USAID
FROM THE AMERICAN PEOPLE

Palladium
MAKE IT POSSIBLE

SOKOTO STATE 2023

PRE-BUDGET RIGHT TO HEALTH MEMORANDUM

SCALE
STRENGTHENING CIVIC ADVOCACY AND LOCAL ENGAGEMENT

CSJ
Centre for Social Justice

First Published in July 2022

By

Centre for Social Justice

Plot 836, Block 1, Emmanuel Aguna Crescent, Off Idris Ibrahim Crescent, Off Obafemi Awolowo Way, Jabi
P.O. Box 11418 Garki, Abuja.
Website: www.csj-ng.org
Blog: csj-blog.org
Twitter: @censoj
Facebook: Centre for Social Justice, Nigeria
Email-censoj@gmail.com

TABLE OF CONTENTS

ABBREVIATION

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

LIST OF TABLES

EXECUTIVE SUMMARY

This Memorandum is divided into eight sections. Section 1 is the background, it provides the rationale for the exercise and reviews key sectoral goals, objectives, targets and strategies. Section 2 reviews Sokoto State specific health indicators and their implications. Section 3 reviews the health budget commitments of the State including the actuals and their compliance with the Abuja 15% Declaration and reviews the whole of government and health in all policies approach. Section 4 reviews whether the State has set and costed a Minimum Service Package for PHC. Section 5 is on the implementation of the Basic Health Care Provision Fund (BHCPF) in the State while Section 6 reviews the sustainability of the current health care financing model. Section 7 is on the operation of Health Insurance Scheme in Sokoto State while Section 8 is on recommendations.

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

- Prepare a New Strategic Health Development Plan 2023-2027 and other Due Policies.
- Prepare a Health MTSS.
- Mainstream the Plan, Policy and Budget Continuum in Health.
- Adopt a Whole-of-Government, Health-in-all Policies Approach.
- Ensure Stakeholder Engagement and Popular Participation in Preparation of MTSS and Annual Budget.
- Adopt a Whole of Society Approach to Health.
- Declare a State of Emergency in the Health Sector.
- Prepare the Costing for the Implementation of the Minimum Service Package for Primary Health Care.
- Increase Funding to the Sector and Invest in Value for Money.
- Moratorium on New Capital Projects.
- Invest in Transparency and Accountability.
- Prepare and present Annual State of Health Report.
- Ensure Maximum Benefits from BHCPF.
- Full Implementation of SOCHEMA Law and the National Health Insurance Authority Act in the State.

SECTION ONE: INTRODUCTION

1.1 Background

The Sokoto State Fiscal Responsibility Law (SSFRL) requires the State Government to prepare the Medium Term Expenditure Framework (MTEF) every year.[1] This is a three year rolling plan containing the macroeconomic framework, fiscal strategy paper, expenditure and revenue framework, consolidated debt statement and statement describing the nature and fiscal significance of contingent liabilities. However, after preparing the MTEF, every Ministry, Department and Agency of the State Government (MDA) is expected to submit its Medium Term Sector Strategy (MTSS), which should focus on the medium term goals of their sectors and will feed into the broad goals of the MTEF. Where the State neither prepares the MTEF nor the MTSS, it still has a constitutional obligation to prepare an annual budget.

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

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

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

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

- Pursue spending policies that are consistent with strategic and high-level health plans and policies and which assures a reasonable degree of stability and predictability.
- Hinge health spending on a whole of government, health in all policies approach.
- Prioritize primary health care (PHC) which is the foundation for secondary and tertiary care.

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

- Provide an enabling environment and motivate domestic resource mobilization as a step towards Universal Health Coverage (UHC).

- Pursue spending within a definitive macro-economic framework with, at a minimum, medium term horizon and which assures a prudent balance between available resources and planned spending.

- Ensure that the scale and focus of health spending address the prevalent disease conditions found in epidemiological analysis in the State.

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

- Maintain the integrity of the Health Information Management System.

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

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

The Health Sector Budget is to be prepared with the Health Sector Envelope contained in the MTEF. The Health Sector Budget is expected to incorporate key programs and projects that the Sokoto State Government shall embark upon within the budget year in order to achieve the health goals and objectives as detailed in high level subnational, national and international standards including the SSSHDP II, National Health Policy, National Strategic Health Development Plan, Sustainable Development Goals (SDGs 3, etc.) and ratified treaties and standards, etc.

