POLICY BRIEF

(IMPROVING MATERNAL, NEWBORN AND CHILD HEALTH PROPOSALS IN THE 2015 FEDERAL BUDGET)

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Contents

Abbreviations

MDGs	Millennium Development Goals
MNCH	Maternal, New-born and Child Health (MNCH)
NASS	National Assembly
SWV	Service Wide Votes
ITNs	Insecticide Treated Nets
MDAs	Ministries, Departments and Agencies of Government
MICS:	Multiple Indicator Cluster Survey
MTSS	Medium Term Sector Strategy
NDHS:	National Demographic and Health Survey
NSHDP:	National Strategic Health Development Plan
PEFA	Public Expenditure and Financial Accountability
PPPs	Public Private Partnerships
WHS:	World Health Statistics

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PART ONE: INTRODUCTION

1.1 Objective and Methodology: The objective of this Policy Brief is to show the state of Maternal, New-born and Child Health (MNCH) in Nigeria, review the 2015 budget proposals for MNCH, draw conclusions and make policy recommendations to the National Assembly (NASS) and the executive. The recommendations are for the purpose of adjusting the proposals to address MNCH challenges and oversee the implementation of relevant laws and policies for improving the MNCH status in Nigeria. The methodology involves a review of the MNCH statistics drawing from the National Strategic Health Development Plan ([2010-2015], [NSHDP]), World Health Organisation and UNICEF statistics and the proposals of the 2015 federal budget. The Policy Brief reviews the proposals of key Ministries, Departments and Agencies (MDAs) working on MNCH. However, it recognises the challenge that many MDAs have mandates including MNCH and other issues. As such, it is difficult to delineate the exact funding that will be spent to resolve MNCH challenges, especially where personnel votes are proposed to pay staff whose duty schedules include MNCH and other issues. While the focus is on MNCH, the Policy Brief draws findings and conclusions from the trajectory of the general health funding, releases, cash backing and utilisation rates.

1.2 The State Obligation: Nigeria is under obligation to use the maximum of available resources for the progressive realisation of the right to health. This includes the obligation to ensure effective MNCH services within its territory. This obligation is encapsulated in national and international standards. The right to health is an integral and inextricable part of the right to life, for without good health, the right to life may be extinguished. All that the authorities need to do to violate the right to life is to deny health supporting facilities and conditions to a group of persons to the point of abrogation.

Issues of MNCH include life expectancy at birth, under five mortality rate, infant mortality rate, immunization of children against preventable diseases; percentage of underweight children, children sleeping under insecticide treated nets (ITNs), maternal mortality, adolescents birth, HIV prevalence among 15-24 years olds, etc. These issues affect pregnant women, infants, under five children[1] and children. This group of persons constitute a good part of the Nigerian population. Primary health care including MNCH has been declared to be part of the minimum core content of the right to health and as such, a part of the minimum core obligation of the state on health[2].

1.3 Indicators, Baselines, Targets and What Has Been Achieved: Table 1 shows the key issues in the NSHDP including the indicators, baselines

[1] As at 2012, the Nigerian Under-5 population was 29,697,000.

[2] General Comment Nos. 3 and 14 of the United Nations Committee on Economic Social and Cultural Rights.

targets and what has been achieved so far.

