Anambra State Recent Budgets and Water and Sanitation Projects across Primary Healthcare Centres in Three Focal LGAs

A Technical Report Submitted to

(Centre LSD)

With Financial Assistance from

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TABLE OF CONTENTS

Table of contents.....i
Acknowledgement.....iii
1. Introduction.....01
2. Study Approach/Methodology.....04
3. Major Findings.....06
3.1 Summary of Findings of the PHC Facility Assessment Report.....06
3.2 Highlight of Findings - Anambra State Public Health Expenditure Review (PHER) 2014 - 2020.....10
3.3 A Review of Anambra State Recent Budgetary Allocations to Water and Sanitation Projects in the Focal LGAs.....12
Figure 1**.....12**
Figure 2**.....15**
Figure 3**.....17**
Figure 4**.....19**
3.4 Budgetary Allocation to the Health Sector.....20
Table 1**.....22**
Table 2**.....23**
Table 3**.....23**
Table 1**.....24**
3.5 Budget Credibility and Experience Trends.....25
Table 5**.....25**
Table 6**.....26**
Table 7**.....27**
Table 8**.....27**
Table 9**.....28**
Table 10**.....29**
Table 11**.....30**
3.6 Composition of the Health Sector Budget.....30
Table 12**.....31**
Table 13**.....31**
Table 14**.....32**
Table 15**.....33**
Table 16**.....33**
Table 17**.....34**

TABLE OF CONTENTS

Table 18**.....39**
Table 19**.....39**
Table 20**.....40**
Table 21**.....41**
Table 22**.....42**
Table 23**.....42**
Table 24**.....44**
3.9 Correlation between issues with Anambra State Recent Budget and Current State of PHCs in the Three Focal LGAs - Responses from the Field.....44
Figure 5**.....45**
Figure 6**.....46**
Figure 7**.....47**
4. Conclusion.....48
5. Recommendations.....49
Annex 1**.....51**
6. About Centre LSD.....57

ACKNOWLEDGEMENT

The consequent improvement in the Primary Health Care (PHC) facilities in Anambra state in the three focal local government of Aguata, Idemili and Nnewi South which came by addressing the concerns of access to clean water, poor sanitation, and hygiene conditions across the facilities was a product of the efforts of the Community Empowerment Network (COMEN), the Justice Development and Peace Caritas (JDPC) Nnewi and the African Centre for Leadership, Strategy and Development (Centre LSD) with the support of IBP Spark.

The #FixMyPHC campaign which was a major output of the project made many individuals and organisations to contribute tangible and intangible resources towards the changes that are noticeable in the PHC facilities today.

We are grateful to the Almighty God, the giver and sustainer of life for preserving us, all through the year of the harvest of death due principally to the covid-19 pandemic. To the IBP Spark team, we are grateful for your sustained support and encouragement. The project undoubtedly changed the PHCs narrative in Anambra state judging by the intersection between access to clean water, sanitation, hygiene and health care delivery. We thank our state level partners including JDPC Nnewi and the COMEN team. Your deliveries were heart warming. And to the staff and management of Centre LSD, you are the best. Your penchant and determination for the transformation of society is legendary and always reinforce the hope that a new Nigeria is possible.

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Centre LSD
February 2020

1. Introduction

The productivity of any society depends on the quality of human capital that is available in the society. The quality of human capital available in a society, on the other hand, depends largely on the health and wellbeing of the people, as well as the level of educational development of the minds of the people for improved productivity. The Constitution of the Federal Republic of Nigeria recognises "right to life" as one of the fundamental human rights of the citizens of Nigeria. However, it can be argued that there is no guarantee to the citizens' right to life without commensurate right to health. The centrality of the health and wellbeing of the people in making for productive society explains the reason for the National Assembly to come up with the National Health Act, 2014.

Health has remained an important issue of discussion on various platforms across the globe. Therefore, the 1978 International Conference on Primary Health Care, which held in Alma-Ata, proved that health does not necessarily imply the absence of disease or infirmity, but implies a State of complete physical, mental, and social wellbeing. The Conference also saw the attainment of highest possible level of health as the attainment of the most important worldwide social goal. This position corroborates our argument that the attainment of "right to life" cannot be guaranteed without the attainment of the right to health of Nigerian citizens.

Nigeria operates a federal system of government and therefore allocates powers and responsibilities to various tiers of government. As a federation, there is the national government otherwise known as the Federal Government of Nigeria. There are also sub-national governments, otherwise known as State Governments and Local Governments. These three tiers of government have their various functions and powers. Certain functions are exclusively reserved for only the Federal Government of Nigeria – Exclusive Legislative List. Some others are shared between the national and sub-national governments – Concurrent Legislative List. The rest of the functions are reserved for only the sub-national governments – the Residual Legislative List.

Provision of health services as a function of government is classified among the concurrent legislative list. This implies that the three tiers of government (Federal, State and Local Governments) share the responsibility of providing all necessary services which will guarantee the attainment of full State of health by Nigerians. However, each tier of government is allocated specific aspects of health service

provision to avoid overconcentration of activities in some areas while neglecting other aspects. Therefore, the provision of primary healthcare services, though a primary function of the Local Governments, yet is closely supervised by the State Government and supported by the Federal Government.

As a response to the stipulations of the National Health Act, 2014, the Federal Government of Nigeria instituted the National Primary Health Care Development Agency (NPHCDA). The State Governments followed the steps to establish their States' Primary Health Care Development Agency (SPHCDA). Therefore, Anambra State Government instituted Anambra State Primary Health Care Development Agency (ANSPHCDA). The State Government therefore makes budgetary provisions for the delivery of primary healthcare services in the State. Even before the institution of ANSPHCDA, the State Government has been making budgetary provisions for the delivery of primary healthcare services in the State through the State Ministry of Health.

However, the provision of primary healthcare services in Anambra State has not yet attained its expected heights. The primary health sub-sector in Anambra State is still associated with lack of basic infrastructures and drugs in the facilities. As a result, those who access primary healthcare services in these public facilities end up not receiving maximum service delivery. On the other hand, those who can afford costlier alternatives usually resort to patronising private healthcare facilities. Similarly, primary healthcare sub-sector in Anambra State is equally burdened by the absence of sufficient healthcare workers who should manage the facilities. Given the depreciating State of public primary healthcare facilities across the State, the African Centre for Leadership, Strategy and Development (Centre LSD) has carried out a study on the State of public primary healthcare facilities across three Local Government Areas (LGAs) of Anambra State. The three focal LGAs of the State covered in the study include Nnewi South, Aguata and Idemili South LGAs.

Apart from some other issues associated with the availability of drugs and healthcare personnel in the facilities, the study identified the State of water and sanitation facilities in the primary healthcare (PHC) facilities as a major problem bedevilling the facilities in the three focal LGAs. Therefore, there is need to examine the budgetary provisions of the State Government in the light of water and sanitation projects across the primary healthcare facilities in the State. As a result, this study examines the report

of the PHC facility assessment exercise by Centre LSD as mentioned above and uses the findings of the report as a basis to unravel the budgetary reasons for service delivery failures/issues at the PHC facilities. The study equally shows and categorises the issues clearly in line with Anambra State budget and carry out a comparative analysis of the issues shown and categorized in the budget. The categorisation of issues in the budget is done in such a way as to suggest means of improving budgetary allocations/funding and execution (release and spend) to address issues identified in the facility assessment.

2. Study Approach/Methodology

This study adopts multiple approaches to the examination of Anambra State budgetary allocations to primary healthcare service sub-sector. The multiple approaches involve both the data collection processes and the data analysis techniques. For the data collection approaches, this study adopts primary and secondary data collection approaches. The primary data collection approaches adopted in this study involve the collection of responses and views from stakeholders in the primary healthcare delivery subsector. These stakeholders include health workers in the primary healthcare facilities, end-users of the primary healthcare services, officials of government supervising the activities of primary healthcare facilities, and the communities where primary healthcare facilities are sited. To be able to elicit information from these relevant stakeholders, this study employs the research instruments of well-structured questionnaires and key informant interview guide. These two instruments are known for their ability to generate and gather relevant quantitative and qualitative information from the stakeholders who serve as respondents.

On the other hand, the secondary data collection approaches adopted in this study involve the collection of existing relevant documents of government on the subject matter of study and sieving the relevant parts of the documents. Prominent among the documents is the annual fiscal budget of Anambra State Government in recent years (FY 2014- FY 2020). Other relevant documents accessed and used in this study include the report of the primary healthcare facilities assessment exercise conducted by Centre LSD.

The multi-method approaches adopted in this study do not end with the process of data collection, but also include the data analysis processes. In essence, this study adopts both quantitative and qualitative methods of data analysis with great emphasis on presenting the information in a well convincing, concise, and precise manner as to be well understood by relevant audiences of this study. To a large extent, this study greatly adopts the quantitative methods of descriptive statistics for data analysis. This method involves the presentation of collected information and data in charts, graphs, and tables. The method also involves the presentation of information in percentages and frequencies, thereby showing popular opinions among various stakeholders of the subject matter.

In addition, the study adopts qualitative method of data analysis. This method involves content analysis of qualitative opinions presented by respondents during interviews. Given that in-depth interviews of key informants do not restrict the opinions of the respondents to certain options, respondents are free to express their views in various manners. Pictorial evidence of status of different PHCs in the three LGAs were also taken and included in the report. However, during analysis, these various opinions are grouped to form analytical points of expression. Therefore, in adopting this method of data analysis, adequate care is always needed and taken to ensure that the information presented represents the opinions of the relevant stakeholders.

Finally, the report was presented for validation by different Stakeholders (Civil Society Organisations, Organised Private Sector, Professional Associations including the State chapter of the Nigerian Medical Association, Association of Midwives and Nurses, Federation of Women Lawyers amongst others) in the State including Government representatives from different Ministries, Departments and Agencies (MDAs) as well as the Anambra State Primary Healthcare Development Agency. After the presentation, questions and comments were equally entertained and the Anambra State Primary Health Care Development Agency requested that some of their recent interventions which have not been published be incorporated in the report. The Anambra State Primary Health Care Development Agency provided the authors with their write up which is included in the report as Annex 1.

3. Major Findings

Looking at the specific objectives of this study, there are major issues considered as the focus of the findings of this study. These issues can be categorised and discussed under two broad subheads. The first subhead is a summary of the findings of the PHC facilities assessment report produced by Centre LSD. Within this subhead, this study critically examines the main issues raised in the report. The study equally shows how the identified status of the PHC facilities can hamper healthcare service delivery across the three focal LGAs of Anambra State. The second subhead has to do with a critical review of Anambra State fiscal budgets in the light of budgetary allocations to water and sanitation facilities in the PHC centres. This subhead of budget review looks at the status of PHC facilities in the State as an outcome of the budgetary provisions of the Government for projects and programmes that enhance service delivery across the facilities.

3.1 Summary of Findings of the PHC Facility Assessment Report

Healthcare service delivery is an important component of the social services sector of government functions. Healthcare service delivery is classified into primary healthcare, secondary healthcare, and tertiary healthcare services. The nature of service depends largely on the nature of ailment and the nature of services needed to be rendered to contain the ailment.

