CHAMPIONS FOR CHANGE

POLICY IN BRIEF

ANALYZING HEALTH FUNDING COMMITMENTS IN THE 2014 & 2015 APPROPRIATION ACTS

BACKGROUND

The health of the citizens of any country is largely dependent on the functionality of the country's health system. In Nigeria, the health sector has suffered due to poor funding, challenges in administration, and inadequate human resources, contributing to poor Maternal and Child Health outcomes.

The Millennium Development Goals (MDGs) which Nigeria committed to in 2000, set out several goals and targets including Goals 3 and 4, which are to "reduce by two thirds, between 1990 and 2015, the under-five mortality rate,'' and ''reduce by three quarters the maternal mortality ratio and achieve universal access to reproductive health," respectively. However, in a 2014 African Union report, Nigeria was listed amongst one of the 15 countries that are not likely to meet the MDG targets.

According to the 2014 Trends in Maternal Mortality report, Nigeria is reported as making slow progress having experienced a reduction in maternal mortality rates from 950 for every 100,000 live births in 2000 to 560 in 2013, this shows an average of about 3% reduction annually . The report reveals further that the estimated maternal deaths for 2013 were 40,000, which arguably is very high when compared to other countries like Rwanda with a MMR of 340 per 100,000 live births. Under five mortality rates (U5MR) have also reduced albeit progressing slowly at an average of 3.4 percent, but the same cannot be said for Nigeria's infant mortality which reduced at a rate of 1.8 percent . Infant mortality rate fell from 75 deaths per 1000 live births in 2008 to 61 deaths per 1000 live births; this is against the 2015 target of 30.3 deaths per 1000 live births, while the U5MR reduced from 157 per 1000 live births in 2008 to 94 deaths per 1000 live births in 2012, also falling short of the 2015 target of 63.7 deaths per 1000 live births.

Civil Society advocates in Nigeria worked assiduously to get the Health Act signed in to law in 2015. The Act seeks to provide additional funding of at least one percent of the Consolidated Revenue Fund to the sector. However, the current drop in oil prices has affected the level of funds accessible to government to meet its obligations.

The purpose of this brief is to provide insights into the trend in health sector funding between 2014-15, to determine the extent to which commitments made by government for health are being met in allocation of resources to Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH), or Integrated Maternal, Newborn, and Child Health (IMNCH), as it is referred to by the Nigerian Government. The brief is intended as a tool to inform civil society efforts to ensure government accountability to its health funding commitments, and to provide information to Legislators to inform their resource allocations to health budgets at the national and sub-national levels.

NIGERIA HEALTH FUNDING COMMITMENTS

Nigeria has made several commitments at both the international and federal levels to provide more funds to the health sector. The first major commitment was made by African Heads of Government in 2001 to commit 15 percent of national budgets to health. At the Every Woman Every Child strategy meeting convened by the UN Secretary General in 2010, Nigeria reaffirmed its commitment to the global community to raise funding for health from an average of 5 percent to 15 percent. At the London Summit on Family Planning in 2013, another commitment was made to increase funding up to US $11.35 million annually to fund Family Planning. Local commitments include a costed plan of the transformation agenda for health, a costed National Health Strategic Plan, and a Vision 20-20-20 National Implementation Plan on Health among others. In spite of these commitments, budgetary allocation in real monetary terms experienced a reduction in growth rate from 2013 to 2015.

In 2014, the health budget allocation as a proportion of the total budget was N264 billion (5.6%). Although in 2015 the total allocation to health reduced to N259 billion, it represented 5.7 percent of the total budget. This reflects a minimal increase of 0.1 percent. The trend in allocations thus demonstrates government's failure to meet its own commitments. The per capita spending on health for 2015 by the Federal government for a population of 170 million people will amount to N1,515 (equivalent to about US $8 per person). This is $23.63 less than the target commitment to increase per capita spending on health, as agreed at the Every Woman Every Child meeting in 2010.