Table 1: Key NSHDP Indicators, Targets and Actuals						
S/N	**Indicator**	**Baseline**	**Targets**			**Actual**
			2011	**2013**	**2015**	**2012/2013**
1.	Life expectancy at birth	47 years	55 years	63 years	70 years	54 years (WHS 2014)
2.	Under-five mortality rate	157/1000 LBs (NDHS, 2008)	130/1000 LBs	103/1000 LBs	75/1000 LBs	128/1000LBs (NDHS 2013)
3.	Infant mortality rate	75 (NDHS, 2008)	60/1000 LBs	45/1000 LBs	30/1000 LBs	64/1000 LBs (NDHS) 2013
4.	Proportion of 1 year old immunized against measles	41.4 (NDHS 2008)	60%	80%	95%	42% (WHS 2014)
5.	Prevalence of children under five years of age who are underweight	23.1 (NDHS, 2008)	24%	20%	17.90%	29% (NDHS 2013)
6.	Percentage of children under 5 sleeping under Insecticide-Treated Bed Nets	5.5 (NDHS, 2008)	24%	42%	60%	16.6% (NDHS 2013)
7.	Maternal Mortality Ratio	545/100,000 LBs (NDHS 2008)	409/100,000 LBs	273/100,000 LBs	136/100,000 LBs	560/100,000 LBs (WHS 2014)
8.	Adolescents Birth Rates	126/1000 (NDHS 2003)	114/1000	102/1000	90/1000	89/1000 (MICS 2011)
9.	HIV prevalence among population aged 15-24 years	4.2% (ANC Sentinel Survey)	3.2%	2.1%	1%	4.1

Source: NSHDP 2010, NSHDP Mid-Term Performance Review 2013 and World Health Statistics 2014

MNCH is a component of the right to health. It is a component that Nigeria has underperformed in over the years leading to high Infant Mortality and Morbidity Rates, high Under-5 Mortality Rate and high Maternal Mortality Rate. From Table 1 above, Nigeria has missed all the targets in NSHDP. According to the World Health Statistics 2014, our immunisation coverage is poor and improvements in the sector have not been sustainable. As at 2012, immunisation coverage for 1 year olds is 42% for measles, 41%, 41% and 10% for DTP3, HepB3 and Hib3 respectively. Nigeria's infant mortality rate dropped from 126 per 1000 live births in 1990 to 112 per 1000 live births in 2000, and lowered to 78 per 1000 live births in 2012. Within the period, Africa's figures of infant mortality per 1000 births was comparatively lower from 105/1000 live births in 1990 to 63/1000 live births by 2012. The Under-5 mortality rate in

Nigeria dropped from 213 per 1000 live births in 1990 to 124 per 1000 live births in 2012. This is still poorer than the African average. Nigeria's maternal mortality rate was 1200 per 100,000 live births in 1990, 950/100,000 in 2000 and "improved" to 560/100,000 in 2013. This is far higher than the numbers of peer countries. Further, Nigeria is committed under the Millennium Development Goals (MDGs) 4 and 5 to reduce child mortality - reduce by two-thirds, between 1990 and 2015 and to improve maternal health by 2015 by reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio. The above statistics show that not much progress has been recorded towards improving MNCH indicators.

PART TWO: THE 2015 FEDERAL BUDGET PROPOSALS ON MNCH

Table 2 below shows the different MDAs of government and the planned expenditure in 2015 related to MNCH issues.

Table 2: Line Items Focussing on MNCH - MDAs Proposed 2015 Budget

0521001001		**FEDERAL MINISTRY OF HEALTH – HQTRS**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT (N)**
	FMOHQ001005213	MDG-IMNCH: ON-GOING PROCUREMENT AND DISTRIBUTION OF CONTRACEPTIVE COMMODITIES; CAPACITY BUILDING FOR SERVICE PROVIDERS AND INFORMATION MANAGEMENT.	ONGOING	728,739,731
	FMOHQ001005242	MDG MALARIA PROGRAMME: PROCUREMENT AND DISTRIBUTION OF INSECTICIDE TREATED BED NETS TO REMAINING ORPHAN STATES.	ONGOING	791,152,904
	FMOHQ001011569	PROVISION OF HOSPITAL EQUIPMENTS FACILITIES AND CAPITAL ITEMS FOR THE FMOH CLINICS (GWARINPA,FED SECRETARIAT ANNEXES 1 AND 2	ONGOING	178,774,458
	FMOHQ001011575	PROCUREMENT OF MOSQUITO NET HANGERS FOR EFFECTIVE USE OF LONG LASTING INSECTICIDE TREATED NETS(LLINS)	ONGOING	145,060,168
0521002001		**NATIONAL HEALTH INSURANCE SCHEME**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	NHIS001008446	MATERNAL AND CHILD HEALTH INSURANCE PROGRAMME (MDG)	ONGOING	642,200,000
0521003001		**NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	NPHCDA001008658	ROUTINE IMMUNIZATION (PROCUREMENT OF VACCINE INCLUDING NEW VACCINES, NEW VACCINES FOR CHILDREN BELOW 1 YEAR AND PREGNANT WOMEN) (MDGS)	ONGOING	2,615,055,925
	NPHCDA001008659	COMMUNITY HEALTH PROJECT (HEALTH EDUCATION/PROMOTION, ADOCACY, MOBILIZATION), (MDGS)	ONGOING	868,016,235
	NPHCDA001008663	POLIO ERADICATION (TO INTERRUPT	ONGOING	2,568,442,234