Primary healthcare facilities are therefore the nearest service points to the people, even at the grassroots. Basic healthcare services are expected to be given to these people who do not need to travel for a long time to access required services. However, the PHC facilities assessment report by Centre LSD reveals that there are about fourteen (14) problems associated with the primary healthcare facilities assessed. The problems include:

a) Absence of Public Electricity
b) Placenta Pits, Disposable Bins, Sewage Tanks
c) Toilets/Bathrooms
d) Solar Refrigerators
e) Mopping Sticks, Mopping Buckets & Disinfectants
f) Water
g) Drug Rooms
h) General Cleanliness
i) Ambulances
j) Waste disposal

k) Drainages
l) Cleaners/Labourers
m) Beds/Beddings
n) Window Blinds/Mosquito Nets/Window Nets

This study focuses on water and sanitation facilities across the primary healthcare centres in the three focal LGAs. Therefore, this summary of the problems found across the primary healthcare facilities also focuses on the problems that are related to water and sanitation infrastructures at the primary healthcare facilities. Out of the fourteen identified problems across the PHC facilities, there are eight (8) problems that are strongly associated with water and sanitation infrastructures. Therefore, this summary focuses on the eight (8) problems as discussed below:

a) **Mopping Sticks, Mopping Buckets & Disinfectants:** The overall cleanliness of interior floors of primary healthcare facilities largely depends on regular mopping of the floor. It therefore follows that to maintain high level of hygiene in the facilities, every facility should have mopping sticks, mopping buckets and disinfectants. All the 21 primary healthcare facilities assessed during the exercise had mopping sticks. Similarly, out of the 21 PHC facilities assessed, only one facility had no mopping bucket. Each of the 21 PHC facilities uses one form of disinfectants or the other during their mopping.

b) **Waste disposal:** It is not arguable that primary healthcare facilities are producers of solid and liquid waste. The wastes can be produced by the healthcare service providers during treatment. They can as well be produced by the patients/caregivers during their visits. As a result, the availability of waste disposal in every primary healthcare facility is a necessity. This will ensure that the facilities constantly maintain an environment of utmost health. Observation during the exercise shows that virtually all the primary healthcare facilities had a form of waste bin for their waste collections and disposals. However, some of the items used as waste bins in the PHC facilities are not hygienic and safe enough. For instance, the practice of using cartons as waste bins may contaminate the person that will dispose them at the end of the day since they may not retain all forms of wastes after collection. Similarly, the practice of using disused drums for waste collection may not also be hygienic and safe. This is because the body and edges of the drums may cut the hands of those who want to dispose of their waste thereby causing wounds.

c) **Placenta Pits, Disposable Bins, Sewage Tanks:** To regularly maintain sanitation and hygiene at the primary healthcare facilities, there should be placenta pits for burying of placentas after child deliveries, and disposable bins as well as sewage tanks for solid and liquid human wastes. Given that primary healthcare facilities are the first point of call for diarrhoea patients, the relevance of sewage tanks and disposable bins in such situations cannot be overemphasised. The PHC facilities assessment report reveals that except in two PHCs, there are placenta pits, disposable bins, and sewage tanks in all the PHCs covered during the assessment. However, one of the PHC facilities had a placenta pit that had been filled up and therefore closed.

d) **Cleaners/Labourers:** Sometimes, the work of keeping the PHC facilities neat cannot be effectively combined with healthcare services. It therefore requires different persons apart from the healthcare service providers to perform the function of cleaning the interior and exterior environments of the facilities. However, observations during the assessment exercise show that in some PHCs, there are community volunteers who assist the staff nurses and midwives with cleaning, while in some others, there are none. But even in those PHC facilities where there are volunteers, the cleaning, mopping, and clearing activities that need to be done at the PHCs are too laborious to be effectively performed by the volunteers alone. As a result, in both cases (i.e., where there are volunteers and where there are none), the staff nurses and midwives still join in performing the ancillary function of cleaning the environment. And the combination of duties leads to inefficiency in both areas of maintaining hygienic standards at the PHCs and rendering adequate healthcare service to the patients.

e) **General Cleanliness:** Being an environment for restoring the health of people, Primary healthcare facilities should be clean and safe. Apart from the cleanliness of the interior environments, the exterior environments and surroundings of the facilities should also be clean and clear. Where the facilities are detached from residential areas, the pathway leading to the facilities should be cleared regularly. This will ensure that users of the facilities do not fall into ditches and are not attacked by reptiles on their way to render or obtain healthcare services. However, the PHC facilities assessment report reveals that only two of the PHC facilities (actually, modern ones) have concrete floors within the exterior part of the premises. The rest of the facilities have their

premises overgrown with weeds and/or littered with refuse. To this end, staff nurses and midwives that are expected to combine general cleanliness at the PHC facilities with their regular healthcare services have proved that it is difficult to combine effectively and efficiently the two.

f) **Water:** Water availability is the pivot of every effort to maintain sanitation and hygiene anywhere, including the primary healthcare facilities. The nature of activities that are carried out in primary healthcare facilities demands regular supply of potable/safe water for drinking, bathing, flushing of toilets and other uses. However, the PHC facilities assessment report shows that potable/safe water is available in only one PHC facility. This facility can boast of supplying potable water as there is a water treatment infrastructure within the PHC facility. In addition to this one, two other facilities have functional boreholes, which enable them to supply water for bathing and flushing of toilets, though not confirmed to be safe for drinking. The rest of the PHC facilities harvest rainwater or buy water in bits for sanitation purposes. As a result, patients/their caregivers bear the extra burdens of drawing their own water for bathing and flushing of toilets as the need arises during rainy seasons. Alternatively, the patients/their caregivers bear the extra burdens of buying their own water for bathing and flushing of toilets as the need arises during dry season. In addition, the patients/their caregivers buy sachet water for drinking, which is not only costly to maintain for a long time, but also come with the propensity to constitute environmental nuisance. Most of the PHC facilities with non-functional water supply systems attest to have only minor challenges, like plumbing corrections of old or broken pipes which need to be replaced or fixed. In some other facilities, the challenges are major like the replacement of non-functional sumo/water pumping machines. Whatever the case may be, the relevance of water supply system in the overall efficient functioning of the PHC facilities cannot be overemphasised.

g) **Toilets/Bathrooms:** Primary healthcare facilities are set up to cater for those in need of basic healthcare services including those that suffer from diarrhoea. In addition, patients and/or their caregivers may be pressed at any point in time within their visit to the PHC facilities and therefore demand visiting the conveniences. It therefore follows that the availability, accessibility and usability of the toilets and bathroom infrastructures within the primary healthcare facilities must be guaranteed at every point in time. However,

observations during the PHC facilities assessment reveal that none of the toilet and bathroom infrastructures in the entire PHC facilities meets minimum standards that may be required of health development systems. In rare cases of some PHC facilities having recently built toilets and bathrooms and covered with modern infrastructures, they are not usually connected to water supply system. In some others, there are no toilets and bathrooms at all. As a result of all the issues above, patients and/or their caregivers' resort to defecating in the surrounding bushes to the healthcare facilities.

h) **Drainages:** To a large extent, the presence or otherwise of drainages at the primary healthcare facilities contribute to the overall cleanliness or otherwise of the PHC facilities. With proper channelling of water to the drainages, flooding and other associated problems will not deter patients as well as their caregivers from accessing healthcare services from the PHC facilities at any time of the year. Apart from flooding, the absence of drainages in the facilities can give the facilities general look of dirtiness and can even create gullies along the pathways that lead to the main facilities. However, the PHC facilities assessment report shows that it is only in two of the PHC facilities that drainages were deliberately factored into during the construction of the facilities. In the rest of the facilities, there were no deliberate provisions for drainages, which could result in flooding especially in the rainy season. As a result, those in need of primary healthcare services may find it difficult accessing the facilities during such seasons.

3.2 Highlight of Findings - Anambra State Public Health Expenditure Review (PHER) 2014 - 2020.

- Annual Budgetary allocation and spending on the Health Sector in Anambra State have remained below 2014 level despite the government's promise to prioritise the sector. The State collected 99.51percent of its targeted revenue between 2015 and 2019, but that failed to translate to improved budget execution. Budget performance for the health sector averaged 41.04percent between 2014 and 2019.

- Anambra State budget for the rehabilitation of PHCCs, a program critical to ensuring water and other necessary sanitation and hygiene equipment is available at the facilities, has severe budget credibility issues. In 2014, the State

government policy set out to rehabilitate and equip 50 primary health care centres in Anambra State between 2015 and 2020. Public expenditure review shows that the State government allocated approximately N11.89 billion between 2014 and 2020 for the rehabilitation of Primary health care centres and general hospitals. However, budget performance in 2014, 2015 and 2016 was only a paltry 13.52 per cent, 6.32percent and 18.02 per cent.

- Public spending on the provision of medical supplies at Primary health care centres was abysmal, hence lack of essential medical and cleaning materials at primary health care centres. Budget performance for programs designed to ensure medical supplies are at the primary health care facilities was the State only N144.29million representing only 6.8percent of the N2.12billion budgetary allocation for medical supplies between 2014 and 2019.

- The Anambra State government did make budgetary allocation for the training of medical personnel in the fiscal year 2018, 2019 and 2020. Still, in the fiscal year 2018 and 2019, no money was released by the State for the program. Given that cleaning of medical facilities requires some form of specialised training, the State government seems not to prioritise the program, and that may be a contributory factor for the issues relating to cleanliness at the primary health care centres.

- Underspending of Anambra State's health sector budget was less of a money issue. Throughout the reviewed period, the unspent amount returned into the treasury was significantly higher than the variance between the amount allocated to the health sector and actual expenditure. For instance, In 2015, the health sector budget was underspent by N6.83 billion even though N13.5billion returned into Anambra State's treasury as an unspent fund. Same can be said for all the years under review.

- Health-related spending averaged 2.78percent of aggregate expenditure between 2015 and 2019, notably short of the "Abuja conference" target, where African Union countries pledged to set a goal of spending at least 15percent of their aggregate expenditure to improve the health sector.

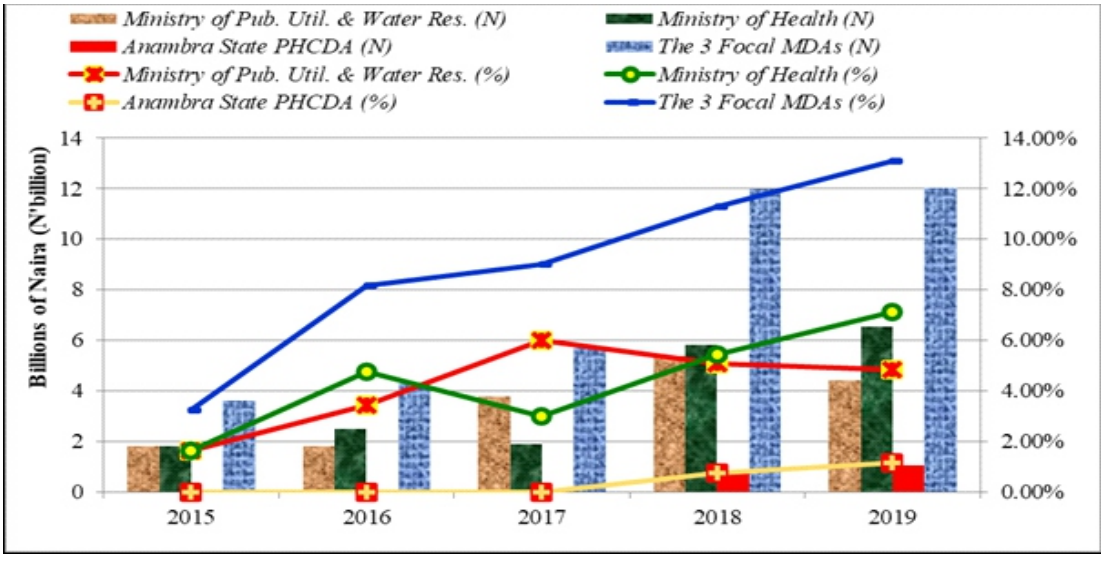
- Per capita public health spending has fallen from 2014 level of $2.87 per person per year to $1.68 per person per year in 2019- which is significantly lower than the World Health Organization(WHO) recommended target of $86.

3.3 A Review of Anambra State Recent Budgetary Allocations to Water and Sanitation Projects in the Focal LGAs

Annual budgets of any State Government are not only an economic document, but also a political document with which the Government makes provisions for actualising the promises it made to the people during electioneering campaigns. As an economic document, the budget makes provisions for items that are of great concern/priority to the State Government.