Accordingly, priority programs and projects are to be ranked in accordance with their contribution to the strategic pillars of SSSHDP II as well as the National Health Policy's theme of "promoting the health of Nigerians to accelerate socioeconomic development". Other broad key considerations for project ranking include their contribution to economic growth (output and income), competitiveness of the economy (increased efficiency and cost reduction), employment generation (direct and indirect), access to quality and affordable education and health care and social welfare improvement and poverty reduction. Other considerations include strong local content (linkages with other sectors), likelihood of completion in the medium term, nature of project (developmental or administrative) and project status (whether ongoing or new).

1.2 Rationale for the Exercise

The SMOH is required to consult with relevant stakeholders including Civil Society Organizations (CSOs) that work in the Health Sector during the preparation of the Health Sector Budget. Therefore, this Memorandum presents the key inputs of CSOs into the Health Sector Budget for 2023. The primary focus is on Primary Health Care (PHC) as an entry point for Universal Health Coverage (UHC).

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

1.3 Sectoral Goals, Objectives, Targets and Strategies

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

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

all necessary health plans with the participation of relevant stakeholders. The SSSHDP goal is to ensure healthy lives and promote well-being of all citizens of Sokoto State across all ages.

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

The foregoing goals, objectives, targets and strategies reinforce the core values and principles of the SSSHDP II vis; accountability and transparency; quality of care; ethics and respect for human rights; accessibility, affordability and acceptability; equity and gender sensitivity: community engagement; teamwork and industrial harmony; alignment and harmonization: and partnership and collaboration. The SSSHDP II seeks to achieve its objectives through the implementation of key essential health care packages in the following areas: (a) Reproductive, Maternal, New-born, Child and Adolescent health, plus Nutrition (RMNCAH +N); (b) Prevention and control of communicable diseases (prioritizing malaria, HIV/AIDS, tuberculosis, hepatitis and Neglected Tropical Diseases – other high burden of diseases covered under child health – acute respiratory tract infections, diarrheal disease and measles); (c) Non-Communicable Diseases Prevention and Control (cancers, cardiovascular diseases, chronic obstructive airways disease, sickle cell disease, oral health, mental health, eye health and care of the elderly); (d) Health promotion and social determinants on health (focusing on water supply, food hygiene, medical waste disposal); and (e) Protection from Health Risks and Emergencies.

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

[4] Section 1 (1) (c) and (e) of the NHA.
[5] Section 3 (3) of the NHA.
[6] See SSSHDP 11, 2018-2022.

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

2.1 Health Indicators

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

The implication of the population figure is that there is increasing pressure on available health facilities in the State. Primary Health Care (PHC) has been identified as a critical part of the minimum core obligation of the state on the right to health.[8] Table 1 documents major health indicators relating to PHC and other tiers of health in Sokoto State. This will facilitate a proper understanding of the health challenges in the State within the context of programming available public resources towards their resolution.

Table 1: Health Indicators – National Average vs Sokoto Rate

S/N	Health Indicator	National Average	Sokoto
	Maternal and Child Health		
1	Neonatal mortality rate*	46 per 1,000 live births#	50 per 1,000 live births
2	Post-neonatal mortality rate*	35 per 1,000 live births#	52 per 1,000 live births
3	Infant mortality rate*	80 per 1,000 live births#	102 per 1,000 live births
4	Child mortality rate*	117 per 1,000 live births#	106 per 1,000 live births
5	Under-five mortality rate*	187 per 1,000 live births#	197 per 1,000 live births
6	Adolescent birth rate**	120 per 1000 population (15-19years)	174 per 1000 population (15-19 years)
7	Maternal Mortality Rate	512 per 100,000 live births	Not Given
8	Percentage of women with unmet need for contraception (spacing)**	18.5%	23.6%
9	Percentage of women without antenatal care**	31.6%	63.9%
10	Percentage of women who deliver at home**	60.2%	87.7%
11	Percentage of women with post-natal checks for their newborns (in a facility or at home)**	32.8%	8.1%