		THE TRANSMISSION OF WILD POLIO VIRUS IN LINE WITH PRESIDENTIAL MANDATE AND TRANSFORMATION AGENDA (MDGS).		
	NPHCDA001008664	MIDWIFERY SERVICES SCHEME (ISS, ICT, CHEWS TRAINING, COMMODITIES, MONITORING AND COMMUNITY HEALTH WORKERS INITIATIVE) (MDGS)	ONGOING	1,012,685,607
	NPHCDA004008667	PRIMARY HEALTH CARE (PHC) MONITORING & EVALUATION/ HEALTH MANAGEMENT INFORMATION SYSTEMS (TRAINING OF HMIS/M&E OFFICERS IN ALL STATES/LGAS , PRINTING & SUPPLY OF REGISTERS/ TOOLS NATIONWIDE, DEPLOYMENT OF SOFTWARE	ONGOING	144,000,000
0521026002		**LAGOS UNIVERSITY TEACHING HOSPITAL**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	LUTH003011740	EQUIPPING OF CHILDREN EMERGENCY CENTRE	ONGOING	54,999,574
0521026005		**UNIVERSITY OF BENIN TEACHING HOSPITAL**		
	UBTH004011902	EXTENSION OF MATERNAL & CHILD HEALTH UNIT	ONGOING	20,000,000
0521026006		**OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITAL**		
	OAUTH002011828	RECONSTRUCTION AND EXPANSION,(REMODELLING AND EQUIPING WITH SIDE LABORATORY OF 60-BED FEMALE MEDICAL WARD)	ONGOING	10,000,000
0521026014		**NNAMDI AZIKIWE UNIVERSITY TEACHING HOSPITAL, NNEWI**		
	NAUTH002011780	COMPLETING THE CONSTRUCTION OF OBSTETRICS WARD AT PERMANENT SITE	ONGOING	25,000,000
0521027019		**FEDERAL MEDICAL CENTRE ABEOKUTA**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	FMCABKT001012623	CONSTRUCTION OF 60 -BEDDED MATERNITY BLOCK.	ONGOING	54,135,911
0521027021		**FEDERAL MEDICAL CENTRE, MAKURDI**		
	FMCMAK004012067	DEVELOPMENT OF FEDERAL MEDICAL CENTRE MAKURDI OUTREACH CENTRE IKPA-MBATIEVE	ONGOING	26,000,000
0521027024		**FEDERAL MEDICAL CENTRE, NGURU YOBE**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	FMCYOB005012228	COMPLETION AND FURNISHING OF ANTE-NATAL WARD	ONGOING	20,000,000
0521027033		**FEDERAL MEDICAL CENTRE, KEBBI STATE**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	FMCKEBB003011290	MATERNITY COMPLEX	ONGOING	40,000,000
	FMCKEBB006011284	CONST.OF ORT.PAEDI & SURGICAL WARD	ONGOING	40,000,000
0521027037		**FEDERAL MEDICAL CENTRE, BAYELSA STATE**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	FMCBYLS003012672	CONTINUE THE EXPANSION OF PAEDIATRIC WARD COMPLEX	ONGOING	54,994,257
0521048001		**NATIONAL OBSTETRIC FITSULA CENTRE, ABAKALIKI**		