In making budgetary provisions for water and sanitation at the PHC facilities level in Anambra State, three focal Ministries, Departments and Agencies (MDAs) of government should be concerned. The three focal MDAs include the State Ministry of Health, Anambra State Primary Health Care Development Agency, and the State Ministry of Public Utilities and Water Resources (which metamorphosed to Ministry of Public Utilities as at 2018 before becoming the Ministry of Power and Domestic Water Development in 2019). Below is a graphical presentation of the budgetary allocations of capital projects to the three focal MDAs in recent years.

Figure 1: Budgetary Allocations to the 3 Focal MDAs for Capital Projects in Anambra State



Source: *Anambra State Approved Budgets (2015 – 2019)*

Figure 1 above shows that as of 2015, capital expenditures budgetary allocation to the State Ministry of Public Utilities and Water Resources stood at N1.8 billion, which represents about 1.62% of the total capital expenditures budget of the State Government in the same year. The allocated amount to the Ministry remained the same N1.8 billion in 2016 but represents about 3.42% of the total capital expenditures budget of the State Government in 2016 fiscal year. There were steady increases in the allocated amounts to the Ministry in 2017 and 2018 to N3.791 billion and N5.396 billion, respectively. The allocated amounts represent about 5.99% and 5.07% of the total capital expenditures budget of the State Government in 2017 and 2018 fiscal years, respectively.

Similarly, capital expenditures budgetary allocation to the State Ministry of Health as of 2015 stood at N1.8 billion, which represents about 1.62% of the total capital expenditures budget of the State Government in the same year. The allocated amount to the Ministry increased to N2.5 billion in 2016 before decreasing to N1.896 billion in 2017. The allocated amounts to the Ministry represent about 4.74% and 3.0% of the total capital expenditures budget of the State Government in 2016 and 2017 fiscal years, respectively. The allocated amounts to the Ministry increased in each of 2018 and 2019 fiscal years to N5.804 billion and N6.541 billion, respectively. The amounts represent about 5.45% and 7.12% of the total capital expenditures budget of the State Government in 2018 and 2019 fiscal years, respectively.

Anambra State Primary Health Care Development Agency is a relatively young institution. The Agency started receiving budgetary allocation from 2018 fiscal year. In that particular year, the total sum of N800 million was allocated to the Agency for capital projects. This amount represents only about 0.75% of the total capital expenditures budget outlay of the State Government in 2018 fiscal year. By the year 2019, capital expenditures budgetary allocations to the Agency increased to N1.048 billion, thereby representing about 1.14% of the total capital expenditures budget of the State Government in 2019.

Drawing from the above discussions, total sum of N3.6 billion representing about 3.24% of total capital expenditures budget of the State Government was allocated to the three focal MDAs as at 2015. There were steady increases in the allocated amounts to the three focal MDAs from N4.3 billion, N5.687 billion, N12.001 billion to N12.012 billion respectively in 2016, 2017, 2018 and 2019 fiscal years. In the same way, there

were increases in the proportions of the allocations to the three focal MDAs in total capital expenditures budget of the State Government. The proportions increased from 8.16% in 2016 to 8.99% in 2017, and a further increase to 11.28% in 2018 before settling at 13.08% in 2019.

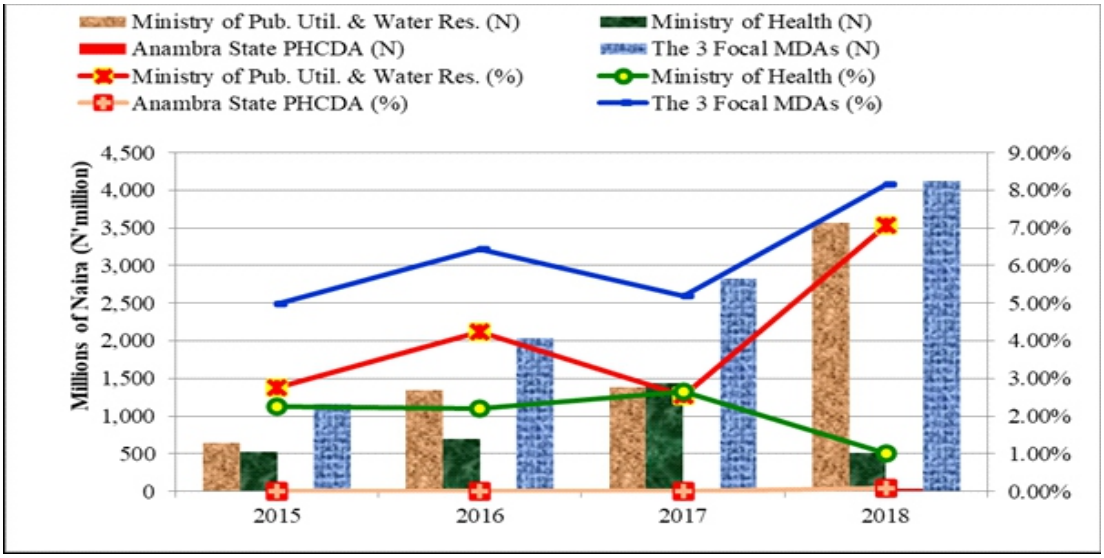
Experience has shown that it is one thing to make budgetary provisions in Nigeria and another thing to spend on the items for which budgetary provisions had been made. As a result, it may not be a holistic discussion to focus only on the budgetary provisions for these focal MDAs without looking at their budget performances. However, it should be noted that even at macro level, there is a general problem of poor budget performance in Anambra State.

Observation from the budget documents of 2015 – 2019 fiscal years reveals that Anambra State Government allocated the sum of N110.979 billion to capital projects in the 2015 approved budget. But out of this huge amount, only the sum of N23.367 billion, which represents about 21.06% of the budgeted amount was spent on capital projects by the State Government in the same year. Similarly, out of the N52.696 billion budgeted for capital projects by the State Government in 2016, only the sum of N31.715 billion, representing about 60.19% of the budgeted amount was spent on capital projects by the State Government in the same year. Within the study period (i.e., 2015 – 2019), the best record of budget performance occurred in 2017 fiscal year. As of 2017, the total sum of N63.282 billion was budgeted for capital projects by the State Government. Out of this amount, the sum of N54.371 billion, representing about 85.92% of the budgeted amount was spent on capital projects by the State Government in the same year. But the tempo was not sustained as budgeted amount for capital expenditures of the Government increased to N106.432 billion in 2018, whereas actual expenditures on capital projects in the same year decreased to N50.583 billion. The actual expenditures represent about 47.53% of the budgeted capital expenditures of the State Government as of 2018.

Given the observation variances in Anambra State budget performances at the aggregate level, it is not strange to observe similar huge variances in the budget performances of the MDAs that make up the State aggregate records. Considering the allocations to the three focal MDAs, the best record of budget implementation occurred in 2017, when out of the total budgeted sum of N5.687 billion, the sum of N2.824 billion was actually spent on capital projects within the focal MDAs. The

actually spent amount represents about 49.66% of the budgeted amount. On the other hand, the worst record of budget implementation occurred in 2015, when out of the total budgeted sum of N3.6 billion, only the sum of N1.166 billion was actually spent on capital projects within the focal MDAs. The spent amount represents only about 32.38% of the budgeted amount. Below is a graphical presentation of actual capital expenditures within the three focal MDAs in recent years.

Figure 2: Actual Allocations to the 3 Focal MDAs for Capital Projects in Anambra State



Source: *Anambra State Approved Budgets (2015 – 2019)*

Figure 2 above shows that as at 2015, actual capital expenditures of the State Ministry of Public Utilities and Water Resources stood at N641.45 million, which represents about 2.75% of total actual capital expenditures of the State Government in the same year. By the year 2016, actual capital expenditures of the Ministry had increased to N1.345 billion, representing about 4.24% of total actual capital expenditures budget of the State Government in 2016. There were similar increases in the actual capital expenditures of the Ministry in 2017 and 2018 to N1.381 billion and N3.572 billion, respectively. The actual amounts represent about 2.54% and 7.06% of total actual capital expenditures of the State Government in 2017 and 2018 fiscal years, respectively.

Similarly, actual capital expenditures of the State Ministry of Health as at 2015 stood at the sum of N524.143 million, which represents about 2.24% of the total actual capital expenditures of the State Government in the same year. There were increases in the

actual capital expenditures of the Ministry in 2016 and 2017 to N693.868 million and N1.443 billion, respectively. The actual amounts represent about 2.19% and 2.65% of total actual capital expenditures of the State Government in 2016 and 2017 fiscal years, respectively. Actual capital expenditures of the Ministry decreased to N509.414 million in 2018. This amount represents about 1.01% of total actual capital expenditures of the State Government as at 2018.

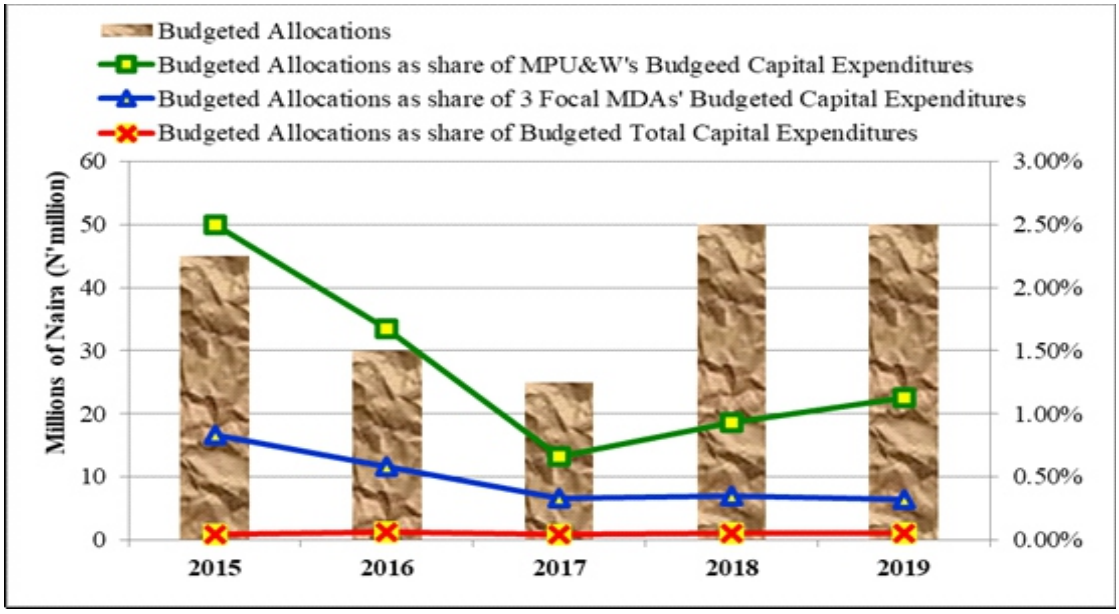
As earlier noted, Anambra State Primary Health Care Development Agency is a relatively young institution that started receiving budgetary allocation from 2018 fiscal year. This explains why figure 2 above shows that the Agency did not record any actual capital expenditures before 2018 fiscal year. In 2018 fiscal year, the Agency's actual capital expenditures stood at N41.391 million, representing about 0.08% of total actual capital expenditures of the State Government in 2018.

From all the above discussions, total sum of N1.166 billion representing about 4.99% of total actual capital expenditures of the State Government was spent by the three focal MDAs as of 2015. There were steady increases in the spent amounts to the three focal MDAs from N2.039 billion to N2.824 billion and to N4.122 billion respectively in 2016, 2017 and 2018 fiscal years. However, there were fluctuations in the proportion of actual capital expenditures of these focal MDAs in total actual capital expenditures of the State Government. The proportions increased from 4.99% in 2015 to 6.43% in 2016 but declined to 5.19% in 2017 before settling increasing to 8.15% in 2018.

Having discussed the trends of budgetary allocations as well as budget performances across the three focal MDAs of this study, it is important to discuss allocations to water and sanitation projects in the primary healthcare facilities. An in-depth scan of the annual budgets of Anambra State reveals that there are no allocations to water and sanitation projects across primary healthcare facilities in the State. Even the annual budgets of the State Primary Health Care Development Agency do not make any budgetary provisions for water and sanitation projects in the primary healthcare facilities. As a result, this study considers any budgetary provisions for water and sanitation projects in the three focal LGAs as a proxy for our discussion instead of focusing only on those water and sanitation projects that are specifically located in primary healthcare facilities.