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

	Immunisation		
12	Percentage of children (1-2yrs) who receive BCG Vaccine**	53.5%	16.3%
13	Percentage of children (1-2yrs) who received Hepatitis B vaccine at birth**	30.2%	4.6%
14	Percentage of children (1-2yrs) who received Polio Vaccine at birth**	47.4%	12.6%
15	Percentage of children (1-2yrs) who received Yellow Fever Vaccine**	38.8%	6.4%
16	Percentage of children (1-2yrs) who received Measles Vaccine (MCV1)**	41.7%	9.8%
	Adequate Supply of Potable Water		
17	Unimproved Source*	34.7%	65.6%
18	Improved Source*	65.3%	34.4%
	Sanitation		
19	Improved Facility Usage*	53.4%	43.5%
20	Unimproved Facility Usage*	23.7%	31.0%
21	Open Defecation*	22.9%	25.5%
	Others		
22	Tuberculosis	-	-
23	HIV/AIDS** – (a) Men: Using condoms and limiting sexual intercourse to one uninfected partner (b) Women: Using condoms and limiting sexual intercourse to one uninfected partner	73.3%[#] 74.0%[#]	65.8% 53.7%
24	Malaria* (a) Percentage who slept under any mosquito net last night (b) Percentage who slept under ITN by persons in the household the previous night (c) Percentage of pregnant women who slept under an ITN last night (d) Prevalence, diagnosis and prompt treatment of children with fever	 43.9% 43.2% 58.0% 24.2%	 54.2% 52.6% 78% 32.7%

*Source: * Indicates NDHS 2018*

*** Indicates MICS (2016-17)*

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

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

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

2.2 Implications of the Indicators

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

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

SECTION THREE: REVIEW OF EXISTING BUDGET COMMITMENTS AND EMERGING ISSUES

There is a state obligation to take concrete and targeted steps and to use the maximum of available resources for the progressive realization of the right to health including PHC.[9] This is to be done with a view to the realization of UHC. Resource includes financial resources appropriated through the budget and other finances leveraged through collaboration with state and non-state actors. Resources also include information, environment, technology and human resources. To set the context for the state health budget review, the overall Sokoto State Budget per capita for the years 2018, 2019, 2020,

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

2021 and 2022 was N44,116.82, N33,943.45, N32,891.38, N35,350.54 and N37,700.23 respectively. There are standards used to benchmark state financial resources dedicated to health. Two of the standards vis, the Abuja Declaration and the Sokoto State Strategic Health Development Plan II will be used to benchmark Sokoto State's health budget allocations in recent years.

3.1 Abuja Declaration

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

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

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

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

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

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

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

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

Source: Sokoto State Budget 2014-2022

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

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

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

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

Table 4A shows that 86.98%, 89.55% and 90.23% of the health budget were released and utilized in the years 2019, 2020 and 2021 respectively. Although there is room for improvement, the above statistics show that the Sokoto State Government is inching towards budget credibility in the health sector.

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

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

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

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

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

3.2 Sokoto State Strategic Health Development Plan II

Under the SSSHDP II, Sokoto State proposed three financing scenarios for the improvement of the standard of health. They are: (a) Baseline – with no coverage scale up and no significant change in HSS investment across the horizon of the plan; (b) Essential Service Moderate Scenario – scale-up of essential services and HSS investments required for implementation of the Primary Health Revitalization Agenda AND (c) Essential Service Aggressive Scenario – Scale-up of Health Service and HSS investments aimed at to achieving UHC while implementing components of the PHC revitalization agenda contained in Moderate Scenario.

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

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

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

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

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

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

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

Year	SSHPD II Policy Scenario (N)		Health Budget (N)	Financing Gap
2018	N/SHDP II Essential Package Aggressive Scale-up Scenario	N89.565bn	N17.509bn	N72.056bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N24.747bn		N7.238bn
	N/SHDP II Baseline Scale Scenario	N18.489bn		N0.98bn
2019	N/SHDP II Essential Package Aggressive Scale-up Scenario	N78.823bn	N10.897bn	N67.926bn
	N/SHPD II Essential Package Moderate Scale-up Scenario	N28.585bn		N17.688bn
	N/SHDP II Baseline Scale-up Scenario	N18.489bn		N7.592bn

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

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

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

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

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

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

SHDPII 2017-2021 Program Areas	2018	2019	2020	2021	2022	total	% Of total cost
Maternal, Newborn and	₦511m	₦592M	₦591M	₦624M	₦710M	₦3,028M	18.9 %

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

Source: SSSHDP 2018-2021

A good number of the issues in Table 7 above are relevant to the maintenance of an effective, functional and efficient PHC system. These include maternal, newborn and

reproductive health; child health, immunization, malaria, TB, nutrition; WASH; health promotion and social determinants of health, etc.