	CODE	PROJECT NAME	TYPE	AMOUNT
	NOFIC0013008862	ALSPHALTING LANDSCAPPING OF PREMISES	ONGOING	20,396,532
	NOFIC011013637	COMPLETION OF THE CONSTRUCTION AND EQUIPPING OF ADMIN/THEATER/CHANGING ROOMS/WARD/LIBRARY	ONGOING	83,000,000
0521048002		**NATIONAL OBSTETRIC FISTULA CENTRE BAUCHI**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	NOFICNINGI004013481	PURCHASE OF HEALTH/MEDICAL EQUIPMENT	ONGOING	50,000,000
	NOFICNINGI006013485	REHABILITATION/REPAIRS OF OFFICE BUILDINGS	ONGOING	33,000,000
0521048003		**NATIONAL OBSTETRIC FISTULA CENTRE KATSINA**		
	CODE	**PROJECT NAME**	**TYPE**	**AMOUNT**
	NOFICKAT002013494	PURCHASE AND INSTALLATION OF HOSPITAL FURNITURE & EQUIPMENT	ONGOING	72,000,000
	NOFICKAT005013511	RENOVATION OF POST VVF WARD AND THEATRE	ONGOING	11,000,000
TOTAL				**10,308,653,536**

Source: 2015 Federal Budget Proposals: Budget Office of the Federation

Table 3 shows the budget proposals of Institutes of Child Health across the Federation.

Table 3: Proposed Budgets of Institutes of Child Health and Fistula Centres

NO	CODE	MDA	TOTAL PERSONNEL	TOTAL OVERHEAD	TOTAL RECURRENT	TOTAL CAPITAL	TOTAL ALLOCATION
60	521030 001	INSTITUTE OF CHILD HEALTH (LUTH) LAGOS	0	1,900,407	1,900,407	0	1,900,407
61	521030 002	INSTITUTE OF CHILD HEALTH (UBTH) BENIN	0	1,900,407	1,900,407	0	1,900,407
62	521030 003	INSTITUTE OF CHILD HEALTH (UCH) IBADAN	0	1,900,407	1,900,407	0	1,900,407
63	521030 004	INSTITUTE OF CHILD HEALTH (ABUTH) ZARIA	0	1,900,407	1,900,407	0	1,900,407
64	521030 005	INSTITUTE OF CHILD HEALTH (ENUGU) ENUGU	0	1,900,407	1,900,407	0	1,900,407
65	521036 001	NOMA CHILDREN HOSPITAL, SOKOTO	0	18,755,803	18,755,803	29,454,612	48,210,415
66	521048 001	NATIONAL OBSTETRIC FITSULA CENTRE, ABAKALIKI	439,150,940	42,326,413	481,477,353	103,396,532	584,873,885
67	521048 002	NATIONAL OBSTETRIC FISTULA CENTRE BAUCHI	486,062,496	47,000,000	533,062,496	83,000,000	616,062,496
68	521048 003	NATIONAL OBSTETRIC FISTULA CENTRE KATSINA	571,379,370	35,000,001	606,379,371	83,000,000	689,379,371
	TOTAL						**1,948,028,202**

Source: 2015 Federal Budget Proposals: Budget Office of the Federation

For SURE-P MNCH, Table 4 shows the provisions.

Table 4: SURE-P MNCH Provisions

Line Item	Amount (N)
MATERNAL AND CHILD HEALTH	4,000,000,000
COUNTERPART FUND FOR HIV/AIDS PROGRAMME	2,000,000,000
COUNTERPART FUND FOR POLIO ERADICATION PROGRAMME & ROUTINE IMMUNIZATION	15,300,000,000
TOTAL	**21,300,000,000**

Source: 2015 Federal Budget Proposals: Budget Office of the Federation

In the Service Wide Votes (SWV), Table 5 shows the provisions for MDGs without a disaggregation into the particular MDGs.