Even with a broad view of water and sanitation projects across the three focal LGAs, the study could not find any sanitation project in the budgets of the three focal MDAs that are targeted at any of the three focal LGAs. This implies that the study must rely only on water projects across the three focal LGAs. It is equally important to highlight that there are only five projects that appeared in the annual budgets of the State Ministry of Public Utilities and Water Resources which are in any of three focal LGAs. However, only four of these five projects received any budgetary allocation in any of the five years under consideration (i.e., 2015 – 2019). The four water projects that received budgetary allocations in any of the annual budgets of State Ministry of Public Utilities and Water Resources within the study period include Agulu-Aguinyi Water Supply Scheme, Oraifite/Ozubulu Water Scheme, Oba Water Supply Scheme, and Alor Water Supply Scheme. On the other hand, Ojoto Water Scheme, which appeared in the annual budgets of the Ministry received no budgetary allocation throughout the study period. Figure 3 below presents the aggregate budgetary allocations to these projects within the study period.

Figure 3: Budgetary Allocations of the 3 Focal MDAs to Water and Sanitation Projects within the 3 Focal LGAs of Anambra State



Source: *Anambra State Approved Budgets (2015 – 2019)*

From figure 3 above, the sum of N45 million was allocated to the water projects located in the three focal LGAs as of 2015. This amount represents about 2.50% of the capital expenditures budget of the State Ministry of Public Utilities and Water Resources, about 0.83% of the capital expenditures budget of the three focal MDAs of this study, and about 0.04% of the total capital expenditures budget of the State Government in 2015.

As of 2016, the total sum of N30 million was allocated to the water projects located in the three focal LGAs. This amount represents a decline of about 33.33% from the amount allocated to the projects in 2015. The amount also represents about 1.67% of the capital expenditures budget of the State Ministry of Public Utilities and Water Resources, about 0.58% of the capital expenditures budget of the three focal MDAs of this study, and about 0.06% of the total capital expenditures budget of the State Government in 2016.

As of 2017, the total sum of N25 million was allocated to the water projects located in the three focal LGAs. This amount represents a decline of about 16.67% from the amount allocated to the projects in 2016 and an aggregate decline of about 44.44% from the amount allocated to the projects in 2015. The amount equally represents about 0.66% of the capital expenditures budget of the State Ministry of Public Utilities and Water Resources, about 0.33% of the capital expenditures budget of the three focal MDAs of this study, and about 0.04% of the total capital expenditures budget of the State Government in 2017.

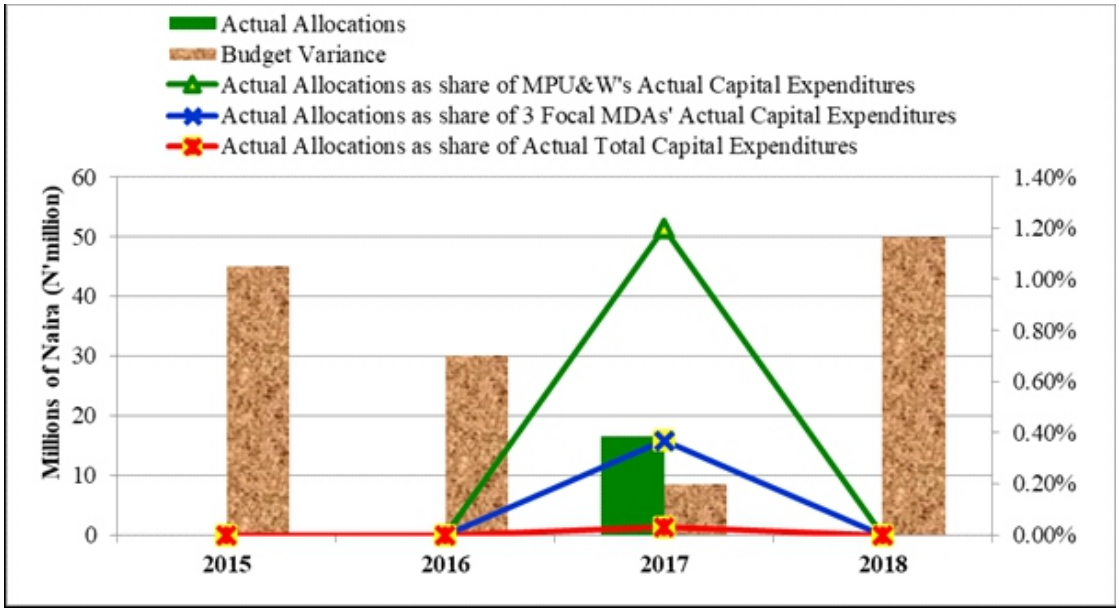
The total sum of N50 million was allocated to the water projects located in the three focal LGAs as at 2018. This amount represents an increase of 100% from the amount allocated to the projects in 2017. The amount equally represents about 0.93% of the capital expenditures budget of the State Ministry of Public Utilities and Water Resources, about 0.35% of the capital expenditures budget of the three focal MDAs of this study, and about 0.05% of the total capital expenditures budget of the State Government in 2018.

The same sum of N50 million allocated to water projects located in the three focal LGAs as at 2018 was still allocated to them in 2019. The amount represents about 1.13% of the capital expenditures budget of the State Ministry of Public Utilities and Water Resources, about 0.32% of the capital expenditures budget of the three focal MDAs of

this study, and about 0.05% of the total capital expenditures budget of the State Government in 2019.

As Stated earlier, making budgetary provisions for projects does not necessarily translate to implementing the projects. It is therefore imperative to consider the level of implementation of these few water projects that appeared in the annual budgets of the State Government throughout the study period of 2015 – 2019. Figure 4 below is a graphical presentation of the level of budget implementation.

Figure 4: Actual Allocations of the 3 Focal MDAs to Water and Sanitation Projects within the 3 Focal LGAs of Anambra State



Source: *Anambra State Approved Budgets (2015 – 2019)*

Figure 4 above shows that within the study period, it was only in 2017 that there was any record of actual implementation of the budgeted water projects located in the three focal LGAs of this study. In each of 2015, 2016 and 2018 fiscal years, there were no records of actual implementation of the budgeted water projects located in the three focal LGAs of this study. As a result, budget variances in each of the three years are as much as the budgeted amounts for each of the three years. However, in 2017, out of the budgeted sum of N25 million, the sum of N16.553 million was spent on the water projects located in the three focal LGAs. The spent amount represents about 66.21% of the budgeted amount and implies a budget variance of about N8.447 million. The spent amount equally represents about 1.20% of the actual capital expenditures of the

State Ministry of Public Utilities and Water Resources, about 0.37% of actual capital expenditures of the three focal MDAs of this study, and about 0.03% of the total actual capital expenditures of the State Government in 2017.

Given the level of budget variance observed in figure 4 above, it is important to State that there is a clear case of unrealistic revenue projections in Anambra State. Whenever actually realised revenues fall below projected revenues, the usual effect is that some capital projects contained in the approved budget of the State Government will not be implemented. In most of the years presented in figure 4 above, budgeted expenditures were never implemented, thereby leading to remarkably high budget variance.

3.4 Budgetary Allocation to the Health Sector

The Anambra State government is planning to spend N137.14billion in 2020. Approximately 57percent or N78.36billion of its spending plan for the fiscal year 2020 will go into capital items, while the balance of N58.77billion will be spent on recurrent items - if all fiscal and monetary indicators come out as forecasted. The State's 2020 budget is predicated on revenue projections of N90.61billion. In the fiscal year 2019, the State government's actual revenue was N81.96billion down from 2018 level of N88.55billion. Between 2015 and 2019, the State collected total revenue of N358.40billion as against projected revenue of N363.63billion. Internally generated revenue averages 24.85percent of Anambra State revenue while transfers from the federal government comprising Statutory revenue and value-added tax makes up the balance.

Poor budget performance in Nigeria is often attributed to revenue under-collection. However, the case in Anambra is different. Despite the State collecting 98.56percent of its targeted revenue between 2015 and 2019, Public Expenditure performance was significantly lower at 70.46percent. The severe budget credibility issues in Anambra State are pronounced in the health sector. For the health sector, the budgetary allocation has been comparatively lower than the desired level. Health-related budgetary allocation averaged 5.74percent of total budget size within 2015 and 2019, notably short of the "Abuja conference" target, where African Union countries pledged to set a target of allocating at least 15percent of their annual budget to improve the health sector. Also, Budget performance for the period under review was even lower at 41.04percent.

While it is true that the State has a long list of challenges ranging from infrastructural deficiencies, housing deficit, education to weak government institutions, the deplorable State of the health sector is one thing COVID-19 pandemic has brought to the fore. Years of under-investment in the critical sector means Nigeria is unprepared for a pandemic. The infant mortality rate and under-five mortality rate in Anambra State remain high at 42 per 1000 and 53 per 1000, respectively. Also, despite relative peace in the State, the Life expectancy of 48years is lower than the national average. Most socio-economic analyses pin the negative indices to the deplorable States of primary health care centres in Anambra State.

Residents prefer traditional birth attendants and alternative care centres to clinics because of the poor sanitary and hygiene conditions at the facilities. FHI360 did document the challenges. For instance, out of 246 women that came for antenatal care in 2014, only about 31 of them delivered here. "They all want to deliver with the TBAs in the community despite the service costing more".

The State government admitted as much in its policy Statements. In 2014, the State announced a plan to renovate and equip 50 primary health care centres between 2015 and 2020. The State also established the Anambra State Primary Health Care Development Agency (SPHCDA) in response to the stipulations of the National Health Act, 2014. However, residents of Nnewi South, Aguata and Idemili South LGAs continue to complain about the Sanitation and hygiene conditions of primary health infrastructure in the community. COMEN in collaboration with the African Centre for Leadership, Strategy and Development (Centre LSD) and JDPC Nnewi did carry out a study on the State of public primary healthcare facilities across three Local Government Areas (LGAs) of Anambra State. Apart from some other issues associated with the availability of drugs and healthcare personnel in the facilities, the study identified the State of water, sanitation, and hygiene at the primary health care facilities as a major problem bedevilling the facilities in the three focal LGAs. Hence, the need to understand the underlying budgetary reasons for the service delivery failure at the facilities.

The main objectives of the Health Sector Public Expenditure Review were to assess the budgetary allocations and expenditures to inform stakeholders about the underlying budgetary reasons for the failure of Primary health care facilities in Anambra State. The paper thus evaluates resource allocation to key priority areas

thrown up in the facility assessment conducted by Centre LSD/JDPC/COMEN as it relates to the delivery of water, hygiene, and sanitation at the Primary health care centres in Anambra State.

Budgetary allocation to the health sector has remained below 2014 level despite the government's repeated promise that the sector will be prioritised.

Table 1 below compares the growth in budgetary allocation to the health sector. In nominal terms, budgetary allocation to health was cut in the fiscal year 2015, 2016 and 2020. The sharpest cut to the health sector budget occurred in the fiscal year 2016 when the allocation was reduced to N4.89billion from 2015 level of N8.79billion. Public health sector budgetary allocation in 2020 was cut by 19.22percent compared to the allocation in 2019.

***Table 1** : Trend in Budgetary allocation (nominal)*

Year	Budget Allocation to the Health Sector (Amount in Naira)	Growth Rate	Cuts to Budgetary allocation?
2014	9,175,000,000.00	-	-
2015	8,795,940,000.00	-4.13%	Y
2016	4,888,567,115.00	-44.42%	Y
2017	5,306,350,861.00	8.55%	N
2018	10,737,753,205.00	102.36%	N
2019	12,062,711,316.00	12.34%	N
2020	9,743,906,801.00	-19.22%	Y

***Source:** Anambra State Government Approved Budget 2014 - 2020*

However, when allocation is adjusted for inflation, cuts to the real budgetary allocation to the health sector occurred four times - in 2015, 2016, 2017 and 2020. Growth in allocation was recorded in 2018 and 2019. However, the amount allocated to the sector was lower than 2014 level (see table 2 below).