3.4 Forward Ever, Backward Never Commitment

The right to health, which is to be realized progressively, under the jurisprudence of economic, social and cultural rights is a "forward ever, backward never" right. Deliberate retrogressive measures are not permitted and if any such measure is to be undertaken by the State, it requires the most careful consideration and justification by reference to other compelling rights and in the context of the full use of the maximum of available resources.[10]

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

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

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

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

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

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

nosedived to $35.820 million and $35.588 million in 2019 and 2020 respectively. Further, it increased to $50.368 million in 2021 and $71.260 million in 2022. Essentially, the funding for health has been undulating but has been increasing in the last two years. So, the State Government in the Appropriation Laws has recently been in compliance with the forward ever, backward never commitment.

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

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

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

SECTION FOUR: MINIMUM SERVICE PACKAGE

The Sokoto State Primary Health Care Development Agency is required to develop a Minimum Service package (MSP) for PHC and this would be implemented through the Ward Health System Service Package. The MSP is the minimum core content of PHC, being the minimum package of health services to be delivered at the primary and secondary levels of care funded by the state. This is to ensure the best health/value for money in government expenditure so that scarce resources are deployed to the areas of greatest need and impact. This will ensure the provision of the best possible health service to citizens within the limits of available resources.

It is reported that Sokoto State has developed the MSP for PHC facilities identified for the one PHC per political ward strategy, but the package has not been fully costed. Sokoto State is also implementing the repositioning component of the Primary Health Care Under One Roof Strategy.[11]

SECTION FIVE: THE BASIC HEALTH CARE PROVISIONS FUND

According to the Sokoto State Primary Health Care Development Agency, Sokoto State Government has met all the criteria for the operationalization of BHCPF and has received

[11] State of Primary Health Care Delivery in Nigeria by ONE Campaign, etal; at page 158.

funds in year 2021 and 2022 respectively. The State Government committed over N100 million for pre-implementation activities. The total sum that has accrued to the BHCPF from the Federal Government through the SSPHCDA Gateway in the State is the sum of N466.732m. 193 PHCs were cleared by NPHCDA to receive funds through Decentralized Facility Financing (DFF) for two quarters. Disbursement to facilities per quarter is N300,750.00 (N100,250.00 per month). The Scheme has recruited 118 midwives. The State's 25% contribution to the fund's basket is done through the SSPHCDA and SOCHEMA's budget starting from the 2021 fiscal year onwards.[12]

Furthermore, according to SOCHEMA, it has enrolled 39,822 beneficiaries in 12 Local Government Areas out of 43,934 allocated to Sokoto State by NHIS.[13]

However, according to the State of Primary Health Care Delivery in Nigeria, 2019-2021;[14]

> *Sokoto State has attained full capacity to utilize BHCPF disbursements from the NPHCDA and NHIS Gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA Gateway and the State has failed to provide either its counterpart or its equity funding for the NHIS Gateway. The State has not sent reports of any Gateway Forum and SOC meetings from Q4 2021 to NHIS and the State does not have formal sector health insurance scheme.*

According to the summary of key steps to improvement, the following is recommended:[15]

- Provide equity funds for the NHIS Gateway of the BHCPF;
- The State must complete all required trainings, establishment of health facility management committees, and regularization of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF.
- Develop an Electronic Workforce Registry in the State to support management of human resources for health;
- Fund the printing and distribution of NHMIS reporting tools for all health services, including HIV services;

[12] *Basic Health Care Provision Fund and the Sokoto State Primary Health Care Development Agency Gateway*, presented by Dr. Tijjani Ahmad Faruk, being a paper presentation by SSPHCDA at the 3-day Stakeholders Capacity Building on Funding for Primary Health Care, Universal Health Coverage and the Right to Health, held by CSJ on the 10th to 12th May, 2022 in Sokoto.

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

[14] State of Primary Health Care Delivery in Nigeria, supra.