Table 5: SWV Provisions for MDGs

CODE	LINE ITEM	AMOUNT
23050116	MILLENNIUM DEVELOPMENT GOALS MONITORING AND EVALUATION	2,109,037,225
23050118	COMMUNICATION AND ADVOCACY (MDG) REPORTING 2011 MDG	427,080,038
23050139	MDG SPECIAL PROJECTS	1,581,777,918
23050140	SPECIAL INTERVENTION MDG's 1	5,378,044,922
23050141	SPECIAL INTERVENTION MDG's 2	4,218,074,449
23050150	COUNTERPART FUNDING INCLUDING GLOBAL FUND/HEALTH	1,500,000,000
23050152	CONDITIONAL GRANTS AND SOCIAL SAFETY NETS (MDGS)	35,284,192,766
	TOTAL	**50,498,207,318**

Source: 2015 Appropriation Proposals from Budget Office of the Federation

PART THREE: MATTERS ARISING FROM THE HEALTH AND MNCH FUNDING PROPOSALS

3.1 Inadequate Budgetary Allocations, Releases and Utilisation Rates: A key challenge responsible for the failure and continuing inability of the nation to achieve the MNCH targets is inadequate budgetary allocations. The health budget from which MNCH is funded is only 5.91% of the overall budget proposal which is lower than the 15% commitment made by African leaders in the Abuja Declaration[3]. Compare this miserly proposal with Rwanda's 18.8%, Botswana's 17.8%, Niger's 17.8%, Malawi's 17.1%, Zambia's 16.4% and Burkina Faso 15.8% respectively of their national budgets.

[3] On 26-27 April 2001, African Heads of State met in Abuja and they committed their countries to allocating, at least 15%, of their total annual government budgets to the health sector.

The second issue is the poor release, cash backing and utilisation of appropriated funds. Table 6 is about the health sector capital budget utilisation rate 2009-2013 and it shows the challenges.

Table 6: Health Capital Expenditure Utilisation Rate (2009 – 2013)

Year	Approved Capital Health Budget (N)	Actual Release (N)	Cash Backed (N)	Utilised sum (N)	% of Approved Capital Budget Utilised	% of Released Sum Utilised	% of Cash Back Sum Utilised
2009	50,803,276,901	48,643,289,834	48,658,789,834	24,509,417,925	48.2	50.4	50.4
2010	53,066,015,191	33,570,452,816	33,562,153,452	17,745,264,501	33.4	52.9	52.9
2011	55,414,957,377	38,785,000,000	38,716,000,000	32,165,000,000	58.0	82.9	83.1
2012	60,920,219,702	45,000,074,681	37,171,222,265	33,682,405,609	55.3	74.8	90.6
2013	60,047,469,274	28,838,429,775	28,838,439,775	19,108,867,782	31.8	66.3	66.3
Average					**45.4**	**65.6**	**68.6**

Source: BOF (Budget Implementation Reports 2009 – Quarter 3 2013)

Based on the sums released, the amounts utilised seem to have a fair performance, as the percentage of the released sum utilised stands at an average of 65.6% from 2009 to 2013; peaking at 82.9% in 2011. The World Bank's Public Expenditure and Financial Accountability standard (PEFA, 2005) recommends at least 97% rate of utilisation as acceptable. With a utilisation rate under 50% for the health budget against the 97% mark, the sector's capital budget implementation is way below average.