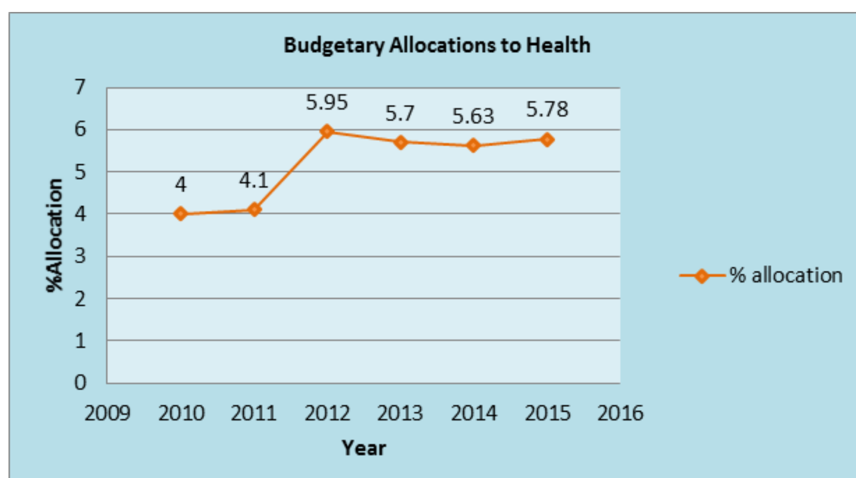

Figure 1: Health Budget Trend Analysis

ANALYSIS OF FUNDING GAPS IN IMNCH PROGRAMS

National Health Insurance Scheme

The three key agencies within the Federal Ministry of Health (FMOH) that have direct roles in providing for IMNCH are the National Primary Health Care Development Agency, the National Health Insurance Scheme and the FMOH headquarters. Others, including all the tertiary hospitals in Nigeria, have an obligation to use part of their income to provide IMNCH services. All three MDAs experienced budget cuts, however the worst hit is the National Health Insurance Scheme, with a budget cut of over 80 percent. The sharp budget cut from N3.042bn in 2014 to N565m presents huge challenges for the agency. The Scheme's entire capital budget is N542m, which is expected to provide for free Maternal and Child Health (MCH) services under the scheme. The table below shows the budget cuts by each agency in nominal terms. This is the face value of the amount, and if the inflation rate is considered, then the real purchasing power of the allocations for 2015 will further decrease.

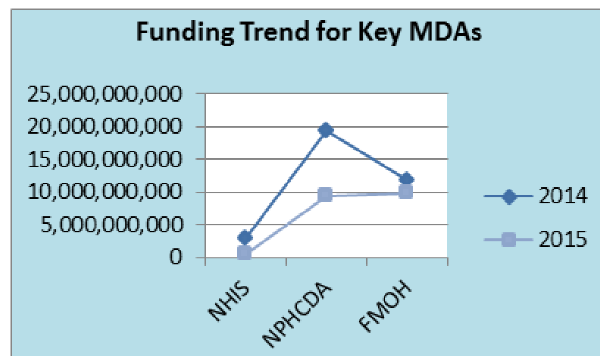

Figure 2: Funding trend Analysis for Key MDAs

Table 1: Showing percentage cuts across key ministries

	NHIS	NPHCDA	FMOH HQ
2014	N3,042,124,039	N19,433,516,695	N11,892,020,677
2015	N565,121,891	N9,426,471,589	N9,914,379,680
Nominal Difference	N2,477,002,148	N10,007,045,106	N1,977,640,997
% Budget Cut	81.4	51.5	16.6

Source: Extracted from 2014 and 2015 Appropriation Acts

FMOH HQ – REPRODUCTIVE HEALTH AND FAMILY PLANNING ALLOCATIONS

The FMOH HQ budget allocations for IMNCH did not only get reduced, but budgetary line items also disappeared in 2015. For instance, provisions for Vesico-Vaginal Fistula (VVF) Centres were no longer considered as seen in table 2 below . It is also common to find budget line items lumped together e.g. ANC and Newborn care, which does not reveal the exact amount budgeted for newborn care. Commitments made by government for Reproductive Health/Family Planning (RH/FP) is to take up funding from US $3m for commodities to US $11,350m annually for the next four years. Nigeria currently has a 16 percent unmet need for Family Planning and contraceptives. At USD 11,350m, Nigeria would need an average of N2.258bn annually to fund its RH/FP commitments. To fund Family Planning Commodities the Nigeria Family Planning Blueprint costed plan indicates USD21.0m and USD28.1m respectively for 2014 and 2015 but only 0.01 percent of this amount was budgeted for, in the 2014 and 2015 Federal health budgets, thus making Nigeria heavily dependent on donors to fill the funding gap.