Table 2 : Trend in Budgetary allocation (inflation adjusted)

Year	Budgetary Allocation Inflation Adjusted (Amount in Naira)	Growth rate	Was Budgetary allocation lower than 2014 level?
2014	14,629,739,916.33	-	-
2015	13,400,209,950.23	-8.40%	Y
2016	7,240,556,073.77	-45.97%	Y
2017	7,174,939,340.23	-0.91%	Y
2018	13,065,495,271.31	82.10%	Y
2019	13,315,783,130.85	1.92%	Y
2020	9,743,906,801.00	-26.82%	Y

Source: *Anambra State Government Approved Budget 2014 - 2020*

Health-related budgetary allocation averaged 5.74percent of total budget size within 2015 and 2019, notably short of the "Abuja conference" target, where African Union countries pledged to set a target of allocating at least 15percent of their annual budget to improve the health sector.

Nigeria is a signatory of the Abuja Declaration, held in 2001, which committed ratifying countries to allocate at least 15percent of their budgets to improve the health sector. Table 3 below shows that budgetary allocation to the health sector is below the Abuja target, despite the government's Stated commitment to increase the share of health allocation in the budget to 15 per cent of the total government budget. While allocation relative to the budget size is higher in 2019 and 2020, when allocation is compared with the desired level (Abuja conference target), the shortfall of N11.51billion and N10.83billion in 2019 and 2020 is a pressure point.

Table 3: Health-related budgetary allocation as a percentage of total budget outlay

Year	Total Budget Size	Health Sector Budgetary Allocation	Budgetary allocation as a percentage of total budget size	Desired Level (15percent of annual budget)	Shortfall
	Amount in N'billion		in percentage	Amount in N'billion	
2014	145.40	9.18	6.31%	21.81	12.64
2015	164.50	8.80	5.35%	24.67	15.88
2016	101.34	4.89	4.82%	15.20	10.31
2017	115.51	5.31	4.59%	17.33	12.02
2018	170.92	10.74	6.28%	25.64	14.90
2019	157.17	12.06	7.67%	23.58	11.51
2020	137.14	9.74	7.11%	20.57	10.83

Source: *Anambra State Government Approved Budget 2014 - 2020*

Per capita public health allocations have fall from 2014 level of $11.07 per person to $4.15 per person which is significantly lower than World Health Organization (WHO)-recommended target of USD86 to address health challenges.

Table 4 below shows that Per-capita health allocation in Anambra averaged N1,1,518.36 ($6.11) per person between 2014 and 2020. Per-capita health allocation is significantly lower than the $86 set by the WHO. The Sharp fall in per capita public health allocation can be connected to the depreciation of the Naira against other major currencies. While the federal and local governments do invest in health, Anambra State's contribution is grossly inadequate.

Table 4: *Per capita public health allocations*

Year	Health Sector Allocation (Amount in Naira)	Population** persons	Per capita public health allocations (Amount in Naira)	Official Exchange Rate Naira/Dollars Exchange rate	Per capita public health allocations in dollars
2014	9,175,000,000.00	5,226,760.00	1,755.39	158.55	11.07
2015	8,795,940,000.00	5,375,177.00	1,636.40	193.28	8.47
2016	4,888,567,115.00	5,527,809.00	884.36	253.49	3.49
2017	5,306,350,861.00	5,684,798.78	933.43	305.79	3.05
2018	10,737,753,205.00	5,846,247.06	1,836.69	306.08	6.00
2019	12,062,711,316.00	6,012,280.48	2,006.35	306.92	6.54
2020	9,743,906,801.00	6,183,029.24	1,575.91	380.00*	4.15

Source: *FiscalTables, CBN, Anambra State government*
***Population - estimate based on a 2.84percent growth rate*
**Exchange rate as of July, 2020*

3.5 Budget Credibility and Execution Trends

Despite the State collecting 99.51percent of its targeted revenue between 2015 and 2019, budget performance for the health sector was a paltry 41.04percent.

Table 5 shows the trends of budget performance. It is quite clear that budget performance for the health sector is extremely low. Poor budget performance in Nigeria is often attributed to revenue under-collection. However, the case in Anambra is different. Despite the State collecting on average 99.5[1]percent of its targeted revenue between 2015 and 2019, Public Expenditure performance for the health sector was significantly lower at 41.04 per cent when compared to that of the total expenditure which averaged 70.46percent between 2015 and 2019.

Table 5: *Budget Performance*

Year	Budget Performance		
	Total Public Revenue	**Total Expenditure**	**Health Sector Expenditure**
	in Percentage	in Percentage	in Percentage
2015	74.20%	42.81%	22.35%
2016	86.78%	80.68%	60.89%
2017	121.02%	105.12%	69.40%
2018	122.66%	70.91%	26.84%
2019	92.90%	66.85%	25.71%
Average	**99.51%**	**73.27%**	**41.04%**

Source: *Anambra State Government Approved Budget 2015 - 2020*

[1]"... Every Low Income Country (LIC) Government should ensure public health expenditure per capita of at least US$86 wherever possible" (Chatham House Centre on Global Health Security Working Group on Health Financing, 2014) - https://www.chathamhouse.org/sites/default/files/field/field_document/20140521HealthFinancing.pdf

Anambra State government underspent the health sector component of its budget.

Anambra State government underspent the proportions of resources allocated to the health sector. In the fiscal year 2017, 2018 and 2019, the State government allocated 4.59 per cent, 6.28percent and 7.67 per cent of its aggregate expenditure to the health sector, respectively. While that shows improvement in allocation to the health sector, budget execution figures suggest otherwise. Actual spending relative to actual aggregate expenditure declined from 3.64 per cent in the fiscal year 2016 to 3.03percent, 2.38percent and 2.95percent in the fiscal year 2017, 2018 and 2019 respectively (see table 6 below).

Table 6: *Actual Expenditure to the Health sector as a percentage of Actual aggregate expenditure*

Year	**Allocation to the Health sector as a percentage of Aggregate Expenditure**	**Actual Expenditure to the Health sector as a percentage of Actual aggregate expenditure**
2014	6.31%	1.87%
2015	5.35%	2.79%
2016	4.82%	3.64%
2017	4.59%	3.03%
2018	6.28%	2.38%
2019	7.67%	2.95%
2020	7.11%	-

Source: *Anambra State Government Approved Budget 2014 - 2020*

Underspending of Anambra State aggregate health sector budget is less of a money issue.

Table 7 compares unspent amounts returned into the Anambra State treasury against the variance between the amount allocated to the health sector and actual expenditure. Throughout the reviewed period, the unspent amount returned into the treasury was significantly higher than the variance between the amount allocated to the health sector and actual expenditure. For instance, in 2015, the health sector budget was underspent by N6.83 billion even though N13.5billion was returned into Anambra State's treasury as an unspent fund. Same can be said for all the years under review.

Table 7: Unspent Amount Returned into the Treasury against underspending of aggregate Health Sector budget

Year	Underspending of aggregate Health Sector budget (Amount in Naira)	Unspent Amount Returned into the Treasury (Closing balance) (Amount in Naira)	Can underspending of the health sector budget in Anambra be attributed to lack of funds?
2015	6,830,177,621.00	13,521,925,733.14	N
2016	1,912,151,728.00	27,827,982,977.88	N
2017	1,623,570,150.51	15,960,177,481.33	N
2018	7,856,242,903.03	9,971,291,471.03	N
2019	8,961,924,528.44	15,601,651,810.33	N

Source: *Anambra State Government Approved Budget 2015 - 2020*

Perhaps unsurprisingly, the biggest credibility problem with the health sector budget is on the capital side. In each year from 2015 to 2019, most of the underspending were related to capital expenditure.

Table 8 shows that understanding of capital expenditure as a proportion of total health underspending ranged between 57.37 percent and 94.47 percent.

Table 8: Underspending of capital expenditure as a proportion of total health sector underspending

Year	Underspending of aggregate Health Sector budget (Amount in Naira)	Underspending of capital Expenditure for the Health Sector budget (Amount in Naira)	Underspending of Recurrent Expenditure for the Health Sector budget (Amount in Naira)	Underspending of capital expenditure as a proportion of total health sector underspending
2014	6,795,558,188.00	3,898,407,994.00	2,897,150,194.00	57.37%
2015	6,830,177,621.00	4,636,296,675.00	2,193,880,946.00	67.88%
2016	1,912,151,728.00	1,806,415,715.00	105,736,013.00	94.47%
2017	1,623,570,150.51	1,383,764,539.01	239,805,611.50	85.23%
2018	7,856,242,903.03	7,360,056,076.24	496,186,826.79	93.68%
2019	8,961,924,528.44	8,017,396,169.95	944,528,358.49	89.46%

Source: *Anambra State Government Approved Budget 2014 - 2020*

Aggregate Health Sector spending in 2018 and 2019 was comparatively lower than 2014 level despite Anambra State government's promise to prioritise the sector.

Table 9 below looks at the trend in actual health sector expenditure between 2014 and 2019. When an allocation is adjusted for inflation, cuts to the real budgetary allocation to the health sector occurred in 2015, 2018 and 2019. Interestingly apart from 2016 and 2017, actual spending by the Anambra State government on health was comparatively lower than 2014 level.

***Table 9**: Trend in Actual Health Sector Expenditure (inflation adjusted)*

Year	Actual Health Sector Expenditure Inflation Adjusted (Amount in Naira)	Growth rate	Was Health Sector Expenditure lower than 2014 level?
2014	3,794,072,463.83	-	-
2015	2,994,748,553.41	-21.07%	Y
2016	4,408,429,300.74	47.21%	N
2017	4,979,642,110.62	12.96%	N
2018	3,506,167,305.75	-29.59%	Y
2019	3,422,895,841.28	-2.37%	Y

***Source:** Anambra State Government Approved Budget 2014 - 2020*

Health-related spending averaged 2.78percent of aggregate expenditure between 2015 and 2019, notably short of the "Abuja conference" target, where African Union countries pledged to set a target of spending at least 15percent of their aggregate expenditure to improve the health sector.

Table 10 below shows that actual health-related expenditure is below the Abuja conference target. Spending on the health sector in 2019 was only a paltry N3.10billion as against the desirable level of N15.76billion if the Anambra State government aligns public expenditure to the fine letters of the "Abuja conference" target, where African Union countries pledged to set a target of spending at least 15percent of their aggregate expenditure to improve the health sector. That is significantly lower than the initial allocation of 5.74percent of total budget size.

Table 10: *Actual Health-related spending as a percentage of aggregate expenditure*

Year	Aggregate Expenditure	Actual Health Sector Expenditure	Actual health sector spending as a percentage of aggregate expenditure	Desired Level (15percent of aggregate expenditure)	Shortfall
	Amount in N' billion		in percentage	Amount in N' billion	
2014	127.46	2.38	1.87%	19.12	16.74
2015	70.43	1.97	2.79%	10.56	8.60
2016	81.75	2.98	3.64%	12.26	9.29
2017	121.42	3.68	3.03%	18.21	14.53
2018	121.20	2.88	2.38%	18.18	15.30
2019	105.06	3.10	2.95%	15.76	12.66

Source: *Anambra State Government Approved Budget 2014 - 2020*

Per capita public health spending has fallen from 2014 level of $2.87 per person per year to $1.68 per person per year in 2019 which is significantly lower than World Health Organization (WHO)-recommended target of USD86 to address health challenges.

Table 11 below shows that Per-capita health sector spending by Anambra State government for the period under review averaged N502.64 ($2.05) which is significantly lower than the per-capita health-sector allocation of N1,1,518.36 ($6.11) per annum. Per-capita health sector spending is considerably lower than the $86 set by the WHO. The Sharp fall in per capita public health allocation can be connected to the depreciation of the Naira against other major currencies. While the federal and local governments do invest in health, Anambra State's contribution to improving the health outcomes is grossly inadequate.