As indicated in Table 6 above, the cash backed sum for the 2009 Appropriation Act was about N48.6bn while only N24.5091bn (50.4%) was utilised as at 31st December, 2009. For the 2010 fiscal year, the sum of N33.562bn was cash-backed and only N17.7 bn (52.9%) was utilised. In 2011, N38.7 was cash-backed and only N32.165bn (82.9%) was used for the implementation of the capital projects/programmes. Similarly, in the 2012 fiscal year, N37.17b was cash-backed while only N33.6bn was utilised for approved programmes. Implicit in the foregoing analysis is the low absorptive capacity of the Federal Ministry of Health. With the relatively low releases and cash-backing of releases, in no year did the Ministry expend all its cash-backed allocation. This evidences that the Health Ministry lacks the capacity to fully utilise cash-backed resources as the percentages of the cash-backed funds utilised were fairly low. Comparing the cash-backed sums to the appropriation further buttresses this low capacity in the MoH.

For the 2015 budget, the total sum proposed is N38,556,681,738[4]. If the utilisation rate of 45.4% is applied for the year 2015, the budget will end up

[4] This is the total of the sums in Tables 2, 3, 4 and N5bn from Table 5. N5bn is taken from Table 5 considering that MNCH is just one of the MDG issues to be tackled by SWV.

with an investment of N17,504,733,509, which is quite inadequate.

3.2 Agencies Without Personnel and Capital Provisions: All the Institutes of Child Health had overhead votes but no personnel or capital votes. These Institutes cannot function without salaries and a capital vote.

3.3 Non Compliance with the National Health Act: The National Health Act 2014 provides great opportunity for funding primary health care including maternal and child health services through the Basic Healthcare Provision Fund which should not be less than 1% of the Consolidated Revenue Fund. 1% is the minimum floor, it could be more if the executive and legislative authorities prioritise healthcare. But the 2015 budget is silent on the provision of this Fund[5].

3.4 Service Wide Votes for MNCH is not Disaggregated: SWV in the sum of N50.498bn is allocated to the MDGs without specifically stating the particular MDGS. Assuming that about 10% (N5bn) goes to MNCH services; this will beef up funding for MNCH. But previous experience indicates that SWV is a ghost account and it is not supported by extant laws and policies. The Oronsaye 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 utilization 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 the above allocation be disaggregated, restructured and given to the respective MDAs in need of them.

3.6 The SURE-P Vote is Bloated: Considering the decline in crude oil prices, the amount that will accrue under the SURE-P may not be up to the sum projected in the budget proposal. The likelihood of N21.3bn being available for MNCH under SURE-P is remote. It is better to plan with a reduced sum rather than building castles in the air.

3. 6 Is Insecticide Treated Nets the Answer to the Malaria Scourge? A large sum of money is budgeted for the procurement of insecticide treated nets and this has been a recurring practice every year. But the need to control malaria or possibly eradicate mosquitoes cannot be done through ITN. The focus should be on strategies to eradicate mosquitoes through the use of appropriate chemicals, good environmental health practices and public sensitisation. This type of intervention has achieved tremendous results in other countries.

3.7 Contribution of Development Partners is not Captured in the Budget: The Budget did not take cognisance of the contribution of

[5] The authorities state that the proposals were prepared before the Act became law. But since it became law in December 2014, the proposals have to be amended to reflect this fact because a law takes effect from the date it is signed by the President.

Development Partners through grants and other support mechanisms. 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.

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.

3.8 Public Private Partnerships (PPPs): The Budget is silent on PPPs in health and MNCH. Modern trends in funding of infrastructure indicate a shift towards PPPS considering the paucity of governmental resources. Even though PPPs insist on cost recovery, there are many Nigerians who spend fortunes accessing MNCH services outside our shores and who can afford to pay for these services if the facilities are available locally. This will raise the standard of services available in the industry.

3.9 The Proposals were not Backed by a Medium Term Sector Strategy (MTSS): The budget proposals were not underpinned by a MTSS. As such, they did not undergo a prioritisation process and may not reflect the best strategies and activities for the realisation of high level policy goals in MNCH.

