually till 2015 when it stood at 484,368 infant deaths. From all the Figures, it is clear that there was a decline of merely 11.8 percent in the absolute number of infant deaths within the 20 year period of 1995 – 2015.

When the rate of decline in infant mortality rate is compared with the rate of decline in absolute number of infant deaths in Nigeria over the period of 1995 – 2015, it is observed that the rate of decline in the absolute number is very insignificant. That is to say that the 11.8 percent decline in absolute number of infant deaths is very small compared to the 43.8 percent decline in infant mortality rate.

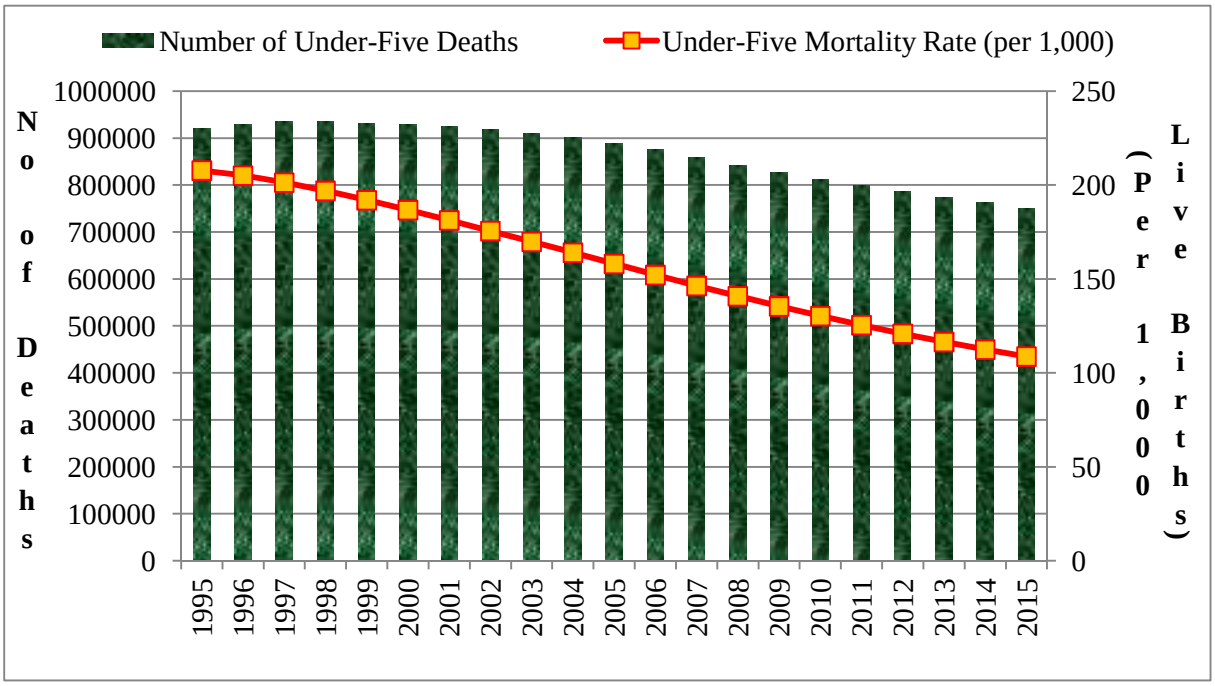
Recall that infant mortality rate is only calculated as the number of infants that die in every set of 1,000 live births of infants. This means that even if 50,000 infants die in each of two years, infant mortality rates in the two years will not be the same depending on the total number of live births in each of the two years. The implication is that increase or decrease in infant mortality rate can be influenced by increased number of crude birth rate. Meanwhile, experts suggest that crude birth rate has been on the increase in

Nigeria over time[34]. This can explain why almost stable number of infant deaths can still imply very significantly declining infant mortality rate between 1995 and 2015.

3.2 UNDER-FIVE MORTALITY RATE

Just like neonatal and infant mortality rate, it is equally important to look at the graphical presentation of the current state of under-five mortality rate in Nigeria over the same period of 1995 – 2015. To this effect, Figure 2 below presents a graphical/pictorial representation of the current level of improvement (or otherwise) in overall under-five mortality in Nigeria between 1995 and 2015.

Figure 2: Number of Under-Five Deaths & Under-Five Mortality Rate in Nigeria



Source: *World Bank (2016) World Development Indicators*

Under-five death is considered as the number of children who died before their fifth birthday. This means that beyond dying as newborns and infants, under-five mortality is used in considering the total number of children who were born alive but died before they could reach their fifth birthday. This category of children includes those that died as newborns and infants. In the same way, under-five mortality rate is usually calculated as the total number of under-five deaths in every 1,000 live births.

Figure 2 above presents the number of under-five deaths in Nigeria, as well as under-five mortality ratio (per 1,000 live births) from 1995 to 2015. The Figure reveals that there has been significant decline in under-five mortality ratio in Nigeria. As at 1995, the value of under-five mortality rate stood at 207.8 deaths in every 1,000 live births. This rate continued declining throughout the period under study. As at 2015, under-five mortality

[34] Olatayo, T. O. and N. O. Adeboye (2013) "*Predicting Population Growth through Births and Deaths Rate in Nigeria*". *Mathematical Theory and Modelling*, 3(1): 96 – 101.

rate has declined down to 108.8 under-five deaths in every 1,000 live births. Impressively, going by the two values of under-five mortality rate (i.e. as at 1995 and 2015), it is clear that under-five mortality rate declined by about 47.6 percent within the study period alone.

However, a critical look at the absolute number of under-five deaths may not present much impressive level of decline from its 1995 value to its 2015 value. Figure 2 above shows that though there has been reduction in the absolute number of infant deaths in Nigeria over the period of 1995 and 2015, yet the reduction is not as impressive and significant as that of under-five mortality rate. As at 1995, the total number of under-five deaths stood at 920,421 under-five deaths. The number of under-five deaths increased consistently from 1995 up to 1998 when it reached the climax of 935,026 under-five deaths. After this point, the number of under-five deaths started declining gradually till 2015 when it fell down to 750,111 infant deaths. From Figure 2 above, it is clear that the absolute number of under-five deaths declined by only 18.5 percent from its value in 1995 to its value in 2015.

When the rate of decline in under-five mortality rate is compared with the rate of decline in absolute number of under-five deaths in Nigeria over the period of 1995 – 2015, it is observed that the rate of decline in the absolute number is very insignificant. That is to say that the 18.5 percent decline in absolute number of under-five deaths is very small compared to the 47.6 percent decline in under-five mortality rate. To be able to understand the above scenario, it is important to note that it is possible to have increased number of total births in a particular period. Such increased number of total births will entail that the rate of under-five mortality in every 1,000 births may decline even when the total number of under-five mortality remains constant at a particular figure. For instance, supposing 750,000 under-five children died every year between 2014 and 2015, under-five mortality rate (per 1,000 live births) will not remain constant in the two years. It will only depend on the total number of live births in each of the two years. This means that supposing there were 7,500,000 live births in 2014 and 10,000,000 live births in 2015, under-five mortality rate will move from 100 under-five deaths per 1,000 live births in 2014 to 75 under-five deaths per 1,000 live births in 2015. The implication is that though there has been a record of decline from 100 to 75 deaths in under-five mortality rate, yet in absolute terms, the number did not change in anyway. It is only the total number of crude birth that has increased over time that accounts for the observed improvement in under-five mortality rate.

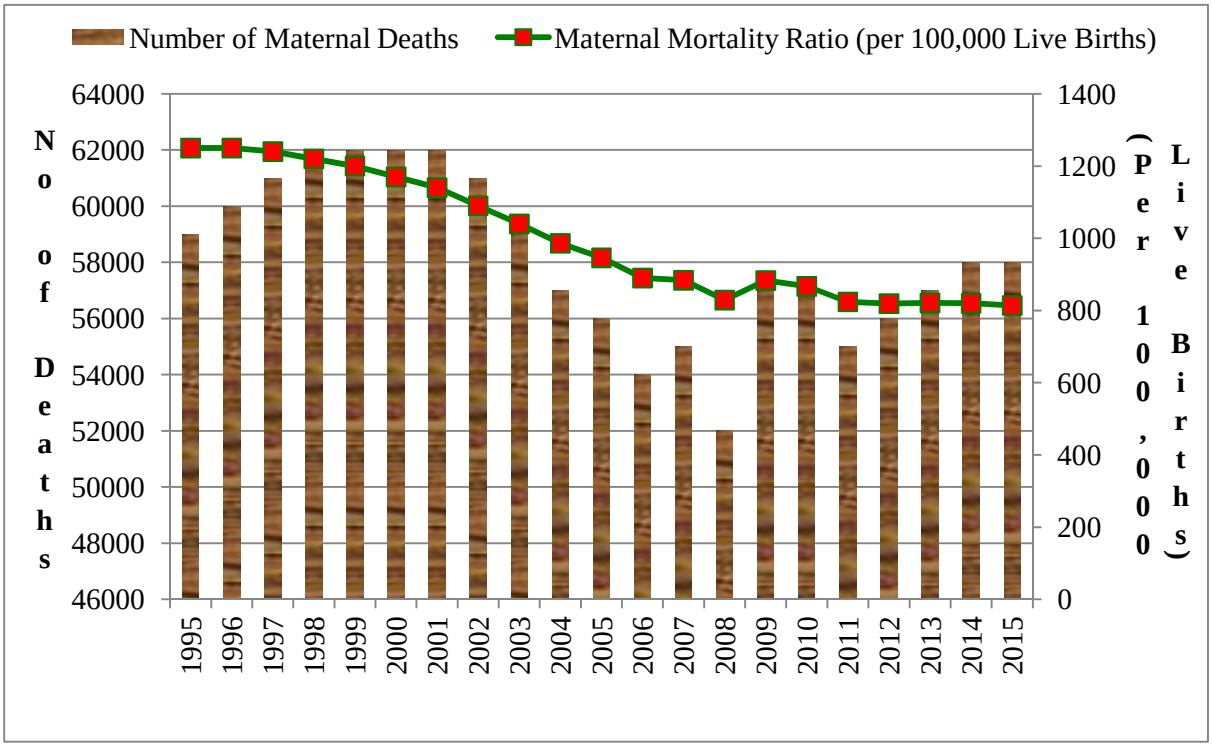
3.3 MATERNAL MORTALITY

Just like neonatal, infant and under-five mortality rates, it is equally important to look at the graphical presentation of the current state of maternal mortality rate in Nigeria over the period of 1995 – 2015. To this effect, Figure 3 below presents a graphical/pictorial representation of the current level of improvement (or otherwise) in overall maternal mortality in Nigeria between 1995 and 2015. The Figure below presents the number of maternal deaths in Nigeria, as well as maternal mortality ratio (per 100,000 live births)

from 1995 to 2015. The Figure reveals that there has not been any consistent trend in the movements of the number of maternal deaths and maternal mortality ratio throughout the study period.

As at 1995, the value of maternal mortality ratio stood at 1250 deaths in every 100,000 live births. The ratio continuously decreased from that point until it reached a low level of 829 in 2008. However, it started increasing from that point to even as high as 883 in 2009 before oscillating annually to settle at 814 maternal deaths in every 100,000 live births as at 2015. Therefore, going by the 1995 level of maternal mortality ratio of 1,250 per 100,000 live births and the 2015 level of maternal mortality ratio of 883 per 100,000 live births, it shows that there was up to 34.9 percent decline in maternal mortality ratio within the 20 year period of 1995 – 2015.

Figure 3: Number of Maternal Deaths & Maternal Mortality Rate in Nigeria



Source: *World Bank (2016) World Development Indicators*

On the other hand, when the absolute number of maternal deaths is considered as an indicator for measuring progress in maternal healthcare, we see an entirely different picture. It is true that Figure 3 above shows that there has been reduction in the absolute number of maternal deaths in Nigeria over the period of 1995 and 2015. But just like the case of maternal mortality ratio within the same study period, the absolute number of maternal mortality has not maintained a consistent trend throughout the study period. As at 1995, the total number of maternal deaths in Nigeria stood at 59,000 deaths. From that point in 1995, the number increased annually by 1,000 until 1998 where it reached 62,000 maternal deaths and remained at that point until 2001. It was only from that point that the number of maternal deaths started decreasing in 2002 until it reached its lowest

mark of 52,000 maternal deaths in 2008. However, it started increasing again from that point to as high as 57,000 in 2009 before oscillating annually to settle at 58,000 maternal deaths in 2015. From all the figures, it is clear that there was merely a decline of 1.7 percent in the absolute number of maternal deaths from its value of 59,000 in 1995 to its value of 58,000 as at 2015.

Standing alone, it may be argued that 1.7 percent reduction in the absolute number of maternal deaths is relatively impressive. However, when the rate of decline in maternal mortality rate is compared with the rate of decline in absolute number of maternal deaths in Nigeria over the period of 1995 – 2015, the 1.7 percent decline in absolute number of maternal deaths becomes very insignificant. In the real essence, 34.9 percent decline in maternal mortality rate is much greater than the 1.7 percent decline in absolute number of maternal deaths in Nigeria within the study period of 1995 – 2015. This situation shows that just like infant and under-five mortality rates, maternal mortality ratio also depends on the total number of crude births within any particular year. Reduction in the ratio may not necessarily imply reduction in absolute number of maternal deaths in any particular year.