Table 2: FMOH Budgetary Allocations for RH/FP

Item	2014 N	2014 FP Blueprint $	2015 N	2015 FP Blueprint $
IMNCH	73,643,220		NA	
ANC/Newborn	7,112,788		NA	
Nutrition	29,400,000		NA	
SOML	69,541,780		NA	
Contraceptives	414,500,000	21.0	624,739,731	28.1
VVF	395,968,773		NA	
Total	990,166,561		624,739,731	

Source: Extracted from 2014 and 2015 Appropriation Acts

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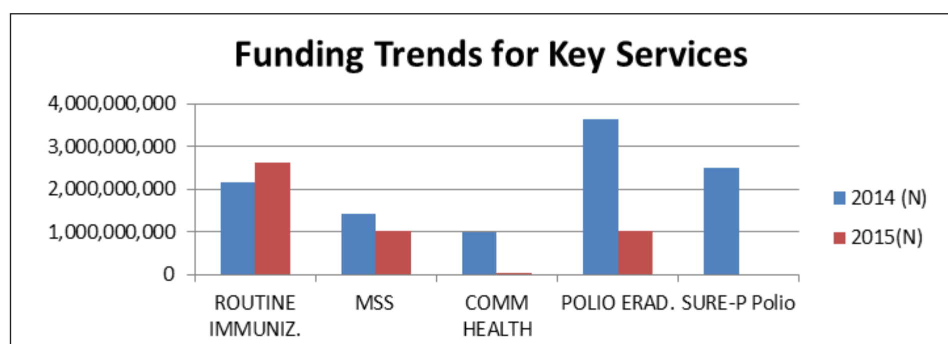

Figure 3: Trend Analysis for MCH Services

PRIMARY HEALTH CARE – IMNCH ALLOCATIONS

The National Primary Health Care Development Agency (NPHCDA) is tasked with the responsibility to coordinate basic health care in Nigeria. It is the agency tasked with Immunization in Nigeria. Its role is mainly to ensure Primary Health Care is accessible to all Nigerians with particular emphasis on coordinating procurement of vaccines and provision of immunization guidelines and technical support to states. NPHCDA, like all other government agencies, enjoys support and funding from many donors, including WHO, World Bank, GAVI, and private foundations. The 2015 budget sets aside N9.964bn as against N17.505bn in 2014 for the NPHCDA capital budget. In 2014, over 150 new construction projects amounting to N7bn were introduced, and in 2015 construction and contracts for supplies were allocated approximately N5.142bn. Budget allocations to Routine Immunization increased by 21 percent in 2015, while polio eradication which was allocated over N6bn in 2014 dropped to N1bn as shown in the graph below.

Vaccine procurement, cold chain and logistics remain a huge challenge in Nigeria, with the urban rich having far more access than rural poor. Much of this challenge is as a result of the delay in the release or non-release of funds to the agencies by the Ministry of Finance (MOF) through the Central Bank of Nigeria (CBN), which has implications for deaths caused by vaccine preventable diseases. The Federal government is the largest contributor to vaccine financing at 76 percent but may likely face huge challenges this year if innovative financing alternatives are not put in place.

The Midwives Service Scheme (MSS) continues to receive funding from the Federal Government, but has suffered a setback in progress made as the states and local government counterpart funding is not paid. This has resulted in personnel abandoning the scheme. The MSS has experienced budget cuts since 2013, while SURE-P provided a stop gap measure. In the coming year there may be no funds from SURE-P, as no clear budget line states so. However there is a lump sum of N3.bn for MCH.

AIDS, TUBERCULOSIS AND MALARIA

With only 8 percent of the entire health budget allocated to the capital budget, funding for services and commodities greatly reduced in the 2015 budget. At an HIV prevalence rate of 3.4% , it is estimated that 3.1 million Nigerians are living with the virus. Of this figure Nigeria contributes 32 percent to the global 80 percent of pregnant women without access to antiretroviral treatment. The impact of HIV has also led to increased Tuberculosis infections. In addition, an average of 215,000 deaths occur yearly from HIV, while Malaria accounts for over 300,000 deaths. The effects of reduced funding for HIV and TB are already being felt, as clients are now asked to pay consultation fees for HIV treatment, which was previously free, thus limiting access for the poor, especially women and children. This may portend serious implications for sustaining the relative progress made in the AIDS Tuberculosis Intervention. Nigeria is heavily dependent on Global Fund to combat ATM, a larger percentage is contributed by Global Fund through the National Agency for the Control of AIDS (NACA), whose budget is not reflected in this analysis, as it is often not made public. However, the Subsidy Reinvestment Program made available in 2015 an additional N2billion to fight AIDS, Tuberculosis and Malaria. The budget is a lump sum which is not disaggregated and may constitute administrative capital expenditure.

SUBSIDY RE-INVESTMENT PROGRAM FOR MATERNAL AND CHILD HEALTH (MCH)

The SURE-P budgeted an additional N3.5bn for the provision of maternal and child health services. It is not clear which agency will benefit from this fund. As with the other programs, the general cuts in budget also applied to the program as seen in the table below.