Table 11: Per capita public health sector spending

Year	Health Sector Spending (Amount in Naira)	Population** Persons	Per capita public health allocations (Amount in Naira)	Official Exchange Rate Naira/Dollars Exchange rate	Per capita public health allocations in Dollars
2014	2,379,441,812.00	5,226,760.00	455.24	158.55	2.87
2015	1,965,762,379.00	5,375,177.00	365.71	193.28	1.89
2016	2,976,415,387.00	5,527,809.00	538.44	253.49	2.12
2017	3,682,780,710.49	5,684,798.78	647.83	305.79	2.12
2018	2,881,510,301.97	5,846,247.06	492.88	306.08	1.61
2019	3,100,786,787.56	6,012,280.48	515.74	306.92	1.68

Source: *FiscalTables, CBN, Anambra State government*
***Population - estimate based on a 2.84percent annual growth rate*

3.6 Composition of The Health Sector Budget

The proportion of collected revenue spent on the health sector is relatively lower than previously planned.

Table 12 below shows that despite budgetary allocation to the health sector as a percentage of projected revenue averaging 11.27 percent between 2015 and 2019, actual health sector spending relative to actual collected revenue was only a paltry 4.12 percent.

[2]"... Every Low-Income Country (LIC) Government should ensure public health expenditure per capita of at least US$86 wherever possible" (Chatham House Centre on Global Health Security Working Group on Health Financing, 2014) - https://www.chathamhouse.org/sites/default/files/field/field_document/20140521HealthFinancing.pdf

Table 12: Proportion of Collected Revenue Spent on the Health Sector

Year	Actual health Sector Spending at a percentage of Actual Revenue	Budgetary allocation to the Health Sector as a percentage of Projected Revenue	Was the Proportion of revenue spent on the health sector lower than previously planned?
2014	3.55%	N/A	-
2015	3.62%	12.02%	Y
2016	4.94%	7.04%	Y
2017	5.02%	8.76%	Y
2018	3.25%	14.87%	Y
2019	3.78%	13.67%	Y

Source: *Anambra State Government Approved Budget 2014 - 2020*

Public Investment in public health is concentrated around recurrent items.

In the fiscal year 2019, about 74.31percent of health sector resources were spent on recurrent expenditures compared to 50.01 percent in the fiscal year 2014 (see table 12 below).

Table 13: Component of Health Sector Budget

Year	Actual Capital Expenditure as a percentage of total health sector spending	Actual Recurrent Expenditure as a percentage of total health sector spending	Most health sector resources are for recurrent costs.
2014	49.99%	50.01%	Y
2015	26.66%	73.34%	Y
2016	23.31%	76.69%	Y
2017	39.19%	60.81%	Y
2018	19.12%	80.88%	Y
2019	25.69%	74.31%	Y

Source: *Anambra State Government Approved Budget 2014 - 2020*

Budget performance for the Health sector capital/Program budget has declined significantly.

In the fiscal year 2016, despite the economic recession that engulfed Nigeria, budget performance for capital items rose from 2015 level of 10.16 percent to 51.05 percent. However, the variance between health sector budgetary allocation for capital items and actual expenditure had grown wide. In the fiscal year 2018 and 2019, budget performance for capital/program budget was a party 6.96 percent and 9.04 percent respectively (see table 14 below).

Table 14: *Performance of Recurrent and Capital/Program Budget of the Health sector*

	Budget Performance			
Year	Aggregate Health Sector Expenditure	Capital/Program Expenditure	Recurrent Expenditure	Budget performance for capital expenditure is lower than Recurrent Expenditure component
2014	25.93%	23.38%	29.11%	Y
2015	22.35%	10.16%	39.65%	Y
2016	60.89%	27.75%	95.57%	Y
2017	69.40%	51.05%	90.33%	Y
2018	26.84%	6.96%	82.45%	Y
2019	25.71%	9.04%	70.93%	Y
Average	**38.52%**	**21.39%**	**68.01%**	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Health sector component of Aggregate capital expenditure was not prioritized.

Table 15 below compares capital expenditure allocations with actual spending on health-related capital items. When compared to aggregate capital expenditure, Anambra State government underspent the proportions of resources allocated to the health sector. In the fiscal year 2017, 2018 and 2019, the State government allocated 4.47percent, 7.43percent and 9.60 per cent of its capital expenditure to the health sector, respectively. While that shows improvement in capital allocation to the health sector, budget execution figures suggest otherwise. Actual capital spending relative to aggregate capital spending declined from 2.65 per cent in the fiscal year 2017 to 1.09 per cent and 1.61 per cent in the fiscal year 2018 and 2019, respectively.

Table 15: *Health sector component of Aggregate capital expenditure was not prioritized.*

Year	Capital Allocation to the Health sector as a percentage of Aggregate Capital Expenditure	Actual Capital Spending as a percentage of aggregate capital spending	Was the health sector component of Aggregate capital expenditure prioritized?
2014	4.93%	1.40%	N
2015	4.65%	2.24%	N
2016	4.74%	2.19%	N
2017	4.47%	2.65%	N
2018	7.43%	1.09%	N
2019	9.60%	1.61%	N
2020	8.26%	N/A	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Health sector component of Aggregate capital expenditure was not prioritized.

Table 16 below compares recurrent expenditure allocations with actual spending on health-related recurrent items. When compared to aggregate recurrent expenditure, Anambra State government underspent the proportions of resources allocated to the health sector. In the fiscal year 2017, 2018 and 2019, the State government allocated 10.16percent, 16.65percent and 18.46 per cent of its aggregate recurrent expenditure to the health sector, respectively. While that shows improvement in recurrent allocation to the health sector, budget execution figures suggest otherwise. Actual recurrent spending relative to aggregate recurrent actual expenditure was relatively flat at 5.49 per cent, 4.08 per cent and 5.58percent in the fiscal year 2017, 2018 and 2019, respectively.

Table 16: *Actual Recurrent Spending as a percentage of aggregate recurrent expenditure*

Year	Recurrent Allocation to the Health sector as a percentage of Aggregate recurrent Expenditure	Actual Recurrent Spending as a percentage of aggregate recurrent expenditure	Was the health sector component of Aggregate recurrent expenditure prioritized?
2014	21.74%	5.58%	N
2015	16.44%	4.18%	N
2016	10.05%	5.95%	N
2017	10.16%	5.49%	N
2018	16.65%	4.08%	N
2019	18.46%	5.58%	N
2020	16.58%	N/A	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

3.7 Performance of the Budget of the Anambra State Primary Health Care Development Agency

In the fiscal year 2020, the Anambra State primary health care development agency, which was established in 2016, was allocated approximately N26.4million for its operations. Compared to the previous year, this allocation is nominally lower by 49.56 per cent. In 2019, the Agency's actual expenditure was 50 Million down from 2018 level of N74.55million. The budget performance was 95.53percent, 310.64percent and 74.47percent in the fiscal year 2019, 2018 and 2017, respectively.

Table 17: *Budget performance for Anambra State Primary health care development Agency*

Year	Budget (Amount in Naira)	Actual (Amount in Naira)	Budget Performance
2017	10,000,000	7,446,819	74.47%
2018	24,000,000	74,554,321	310.64%
2019	52,340,000	50,000,000	95.53%
2020	26,400,000	N/A	-

Source: *Computed from Anambra State Government Approved Budget 2017 - 2020*

3.8 Expenditures by Key Intervention Areas (Water, Sanitation & Hygiene at Primary health care centres)

Healthcare service delivery is an important component of the social services sector of government functions. Healthcare service delivery is classified into primary healthcare, secondary healthcare, and tertiary healthcare services. The nature of service depends largely on the nature of ailment and the nature of services needed to be rendered to contain the ailment.

Primary healthcare facilities are, therefore, the nearest service points to the people, even at the grassroots. Basic healthcare services are expected to be given to these people who do not need to travel for a long time to access required services. However, the PHC facilities assessment report by COMEN with technical support from Centre LSD and JDPC Nnewi reveals that there are about fourteen (14) problems associated with the primary healthcare facilities assessed. The problems can be classified into three broad groups:

Lack of Infrastructure and Medical Equipment

The condition of the primary health facilities critical to delivering delivery of health care service in the targeted local government was appalling. Most of the primary health care facilities in the communities lack the basic infrastructure critical to ensuring a clean environment. Some of the buildings are witnessing decays; the walls and ceiling are cracked or broken while the floors, windows and doors are partially destroyed.

This study focuses on water and sanitation facilities across the primary healthcare centres in the three focal LGAs. Therefore, this summary of the problems found across the primary healthcare facilities also focuses on the problems that are related to water and sanitation infrastructures at the primary healthcare facilities. Some of the issues identified include:

Waste disposal: It is not arguable that primary healthcare facilities are producers of solid and liquid waste. The wastes can be produced by healthcare service providers during treatment. They can as well be produced by the patients/caregivers during their visits. As a result, the availability of waste disposal in every primary healthcare facility is a necessity. This will ensure that the facilities continuously maintain an environment of utmost health. Observation during the exercise shows that virtually all the primary healthcare facilities had a form of waste bins for their waste collections and disposals. However, some of the items used as waste bins in the PHC facilities are not hygienic and safe enough. For instance, the practice of using cartons as waste bins may contaminate the person that will dispose of them at the end of the day since they may not retain all forms of wastes after collection. Similarly, the practice of using disused drums for waste collection may not also be hygienic and safe. This is because the body and edges of the drums may cut the hands of those who want to dispose of their waste, thereby causing wounds.

Placenta Pits, Disposable Bins, Sewage Tanks: To regularly maintain sanitation and hygiene at the primary healthcare facilities, there should be placenta pits for burying of placentas after child deliveries, and disposable bins as well as sewage tanks for solid and liquid human wastes. Given that primary healthcare facilities are the first point of call for diarrhoea patients, the relevance of sewage tanks and disposable bins in such situations cannot be overemphasised. The PHC facilities assessment report reveals that except in two PHCs, there are placenta pits, disposable bins, and sewage tanks in

all the PHCs covered during the assessment. However, one of the PHC facilities had a placenta pit that had been filled up and therefore closed.

Water: Water availability is the pivot of every effort to maintain sanitation and hygiene anywhere, including the primary healthcare facilities. The nature of activities that are carried out in primary healthcare facilities demands a regular supply of potable/safe water for drinking, bathing, flushing of toilets and other uses. However, the PHC facilities assessment report shows that potable/safe water is available in only one PHC facility. This facility can boast of supplying potable water as there is a water treatment infrastructure within the PHC facility. In addition to this one, two other facilities have functional boreholes, which enable them to supply water for bathing and flushing of toilets, though not confirmed to be safe for drinking. The rest of the PHC facilities harvest rainwater or buy water in bits for sanitation purposes. As a result, patients/their caregivers bear the extra burdens of drawing their water for bathing and flushing of toilets as the need arises during rainy seasons. Alternatively, the patients/their caregivers bear the extra burdens of buying their own water for bathing and flushing of toilets as the need arises during the dry season. In addition, the patients/their caregivers buy sachet water for drinking, which is not only costly to maintain for a long time but also come with the propensity to constitute an environmental nuisance. Most of the PHC facilities with non-functional water supply systems attest to have only minor challenges, like plumbing corrections of old or broken pipes which need to be replaced or fixed. In some other facilities, the challenges are major, like the replacement of non-functional sumo/water pumping machines. Whatever the case may be, the relevance of the water supply system in the overall efficient functioning of the PHC facilities cannot be overemphasised.

Toilets/Bathrooms: Primary healthcare facilities are set up to cater for those in need of basic healthcare services, including those that suffer from diarrhoea. In addition, patients and/or their caregivers may be pressed at any point in time within their visit to the PHC facilities and therefore demand to visit the conveniences. It, therefore, follows that the availability, accessibility and usability of the toilets and bathroom infrastructures within the primary healthcare facilities must be guaranteed at every point in time. However, observations during the PHC facilities assessment reveal that none of the toilet and bathroom infrastructures in the entire PHC facilities meets minimum standards that may be required of health development systems. In rare

cases of some PHC facilities having recently built toilets and bathrooms and covered with modern infrastructures, they are not usually connected to the water supply system. In some others, there are no toilets and bathrooms at all. As a result of all the issues above, patients and/or their caregivers' resort to defecating in the surrounding bushes to the healthcare facilities.