3.4 PENETRATION OF PREVENTIVE MEASURES AGAINST MORTALITIES

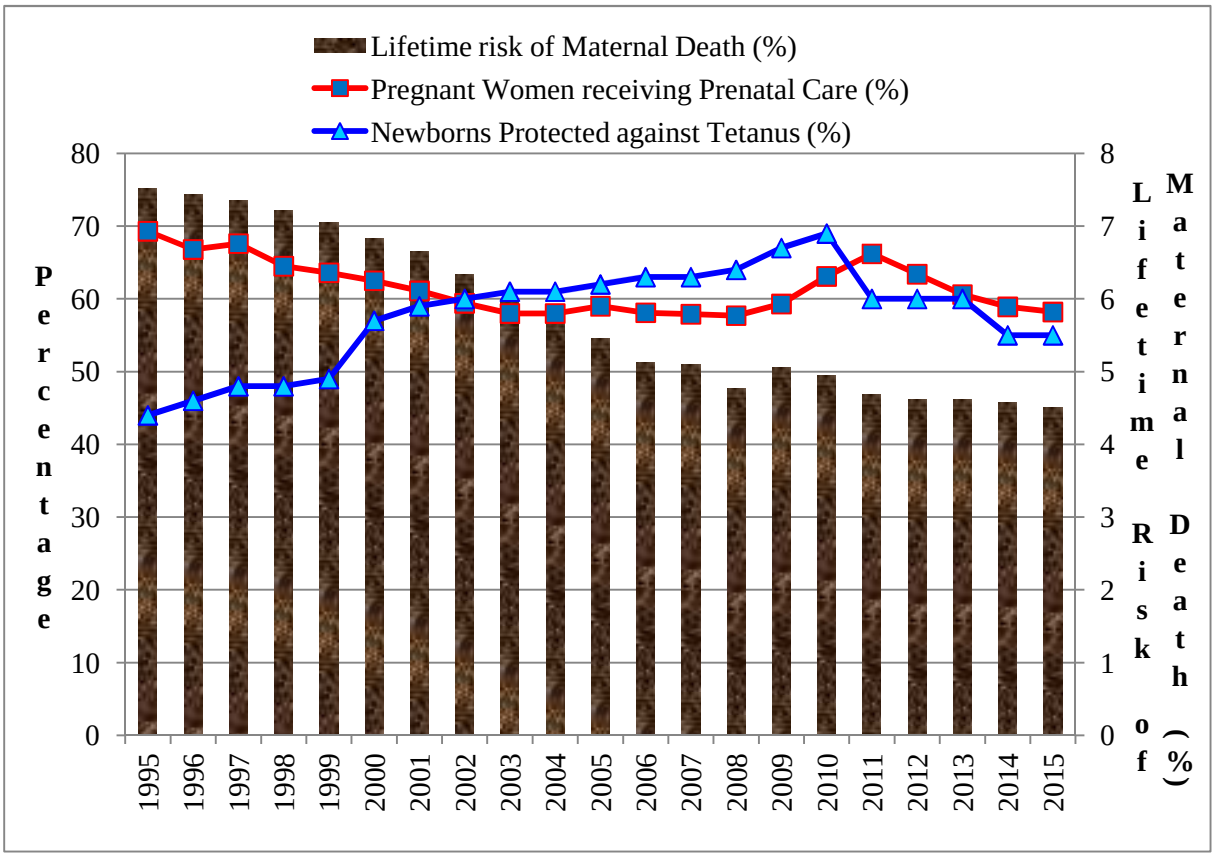
In order to understand why the current state of maternal, newborn and child healthcare is as presented above, it is important to find out the level of penetration of preventive measures against such mortalities. Therefore, Figure 4 below presents a graphical/pictorial representation of the current level of improvement (or otherwise) in overall prenatal care, protection against tetanus among infants and children, and lifetime risk of maternal death in Nigeria between 1995 and 2015.

Figure 4 below presents the proportion of newborns that are protected against tetanus through immunisation. The Figure reveals that as at 1995, only about 44 percent of the newborns were immunised against tetanus. This proportion continued increasing until it reached the climax of 69 percent in 2010. However, the proportion of newborns that were immunised started declining from 2011 and continued decreasing up to 2015 where it settled at 55 percent of all the newborns in Nigeria. On the whole, the figure still shows that there was an improvement in the proportion of newborns that were immunised against tetanus from 44 percent as at 1995 to 55 percent in 2015. The 55 percent of newborns immunised against tetanus as at 2015 represents an improvement of 25 percent from the 1995 proportion of newborns immunised against tetanus.

On the other hand, the proportion of pregnant women who received prenatal care reduced over the study period. As at 1995, the proportion of pregnant women who received prenatal care stood at 69.3 percent of all the pregnant women. However, the proportion declined annually until 2003 when it reached 58 percent of all the pregnant women. From the point of 58 percent in 2003, the proportion oscillated annually until it settled at 58.2 percent in 2015. Going by the figures above, it is clear that instead of an improvement in the proportion of pregnant women who received prenatal care, the

proportion declined from 69.3 percent in 1995 to 58.2 percent in 2015. Based on the figure, we can state that this amounts to 16.01 percent decline in a period of 20 years from its 1995 figure. It should be noted that this period of decline in the proportion of pregnant women who received prenatal care in Nigeria coincides with the period when there was increased awareness campaign in favour of maternal, newborn and child healthcare. Between 2000 and 2010, much emphasis and efforts were made to ensure that Nigeria attained the MDGs before the deadline. Therefore, it is rational to expect that the proportion of pregnant women who received prenatal care would have increased from 69.3 percent to the neighbourhood of 90 – 95 percent of all pregnant women. But this was not the case as shown in Figure 4 below.

Figure 4: Prenatal Care, Protection against Tetanus & Lifetime Risk of Maternal Death in Nigeria



Source: *World Bank (2016) World Development Indicators*

Notwithstanding the proportion of pregnant women that received prenatal care over the period of 1995 and 2015, Figure 4 above also shows the level of lifetime risk of maternal death among Nigerian women. From the Figure, there is impressive decline in the lifetime risk of maternal death from its value in 1995 to its value in 2015. As at 1995, lifetime risk of maternal death stood at 7.5 percent and it continued declining annually at almost a stable rate until 2008 when it stood at 4.8 percent. However, it made a slight increase to 5.1 percent in 2009 before falling again throughout the period of 2010 – 2015. As at 2015, lifetime risk of maternal death for Nigerian women stood at 4.5 percent. Given that lifetime risk of maternal death among Nigerian women within reproductive age

stood at 7.5 percent in 1995, it is clear that the risk reduced by 39.97 percent of its value in 1995 for it to settle at 4.5 percent of all Nigerian women of reproductive age in 2015.

From all the facts presented in Figures 1 – 4 above, it is clear that the current level of absolute number of infant deaths is still very alarming. There is need to improve healthcare services to be able to curtail this high level of infant deaths. The same scenario applies to maternal health. The absolute number of maternal deaths is still very high in Nigeria. Therefore, efforts from all stakeholders in the health services sector must be pooled together in order to chart ways out of the current state of neonatal and infant healthcare services in Nigeria.

CHAPTER FOUR

Reconciling the Budget with the Standards

4.1 ALLOCATIONS TO THE HEALTH SECTOR

This Chapter focuses on federal budget's capital provisions for the years 2010 to 2015 to determine the trend and pattern of allocations and how they reflect on the needs of the MNCH sector. The overall health budgetary vote sets the tone for other components of the right to health such as MNCH. Table 2 shows the federal allocations to the health sector between the years 2010 to 2016 and its variance with international and national standards.

Table 2: ***Shortfall in the 15% Benchmark to Health Sector***

Year	Total Budget (N' Billion/Trillion)	Health Allocation (N' Billion)	As % of Total Budget	As 15% of Total (N' Billion)	Variance from 15% Benchmark (N' Billion)
2010	4,427,184,596,534	164,914,939,155	3.73	664,077,689,480	499,162,750,325
2011	4,484,736,648,992	257,870,810,310	5.75	672,710,497,349	414,839,687,039
2012	4,648,849,156,932	284,967,358,038	6.13	697,327,373,540	412,360,015,502
2013	4,987,220,425,601	282,501,464,455	5.66	748,083,063,840	465,581,599,385
2014	4,695,190,000,000	264,461,210,950	5.63	704,278,500,000	439,817,289,050
2015	4,493,363,957,158	259,751,742,847	5.78	674,004,593,574	414,252,850,727
2016	6,060,677,358,227	250,062,891,075	4.13	909,101,603,734	659,038,712,659
Totals		1,764,530,416,830		5,069,583,321,517	3,305,052,904,687

Source: *Approved Budgets - Budget Office of the Federation*

Table 3 shows the capital votes; released, cash backed and utilized sums and the respective percentages of utilised and approved sums and utilised and cash backed sums.

Table 3: ***NSHDP, Health Capital Budget Allocation, Releases, Cash Backed and Utilisation***

Year	FG Projected Contribution to the NHSDP (N'bn)	Approved Capital Health Budget (N'bn)	Released Health Capital Budget (N'bn)	Cash Backed Health Capital Budget (N'bn)	Utilised Sum of the Health Capital Budget (N'bn)	Utilised as a Percentage of Approved Budget	Utilised as a Percentage of Cash Backed Sum
2010	189,244.09	53,066	33,570	33,562	17,745	33.44	52.87
2011	189,244.09	55,415	38,785	38,716	32,165	58.04	83.08
2012	189,244.09	60,920	45,001	37,171	33,682	55.29	90.61
2013	189,244.09	60,047	28,838	28,838	19,109	31.82	66.26
2014	189,244.09	49,517	20,472	20,472	18,688	37.74	91.28
2015	189,244.09	22,676	16,445	16,445	12,214	53.86	74.27
Total	**1,135,464.54**	**301,641**	**183,111**	**175,204**	**133,603**	**Average for 6 years: 45.03**	**Average for 6 years: 76.40**

Source: *Budget Implementation Reports - Budget Office of the Federation*

From Table 2, the average allocation for the 7 years is 5.26 percent which is N252.07billion. Table 3 shows the variance between the projections in NHSDP, approved budget, the released sums, the cash backed sums and the actual utilised sums. The average utilisation rate of 45 percent of the approved capital budget is very low. The World Bank's Public Expenditure and Financial Accountability standard (PEFA, 2005) recommends at least 97 per cent rate of utilisation as acceptable. With an utilisation rate under 50 per cent for the health budget against the 97 percent mark, the sector's capital budget implementation is way below average. Even the cash backed utilisation rate of 76 percent shows challenges of absorptive capacity. It may be unrealistic advocating for additional resources when existing resources have not been fully utilised. The under-spending is a failure by government to use the maximum of available resources for the progressive realisation of MNCH rights. There is the need to identify and correct the binding constraints, challenges and reasons leading to under-spending of budgeted sums.

The implications of Tables 2 and 3 above is that FGN is not dedicating the full resources required by the Abuja Declaration and other standards for the realisation of the right to health of Nigerians. This would definitely affect the realisation of MNCH rights. Even the paltry resources dedicated to health were not fully released and utilized thereby making the budget a poor gauge of public expenditure. The Table shows that retrogressive steps (in violation of the use of maximum available resources) were taken when the allocation climbed to 6 percent of the overall budget in 2012. Instead of a forward movement, it started a decline until the 2016 rate of 4.13percent.

4.2 ALLOCATIONS TO MNCH AND THE IMNCH STRATEGY

This section reviews the allocations to MNCH against the background of the provisions made in the Integrated Maternal, New Born and Child Health Strategy of 2007 and other standards to determine the adequacy of public funding. The IMNCH Strategy appears to be the only major standard that put a cost on MNCH interventions over the study period. The allocations to MNCH are calculated through a review of MNCH related funding in the federal budget, especially, the votes of the Federal Ministry of Health and its agencies (including NPHCDA), Ministry of Women Affairs, National Action Committee on Aids, Service Wide Votes, SURE-P, etc. The Study's calculations focused on capital expenditure and did not include recurrent votes.

In 2010, FGN provided the total sum of N22.011bn in the federal budget for MNCH. However, of the sum provided in the budget, N13.014bn was for the construction and rehabilitation of PHCs and ancillary services; and this sum amounts to 59.2 percent of the overall MNCH vote. It is important to note that while PHCs facilitate the realisation of MNCH, not all the activities of PHCs are MNCH focused. Indeed, this suggests an unrealistic budget which votes less money for the actual service provision whilst investing heavily in brick and mortar.

In 2011, FGN provided the total sum of N28.819bn in the federal budget. However, of the sum provided in the budget, N3.066bn was for the completion/rehabilitation of ongoing construction of PHCs and other ancillary expenses which represents 10.64 per cent of the vote.

In 2012, FGN provided the total sum of N50.33bn made up of N34.385bn from the mainstream budget and N15.94bn from SURE-P. However, the sum of N3.5474bn was provided in the mainstream budget for the completion/rehabilitation of ongoing construction of PHC centres which represents 10.10 percent of the mainstream budget. Only 23.9 percent of the SURE-P vote in the sum of N3.803bn was utilised at the end of the year[35] and the outstanding sums were purportedly carried over to 2013 fiscal year. The MCH utilisation rate was the lowest of the six intervention areas of SURE-P which had recorded an average utilisation rate of 49.9 percent[36].

In 2013, the federal government provided the total sum of N41.914bn for MNCH made up of the sum of N25.004bn from the mainstream budget and N16.91bn from SURE-P. However, of the sum provided in the mainstream budget, N7.847bn representing 31.38 percent was for the construction of Primary Health Care (PHC) centres and ancillary expenses. Most of these construction seemed like constituency projects of federal legislators. The 2013 utilisation rate of SURE-P funds amounted to 66.44 percent which meant that funds voted for MCH were further carried over to 2014[37].

Also in 2013, there were lump un-disaggregated sum provisions under the Service Wide Votes for MDG special projects, special intervention MDGs 1 and special intervention MDGs 2 in the sums of N8.1bn, N13.455bn and N10.8bn bringing the total to the sum of N32.355bn[38]. Considering the centrality of MNCH to the MDGs, some sums of money from this pool must have been voted to MNCH. It is not clear what exactly was spent on MNCH from this pool of funds. But it is estimated that about 25 percent of the funds will go into MNCH provisioning[39]. If you add the 25 percent of the MDG votes in Service Wide Votes, which amounts to N8.089bn, to the above figure of N41.914bn, it will come up to N49.99bn.

In 2014, the overall MNCH vote was N38.769bn. The mainstream budget provided N20.099bn whilst SURE-P provided N18.67bn. Construction of PHCs and ancillary services in the mainstream budget gulped N7.057bn representing 35.11 percent of the main budget. Again in the SWV, there was a provision of N25.755bn for MDGs and if we

[35] SURE-P 2012 Annual Report and testimony of SURE-P before the House of Representatives Joint Committee on SURE-P.
[36] SURE-P Annual Report 2012, supra.
[37] 4th Quarter and Consolidated Budget Implementation Report 2013 at page vi; Budget Office of the Federation of Nigeria, 2013.
[38] There were also votes under the National Agency for the Control of AIDS for the dissemination of prevention of mother to child transmission (PMTCT) messages in print and electronic media in the sum of N150m and training of health care workers on PMTCT and related capacity building activities in the sum of N68m.
[39] 3 out of 8 MDGs focused on MNCH (MDGs 4.5 and 6); as a percentage, 3/8 amounts to 37.5 percent. But to be on the conservative side, we adopt the lower limit of 25 percent of the MDG funds going to MNCH.

calculate 25 percent of it for MNCH, it amounts to N6.439bn. When this is added to the earlier overall figure, it amounts to N45.21bn for MNCH related services in the year. The utilization rate of SURE-P funds was 86.59 percent[40].

In 2015, the overall MNCH vote was N14.060bn, out of which construction of PHCs and ancillary services gulped N1.531bn representing 10.89 percent of the overall vote. The overall MNCH vote is inclusive of the N3.5bn voted for MCH under SURE-P. The SURE-P vote was reported as fully utilised[41]. There were also other votes that would have impacted on MNCH under SWV, especially the votes for MDGs. A total sum of N36.514bn was voted for MDGs excluding Social Safety Net programmes; one quarter of this sum if applied to MNCH would amount to N9.128bn. If this is added to the mainstream vote of N14.060bn, this would amount to N23.188bn.

Table 4 shows the estimates of FGN expenditure in the IMNCH Strategy and the actual provisions in the budgets between 2010 and 2015.