[15] State of Primary Health Care delivery in Nigeria, supra, pages 158-159.

- Commission a legal assessment and provide political leadership for the drafting and passage of a Comprehensive State Health Law;

- Develop a Health System Wide Accountability and Performance Management Framework, and engage technical assistance to support its implementation;

- Create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the State, by aligning with the new national drive to adopt a PHC building on its strong Diaspora community.

- Develop a State MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III and forms the basis of state budgeting for health;

- Invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria and HIV control commodities are also available at service provision points.

From available information, the State needs to take further steps to ensure full accessing of resources from the BHCPF. It also needs to deepen the engagement with the BHCPF through transparency, accountability, value for money and citizens' engagement.

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

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

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

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

people, especially the poor to make unnecessary choices between their health and expenditure on other basic rights such as food, housing and education.

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

SECTION SEVEN: HEALTH INSURANCE TO THE RESCUE

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

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

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

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

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

been made marketed to non-government workers. An all-inclusive Scheme will do Nigeria a greater and better deal than the current state of the National Health Insurance Scheme".

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

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

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

S.19 of the SOCHEMA Law provides inter alia for the establishment of the Fund:

There is created the Sokoto State Health Fund (SKSHF) (hereinafter referred to as 'The Fund' to be managed by the Agency.

The Fund shall consist of:
(a) the initial take-off grant from the Sokoto State Government;

(b) Formal Sector Fund; comprising of contributions from students, public and private sector employers who shall contribute 10% and employees shall contribute not more than 5% of the monthly basic salary;

(c) contributions of not more than 10% of monthly basic salaries of all elected and political office holders in the State;

(d) contributions from the informal sector;

(e) Equity Fund; comprising of contributions of not less than 2% of Consolidated Revenue Fund of the Sokoto State Government, 1% of Consolidated Revenue

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

Fund of the Local Government Councils, funds from NHIS for pregnant women, children under-five (5) years and other relevant programs; funds from NHIS and National Primary Health Care Development Agency (NPHCDA) for guaranteeing a minimum health package, donations or Grants-in-Aid from private Organisations, philanthropists, Zakat and Waqf, International Donor Organizations and Non-Governmental Organizations from time to time;

These provisions need to be scrupulously and meticulously implemented.

SECTION EIGHT: RECOMMENDATIONS

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

8.1 Prepare a New Sokoto State Strategic Health Development 2023-2027 and Other Due Policies: The existing SSSHDP II is expiring by effluxion of time in 2022. The Ministry of Health should take steps towards the preparation and adoption of a new SSSHDP III. Beyond the SSSHDP II that is due for review, the State Ministry of Health should also come up with a comprehensive list of all policies and plans that are no longer current and ensure they are revised and updated.

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

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

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

Health-in-all-policies approach is a collaborative approach that integrates and articulates health considerations into policy making across sectors to improve the health of all

communities and people. Health should be made an explicit objective of every policy decision.

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

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

8.7 Prepare the Costing for the Implementation of the Minimum Service Package for Primary Health Care: To ensure proper implementation and funding of the Minimum Service Package, the MSP should be complimented with an Investment Plan that is guided by a Fiscal Space Analysis. The MSP is the minimum core content of PHC, being the minimum package of health services to be delivered at the primary and secondary levels of care funded by the state. This is to ensure the best health/value for money in government expenditure so that scarce resources are deployed to the areas of greatest need and impact.

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

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

8.10 Moratorium on New Capital Projects: Considering that the year 2023 will witness a change in the executive and legislative leadership of the State, there should be a

moratorium on new capital projects and the focus should be on completing existing and ongoing projects. In this way, the resources of the State will not be spread too thin and project abandonment will be minimized.

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

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

8.13 Ensure Maximum Benefits from BHCPF: The State should ensure that it derives the maximum benefits available from the BHCPF through guaranteeing the required counterpart funding, accrediting more health institutions especially PHCs, timely and meticulous retirement of disbursed funds from the NPHCDA and NHIS Gateways.

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

The provisions of the SOCHEMA Law especially a vote of one percent of the CRF of the State and one percent CRF of Local Governments as well as contributions of not more than 10% of monthly basic salaries of all elected and political officeholders in the State to the Sokoto State Health Fund should commence from the 2023 budget.