Drainages: To a large extent, the presence or otherwise of drainages at the primary healthcare facilities contribute to the overall cleanliness or otherwise of the PHC facilities. With proper channelling of water to the drainages, flooding and other associated problems will not deter patients as well as their caregivers from accessing healthcare services from the PHC facilities at any time of the year. Apart from flooding, the absence of drainages in the facilities can give the facilities a general look of dirtiness and can even create gullies along the pathways that lead to the main facilities. However, the PHC facilities assessment report shows that it is only in two of the PHC facilities that drainages were deliberately factored into during the construction of the facilities. In the rest of the facilities, there were no deliberate provisions for drainages, which could result in flooding, especially in the rainy season. As a result, those in need of primary healthcare services may find it difficult accessing the facilities during such seasons.

Budgetary Provisions for the Rehabilitation and Equipping of PHCCs

Anambra State budget for the rehabilitation of PHCCs has severe budget credibility issues.

In 2014, the State government policy set out to rehabilitate and equip 50 primary health care centres in Anambra State. Table 18 below shows that the State government allocated approximately N11.89 billion between 2014 and 2020 for the rehabilitation of Primary health care centres and general hospitals. In the implementation of 2014, 2015 and 2016 budget, the budget performance was only a paltry 13.52 per cent, 6.32percent and 18.02 per cent. Budget execution improved significantly in 2017 but fell subsequently to 18.43 per cent and 14.51percent in 2018 and 2019, respectively.

Table 18: Rehabilitate 10 Primary Healthcare Centres & Two Gen Hospitals annually between 2015 & 2020

Year	Budget (Amount in Naira)	Actual (Amount in Naira)	Budget Growth Rate	Actual Growth Rate	Budget performance
2014	2,294,000,000	310,158,133	-	-	13.52%
2015	2,034,000,000	128,492,590	-11.33%	-58.57%	6.32%
2016	929,177,067	167,433,175	-54.32%	30.31%	18.02%
2017	1,037,800,000	559,425,893	11.69%	234.12%	53.90%
2018	881,870,000	162,538,742	-15.03%	-70.95%	18.43%
2019	2,060,000,000	298,863,143	133.59%	83.87%	14.51%
2020	2,650,000,000	N/A	28.64%	-	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Resources allocated for the rehabilitation of Primary health care centres have been abysmal.

Budgetary allocation critical for the improvement of infrastructure at the primary health care centres, when adjusted for inflation, is less than 2014 level. Spending on the rehabilitation of primary health care centres has also been lower than the 2014 level (see table 19 below). Actual expenditure in real terms stood at N329.9million in 2019 up from 2018 level of N197.77million but significantly lower than 2017 peak of N759.42million.

Table 19: Rehabilitate 10 PHCs & 2 Gen Hospitals annually between 2015 & 2020 (Inflation Adjusted)

Year	Budget (Amount in Naira)	Actual (Amount in Naira)	Budget Growth Rate	Actual Growth Rate	Budget performance
2014	3,657,833,610	494,553,986	-	-	13.52%
2015	3,098,705,430	195,752,550	-15.29%	-60.42%	6.32%
2016	1,376,223,032	247,988,677	-55.59%	26.68%	18.02%
2017	1,403,252,865	756,423,190	1.96%	205.02%	53.90%
2018	1,073,042,758	197,774,071	-23.53%	-73.85%	18.43%
2019	2,273,992,350	329,908,981	111.92%	66.81%	14.51%
2020	2,650,000,000	-	16.54%	-	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Anambra State government did not prioritise budgetary allocation for the rehabilitation of clinics.

Table 12 below compares the proportion of capital expenditure allocated for the rehabilitation of PHCs and General hospitals with actual spending. In the fiscal year 2017, 2018 and 2019, the State government allocated 0.83 per cent, 2.24 per cent and 3.38 per cent of its capital expenditure for the rehabilitation of primary health care centres and hospitals, respectively. While that shows improvement in capital allocation to the health sector, budget execution figures suggest otherwise. Actual spending relative to aggregate capital spending declined from 1.03 per cent in the fiscal year 2017 to 0.32 per cent and 0.60 per cent in the fiscal year 2018 and 201,9 respectively.

Table 20: *Actual spending on health Infrastructure as a percentage of actual capital expenditure*

Year	Budget for Health Infrastructure as a percentage of aggregate capital expenditure	Actual spending on health Infrastructure as a percentage of actual capital expenditure	Was the budget for the rehabilitation of clinics prioritized?
2014	2.22%	0.37%	N
2015	1.83%	0.55%	N
2016	1.76%	0.53%	N
2017	1.64%	1.03%	N
2018	0.83%	0.32%	N
2019	2.24%	0.60%	N
2020	3.38%	-	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Lack of medical/cleaning supplies

Essential medical supplies, including disinfectants, protective gears and drugs needed to deliver health care services are in most cases not available in the primary healthcare centres in Anambra. Some of the identified problems include:

Lack of Disinfectants: The overall cleanliness of interior floors of primary healthcare facilities largely depends on regular mopping of the floor. It, therefore, follows that to maintain high levels of hygiene in the facilities, every facility should have mopping sticks, mopping buckets and disinfectants. All the 21 primary healthcare facilities assessed during the exercise had mopping sticks. Similarly, out of the 21 PHC facilities

assessed, only one facility had no mopping bucket. Each of the 21 PHC facilities uses one form of disinfectants or the other during their mopping.

Budgetary Provisions for the medical/cleaning supplies

The State government in 2014 instituted a program which aims to improve the availability of medical supplies in all State clinics by 2020.

Anambra State budget for the procurement of medical supplies has severe budget credibility issues.

Table 21 below shows that the State government only spent N144.29million on the procurement of medical supplies despite allocating approximately N2.12billion between 2014 and 2019. The budget performance, which was 54.96percent in 2014 fell to a periodic low of 0.72percent in the fiscal year 2019. The budget performance was 2.97 per cent, 21.81percent and 16.27 per cent in the fiscal year 2018, 2017 and 2016, respectively.

Table 21: *Budgetary provision for Medical Supplies (Nominal)*

Year	**Budget** (Amount in Naira)	**Actual** (Amount in Naira)	**Budget Growth Rate**	**Actual Growth Rate**	**Budget performance**
2014	50,000,000	27,479,000			54.96%
2015	468,000,000	67,150,860	836.00%	144.37%	14.35%
2016	58,000,000	9,700,000	-87.61%	-85.55%	16.72%
2017	51,150,000	11,157,600	-11.81%	15.03%	21.81%
2018	801,291,300	23,800,815	1466.55%	113.31%	2.97%
2019	691,900,000	5,000,000	-13.65%	-78.99%	0.72%
2020	409,500,000	N/A	-40.82%		

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Public spending on the provision of medical supplies at Primary health care centres has been abysmal.

Public spending on the procurement of medical supplies when adjusted for inflation is less than 2014 level. Although spending rose sharply in 2015 to N102.3million, Anambra State government spending on medical supply has been generally abysmal. The State spent the only N5.5million on medical supplies in the fiscal year 2019, down from 2018 level of N28.96million (see table 22 below).

*Table 22: **Procurement** of medical supplies (Inflation Adjusted)*

Year	Budget (Amount in Naira)	Actual (Amount in Naira)	Budget Growth Rate	Actual Growth Rate	Budget performance
2014	79,726,103	43,815,872			54.96%
2015	712,976,471	102,301,246	794.28%	133.48%	14.35%
2016	85,904,978	14,366,867	-87.95%	-85.96%	16.72%
2017	69,162,058	15,086,658	-19.49%	5.01%	21.81%
2018	974,996,118	28,960,382	1309.73%	91.96%	2.97%
2019	763,774,421	5,519,399	-21.66%	-80.94%	0.72%
2020	409,500,000		-46.38%		

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Anambra State government did not prioritise budgetary allocation for the procurement and distribution of medical supplies.

Table 23 below compares the proportion of capital/program expenditure allocated for the procurement and distribution of medical supplies. In the fiscal year 2017, 2018 and 2019, the State government allocated 0.08 per cent, 0.75 per cent and 0.75 per cent of its capital/program budget for the rehabilitation of primary health care centres and hospitals, respectively. While that shows improvement in allocation to the subsector, budget execution figures suggest otherwise. Actual spending relative to aggregate capital spending declined from 0.29 percent in fiscal year 2015 to 0.01percent, 0.05percent and 0.02percent in fiscal year 2019,2018 and 201,7 respectively.

Table 23: Actual spending on Medical Supplies as a percentage of actual capital/program expenditure

Year	Budget for Medical Supplies as a percentage of aggregate capital expenditure	Actual spending on Medical Supplies as a percentage of actual capital expenditure	Was budgetary allocation for the provision of medical supplies prioritised?
2014	0.05%	0.03%	N
2015	0.42%	0.29%	N
2016	0.11%	0.03%	N
2017	0.08%	0.02%	N
2018	0.75%	0.05%	N
2019	0.75%	0.01%	N
2020	0.52%	-	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

Lack of Trained Personnel

Health care facilities, by their very nature, pose several challenges, including how they should be cleaned and the risks that workers will face. Due to physical and health-related risks, the technical nature of the work, and the required documentation and supervision, intensive orientation and ongoing training are required. Training cleaners is critical to ensuring the hygiene and sanitary conditions of primary health care centres are in line with the minimum standards set by the National primary health care development agency. Some of the identified problem thrown up in the recent facility assessment includes:

Cleaners/Labourers: Sometimes, the work of keeping the PHC facilities neat cannot be effectively combined with healthcare services. It, therefore, requires different persons apart from the healthcare service providers to perform the function of cleaning the interior and exterior environments of the facilities. However, observations during the assessment exercise show that in some PHCs, there are community volunteers who assist the staff nurses and midwives with cleaning, while in some others, there are none. But even in those PHC facilities where there are volunteers, the cleaning, mopping, and clearing activities that need to be done at the PHCs are too laborious to be effectively performed by the volunteers alone. As a result, in both cases (i.e., where there are volunteers and where there are none), the staff nurses and midwives still join in performing the ancillary function of cleaning the environment. And the combination of duties leads to inefficiency in both areas of maintaining hygienic standards at the PHCs and rendering adequate healthcare service to the patients.

General Cleanliness: Being an environment for restoring the health of people, Primary healthcare facilities should be clean and safe. Apart from the cleanliness of the interior environments, the exterior environments and surroundings of the facilities should also be clean and clear. Where the facilities are detached from residential areas, the pathway leading to the facilities should be cleared regularly. This will ensure that users of the facilities do not fall into ditches and are not attacked by reptiles on their way to render or obtain healthcare services. However, the PHC facilities assessment report reveals that only two of the PHC facilities (actually, modern ones) have concrete floors within the exterior part of the premises. The rest of the facilities have their premises overgrown with weeds and/or littered with refuse. To this end, staff nurses and

midwives that are expected to combine general cleanliness at the PHC facilities with their regular healthcare services have proved that it is difficult to connect effectively and efficiently the two.

Budgetary provision for the training of medical personnel

The Anambra State government did make provision for the training of medical personnel in the fiscal year 2018, 2019 and 2020. However, in the fiscal year 2018 and 2019, no money was released by the State for the program. Given that cleaning of medical facilities requires some form of training, the State government seems to prioritise the program.