Table 4: ***IMNCH Strategy Estimates and Actual Budget Provisions 2010-2015***

Year	Exchange Rate	IMNCH Estimate (mn US$)	IMNCH Estimate (NGN)'bn	Appropriation (NGN)'bn	Variance (NGN)'bn	Appropriation as a % of IMNCH Estimate (NGN)
2010	150	260,052	39.007	22.011	16.996	56.43
2011	150	310,385	46.558	28.819	17.739	61.90
2012	155	371,800	57.629	50.330	7.299	87.33
2013	160	469,136	75.062	49.990	25.072	66.60
2014	160	562,130	89.941	45.210	44.731	50.27
2015	190	676,270	128.491	23.188	105.303	18.05

Source: *IMNCH, Federal Ministry of Health, Abuja and Approved Budgets: BOF*

Table 4 shows that in no year did the FGN meet its obligations in terms of the estimates in the IMNCH Strategy. The trend is fluctuating, rising from the baseline of 56 percent in 2010 and attaining a peak of 87percent in 2012 before declining to 66percent and 50 percent in 2013 and 2014 respectively, whilst reaching the lowest point in 2015 at 18 percent. The implication of the divorce between plan projections and appropriations is captured in the words of experts[42]:

> *Careful planning is necessary for the progressive realisation of rights, but plans alone are not enough. It is essential that the government develops realistic, targeted budgets that are in line with details in the plans. In this way, it can better ensure that there will be sufficient funding to allow implementation to proceed smoothly and effectively. In this context, a performance budget, which relates a government's plan closely to its budgets, can be valuable*.

[40] 4th Quarter and Consolidated Budget Implementation Report 2014 at page vi; Budget Office of the Federation of Nigeria, 2014.
[41] 4th Quarter and Consolidated Budget Implementation Report 2015 at page 31; Budget Office of the Federation of Nigeria, 2014.
[42] The Article 2 Project by Ann Blyberg and Helena Hofbauer: *Progressive Realisation - Budget Increases and Meeting the Obligations of Progressive Realisation.*

Thus, the progressive realisation obligation of the ICESCR was obeyed in the breach in this instance.

4.3 ALLOCATIONS TO PRIMARY HEALTH CARE

Although not all allocations to Primary Health Care are for MNCH, however, MNCH is embedded in PHC. There is the need to review the funding of PHC in the light of this connection with MNCH, especially, the allocations to the National Primary Health Care Development Agency[43].

Table 5: FGN Budgetary Allocation to Primary Healthcare (Value and Proportion)

Year	Overall Health Budget	Overall PHCDA Budget	% of PHCDA Budget to Overall Health Budget
2010	164,914,939,155	16,671,519,663	10.11
2011	257,870,810,310	17,496,285,543	6.78
2012	284,967,358,038	23,926,274,303	8.40
2013	282,501,464,455	20,066,496,612	7.10
2014	264,461,210,950	19,433,516,695	7.35
2015	259,751,742,847	12,145,147,334	4.68

Source: *FGN Approved Budgets (2010, 2011, 2012, 2013, 2014, and 2015)*

From Table 5 above, the total value of budgetary allocation to Primary Healthcare in Nigeria has been very unstable over the years. From ₦16.671billion that was allocated to PHC in 2010, the federal government of Nigeria increased budgetary allocation to the sub-sector to N17.496bn in 2011 and N23.926bn in 2012. But in 2013, it came down to N20.066bn and N19.433bn in 2014 and further declining to N12.145bn in 2015. From a height of 10.11percent in 2010, the allocation declined to 4.68percent in 2015, over the six year period. This represents a 7.40 percent of PHC allocation to overall health budget over the period of assessment.

It is imperative to note that recurrent budgets consisting of personnel and overheads are usually drawn down every year but capital budget implementation remains low. For several years, actual capital spending on health has remained significantly lower than budgeted capital allocation to health sector. Table 6 shows the details of the overall health capital budget expenditure and the capital allocation to NPHCDA as a percentage of the approved health capital budget. It also shows the utilisation of overall health capital budget and from which we extrapolate the percentages to work out the level of implementation of the NPHCDA budget.

[43] The allocations to NPHCDA are treated as a proxy to PHC allocations of which MNCH is a central part.

Table 6: ***Capital Budget Implementation in the Health Sector including MNCH***

Year	Overall Health Capital Budget	Overall PHCDA Capital Budget	% of PHCDA Capital Budget to Overall Health Capital Budget	Percentage of Utilised Health Approved Budget	Utilised PHCDA Capital Budget
2010	53,006,615,191	15,476,899,115	29.20	33.44	5,175,475,064
2011	55,411,957,377	15,314,708,147	27.64	58.04	8,888,656,608
2012	60,920,219,702	21,885,142,688	35.92	55.29	12,100,295,392
2013	60,047,469,275	18,202,163,900	30.31	31.82	5,791,928,552
2014	49,517,380,725	17,505,262,623	35.35	37.74	6,606,486,113
2015	22,676,000,000	9,964,107,457	43.94	53.86	5,366,668,276

Source: *Budget Implementation Reports 2010-2015: Budget Office of the Federation of Nigeria*

From Table 6 above, actual capital expenditures on health ranged between 33.44percent in 2010 to 53.86percent in 2015 averaging 45.03percent over the study period.

The oscillation of the votes to PHC and actual capital budget implementation is a case of forward and backward movement showing no empirical consistency. It is also indicative of not deploying the maximum of available resources for the progressive realisation of MNCH rights.

4.4 RECENT ALLOCATIONS TO MNCH AND THE NHA

The budgets of 2015 and 2016 ignored the provisions of the National Health Act which mandates the provision of not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provision Fund. The authorities indicated that in late 2014, the 2015 budget proposals were already prepared before President Goodluck Jonathan assented to the bill to become law. But since it became law, it was incumbent of the fiscal authorities, on the prompting of the Federal Ministry of Health to amend the budget and reflect the fact of the provisions of the law because a law takes effect from the date it is assented to by the President. The 2016 experience of leaving out the Basic Health Care Provision Fund is inexcusable and is clearly a violation of the law. It needs to be noted that what the law stated is not less than 1 percent of the Consolidated Revenue Fund which is the minimum floor. It could therefore be more than 1 percent.

The implication of the foregoing is that MNCH and related services (using the minimum floor of 1 percent) lost good sums of money. With a total Consolidated Revenue Fund of N3.419trilion in 2015, one percent amounts to N34.190bn which should have been remitted to the Basic Health Care Provision Fund. With a total Consolidated Revenue Fund of N3.855trilion in 2016, 1 percent amounts to N38.555bn which should have been remitted to the Basic Health Care Provision Fund. Of these sums, 45% percent of the Basic Health Care Provision Fund would have gone to the National Primary Health Care Development Agency which would have used it for a number of programmes including MNCH. This would amount to N15.385bn and17.350bn in 2015 and 2016 respectively; bringing the total to N32.735bn over the two years. Also, the 50 percent of the Basic

Health Care Provision Fund going to basic minimum package of health services to citizens through the National Health Insurance Scheme would have impacted on MNCH.

4.5 THE SURE-P INTERVENTION IN MNCH

4.5.1 Objectives

The SURE-P Maternal and Child Health Care programme (MCH) aimed to reduce child and maternal morbidity and mortality in Nigeria through the utilisation of cost effective demand and supply interventions to increase access to and provide quality delivery of health services to ensure that Nigeria is on track towards achieving MDG Goals 4 and 5[44]. It also sought to tackle inequalities in the provision of primary health care[45]. Some of the expenditures are as indicated in Table 7.

Table 7: Extracts of Expenses in the MCH Intervention Scheme

Amount	Purpose
N209,257,229.76	Recruitment of 4,604 health workers (1,168 midwives, 2,188 community health workers and 1,248 village health workers)
N2,304,686.48	Training of health workers in Kuje and Karu and cash support for beneficiaries
N12,708,130	Two weeks state of readiness assessment in 9 pilot states – including advocacy and sensitization
N9,079,100	Selection and assessment of 500 primary health centres and 125 general hospitals
N810,500,000	Purchase and supply of branded medical supplies and drugs to 500 PHCs
N93,579,775.99	Setting up state implementation units – rents, running costs, allowances and consultants
N4,302,190	Production of programme manual and advocacy materials
N600,000,000	Purchase of buffer drug stock

Source: *2012 Annual Report and Ministerial Platform Progress Report July 2013*

4.5.2 Achievements and Challenges

(i) Human Resources for Health and Service Delivery

In terms of achievements, the Progress Report as at July 2013[46] stated that SURE-P had increased the supply of human resources for health and created jobs by recruiting 6,630 health care workers. These health care workers comprise: 1,304 midwives; 2,254 community health extension workers (CHEWs); and 3,072 female village health workers (VHWs). These new workers cut across the six geo-political zones of the country. They were deployed to provide quality ante-natal, skilled birth delivery and post-natal services for previously under-served rural poor women. The report stated that maternal, neonatal and child health services were accessible in 500 SURE-P supported Primary Health Centres (PHC) spread across the 36 states and FCT. A total of N209.257million was

[44] SURE-P Annual Report 2012 at page 11.
[45] SURE-P Final Draft: Federal Government 41% Share at Work (accessed 27/3/2014)
[46] SURE-P Progress Report, Ministerial Platform, July 2013 by Nze Akachukwu Nwankpo (Secretary SURE-P)

used to recruit the heath workers. This amounts to N45,451 per health worker recruited. This is a little bit on the high side. In 2013, the programme sought to add additional 1500 midwives to bring the number to 2804; new 2,800 CHEWS to bring the number to 5,054 and additional 4,200 VHWs to bring the total to 7,272. The SURE-P MCH office, noted that as at December 2013, the number of health care workers deployed by SURE-P MCH increased to 11,896 workers made up of 2,554 midwives, 3,342 CHEWs and 6,000 VHWs.

The SURE-P MCH Programme generated significant increase in the uptake of services at PHCs in communities hosting them. 223,786 pregnant women received antenatal care services in SURE-P MCH supported facilities; 28,435 deliveries have been taken by skilled birth attendants in these same facilities and 19,514 new acceptors of family planning have been recorded in these same facilities.

The challenges encountered in the recruitment of health workers include[47]:

- Shortage of midwives accommodation in the states;
- Low literacy level of the participants;
- Discrepancies in the list of midwives and CHEWs submitted;
- Shortage of information technology equipment for bio data capturing;
- Low response of midwives in the Northern zones when compared to the South.

(ii) Conditional Cash Transfer (CCT)

SURE-P MCH also launched the Conditional Cash Transfer (CCT) Pilot Programme. It is a demand side cash incentive of N5000 offered to pregnant women to encourage the uptake and use of PHCs after completing and fulfilling certain conditions. The inauguration of State Steering Committees took place in eight pilot states and the FCT namely Anambra, Bauchi, Bayelsa, Ebonyi, Kaduna, Niger, Ogun and Zamfara States. 45 PHCs in the six geo-political zones were chosen to administer the programme. The CCT was designed against the background that user fees charged by PHCs and transport costs were major barriers impeding access of poor and rural women to health services.

The CCT services available in the FCT were in 5 PHCs and a total of 2,150 beneficiaries were enrolled into the programme as at 30th June, 2013 as follows:

- Dei-Dei Comprehensive Health Centre: 670 beneficiaries
- Old Dei-Dei Health Post: 200 beneficiaries
- Byazhin Health Centre: 272 beneficiaries
- Dutse Alhaji Health Centre: 449 beneficiaries
- Kuje Health Centre: 559 beneficiaries

[47] SURE-P 2012 Annual Report at page 16.

Ward Development Committee (WDC) members were enrolled in 32 pilot PHC facilities in the 8 pilot states.

(iii) Health Facility Upgrade

In 2012, SURE-P MCH selected 625 health facilities made up of 500 PHCs and 125 General Hospitals across the 36 states of the Federation and FCT in collaboration with states and local governments. These health facilities were to be transformed into model health facilities with funding support from the SURE-P MCH Programme through extensive renovation and infrastructural upgrade which will include provision of boreholes and toilet facilities. According to the SURE-P 2012 Annual Report:

> *"In each state and the FCT, 3-4LGAs/wards were selected and in each of these wards, 4 PHCs and GH were selected for the SURE-P MCH programme. The 4 PHCs and 1 GH formed what is called a "Cluster, so in each state 3 or 4 clusters were formed. The health facilities selected were all from health facilities that had no form of donor partner".*

SURE- P MCH completed the Bill of Quantities Assessment of all 625 health facilities to determine the state of physical infrastructure upgrade required for their visible transformation. As at the middle of 2014, only 74 facility renovations were approved and awarded. In addition, 313 boreholes were approved and awarded. In 2013, the projection was to support additional 700 PHCs by the SURE-P MCH Programme to bring the number of upgraded PHCs to 1200. 175 new GH were to be supported to bring the number of GHs supported to 300. Based on lessons learnt and hardship experienced by deployed healthcare workers, provision of accommodation for health workers was a paramount consideration for 2013. Responding to the draft report of our SURE-P MCH study, the SURE-P office indicated that it was supporting 1000 PHC facilities in rural and hard to reach communities across the 36 states and the FCT. It stated that the facilities were selected by the states based on an agreed criteria reached between the states and the SURE-P MCH Project Implementation Unit. However, the website www.surepmch.org still indicated 500 PHC facilities and 125 GHs.

(iv) Drug and Equipment Supplies

The MCH committee initiated the supply of essential drugs, health commodities and medical equipments to all 625 SURE-P supported primary and secondary health facilities. The SURE-P MCH Programme stated its commitment to ensure that no programme beneficiary will be required to pay user fees when accessing services at any SURE-P supported PHC by ensuring all-year round availability and supply of basic maternal, newborn and child health drugs and health commodities. In addition, the right set of medical equipments was supposed to be available to provide quality antenatal, delivery and post-natal services to all programme beneficiaries accessing any SURE-P supported PHC across the country. The standard list of items include medical equipment,

MAMA Kits, Midwifery Kits, outreach Kits, VHW kits, maternal neonatal and child health drugs and medical consumables[48].

In 2012, a total of N810.5million was spent on drugs and equipment and by July 2013, the expenditure had gone up to N1.8billion. This is an increased expenditure of about N1billion. Also, N600million worth of buffer stock was procured and stored in zonal medical stores to stamp out "out of stock syndrome". In all, 425 facilities across the country were supplied a full complement of drugs, consumables and medical equipments

(v) Communications and Advocacy

SURE-P undertook communication and advocacy activities towards ensuring sustainability and to preserve the gains of the SURE-P MCH. The National Primary Health Development Agency (NPHDA) constructively engaged state and local government authorities through advocacy visits and sensitisation meetings with a wide variety of stakeholders including state and local government officials, traditional leaders, community based organisations and professional associations. It also developed a draft Memorandum of Understanding (MOU) that was signed by State Governments to facilitate their ownership and partnership contribution to the SURE-P MCH Programme. Advocacy visits were successfully conducted in the 13 states of the North East and North West geo-political zones and 11 states in the South East and South West geo-political zones; production and airing of radio and television jingles commenced in 3 stations in the FCT and a quarterly MAMA magazines was published and launched.