PART FOUR: CONCLUSIONS

The 2015 Budget MNCH proposals are inadequate to meet the needs of Nigerian women and children. The trend of budget releases and utilisation show that the appropriated sums will not be fully released and the released portion will not be fully utilised. The poor MNCH statistics and figures are not about cows and poultry dying from foot and mouth disease or bird flu, but figures of our mothers, sisters and daughters; real Nigerians who are full citizens of this country. The poser is: Should getting pregnant to reproduce the future generation of Nigerians be a death sentence? Thus, these deaths could to a great extent be traced to our poor fiscal governance and budgeting system.

It is impossible to run the Institutes of Child Health without a vote for personnel emoluments unless the salaries are paid by another MDA or it is entirely run by volunteers. The provision of the NHA demanding the setting aside of not less than 1% of the Consolidated Revenue Fund to primary health care

has not been complied with while over N50bn has been proposed for MDGs related expenditure in SWV without a disaggregation of the exact investment items. The SURE-P Vote is bloated and may not be realised considering dwindling crude oil prices. The predominance of votes for ITNs neglects the need to eradicate mosquitoes and the environmental conditions under which they breed and multiply. The contribution of development partners is not captured in the budget whilst the budget is silent on PPPs; the budget proposals are not underpinned by an MTSS.

Nigeria has not met the MNCH targets it set in the NSHDP. However, the targets are realisable with strong political will and the right attitude by stakeholders. Essentially, Nigeria is not using the maximum of available resources for the progressive realisation of MNCH rights.

PART FIVE: RECOMMENDATIONS

5.1 For the Legislature

- Improve MNCH funding by increasing health sector budget to 15% of the total budget in accordance with the Abuja Declaration.
- Ensure that at least 1% of the Consolidate Revenue Fund is allocated to MNCH issues as contained in the NHA, 2014.
- Provide for personnel and capital votes in the Institutes of Child Health.
- Disaggregate the expenditure on MDGs in the SWV and allocate them to the MDAs that will execute the projects.
- Use empirical evidence to reduce the proposals and arrive at proper estimates of revenues that will accrue to SURE-P within the year and adjust the MNMCH vote accordingly.
- While providing for ITNs in the interim, budgetary provisions should be made for effective environmental health interventions to eradicate mosquitoes and wipe out malaria.
- The contributions of Development Partners in MNCH should be reflected in the budget to ensure comprehensiveness; minimise corruption and strategically invest available resources to high priority areas of MNCH policy.
- Monitor the management of allocated funds to MNCH MDAs through periodic record checks, site visits, programme reviews and invitation of chief executives of MDAs to appear before Committees of the Legislature for accountability which will facilitate value for money.
- Consider a bill for universal access to MNCH services through a combination of funding strategies including public funding, health insurance, etc.

5.2 For the Executive

- Future budget proposals should be backed by a Medium Term Sector Strategy which goes through the full rigour of prioritisation of activities and aligning them with high level policy documents in MNCH.
- PPPs should be deployed as alternative sources of funding MNCH interventions.
- Deploy technology and media resources to improve sensitisation and education on MNCH services for vulnerable and underserved groups.

ABOUT CENTRE FOR SOCIAL JUSTICE (CSJ - RC:737676)

Centre for Social Justice Limited by Guarantee (CSJ) is a Nigeria non-governmental organization with a vision of a Nigeria where social justice informs public decision making. Its mission is to be a principal catalyst for mainstreaming social justice and fairness in all facets of public life. The main objectives are to:

- Contribute to the development and implementation of national laws and policies on social rights and justice in accordance with international best practices;
- Promote accountability, transparency and popular participation in public expenditure management;
- Promote poverty reduction strategies as a tool for social justice;
- Promote popular participation and gender mainstreaming in public decision making;
- Broaden the constituency of professionals interested in development and wealth creation by creating and maintaining a multidisciplinary network of professionals committed to work for the realization of these objects.

PROGRAMMES

The programmes of CSJ focus on a rights based approach to public expenditure management, power sector reforms, political finance reforms and rights enhancement.

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