Table 3: SURE-PMCH PROGRAM FUNDS

Item	2014 (N)	2015 (N)
MCH	12,050,000,000	3,500,000,000
FMOH-Polio Erad	4,120,000,000	0
NPHCDA- Polio Erad	2,500,000,000	0
Counterpart:HIV/AIDS (NACA)	8,000,000,000	2,000,000,000

Source: FGN 2014/2015 Appropriation Act for SURE-P

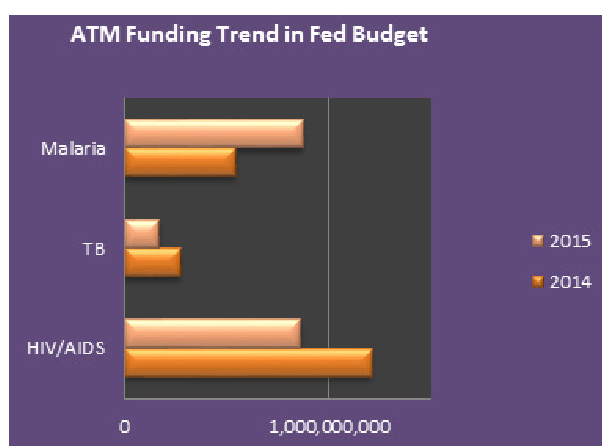

Figure 4: Funding Trend for ATM Programs

CONCLUSION

Nigeria's health policy environment does not lack for good intentions. The expertise that goes into developing policies, plans, blueprints and costing them is commendable because they present the roadmap to overcoming challenges the sector faces. However, these good intentions are not matched by funding, and often the budgeting process does not consult the well laid out plans and commitments made by the Government. Civil Society, which is also actively involved in developing the plans and are aware of the

costs and commitments, are not engaged in the budgeting process and may not be able to influence allocation of funds. None of the MCH programs reviewed in this analysis will operate optimally if alternative funding measures are not put in place.

Donor funding and ad hoc funds such as the SURE-P and MDG seem to be the bedrock of funding strategic programs within the health sector, seemingly hanging citizens' health in a balance. Consistent and timely release of funds by the FMOF has also become an obstacle to access already appropriated funds. Thus delays in the process have resulted in delays in procurement of important MCH commodities and consumables. It is also noticed that all the key programs, such as routine immunization and provision of free MCH, are provided for within the capital budget and often get affected when capital budgets are cut. For the health outcomes of Nigerians to improve, government must strive to keep to its commitments to fund the health sector over a period of time to address these challenges.

RECOMMENDATIONS

- Donor funding makes up a large percentage of funding for very critical areas such as Reproductive Health, Family Planning and the entire Continuum of Care for MCH. Over-dependence on external funds should be discouraged and a homegrown innovative financing mechanism developed to raise funds to support these programs.
- There is a need for government to refer to its plans, policies and commitments and link such to annual budgeting process. This will ensure that government is also tracking the extent to which it is progressively meeting its commitments.
- Budget line items should be more specific and not lumped together as this creates difficulty to track what is budgeted for specific programs.
- Targeted funding schemes, such as SURE-P, are created as stop gap measures, and therefore government should not see them as an alternative source, rather as additional funds to relieve specific funding challenges.
- CSO participation in the budgeting process is important and must be encouraged. CSOs are involved in developing and costing plans, and it is important for them to also be part of the budgeting process.
- Government should move the most critical programs, such as Routine Immunization, to the recurrent section of the budget.

I 2014, Trends in Maternal Mortality: 1990-2013, by United Nations Agencies

II 2014, Nigeria's call to Action to save New born lives, Policy Brief, Federal Ministry of Health

III Nigeria Family Planning Blue print, October, 2014

IV National Primary Health Care Development Agency (2009). Comprehensive Multi Year Plan (CMYP) 2009- 2014

V National HIV&AIDS and Reproductive Health Survey (NARHS Plus II, 2012)

FOR A COPY OF THE NATIONAL POLICY ON THE HEALTH AND DEVELOPMENT OF ADOLESCENTS AND YOUNG PEOPLE IN NIGERIA, PLEASE VISIT:

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New Federal Secretariat Complex, Phase III,
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ABOUT CHAMPIONS FOR CHANGE:

Champions for Change (C4C) invests in visionary local leaders and organizations to sustainably improve health outcomes for women, children and youth in Sub-Saharan Africa. C4C achieves large-scale impacts through advocacy, leadership development, organizational strengthening, and grant making. In Nigeria, C4C's national network is advocating for improved reproductive, maternal, newborn, child, and adolescent Health (RMNCAH). In Kenya, C4C works to prevent and combat Non-Communicable Diseases (NCDs) among young people through locally-led advocacy.

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