(vi) Observations

Visits to the SURE-P headquarters to get a detailed breakdown of the expenditure for the provisions of MCH services did not yield any results. How much was actually used to procure the drugs and kits? SURE-P headquarters refused to provide details of expenditure on MCH and directed the researchers to the Budget Office of the Federation, which in turn declined giving the information.

At the initial stage of the Study, location of the selected PHCs and GHs could not be independently verified but a website was later found based on information from SURE-P MCH. However, the locations in some states for example, Imo State seem to be based on political considerations rather than the stated rural and hard to reach communities. In Imo State, only five local governments benefitted from the 12 PHCs located in the state. The claim that thousands of health workers have been employed could not also be independently verified since the names, addresses and locations of the employees were not available to the public.

Some of the stated challenges on the recruitment of health workers need further interrogation. The low literacy level of participants raises the concern of whether the programme needs health workers (may be CHWs) who have very low literacy; how will

[48] Page 25 of the 2012 Annual Report.

they be able to render services to the intended beneficiaries? A major challenge that faced this component of the MCH is about sustainability. The 2012 Annual Report states that a memorandum of understanding with clearly spelt out roles and responsibilities for federal, state and local government will be signed as binding agreements including a responsibility for state governments to absorb the SURE-P health workers into the state workforce. Although SURE-P MCH indicates that some states absorbed the health workers, the overall picture looks problematic because states may not easily give in to including new staff on their payroll if they did not plan for them initially. The picture that came out later was that most states refused to absorb the MNCH workers. Although MCH interventions done at the local level by FGN saved lives, it would have been more appropriately left to states and local governments. This would over time build the capacity of these governments to undertake their basic responsibilities. The MCH interventions are laudable but the sustainability of the human resources for health programme after the SURE-P intervention was in doubt and the evidence emerging after the programme confirmed the doubt.

Again, the criteria for the selection of the beneficiaries of the CCT was not clear since it is stated by SURE-P MCH that all pregnant women residing in the communities where the CCT pilot facilities are located are eligible to benefit from the cash incentives. Unidentified co-responsibilities are expected from these women according to the SURE-P MCH. The long term sustainability of this activity was also doubtful and it has been discontinued after the Jonathan administration left office. For the PHC and GH facilities being upgraded and renovated, the authority to continue their maintenance after the end of SURE-P is not clear. In 2016, there are still provisions for the continued maintenance of PHCs in the federal budget. Will the FGN continue to maintain PHCs which essentially should be the domain of states and LGAs? For the projections to increase the number of PHCs and GHs to be upgraded in 2013, there was no confirmation on whether the increase did take place. The website www.sure-pmch.org still contains the list of the 500 earlier indicated.

CHAPTER FIVE

Matters Arising from Budgetary and Other Provisions

5.1 SERVICE WIDE VOTES AND MNCH

A good part of the allocations to MNCH were contained in SWV which is almost a ghost account, not supported by law and policy. SWV centralises funds which should have gone to respective implementing MDAs in a way and manner that inhibits accountability of expenditure and tracking of results. Even the provisions most times are nebulous and designed to ensure that the projects and programmes are known only to the budget makers. For instance in the 2016 federal budget; there were provisions for Special Intervention MDGs1 and Special Intervention MDGs 2 for N15.378bn and N15.018bn respectively. What exactly are the programmes and projects covered by these huge allocations?

The Oronsanye Committee on reforming the cost of governance stated as follows of Service Wide Votes:

> *The Committee noted the widely held view of the abuse of the utilisation of the Service Wide Votes. It was the view of the Committee that budget heads currently captured under that vote could actually be captured either under specific MDAs or the contingency vote. Considering the constitutional provision for the contingency vote, it is believed that the Service Wide Vote is not only an aberration, but also an avoidable duplication. The committee therefore recommended that the Service Wide Vote should be abolished and items currently captured under it transferred to the contingency vote or the appropriate MDAs.*

It is therefore our considered view that allocations under SWV to MNCH be discontinued. The sums should be disaggregated, restructured and given to the implementing agencies.

5.2 CONTRIBUTION OF DEVELOPMENT PARTNERS IS NOT CAPTURED IN THE BUDGET

The reviewed federal budgets did not take cognisance of the contribution of Development Partners through grants and other support mechanisms. It is possible that in calculating the resources voted to the sector, the authorities may have taken cognisance of the development aid, but this is not clear on the face of the budget. Admittedly, there are provisions for counterpart funding, especially in the SWV, but the percentages and overall sums are not clear. This is faulty as it does not portray a true picture of the level of funding available for MNCH and other health interventions. This is not the practice in other African countries and runs against the standard Nigerian Appropriation Bill clause that:

> *All Accounting Officers of Ministries, Parastatals and Departments of Government who control heads of expenditure shall upon the coming into effect of this Bill furnish the National Assembly on a quarterly basis with detailed information of all foreign and or*

domestic assistance received from any agency, person or organisation in any form whatsoever[49]*.*

If this is the law, all grants sums that are due for a draw down within the year should have been declared and incorporated into the budget. The fact that these contributions are not captured may lead to double counting in terms of FGN paying for services and facilities already funded by donors. It may also lead to corruption by MDA officials. This may also be responsible for the poor absorptive capacity of the Federal Ministry of Health to the extent that it focuses more on using donor funds whilst neglecting the official FGN funds.

5.3 BASIC MINIMUM PACKAGE OF HEALTH SERVICES UNDER THE NHA

The NHA provides in section 3 (3) that all Nigerians shall be entitled to basic minimum package of health services. But the package is yet to be defined. It is posited that in defining the package, MNCH services should be a fundamental and core aspect especially in view of the relationship between MNCH services and the constitutional rights to life and human dignity. Also, the definition must take cognizance of the minimum core obligation of the state and the minimum core content of the right to health.

5.4 VVF AND HUMAN LIFE AND DIGNITY

There are about 800,000 women affected by Vesico Vaginal Fistula (VVF) in Nigeria which is about 40percent of the world estimate of 2,000,000 VVF patients[50]. The endemic states are Sokoto, Kebbi, Borno, Kano, Katsina, and Plateau States all in Northern Nigeria as well as pockets of cases in Ebonyi and Akwa Ibom States in the South. VVF is caused by the challenges of child birth especially for child brides whose reproductive organs have not fully developed and matured to start to give birth to a baby. It has been stated by experts that[51]:

> *Most of the affected girls are known to lose their children and even their lives during childbirth and many lose bladder control and constantly leaks urine which leaves them with no option than to wear bags or bucket. The stench from the urine makes them unapproachable even to family members including their husbands who often abandon them sometimes in search of replacement with another child bride. And so, the circle continues.*

A typical VVF patient in Nigeria loses her human dignity and also risks losing her life. As such, the treatment and remediation should attract utmost priority in health funding. The cost of repair surgery was estimated at N39,000 and additional N50,000 for rehabilitation bringing the total to N89,000, as at 2013[52]. Rounding up the cost to approximately N100,000, it would cost FGN the sum of N80bn only for the corrective surgeries and

[49] See section 8 of the 2013 Appropriation Act and section 10 of the 2014 Appropriation Act.
[50] http://nigerianhealthjournal.com/?p=693
[51] http://nigerianhealthjournal.com/?p=693
[52] Credited to Iyene Efem, Programme Manager, USAID Fistula Care project, Nigeria. http://www.news24.com.ng/National/News/200000-Nigerian-women-suffer-VVF-conditions-USAID-20130120

rehabilitation. This is not beyond the resources of Nigeria, especially if other tiers of government step in to assist. This would also be complimented by effective maternal services for pregnant women and enforcing laws and policies against child marriage so that new cases would be minimised. But what does the funding scenario look like.

Table 8: *FGN Capital Budget Provisions for VVF Centres 2010-2015*

Year	Allocation (NGN)
2010	-
2011	-
2012	658,097,402
2013	850,503,030
2014	250,593,368
2015	221,676,532

Source: *Approved Budgets- Budget Office of the Federation*

Evidently, FGN has not prioritised the VVF intervention and the sums provided are paltry. According to the Chief Medical Director of the National Obstetric Fistula Centre (NOFIC) in Katsina, Dr Aliyu Muhammad El-Ladan, the Centre treats at least four hundred VVF patients every year but could only rehabilitate one hundred[53]. VVF institutions need resources for the repair of VVF patients, their rehabilitation through provision of skill training and teaching on VVF. Most the existing interventions are from donors and the FGN provides very little for VVF remediation.

5.5 IRRECONCILIABLE DIFFERENCES IN UNIT COST OF PHC CENTRES CONSTRUCTION

The NPHCDA undertakes most of the construction of the PHCs and a lot were planned in 2013. This massive construction of PHCs is commendable because it enhances physical access of service users to MNCH services. However, the PHCs which are ideally the same prototype were costed at very different prices. Although soil and terrain conditions may justify the price differences, but the range of differences in cost cannot be justified by the terrain. Some of them were priced as high as N50m; some at N40m, N30m and N20m respectively. However, others went for a modest figure of about N10m.

Three issues are worthy of highlight from the allocations. First, the PHCs constructed with above NGN10m seem to be extra costly because in reality, the facilities could be developed within that modest sum. The problem is that budget makers and even contractors believe that Government is the biggest spender in the economy, and hence they could provide uneconomical cost estimates for projects. Second, it is inefficient to spend N10m to build a PHC and use NGN50m to build another, even when they are in different parts of the country. The difference is so huge that no economically reasonable factor (materials price difference from region to region for example) can explain it and it shows that the Agency does not have a standard pricing mechanism for similar projects.

[53] http://www.dailynigerianews.com/2016/02/28/poor-funding-vvf-centre-begs-katsina-govt-for-help/

Third, such wastages make budgets ineffective in reaching the targets for MNCH services because the money that would have been applied in constructing many more PHCs would be spent on just one. For example, the PHCs built with NGN50m vote could have been used for five, if the modest sum of NGN10m is standardised (with reasonable exceptions) as the unit cost for a PHC construction.

5.6 AMBIGUOUS NOMENCLATURE/DESCRIPTION OF MNCH PROJECTS

A review of the MNCH budgets reveal that some projects are ambiguously named or described and this makes their monitoring very challenging. Even when large sums are budgeted for them, they are couched in such a way that an average analyst cannot understand them. Some examples may drive home the inefficiency in this practice.

In the 2011 budget, a project "Primary Health Centre at Faruruwa & Magami in Sumaila/Takai" was costed for NGN50.185m. But there is no clear mention of what is to be done about the Centre. Is it for construction, rehabilitation, supply of equipment or drugs? Neither is it easy for everyone to know where the projects are located as the LGA and States involved were not mentioned. The same is also noted for another project "Primary Health Centre at Ogbonoko", all found under the capital projects listed for NPHCDA to execute. A lot of resources could be put into these projects that the public cannot track or be in a position to determine whether what was intended was done or not. Listing projects without clear description and necessary information for monitoring amounts to inefficient allocation because resources could be misapplied or wasted with little or no possibility for detection.

The projects listed for Federal Psychiatric Hospital Kaduna raises some efficiency and effectiveness concerns - "completion of child and adolescent ward (on-going)" at N14.425m and another "completion of child and adolescent ward (New project)" at N17.728m. While they are understood as on-going and new, what is the justification for starting a new child and adolescent ward when the first is yet to be completed? Is it more effective for reaching the teeming users of MNCH services in Nigeria that two similar projects are going on in one facility with many others having none? Under the projects listed for implementation by NPHCDA in 2011, a "Primary Health Centre Idogo, Ifonyintedo" was planned but no cost was provided. What purpose was the project's listing in the budget meant to achieve? There are also cases of playing around words and repeated capital votes as shown in Table 9 below.

Table 9: Repeated Items in the MNCH Budget

MDG-Support for Strategic Health Management System Strengthening (HSS)	50,000,000
MDG-Support for the Prevention and Control of Non Communicable Diseases in Nigeria (NCD)	215,000,000
MDG-Support for Strategic Health Management Systems Strengthening including Support for the Prevention and Control of Communicable Diseases in Nigeria (SCD)	50,000,000

Source: *Approved 2013 Budget*

Table 9 above shows some capital projects meant to be executed by the FMoH in the year 2013. A careful study of the items shows that they seem to be designed to confuse the average analyst and even impossible to monitor and verify. The three have active verbs 'support' and it is not clear what that means in concrete terms. Also, observable is that the third item is a combination of the first and the second both in terms of words and technical meaning. What this practically implies is that NGN50,000,000 budgeted for the third item could have been efficiently applied for all three. This kind of budget heads litter the health budget and resources that could have been channelled for other MNCH services are otherwise wasted.

5.7 ALIGNMENT OF FEDERAL BUDGETS WITH POLICY DOCUMENTS AND BEST PRACTICES IN BUDGETING

The research found that for all the national policy documents that discussed and planned for MNCH - Vision 20 2020; Transformation Agenda; and National Strategic Health Development Plan, appropriations could not match the financial projections for the study period. Projections are more than actual appropriations; appropriations are more than releases; cash-backed sums are less than releases and actual expenditures are less than cash-backed sums. In all and in practice, actual expenditures are far less than projections. Bearing in mind that crafters of the projections have calculated what will be required to meet the targets, providing less means that the targets will never be met. The best practice in policy making and budgeting is that policy makers plan as realistically as possible without over-ambitious targets and projections; budget makers review the policy documents and ensure that programmatic activities are costed in line with the projections[54]; the funds are requested by the MDAs and are released promptly to them; and the MDAs spend the monies as planned. But as seen in this Study, paucity of resources, the capacity to expend resources; political will to execute and deliver results are factors that create the gap between policy and practice in Nigeria.

5.8 THE REIGN OF BUDGET FRIVIOLITIES

Nigerian budgets are suffused with frivolous, wasteful, inappropriate and unclear expenditures. This includes the budgets of the FMoH and other MDAs. A state that is spending so much for these kinds of expenditure cannot be heard to plead lack of resources as the basis for its failure to fulfil the basic MNCH obligations. Examples of these wasteful and inappropriate expenditures are detailed hereunder. In the 2012 budget, the State House in the Presidency got N357.7m for the purchase of plates and cutleries while the furnishing of the Vice President's House got N437m[55]. The Budget Office of the Federation got N194m for refreshment and meals and N122m for welfare

[54] Usually forecasts but can be made more realistic at the time of planning and projecting.
[55] See *In the Name of Appropriation: All Things are Possible, being a review of the approved 2012 budget documenting wasteful and unclear expenditures and the position of Citizens Wealth Platform*. CWP, 2012.

packages. The Federal Ministry of Finance got N96m for welfare packages, N26.3m for security vote and N66.9m for refreshment and meals[56].

In the 2013 budget of the National Health Insurance Scheme, the sum of N100m is budgeted for advocacy on the NHIS Bill. If a bill has been submitted to the legislature, what would this sum of money be dedicated to? If a fresh bill is to be developed, it would not cost this much. The office of the Vice President got N366m for the furnishing of guest houses in the same year. There is a yearly vote for Christian and Muslim pilgrimages running into billions of naira - a private religious affair funded by appropriation in a country whose constitution prohibits the adoption of state religion. In 2013, the vote was N720.4m and N643m respectively for Christian and Moslem pilgrimages[57].

In the same year, many government departments that had nothing to do with security had approvals for security votes. Examples include the Head of the Civil Service of the Federation for N87.336m, Standards Organisation of Nigeria for N75.175m, etc. Welfare packages, refreshment and meals also suffuse the budget. Examples for 2013 include the Ministry of Finance with N43.5m in refreshment and meals, N111.8m in welfare packages; Accountant General of the Federation with N103m in refreshments and meals. Transport and travels is also abused as the same Accountant-General of the Federation got N539 for travels and transport in 2013[58]. In 2015, the same procurement of plates and cutleries got N77m and upgrade of State House facilities got N1.126bn. Over the 2010-2015 period, most MDAs were demanding monies for computers and computer software on a yearly basis as it became the easiest way to get resources out of the public treasury.

Essentially, there is a clear case of misuse of available resources and directing them at areas that do not contribute to the realisation of economic and social rights for the broad segment of the population, especially the vulnerable groups. Some of the votes even contravened existing laws[59]. Government has a commitment to ensure that first and foremost, the available resources are prioritised for the realisation of basic rights, of which MNCH ranks high in the scheme of things.

5.9 BUDGETING FRAMEWORKS: MARGINAL BUDGETING FOR BOTTLENECKS (MBB), MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) AND NOW ZERO BASE BUDGETING (ZBB)

Several prescriptions and changes in budgeting frameworks appear to create confusion in the choice of the appropriate framework to use for health budgeting. The IMNCH

[56] *In the Name of Appropriation: All Things are Possible,* Supra.
[57] Appropriating for Frivolities, CWP, 2013.
[58] Appropriating for Frivolities, supra.
[59] Public sponsorship of pilgrimages.

Strategy prescribes the Marginal Budgeting for Bottlenecks (MBB) Tool[60]. According to the IMNCH Strategy:

> *The Tool helps developing countries to plan and estimate additional costs and the potential impact of scaling up investments by removing bottlenecks in the health system. The MBB promotes result driven expenditures by linking health budgeting to outcomes. This approach is based on the concept of high coverage of a selection of evidence based interventions on a nation-wide scale, while simultaneously identifying and removing system-wide constraints that impede health care delivery. The process starts with the selection of key intervention packages organised through service delivery mode, an analysis of the current implementation rates and the identification of bottlenecks. The subsequent analysis of underlying causes, potential strategies to address them and the review of opportunities allows the definition of "frontiers" which are realistic for effective coverage levels of achievable intervention packages[61].*

The second is the Medium Term Sector Strategies (MTSS) envisaged under the Fiscal Responsibility Act as a compliment to the Medium Term Expenditure Framework (MTEF). The MTSS is prepared by a sector strategy team and selects priority projects and programmes that will facilitate the achievement of high level national policies and goals at the least cost, fitting into the available resource envelope[62]. The National Health Act, on the other hand requires the preparation of strategic medium term health and human resources plans annually for the exercise of the Ministry's powers and the performance of its duties under the Act.[63] The Ministry is to ensure that the national health plan forms the basis for budget preparation and other government planning exercise as may be required by law[64].

Enter the Zero Base Budgeting (ZBB) concept of the Muhammadu Buhari administration. It provides the opportunity to interrogate, reconsider and reconcile MNCH investment options to determine the best way to spend available resources and to re-engineer the budget to deliver greater value for money. Budget lines are queried and approved in consideration of their comparative benefits and costs. New and old budget ideas compete for resources. Instead of justifying increments to the existing baseline, the entire budget needs to be justified. However, although the ZBB is the official policy of the present administration, it has no legal foundations.

The Fiscal Responsibility Act and the National Health Act are all extant law and the ZBB is extant policy. So, which one should the FMoH use? Was the MBB ever used for

[60] MBB was developed by UNICEF, World Bank and WHO.
[61] At page 59 of the IMNCH Strategy Document, Federal Ministry of Health 2007.
[62] The Sector Strategy Team includes representatives of the Ministry, the legislative committee exercising oversight over the sector, organised labour and private sector, relevant academia, non-governmental organisations, etc.
[63] See section 2 (2) of the Act.
[64] Supra.

MNCH or general health budgeting? It is even doubtful whether the ZBB approach fits health and MNCH budgeting considering that[65]:

> *Multi-year budgets are also important, because progressive realisation by its very nature requires several years, and it is necessary to know the funds that will be necessary in future years to implement well-conceived plans.*

Policy clarity in the budgeting arena is required for sustainable improvements in MNCH and the MTSS/MTEF approach is highly recommended.

5.10 CONTRIBUTION OF DEVELOPMENT PARTNERS

Beyond public funding, agencies such as WHO, GAVI, USAID, UNICEF, BMGF, Rotary International, World Bank, JICA and Dangote Foundation have contributed resources towards improving MNCH. Others include German Government, CDC, JICA, Global Fund, CHAI, DFID, UNFPA, DFATD, UNAIDS. The details provided below are not exhaustive but examples of the contributions of development partners.

UNICEF has worked in prevention of mother-child HIV transmission, excluding ARVs for mothers; maternal health/safe motherhood, polio eradication, etc and since 2010 has invested not less than $12.177m in Nigeria's MNCH programmes[66]. USAID is involved in as plethora of programmes that address HIV/AIDS, tuberculosis, maternal and child health, family planning, reproductive health, and malaria.

The Global Fund has committed more than US$1.4 bn in Nigeria since 2003. The Saving One Million Lives Programme is a $500m project supported by the World Bank to run for period of four years between 2015 and 2019. It focuses on child health, health system performance, nutrition and food security, population and reproductive health; and malaria. However, it is a long term concessional loan to be repaid by Nigeria. The Dangote Foundation supports immunisation and the Primary Health Care under One Roof Initiative. In Jan 2015, Rotary International announced an $8.1mn grant to Nigeria to help in the country's push to eradicate Polio[67]. The Funds will be used by WHO and UNICEF to support Polio Immunisation campaigns, research and surveillance in the country.

The United Nations Population Fund (UNFPA) supports projects mainly in the area of reproductive healthcare and have assisted with not less than $13.907m since the year 2010[68]. CDC has worked with health facilities staff and nine local partners to establish 3,367 sites offering PMTCT services across Nigeria. Between October 1, 2012 and September 30, 2013, CDC-Nigeria and its partners provided HIV testing and counselling

[65] The Article 2 Project by Ann Blyberg and Helena Hofbauer: Progressive Realisation - Budget Increases and Meeting the Obligations of Progressive Realisation.
[66] http://www.openaiddata.org/purpose/261/130/963/; see also http://www.unicef.org/publications/files/UNICEF_Annual_Report_2014_Web_07June15.pdf
[67] http://healthnewsng.com/rotary-international-releases-funds-help-end-polio-nigeria/
[68] Source: http://www.openaiddata.org/purpose/261/130/974/

to over 1.2 million pregnant women and antiretroviral therapy (ART) to 31,732 HIV-positive pregnant women to prevent mother-to-child transmission of HIV (over the one year period)[69].

JICA is supporting FGN with a loan of N18.6bn worth of vaccines to be procured through UNICEF[70]. The loan is to be guaranteed by Bill and Melinda Gates Foundation and would be paid in 20 years, with a grace period of 7 years. This was under President Goodluck Administration. In May 2014, JICA signed an ODA Loan Agreement with the FGN to provide up to 8.285bn Japanese Yen for the Polio Eradication Project[71]. The Loan Funds will be allocated for the procurement of 476 million polio vaccine doses. The timeframe for the completion of the project is December 2015. In September 2014, the Japanese Government, together with JICA and Bill and Melinda Gates Foundation, signed a JICA loan conversion for Nigeria to the tune of US$ 70.28mn[72]. This was for polio eradication.

In 2010, the German Government during Rotary's Polio Eradication Summit in Abuja announced a $20mn funding for Polio Eradication[73]. This is a contribution to the UN Millennium Development Goals (Goal 5) in Nigeria. The German Government released the sum of $15.6mn to UNICEF and WHO for Polio Eradication in Nigeria as part of her 2013-2017 €105mn commitment[74]. In 2013, the German Government gave an ODA grant to the sum of US$ 301, 037 to Nigeria towards reducing maternal and newborn mortality[75] .

The Canadian Government in keeping with her C$250mn commitment made at the 2013 Vaccine Summit, disbursed approximately US$39mn for a group of countries namely – Afghanistan; DR Congo; Nigeria, and Pakistan for the support of the Global Polio Eradication Initiative (GPEI) Endgame Strategic Plan[76]. This Fund was received in 12 December, 2013. Korean Foundation for International Healthcare (KOFIH), a specialized organisation under the South Korean Ministry of Health and Welfare, in her polio eradication efforts in Nigeria, made US$ 1mn available to WHO towards Acute Flaccid Paralysis (AFP) surveillance in Nigeria[77]. This was in 2014 and the grant was made possible by the Community Chest of Korea.

5.11 DEVELOPMENT AID RESOURCES FOR MNCH WERE MISMANAGED

Global Fund grants to the Federal Republic of Nigeria were audited and the audit report in 2016 indicates the following key findings:

[69] http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/countries/nigeria/default.html
[70] http://www.nphcda.gov.ng/index.php/78-featured/73-article-b
[71] http://www.jica.go.jp/english/news/press/2014/140527_01.html
[72] http://www.polioeradication.org/Portals/0/Document/AnnualReport/2014/GPEI_AR2014_EN.pdf Pg. 28
[73] http://www.maternal-health.org/documents/rotary_scales_up_efforts_to_support_mate_166.pdf
[74] http://www.polioeradication.org/Portals/0/Document/AnnualReport/2014/GPEI_AR2014_EN.pdf pg. 27
[75] http://www.openaiddata.org/purpose/261/130/5/
[76] http://www.polioeradication.org/Portals/0/Document/AnnualReport/2014/GPEI_AR2014_EN.pdf Pg. 27
[77] http://www.polioeradication.org/Portals/0/Document/AnnualReport/2014/GPEI_AR2014_EN.pdf pg. 28

- *Inadequate controls over procurement processes resulted in US$4.2 million of variances between Pooled Procurement Mechanism orders and deliveries to the central medical stores. In addition, NACA made payments of US$20 million to suppliers without confirmation of delivery.*

- *Inadequate financial management controls and a lack of financial discipline at the implementer level have resulted in US$7.65 million of unsupported expenditures, including irregular human resource payments and un-reconciled project advances. Monitoring of sub-recipient expenditures is also insufficient.*

- *Processes and controls around data collection and reporting are ineffective leading to inaccurate reporting and poorly informed decision-making. Monitoring and evaluation of program activities is insufficient and not documented.*

- *Although health care delivery has been fully devolved to the state level governments, Global Fund-supported programs are implemented at the national level through federal and parastatal entities. This affects the accountability, oversight and impact of the programs in the long term.*

- *However, despite significant investments in Nigeria, the Global Fund has faced a number of challenges, including grants not achieving impact targets, poor quality of health services, treatment disruptions and fraud, corruption and misuse of funds.*

- *Despite the efforts made by the Secretariat and over US$800 million disbursed to the country in the past four years, major deficiencies in the internal control environment persist in the portfolio. In addition, substantial reforms are required to the Global Fund's risk management framework and the current grant implementation arrangements in Nigeria in order to achieve the Global Fund strategic objectives*.

Nigeria and the Global Fund have agreed to management decisions to remedy the observed infractions. But this shows that available resources have not been deployed efficiently, there have been leakages in the system and as such, the use of the maximum available resources for the realisation of MNCH may not have taken place.

5.12 POLIO DELISTING

On July 24, 2015 Nigeria marked one year with no reported polio cases and on September 26th of the same year, the World Health Organization's (WHO) removed Nigeria from the list of polio endemic countries and presented a certificate of recognition to the Nigerian President. The certificate comes with a proviso that if the current efforts were sustained till 2017, Nigeria will be completely de-listed from among polio infected countries of the world. Hitherto, Nigeria was in the league of Pakistan and Afghanistan as polio endemic countries before this development. Polio causes lifelong paralysis and its eradication was only possible through the combined efforts of the government, development partners and communities[78].

[78] http://www.who.int/mediacentre/news/releases/2015/nigeria-polio/en/

5.13 INCLUSIVENESS OF YOUTH AND DISABILITY IN IMPLEMENTATION OF MNCH POLICIES

From the standards developed by NPHCDA, it is discernible that there are plans to include youths and people living with disabilities (PLWDs) in MNCH policy and programme implementation. In one of its standards,[79] the mechanisms to involve young people were listed to include:

(a) *Establishment of Youth Advisory Group to input into service design and programme related issues;*
(b) *Training and engagement of youths as community-based Adolescent and Youth Friendly Health Services (AYFHS) promoters and peer educators; and*
(c) *Engagement of young people as volunteers in the health facilities.*

Similarly, another standard[80] suggests NPHCDA recognises and integrates disabled and handicapped persons such as the blind, deaf, mentally retarded, learning disabled; crippled, mentally disordered; speech impaired, epileptics and chronically diseased (sickle cell, AIDS, cancer, diabetes, heart condition) as part of the society that need be served under MNCH. What this means technically is that if any MNCH service user is facing any of the challenges above, it would still access MNCH services as necessary.

This inclusion is seen in practice through the non-discriminatory approach of the MNCH Week conducted biannually by the NPHCDA where children aged 0-59months and women of child bearing age (15-49years) are targeted irrespective of their status. Secondly, youths and PLWDs are represented in the structures[81] set up to facilitate MNCH services in community health facilities which potentially encourage their peers to access services. Thirdly, the NPHCDA collaborates with the Planned Parenthood Federation of America to implement some youth friendly services. So, it can be argued that youth and disability issues are well captured in MNCH programming and policy.

However, given that monetary cost of accessing MNCH services can be a barrier to some, the NPHDA seems to only subsidise costs through the decisions of the Ward Development Committees (WDCs). They do a case-by-case consideration of youths and PLWDs to determine who qualifies for subsidy. Since it appears that there is no guideline regulating this decision making process, it may in our view, be abused. To forestall this, it may be helpful and more effective and efficient for NPHCDA to work with its partners to develop criteria for benefiting from the subsidy.

The research could not find information on percentages of youths and PLWDs that have benefitted from MNCH services in any or all of the years covered by this work. To the

[79] The National Guidelines for the Integration of Adolescent and Youth friendly services into Primary health Care Facilities, FMoH, 2013.
[80] Revised Policy Programme and Strategic Plan of Action
[81] Ward Development Committees (WDC)

extent that there is no data to support inferences, we fall back on the theoretical contents of NPHCDA standards. There is the need for NPHCDA to collect evidence through a functional data collecting and collating system that is made more effective beyond the existence and completion of Health Management Information System Forms[82] at the health facilities.

[82] Those accessing services are expected to fill a Form

CHAPTER SIX

The MNCH Funding Gap

6.1 CRITICAL ISSUES FOR CONSIDERATION IN MNCH (HEALTH) BUDGET FUNDING IN NIGERIA

Countries strive towards adequate budgeting and spending in the health sector to boost the life expectancy and standard of living with an attendant promotion in individual savings and private investment. With this in mind, countries may not peg health sector spending to any amount[83]. Though there was an alleged World Health Organization (WHO) recommendation that countries should spend 5 percent of their Gross Domestic Product (GDP) on health but in the opinion of Savedoff (2003)[84]:

> *"It is hard to say what a country should spend on maintaining and improving its health without knowing the challenges it faces".*

This opinion therefore suggests that adequate or appropriate amount of spending in a country like Nigeria, with a malnourished population, facing endemic malaria and other ailments, a high incidence of neoplasms and chronic conditions and an epidemic of HIV/AIDS is likely to be very different from one with limited infectious diseases. This further implies that how much a country should spend on health should be based on the country's epidemiological profile rather than a general ratio or approved recommendation whether by Abuja Declaration or prescription from the WHO. In the line of Savedoff's argument:

> *"How much should Nigeria spend on health should be driven by her current epidemiological profile relative to the desired level of health status, considering the effectiveness of health inputs that would be purchased at existing prices, and taking account of the relative value and cost of other demands of social resources."*

It is very clear that at this point, the question of how much Nigeria should spend on health may not be given by any World Body but requires specification of a number of factors that will yield differing estimates. But this is not to state that international standards are irrelevant to the point of making informed analysis. Existing epidemiological conditions, social aspirations, the technical and allocative efficiency of health inputs, existing prices, and alternative social uses of funds all play critical roles in determining the right amount of money Nigeria should budget and spend in the health sector. It is also imperative to understand the concept of health spending because there are lots of expenditure different countries regard as health spending. According to Savedoff, the question of health spending may be asked in absolute terms (for example,

[83] This section (6.1) is taken from *Good and Fit Practices in Health Budget Development, Monitoring and Tracking* by Uzochukwu Amakom Ph.D.; being a paper presented at a MNCH retreat organised in Abuja by Centre for Social Justice in February, 2016.

[84] Savedoff, W. 2003. *How Much Should Countries Spend on Health?* Geneva, World Health Organization (WHO).

amount of money per person) or relative to income (for example, share of GDP). Efforts to answer the question in absolute terms are usually concerned with how much it costs to provide a particular set of services, whereas efforts to answer it in relative terms are more concerned with how much a country can afford. Therefore, focusing the question on absolute amounts is grounded in decisions about the kinds of amount of healthcare services which is contrasted by the share of income that bears little relation to the kinds of services needed or desired.

Savedoff shaded some light on different models that can be adopted in arriving at what a country should be spending in the health sector. These approaches are categorised under five headings viz: Peer Approach, Total Health Spending and National Income Approach, Political Economy Approach, Production Function Approach as well as the Budget Approach.

(i) Peer Approach

One approach is to ask whether a country is spending more or less than countries with similar characteristics, such as income levels, culture or epidemiological profiles. This approach accepts that the underlying relationship between health spending and health outcome is difficult to specify and aims instead at observing and learning from comparable experiences. It is conceptually most similar to the process of "benchmarking", in which firms or administrative units set targets relative to what other similar entities are achieving. This approach can be quite satisfying for policy debate purposes because it easily generates a single target amount. This is the approach implied when British politicians claim that their country is spending too little on health (6.9 percent of GDP) by comparison with their peers in the European Union (for example, public health spending in France is 7.7 percent of GDP; in Sweden it is 8.0 percent).

(ii) Total Health Spending and National Income Approach

The main problem with this approach is that it tends to focus almost exclusively on inputs and expenditures and fails to consider the main goal, which is presumably, better health. To address this concern, a benchmarking exercise might focus on similar countries that have achieved among the best health outcomes. Unfortunately, this will generate widely varying estimates depending on which countries are chosen. For example, a country with per capita income of US$ 5,000 - US$6,000 could choose to compare itself to countries with similar income levels, such as Peru or the Philippines. The two countries have similar child mortality rates (29 per 1,000 for Peru and 34 per 1,000 for the Philippines). Yet public-sector health spending is 2.1 percent of GDP in Peru and only 1.3 percent in the Philippines. In countries with good health outcomes, the range of health spending is extremely wide and rarely gives a clear answer regarding an optimal amount. For example, countries with child mortality rates below 30 per 1,000 have public-sector health spending ranging from 1.4 percent to 8.7 percent of GDP and from US$7 per capita to US$4,200 per capita.

(iii) Political Economy Approach

A third approach alters the question slightly. Instead of asking "What should a country spend on health care"? It asks: "Why is my country spending more (or less) on health than it should?" The implicit assumption by those advocating a change in health spending is that they believe that the current allocation of national income or public budgets to health is too low, presumably as a result of a variety of political and economic forces that beset budgets and public policy. In a country where health spending is artificially high or low because of the actions of a particular lobby groups (such as military contractors, teachers' unions, medical associations, and pharmaceutical companies), this approach tries to determine the magnitude of the alleged distortion.

(iv) Production Function Approach

A fourth way to address the question is to explicitly estimate a health production function through cross-national or panel data analyses. This approach uses aggregate data to estimate the impact of health spending, socioeconomic characteristics, demographics, and other factors on a population's health condition. The resulting equation can incorporate three of the issues raised earlier: the current epidemiological profile, prices of inputs, and the effectiveness with which inputs can be transformed into improved health status. Once a particular level or change in health status is specified, the equation can be used to predict the change in health spending that would be necessary to reach that goal.

(v) Budget Approach

The most complete approach to incorporate the five issues presented above is to identify the desired health status changes and determine what needs to be purchased-whether health services or health service inputs-to achieve those goals. Next, these items need to be costed and summed, generating an estimate of the funds necessary to buy that level of service. This approach is common at the level of specific programmes and is regularly carried out by most governments during their budget processes. The World Bank and the Commission on Macroeconomics and Health both published studies in which they designed packages of health care services and then estimated how much it would cost to make that package available to a given population. A similar exercise, undertaken with much greater precision in Ethiopia, estimated that addressing bottlenecks in the delivery package of cost-effective health interventions would cost an additional US$1 per capita, representing a little less than 1 percent of GDP, and would reduce child mortality rates and the lifetime risk of mothers dying by 30 percent.

6.2 POPULATION AND ECONOMIC GROWTH

The 2006 national census population figure of Nigeria shows that the female gender makes up about 49.2 percent of the country's total population of 140.43 million persons. This figure amounts to 69.09 million persons. Of the 69.09 million female population in Nigeria, about 50.6 percent were within their reproductive age – 15 to 49 years of age. This proportion amounts to 34.96 million women of reproductive age in Nigeria. In addition, the national census population figure put the total population of under-five

children at 22.59 million. This figure makes up about 16.09 percent of the country's total population. Therefore, adding the population figure of women of reproductive age to the population figure of under-five children, we have a total population of 57.56 million persons that should stand to benefit from maternal, newborn and child healthcare services in Nigeria as at 2006. The 57.56 million persons represent 40.99 percent of Nigeria's total population as at 2006[85].

Taking the above to mean that 40.99 percent of Nigerian population are either women of reproductive age or under-five children, we can calculate the current population of Nigerians that should benefit from maternal, new born and child healthcare service in Nigeria. According to the World Bank (2015), Nigeria's total population is estimated to be 177.48 million in 2014. Going by 40.99 percent figure obtained above, we can estimate the total population of women who are within their reproductive age and under-five children to be 72.75 million.

Maternal, new born and child healthcare is only an aspect of the overall healthcare services. This aspect of healthcare services seems to depend, to a great extent, on foreign funds. This is because the vaccines used for free immunisation and free prenatal care have always been subsidised by donor agencies (e.g. Global Alliance for Vaccines and Immunisation – GAVI). This means that the sustainability or otherwise of the immunisation and vaccination programmes depends largely on external funds. However, it has been stated above that such external funds are released to countries that are considered as low income country.

Growth is expected of any economy. As a result, Nigeria has moved from being classified among the low income countries to one of the lower middle income countries[86]. This upward movement in the ladder of country classification is a commendable one for Nigeria, especially at a time when many countries in the world experienced some negative growth in their various economies. However, the upward movement comes with its costs. One of such costs includes withdrawal from the list of countries that should receive free or subsidised vaccines in taking care of maternal, new born and child healthcare from donor agencies.

Several donor agencies have designed a strategy for total exit from funding Nigeria's health sector. As Tyessi and Okeke observe[87], GAVI has planned to withdraw 20 percent

[85] National Bureau of Statistics – NBS (2012). *Annual Abstract of Statistics*. Abuja: NBS Publications.

[86] United Nations (2015a) *World Economic Situation and Prospects*. New York: United Nations Publication. Accessed on 27/04/2016 14:37 from: http://www.un.org/en/development/desa/policy/wesp/wesp_archive/2015wesp_full_en.pdf. See also Federal Government of Nigeria – FGN (2015) "Nigeria's Intended Nationally Determined Contribution". A Required Submission for the Conference of Parties to the United Nations Framework Convention on Climate Change (COP-UNFCCC) in Preparation for the Adoption of Climate Change Agreement at the Paris Conference on Climate Change, held in December, 2015.

[87] Tyessi, K. and Okeke, V. (2015) *"Crisis Looms in Nigeria's Health Sector as Donor Partners Withdraw Funds";* in Leadership Newspaper, 24 November, 2015. Accessed on 27/04/2016 14:59 from: http://leadership.ng/news/477665/crisis-looms-nigerias-health-sector-donor-partners-withdraw-funds

of its contributions to healthcare financing in Nigeria annually from 2016 to 2020. This means that in the 2016 fiscal year, Nigerian governments will pay 20 percent of the values of all the vaccines that were previously fully funded by GAVI. The proportion of contribution of Nigerian governments will increase to 40 percent, 60 percent, 80 percent and 100 percent in 2017, 2018, 2019 and 2020 fiscal years. This implies a gradual withdrawal of funding of Nigeria's healthcare services by GAVI. However, Nigeria is about to slip into economic recession with negative growth figures. It has lost its bragging right as the largest economy in Africa to South Africa and the per capita income has plummeted. It may therefore be imperative for donors to reconsider the exit which as at now, seems premature.

The implication of the above withdrawal strategy is that Nigerian governments will begin to pay for all the vaccines used for immunisation, prenatal care, HIV treatment, and others. It therefore implies that there is need for subsequent budgets of the FGN to reflect an increase in the healthcare financing burden of the government. This should also be the case with the sub-national governments that make up the federating units of Federal Republic of Nigeria. Donors merely assisted the government and people of Nigeria and it is the country's duty to take care of its health needs using the maximum of available resources.

Given that there is a "looming danger" in Nigeria's health sector as a result of withdrawal of donor partners' funds[88], it is important to understand the current status of maternal, new born and child healthcare financing in Nigeria. There is also the need to understand the funding gaps that exist in the current maternal, new born and child healthcare financing system in Nigeria (if any).

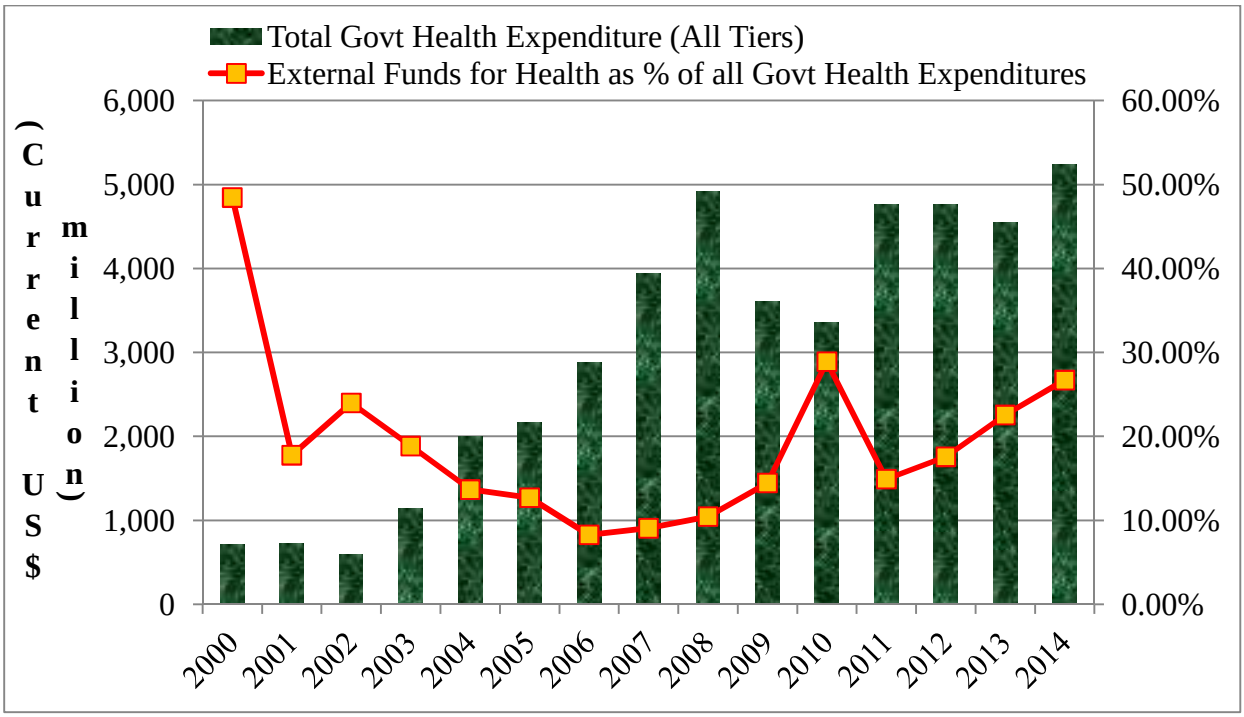
6.3 SOURCES OF FUNDS FOR NIGERIA'S HEALTH SECTOR FINANCING

Health care financing is an item on the concurrent legislative list of Nigeria. This implies that the three tiers of government in the country are free to invest in the sector. As a result, every tier of government tries to finance health depending on its stake and interest in the sector. In some cases, some states have a peculiar epidemic. Such an epidemic will entail that the affected states in collaboration with the federal government will fund health services focused on that particular epidemic.

Generally, health in Nigeria is funded through governmental appropriations, the National Health Insurance Scheme which is yet to reach a critical mass of Nigerians, private health insurance services and out of pocket expenses of individuals and households. Based on the explanation above, it is important to aggregate all the healthcare expenditures incurred by the three tiers of government in Nigeria and also look at the sources of those funds. Figure 5 below shows the value of health expenditures of the three tiers of governments in Nigeria and the sources of the funds.

[88] Tyessi and Okeke, 2015, supra.

Figure 5: Health Expenditures of the Three Tiers of Governments in Nigeria (Values and Sources of the funds)



Source: *WHO, Global Health Statistics (2015)*

From Figure 5 above, it is clear that large sums of money moved into Nigeria's health sector from the three tiers of governments in Nigeria. This is clear in the fact that between 2011 and 2014, more than US$4.5 billion has been spent on the health sector by the three tiers of governments annually. As actual amounts, the 2014 figure recorded the highest of all the years in terms of value – more than US$5 billion was spent on the health sector in 2014.

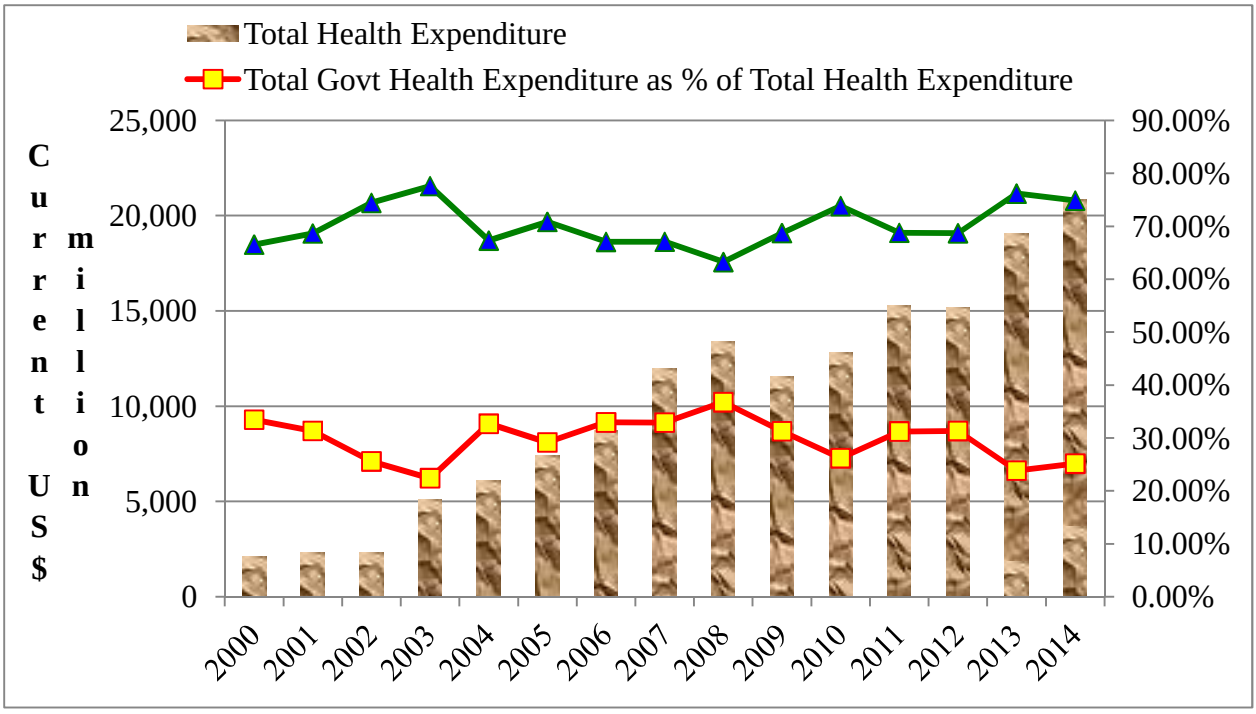
However, considering the fact that foreign donor agencies will be exiting Nigeria's health sector in a matter of few years from now due to the new economic status the country has earned, it is important to consider the role of foreign funds in total government's health expenditures. Figure 5 above shows the large foreign component in Nigeria's health care financing. After several oscillations, the share of foreign funds in total government health expenditures in Nigeria stood at about 26.71 percent in 2014. The implication of this high level foreign intervention in healthcare financing, especially in a situation when the intervention may cease without proper preparedness of the governments that have always been assisted, may be dire.

Comparing the share of foreign sources of healthcare financing in total government healthcare expenditures with the share of FGN primary healthcare budgetary allocation in FGN total health sector budgetary allocation, we observe that there is a wide margin. Health sector external funding in 2010 recorded about 29 percent of total expenditures of the three tiers of government on health. This exceeds the meagre 10.11 percent proportion of FGN primary healthcare expenditures in FGN total health sector

expenditures in the same 2010. In the same way, external funds for health sector amounted to about 15 percent of total govt health expenditures in 2011, compared to the share of FG primary health expenditures in FG health sector expenditures that amounted to only about 6.78 percent in the same year. This is not different from the share of external funds for health sector which amounted to about 18percent of total government health expenditures in 2012 compared to 8.40percent of PHC allocation as a percentage of total FGN health expenditure. 2013 and 2014 recorded external health funding of 22 percent and 26.71 percent as against 7.10percent and 7.35percent of FGN allocation to PHC in total FGN health expenditure.

Going back a little, the three tiers of governments in Nigeria estimated a cumulative budget of about ₦218.87bn for MNCH in 2009. Against the estimated amount, OSSAP-MDGs (2009) observed that about ₦743bn was needed to optimally fund MNCH in the same year. Comparing the amount estimated by the three tiers of governments in Nigeria with the amount needed for optimal funding, it is clear that the two leave a funding gap of ₦524bn in 2009 alone. Going by the observed decline in the value and share of health sector financing (especially by FGN), with its attendant effect on MNCH financing in the recent past, it is safe to assume that the funding gap of ₦524bn in 2009 alone has continued to widen in recent years. However, even if we assume that the funding gap has remained constant since 2009 and has remained annually at that point, we can categorically infer that the current funding gap in Nigeria's MNCH has risen to about ₦3,144 bn as at December 2015. Reviewing the shares of government and private health expenditures in Nigeria may provide a clue as to filling the funding gap.

Figure 6: Shares of Government and Private Health Expenditures in Nigeria's Total Health Expenditures



Source: *WHO, Global Health Statistics (2015)*

Given that there is a widening funding gap of at least about ₦3,144bn as at December 2015, it is important to find out how the gaps are being filled and efforts that can be made to fill the funding gap. Figure 6 above is a graphic presentation of the various sources of funds in filling the funding gap. From the figure, total expenditures on health have continued to rise over the years from below US$2.5bn in 2000 fiscal year to above US$20.8bn in 2014. This amount represents all the money spent on anything that has to do with the health sector including health infrastructures and health sector consumables.

The Figure shows that the proportion of total health expenditures funded by the three tiers of governments in Nigeria has remained almost stable at between 23 percent and 37 percent of total health expenditures between 2000 and 2014. This leaves the balance of whatever needs to be spent in the hands of the households. The proportion of total health expenditures funded by individuals/private sector consumers of health services in Nigeria has also remained almost stable and very high at between 63percent and 77percent of total health expenditures between 2005 and 2015.

Recall that in Figure 5 above, it was shown how foreign development partners fund between 18 percent and 28 percent of total government health expenditures in Nigeria. With that volume of foreign funds from donor agencies, the three tiers of governments in Nigeria spend only about 22 percent – 30 percent of total health expenditures in Nigeria. With the planned exit of these foreign development partners, it is easy to forecast that there will be a reduction of about 19.22 percent from total government funding of MNCH and child healthcare in Nigeria. The forecast is based on the fact that as shown in figure 6 above, foreign partners' funds averaged 19.22 percent of all government health expenditures between 2000 and 2014 in Nigeria. The effect of the reduction in government funding of MNCH is especially the case as most of the vaccines used for pregnant women and children come into the country with huge subsidies. Given that as at 2014, total health financing burdens borne by individuals/households in Nigeria stood at 74.85 percent, it is clear that should the trend be sustained, households and private individuals in Nigeria will bear up to 81.5 percent of all the health expenditures in Nigeria by 2019 and beyond.

6.4 KEY FIGURES OF INTEREST

Immunisation is a core component of MNCH and contributes in no small measure to improved MNCH outcomes. According to the Executive Director, National Primary Health Care Development Agency, Dr Ado Mohammed, the full immunisation of a child currently costs N4000 but the introduction of four new vaccines could push the cost up to N14,000 per head. At the current cost, this amounts to a funding need of $274m annually but the new vaccines will push the immunisation cost to $435m annually[89]. For the years 2017

[89] http://healthreporters.info/2016/04/24/immunization-trust-fund-as-panacea-for-sustainable-immunization-financing-in-nigerian/; 21st Anglophone Africa Peer Review Workshop on Sustainable Immunisation.

and 2018, the estimated funding gap considering the withdrawal of donors is $181million for routine immunisation vaccines procurement[90].

Ideas have been floated around an Immunisation Trust Fund but the finer details have not been worked out and it is not yet a bill before the legislature to give it legal backing. The NPHCDA has set up the National Immunisation Finance Task Team which envisions a Nigeria where immunisation financing is prioritised by government and backed with a strong legal framework to guarantee sustainability of finance without reliance on donors. Another angle to proper funding of health care including MNCH, beyond budgetary allocations is compulsory and universal health insurance for all Nigerian citizens. This will pool funds across the federation and population to fund health care over the medium to the long term.

Tables 10 (A) and 10 (B) presents the funding gap and the underlying assumptions over the Study period.

[90] Supra.

Table 10 (A): Estimated Total Funding Gap for MNCH in Nigeria, 2010 – 2013 Fiscal Years

		2010	2011	2012	2013
a	Unit Cost of MNCH Services Per Person (US$)	30.45	38.80	38.80	38.80
b	Total Population of Nigeria	159,424,742	163,770,669	168,240,403	172,816,517
c	Population of Under-5 Children	27,759,100	28,411,000	29,118,000	29,816,000
d	Population of Women within Reproductive Age (15-49 Years)	36,106,300	37,199,000	38,163,000	39,173,000
e	Population of those in need of MNCH Services	63,865,400	65,610,000	67,281,000	68,989,000
f	Cost of Full MNCH Service Coverage in Nigeria (US$)	1,944,701,430	2,545,668,000	2,610,502,800	2,676,773,200
g	Prevailing Exchange Rate	150.30	153.86	157.50	157.31
h	Cost of Full MNCH Service Coverage in Nigeria (NGN)	292,288,624,929.00	391,676,478,480.00	411,154,191,000.00	421,083,192,092.00
i	Amount Provided by Donor Agencies for Health Services in Nigeria (US$)	969,000,000.00	711,000,000.00	837,000,000.00	1,025,000,000.00
j	Proportion of Donors' Health Sector Funds meant for MNCH Services in Nigeria (%)	30.00%	30.00%	30.00%	30.00%
k	Amount Provided by Donor Agencies for MNCH Services in Nigeria (US$)	290,700,000.00	213,300,000.00	251,100,000.00	307,500,000.00
l	Amount Provided by Donor Agencies for MNCH Services in Nigeria (NGN)	43,692,210,000.00	32,818,338,000.00	39,548,250,000.00	48,372,825,000.00
m	Amount Provided by FGN for MNCH Services in Nigeria (NGN)	36,254,079,824.00	20,876,383,819.00	44,602,392,158.00	31,458,261,265.00
n	Total Amount Provided by the Government and Donor Agencies for MNCH Services in Nigeria (NGN)	79,946,289,824.00	53, 694,721,819.00	84,150,642,158.00	79,831,086,265.00
o	Funding Gaps (NGN)	-212,342,335,105.00	-337,981,756,661.00	-327,003,548,842.00	-341,252,105,827.00
p	Funding Gaps (US$)	-1,412,789,987.39	-2,196,683,716.76	-2,076,213,008.52	-2,169,296,966.67

Table 10 (B): Estimated Total Funding Gap for MNCH in Nigeria, 2014 – 2015 Fiscal Years

		2014	2015	Total for the Period (2010 – 2015)
a	Unit Cost of MNCH Services Per Person (US$)	38.80	38.80	
b	Total Population of Nigeria	177,475,986	182,201,962	
c	Population of Under-5 Children	30,483,000	31,109,000	
d	Population of Women within Reproductive Age (15-49 Years)	40,238,000	41,363,000	
e	Population of those in need of MNCH Services	70,721,000	72,472,000	
f	Cost of Full MNCH Service Coverage in Nigeria (US$)	2,743,974,800	2,811,913,600	15,333,533,830.00
g	Prevailing Exchange Rate	158.55	197.00	197.00
h	Cost of Full MNCH Service Coverage in Nigeria (NGN)	435,057,204,540.00	553,946,979,200.00	2,505,206,670,241.00
i	Amount Provided by Donor Agencies for Health Services in Nigeria (US$)	1,401,000,000.00	1,558,000,000.00	6,501,000,000.00
j	Proportion of Donors' Health Sector Funds meant for MNCH Services in Nigeria (%)	30.00%	30.00%	
k	Amount Provided by Donor Agencies for MNCH Services in Nigeria (US$)	420,300,000.00	467,400,000.00	
l	Amount Provided by Donor Agencies for MNCH Services in Nigeria (NGN)	66,638,565,000.00	92,077,800,000.00	323,147,988,000.00
m	Amount Provided by FGN for MNCH Services in Nigeria (NGN)	29,833,943,158.00	31,895,743,281.00	194,920,803,505.00
n	Total Amount Provided by the Government and Donor Agencies for MNCH Services in Nigeria (NGN)	96,472,508,158.00	123,973,543,281.00	518,068,791,505.00
o	Funding Gaps (NGN)	-338,584,696,382.00	-429,973,435,919.00	-1,987,137,878,736.00
p	Funding Gaps (US $)	-2,135,507,388.09	-2,182,606,273.70	-10,086,994,308.30

a) Unit Cost of MNCH Services Per Person (US$): The Organisation for Economic Cooperation and Development (OECD) shows that the unit cost of full course of vaccines in Africa rose from US$1.37 in 2001 to US$2.23 in 2004 (with the addition of Hepatitis B Vaccines). The cost later rose to US$11.23 in 2006 (with the addition of Hib vaccines) and remained at that level until 2009 before rapidly moving up to US$30.45 in 2010 (with the addition of PVC). However, as at 2011, the cost of a full course of vaccines (routine immunisation schedule as recommended by WHO) increased further to US$38.80 as a result of the addition of Rotavirus and Rubella vaccines. Further increases should have occurred in the cost of immunisation and other MNCH vaccinations, but such increases have not yet been captured in statistical reports. We therefore base this funding gap analysis on the 2010 and 2011 costs of MNCH vaccines.

This implies that contrary to the expectation of continued rise in the costs of vaccines, this study assumes constant costs of vaccines between 2011 and 2015.

b) **Total Population of Nigeria:** The World Development Indicator of the World Bank publishes the population figures of all UN member countries on annual basis. The population figures stated in the Table are generated from this source. The reason for relying on this source is that the latest version of the Annual Abstract of Statistics of the National Bureau of Statistics (NBS) only has the projected population figures of Nigeria up to 2011. Therefore, we cannot rely on a source that ended in 2011 for a period of 2010 – 2015.

c) **Population of under-5 Children:** Since the total population figures presented in the Table are from external source, it is equally important to take the population of under-5 children from external source. The World Health Organisation publishes the population of under-5 children in Nigeria on their country health profiles. It is from this source that the figures on the population of under-5 children were generated.

d) **Population of Women within Reproductive Age (15-49 Years):** Just like the population of under-5 children, the World Health Organisation also publishes the population of women within reproductive age (15-49 years) in Nigeria on their country health profiles. It is from this source that we generated the figures on the population of women within reproductive age (15-49 years).

e) **Population of those in Need of MNCH Services:** Having generated the population of under-5 children and that of women within reproductive age (15-49 years) in Nigeria from the country health profiles of the World Health Organisation, we sum up the two to get the total population of those that need MNCH services.

f) **Cost of Full MNCH Services Coverage in Nigeria (US$):** Having established from OECD records that the sum of US$38.80 is needed to meet the full vaccination needs of a child in Nigeria, we merely multiply this amount by the total number of those in need of MNCH services in Nigeria. Therefore the figures stated in this row represent ***row a*** X ***row e***.

g) **Prevailing Exchange Rate (US$:NGN):** The Central Bank of Nigeria publishes the monthly and annual exchange rates of Naira to a US Dollar. This usually serves as the prevailing exchange rate for any transaction. Therefore, we generated the data on exchange rate from the Statistical Bulletins of the Central Bank of Nigeria.

h) **Cost of Full MNCH Services Coverage in Nigeria (NGN):** Having generated the dollar value of the cost of full coverage of MNCH services in Nigeria, all that is needed at this point is to change the figure to Naira using the prevailing exchange rate. Therefore, we generated the data here by multiplying ***row f*** by ***row g***.

i) **Amount Provided by Donor Agencies for Health Services in Nigeria (US$):** The World Health Organisation publishes the total donor funds that moved into any country's health sector on their country health profiles. It is from this source we generated the data on health sector donor funds to Nigeria.

j) **Proportion of Donors' Health Sector Funds meant for MNCH Services (%):** To be able to separate the funds that moved into MNCH services from the donor funds that moved to the entire health sector, we looked at available records. In one of the records, the World Health Organisation stated that out of the donor funds that moved to Sub-Saharan Africa, 70% of the funds were meant for MDG6, while

the rest were for MDG4 and MDG5. MDGs 4 and 5 are focused on MNCH, therefore the remaining 30% stated by WHO were meant for MNCH. In a similar way, Innovation for Peace and Development (IPD, 2014) stated that 30% of all the health sector donor funds by DFID were released in support of MNCH programmes. It is on the basis of these two sources that the proportion of donors' health sector funds meant for MNCH services was set at 30% throughout the study period.

k) **Amount Provided by Donor Agencies for MNCH Services in Nigeria (US$):** Having generated the proportion of donors' health sector funds that is meant for MNCH services, we use the proportion to generate the estimated dollar values of the funds. Therefore, we multiply ***row i*** by ***row j*** in order to generate the data on this row.

l) **Amount Provided by Donor Agencies for MNCH Services in Nigeria (NGN):** We merely generated the Naira equivalent of the amounts previously stated in dollars using the prevailing exchange rates. This means multiplying ***row k*** by ***row g***.

m) **Amount Provided by FGN for MNCH Services (NGN):** Annually, the Federal Government of Nigeria budgets for MNCH services and domiciles such at the National Primary Healthcare Development Agency (NPHDA). In addition, the conditional grant scheme targeted at achieving the Millennium Development Goals (MDGs) also had annual allocations through special intervention funds. The Federal Ministry of Women Affairs also allocated some financial resources towards MNCH services through its MDGs projects. The Federal Government further allocates some funds through the National Agency for the Control of AIDS (NACA). All the various allocations are summed up to get the amount provided by the FGN for MNCH services annually. Therefore, the figures presented in this row represent a sum of various allocations of various agencies engaged in MNCH services for the 2010 – 2015 fiscal years.

n) **Total Amount Provided by FGN and Donor Agencies for MNCH Services in Nigeria (NGN):** The summation of the amount budgeted by the FGN and the amount provided by donor agencies for MNCH yields this figure.

o) **Funding Gaps (NGN):** The differences between the total amount provided for MNCH services in row n above and the cost of full MNCH services coverage in Nigeria as shown in Row h yield the figure on this row. This means row h minus row n gives row o.

p) **Funding Gaps (US$):** This is generated by dividing row o by the prevailing exchange rate in Row g annually.

CHAPTER SEVEN
Conclusions and Recommendations

7.1 CONCLUSIONS

Nigeria is a signatory to a plethora of international standards which make provisions for MNCH including the Universal Declaration on Human Rights, International Covenant on Economic, Social and Cultural Rights, African Charter on Human and Peoples Rights, Millennium Development Goals- now SDGs. At the national level, the Constitution, NV20-2020, Transformation Agenda, National Health Policy, National Strategic Health Development Plan, Integrated MNCH Strategy and the National Health Act guaranteed the right to MNCH.

The foregoing standards have very beautiful provisions, which if implemented, will improve MNCH indicators and save lives. MNCH is seen as a minimum core content of the right to health and there is a state obligation to fulfil the right. Two of the national standards namely, the NSHDP and the IMNCH Strategy seemed to have been planned against the MDG terminal date of 2015 and therefore needs to be reworked and re-costed to bring them in line with the post 2015 period. The standards impose an obligation on government to use the maximum of available resources for the progressive realisation of MNCH rights. This *inter alia* involves economy, efficiency and effective use of available resources. It admits no retrogressive steps to roll back already entrenched components of rights.

The budget is among the instruments that can be used for the realisation of rights including MNCH. The NHA demands the setting aside of 1 percent of the Consolidated Revenue Fund of the federal government for the Basic Health Care Provision Fund which partly goes to PHC including MNCH. However, the FGN failed in two years (2015 and 2016) to provide for this fund in the federal budget. Also, the funds necessary to implement the MNCH provisions of Vision 20:2020, Transformation Agenda and National Strategic Health Development Plan were not provided in full.

The Infant Mortality Rate in Nigeria stands at 69 per 1000 live births representing a 48.3 percent decline in the rate over the period 1995 -2015. The absolute number of infant deaths stands at 484,368 deaths per year which is an 11.8 percent decline over the period 1995-2015. But this dissonance between the percentage of decline in IMR and the percentage of decline in absolute numbers can be explained by the crude birth rate. The Under 5 Mortality Rate stands at 108.8 in every 1000 live births and this is a decline of 47.6 percent over the 1995 figures. But the absolute numbers is 750,111 infant deaths as at 2015 which represents 18.5 percent decline from the 1995 figures. Again, this can be explained by the rising crude birth rate. The Maternal Mortality Rate stands at 814 maternal deaths for every 100,000 live births in 2015 representing a 34.9 percent decline between 1995 - 2015. However, the absolute number of maternal deaths stands at 58,000 in 2015 representing a 1.7 percent decline. Also, this can be explained by the

rising crude birth rate. The penetration of preventive measures against new born, infant and maternal mortality improved within the study period but the improvement is not commensurate with the resource profile of the country.

The MNCH budget is set within the overall health budget especially the component on PHC. Any Study of appropriations for MNCH must therefore take cognisance of the health and PHC budgets. For the Study period, 2010-2015, the health vote averaged 5.42percent of the overall budget contrary to the Abuja Declaration which demands 15percent of the overall budget. The utilisation rate of the approved capital budget averaged 45 percent over the Study period. These budgetary votes fell short of the demand of the NSHDP. The investment allocations for the period 2010-2015 also failed to meet the projections of the IMNCH Strategy. The special intervention of SURE-P in MNCH provided resources that were under-utilised. In 2012 and 2013, only 23.9 percent and 66.44 percent of the allocated sums were utilised. SURE-P's claimed interventions in human resources for health and service delivery; conditional cash transfer scheme; health facilities upgrade and drug and equipment supplies could not be independently verified for a conclusion on whether value for money had been applied in its operations. Requests made for clarification to the office attracted no replies. Also, governmental failure to allocate funds to the Basic Health Care Provision Fund cost the sector a total sum of N32.735bn between the years 2015 and 2016. Thus, plans and budgets did not complement each other.

In all the national policy documents that discussed and planned for MNCH - Vision 20 2020; Transformation Agenda; and National Strategic Health Development Plan; appropriations could not match the financial projections for the study period. Projections were more than actual appropriations; appropriations were more than releases; cash-backed sums were less than releases and actual expenditures was less than cash-backed sums. In all and in practice, actual expenditures were far less than projections. Bearing in mind that crafters of the projections have calculated what will be required to meet the targets, providing less means that the targets will never be met. The best practice in policy making and budgeting is that policy makers plan as realistically as possible without over-ambitious targets and projections; budget makers review the policy documents and ensure that programmatic activities are costed in line with the projections[91]; the funds are requested by MDAs and are released promptly to them; and the MDAs spend the monies as planned. But as seen in this Study, paucity of resources, the capacity to expend resources; political will to execute and deliver results are factors that create the gap between policy and practice in Nigeria.

MNCH budgeting faced a couple of other challenges including the following listed below. Some of the resources meant for MNCH were put under the infamous Service Wide Votes which are non-disaggregated sums, centrally managed away from the implementing MDAs. Some of the votes were lumped under nebulous headings such as "Special Intervention MDGs 1 and 2". Also, the contributions of development partners

[91] Usually forecasts but can be made more realistic at the time of planning and projecting.

were not captured in the budget despite their large contribution to MNCH services. To worsen matters, there were verified reports of misuse and abuse of donor support and contributions.

To facilitate budgeting, the provision of the NHA for the definition of the basic minimum package of health services has not been done. This would give the idea of the package of services that need to be funded to meet this minimum. Some important components of maternal health such as the repair of VVF patients were grossly under-funded compared to those in need of remediation surgery. There were irreconcilable differences in the unit cost of proposals for the funding of Primary Health Care centres. The price oscillated between N10m to N50m. There were also ambiguous descriptions and nomenclature of projects in the MNCH budget making it difficult for interested stakeholders who were not part of the budget crafting process to understand what exactly was provided for. The general budget faced a reign of frivolities, as wasteful and inappropriate expenditures suffused the budget. These sums could have been saved and invested in life saving MNCH services.

In terms of the budgeting framework, the extant law which is the Fiscal Responsibility Act mandates a medium term planning perspective under the MTEF and the undergirding MTSS. But literature used for the development of the IMNCH Strategy had recommended the Marginal Budgeting for Bottlenecks approach whilst the new government that took over in 2015 adopted the Zero Based Budget approach. This seems like introducing confusion as to the appropriate budgeting framework to be used in the sector.

Nigeria's de-listing as polio endemic country recognises the efforts and achievements made so far in improving new born and child health. Also, the NPHCDA has policies showing that it mainstreams youth and disability issues into its work and service provisioning.

In ascertaining the funding gap for MNCH in Nigeria, the critical issues in MNCH funding were analysed in terms of the dialectical approaches to funding. There is the peer review approach; total health spending and national income approach; political economy approach; production function approach. The budget approach combines the key features of all the other approaches and seems to be the approach in use in Nigeria. Population and economic growth are also factors to consider in arriving at the funding gap. The extant sources of funding MNCH shows that with the intended withdrawal of some development partners, considering Nigeria's new classification as a lower medium income country, FGN needs to increase funding of the sector. In the alternative, FGN can devise sources of funding that is not reliant on the public treasury whilst at the same time not imposing undue burdens of out of pocket expenditure on citizens.

Finally, the FGN did not use the maximum of available resources for the realisation of MNCH rights. Budgetary votes were oscillating and there were backward movements

and retrogression in the quantum of resources even at a time the overall budget was increasing.

7.2 RECOMMENDATIONS

Framework Issues

- Adopt a rights framework for the realisation of MNCH instead of the current basic needs approach. This will involve a clear definition of MNCH services as entitlements of persons in need of them; definition of rights holders and duty bearers.

- Guarantee MNCH rights as a fundamental human right in Chapter Four of the Constitution of the Federal Republic of Nigeria, 1999 as amended. The last amendment by the Seventh National Assembly of section 45 (b) to add that: *every citizen of Nigeria is entitled to free primary and maternal health care services* should be considered[92].

- Update the NSHDP and IMNCH Strategy to the post 2015 era including new projections and targets of achievement and costing.

- FGN should operationalise the Basic Health Care Provision Fund in the NHA through the provision of a minimum of 1 percent of the Consolidated Revenue Fund. It is imperative to note that 1 percent is the minimum and not the maximum that could be provided.

- FGN should explore new sources of funding healthcare and by extension MNCH to include universal, compulsory and contributory health insurance, and new incentive based taxes and levies.

- Specifically and further to the above, FGN should expedite action and steps towards a policy and legal framework for sustainable immunization financing.

- Female child marriage should be prohibited by law with strong penalties for male offenders.

Budgeting Issues

- The FMoH should articulate the definition of basic minimum package of health services required by the NHA and this should include MNCH. The minimum package should reflect Nigeria's minimum core obligations in health care. The definition is important for costing and funding the minimum package.

[92] The entire constitutional amendment was stuck in the Presidency-National Assembly rivalry and did not sail through.

- Health and MNCH budgets should be backed by a clear Medium Term Sector Strategy which is linked to high level national and international standards; fully costed and progressively allocates more resources to MNCH based on increased availability of resources.

- Increase health funding to meet the 15 percent of total budget as stipulated in the Abuja Declaration.

- The full and timely release and cash backing of all funds appropriated for the health sector.

- Ring-fencing of all funds appropriated for health including the capital votes which have not been fully released over the years.

- Increase the component of PHC and MNCH funding in the budget to not less than 50 percent of overall health funding.

- Service Wide Votes should be scrapped and the funds allocated to the relevant implementing agencies.

- The full contribution of development partners should be reflected in the budget to enhance transparency and accountability, improve monitoring and evaluation of projects and programmes. This will ensure budget comprehensiveness and strategically invest available resources to high priority areas.

- More resources should be made available for the remediation of VVF patients; sensitisation and awareness creation on the causes of VVF. A three year target date to reduce VVF occurrence to less than 5 percent of the current rate should be set.

- Good and fit procurement practices should be adopted by FMoH and NPHCDA; with a standard price database to remove price differentials for the same projects, programmes and activities and to enhance value for money in MNCH operations.

- Considering the paucity of resources, frivolous, inappropriate and wasteful expenditure heads should be weeded from the budget and the resources channelled to MNCH and other areas of need. This will involve a scrupulous review of expenditure heads to determine their contribution to economy, efficiency and effectiveness of operations.

- Projects should be clearly and properly described in the budget and repetition of budget heads and items should be avoided.

- All stakeholders in the budgeting process need to commit to ensure that all the bottlenecks that affect the full implementation of MNCH budgets are removed. From appropriation to releases and utilisation, all factors that cause delay and reduce percentage of appropriated budget utilised should be minimised.

- Further to the above, a penalty should be instituted to punish persons or institutions that fail to fulfil their statutory and constitutional roles in budgeting.

- A clear framework, with an inbuilt monitoring and evaluation strategy which can be independently evaluated should be devised to gauge the accessibility of MNCH services to PLWDS and youths.