Table 24: *Budgetary Provision for Training of Health personnel*

Year	Budget (Amount in Naira)	Actual (Amount in Naira)	Budget performance
2014	0	0	-
2015	0	0	-
2016	0	0	-
2017	0	0	-
2018	32,000,000	0	0.00%
2019	32,000,000	0	0.00%
2020	10,000,000	N/A	-

Source: *Computed from Anambra State Government Approved Budget 2014 - 2020*

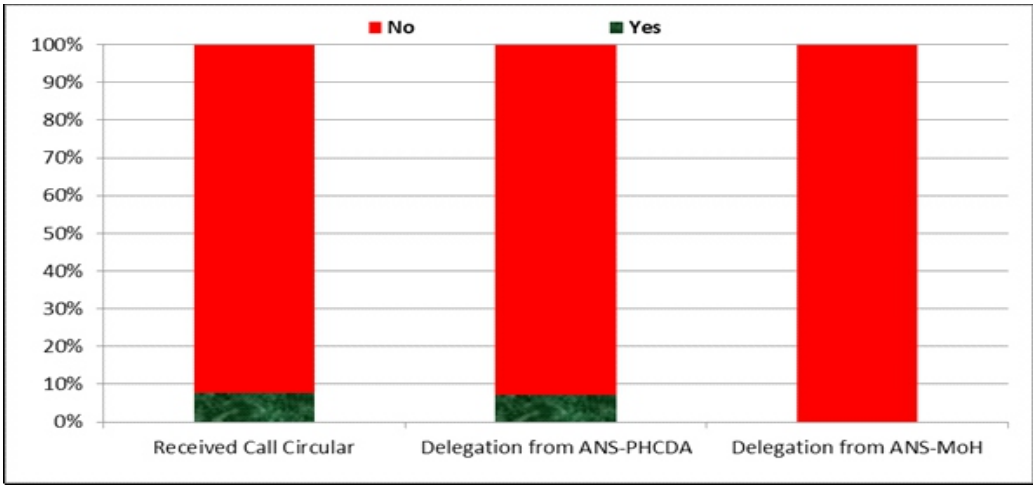
3.9 Correlation between Issues with Anambra State Recent Budgets and current State of PHCs in the Three Focal LGAs – Responses from the Field

Modern budgetary systems require that projects that make up the budget line items are generated by the people for whom the projects are to be executed. This is the whole essence of participatory budgeting. It is therefore rational to expect that either the health workers at the various PHC facilities or the representatives of the communities where they are sited are consulted during the budget preparation stage. As a result, this study tries to find out the extent to which the opinions of the community representatives/health workers at the PHC facilities are being sought during budget preparation.

There are two main strategies through which the opinions of the representatives of the PHC facilities can be sought. One strategy is to send them call circular and request for their submissions. The second strategy is to send delegation to the facilities to interact with the health workers there, and from the interaction generate a list of their needs according to their order of priority. This study therefore considers the two methods and asks the health workers as well as the representatives of the communities the extent to which they were consulted during the preparation of 2020 budget of the State Government. Figure 5 below presents the findings from the responses gathered.

From figure 5 below, only 8 percent of the representatives of the communities as well as the health workers at the Primary Healthcare facilities agreed to have been consulted through the two strategies identified above. This set of representatives received call circular from the State Primary Healthcare Development Agency, and at the same time received delegation from the same agency who came to interact with them on their needs. It is important to highlight that it is the same group of PHCs that received call circular that also received delegation from the State Primary Healthcare Development Agency. The remaining 92 percent of the representatives of PHC facilities and communities did not receive any call circular neither did they receive any delegation from the State Primary Healthcare Development Agency. On the other hand, the State Ministry of Health did not send any delegation to any of the primary healthcare facilities for inputs to the budget.

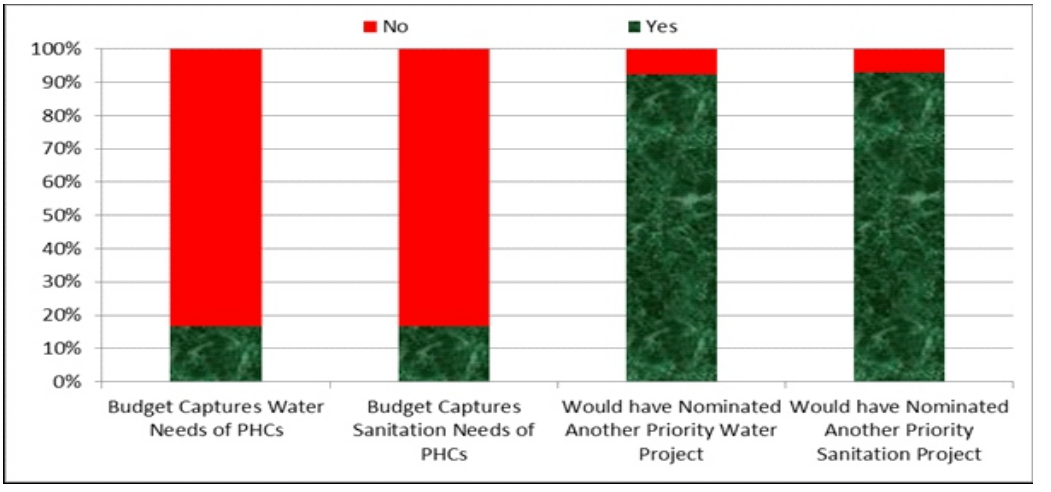
Figure 5: The Extent to which Practitioners at the PHC Facilities were Consulted during the Preparation of ANSG 2020 Budget



Source: *Field Survey (2020)*

Given the observation that the process of budget preparation has not been very participatory, especially with respect to the water and sanitation needs of primary healthcare facilities, this study equally investigates the views of the practitioners pertaining to budgeted projects. Figure 6 below presents the findings.

Figure 6: The Extent to which Practitioners at the PHC Facilities were Consulted during the Preparation of ANSG 2020 Budget

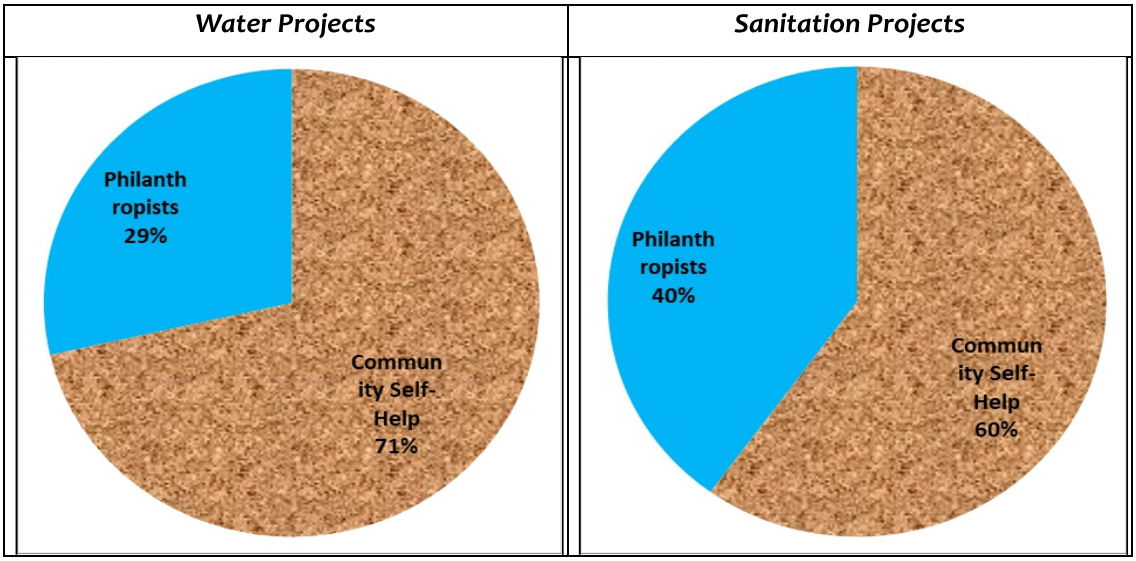


Source: *Field Survey (2020)*

From figure 6 above, about 17 percent of the respondents think that the approved budget captures the water and sanitation needs of their PHC facilities. On the other hand, about 83 percent of the respondents think that the approved budget does not capture the water and sanitation needs of their PHC facilities. With further enquiry, the study observes that about 92 percent of the respondents also think that there are other water and sanitation projects that they consider to be of higher priority than the ones which eventually appeared in the budget. To them, if they had been consulted at the stage of budget preparation, they would have nominated those other priority water and sanitation projects into the budget instead of the ones approved. The implication is that the budget process has not helped the State budget instrument to really address the water and sanitation needs of primary healthcare facilities in Anambra State.

Given the situation as discussed above, this study enquires into other sources of funding with which the primary healthcare facilities meet their water and sanitation needs. This enquiry also looks at the sustainability of those other sources of funding. Figure 7 below presents the findings based on the responses of the representatives.

Figure 7: Alternative Sources of Funds for Executing Water and Sanitation Projects at the PHC Facilities



Source: *Field Survey (2020)*

Figure 7 above shows that there are two major alternative sources of funds for executing water and sanitation projects at the PHC facilities across the three focal LGAs of this study. These two alternative sources of funding include community self-help and philanthropists. Across the three LGAs, philanthropists make up about 29 percent of alternative sources of funds for water projects across the PHC facilities, and at the same time about 40 percent of the alternative sources of funds for sanitation projects across the PHC facilities. This means that community self-help make up about 71 percent of alternative sources of funds for water projects across the PHC facilities, and at the same time about 60 percent of alternative sources of funds for sanitation projects across the PHC facilities. The implication is that for both water and sanitation projects at the PHC facilities across the three focal LGAs of this study, community self-help remains the most vibrant alternative source of financing.

Apart from being acknowledged as alternative sources of financing for water and sanitation projects across the PHC facilities, it is equally important to understudy how reliable and sustainable such alternative sources of financing are. It is possible that an available source may not be reliable and/or sustainable in the long run, while a reliable and/or sustainable source of alternative financing may not be available in the short run. It is on this note that this study investigates into the reliability and sustainability of the alternative sources of financing identified above.

The further enquiry reveals that the two main alternative sources of financing for water and sanitation projects at the PHC facilities (i.e., community self-help and philanthropists) are reliable and sustainable. However, in some of the communities, these sources are still potential sources that are yet to be tapped into. In some other communities, the two sources are highly active sources of financing. The PHC facilities located in the communities where communities and philanthropists play active roles in funding water and sanitation projects showcased some of the projects that had been carried out by these alternative sources of funding.

4. Conclusion

The main message of figures 2 and 4 above is that of extremely poor implementation of budgetary provisions for projects that could benefit the general populace. From both figures, there is a general tradition of poor budget performance. Such traditions of poor budget implementation have severe implications on the overall wellbeing of the people. This is because stakeholders in the sector who could have made alternative arrangements to cater for the projects would not do so as the projects appear in the budget of the State Government. It is observed that the reason always alluded to the problem of non-implementation of capital projects in the budget is that of non-realisation of projected revenues. That means, revenue projections of the State Government are usually unrealistic. Such unrealistic revenue projections present false hopes for the citizens by forming the basis for unrealistic expenditures projections.

However, a second feature of the State budget with severe implications that needs to be highlighted in this study is that of generic project caption. Giving generic captions that do not show the nature of work that needs to be done in projects may be misleading. Such generic captions usually make it difficult for implementation, monitoring and evaluation. For instance, the project captioned "Alor Water Supply Scheme" will leave a layman on the street to wonder if the State Government wants to set up a second version of the existing water scheme. It may even be difficult to specifically say if the amount is for complete reconstruction of the existing one or for the rehabilitation of existing one. However, looking at the amount voted for the project, a critical analyst may conclude that the budget is for taking care of some specific aspects of rehabilitation that needs to be done to make the scheme more functional. However, it is still not clear what the project title wants to address. This means that the project can be implemented without the people knowing what exactly

has been done.

Based on discussions in the two previous sub-sections, there have not been adequate budgetary provisions for water and sanitation infrastructures in public primary healthcare facilities within the State. These are relevant infrastructures that contribute to the overall functionality of the primary healthcare facilities. Their absence therefore has great implications for the overall functionality of the PHC facilities. Apart from their implications on the functionality of the PHC facilities, their absence also has great implications for the overall wellbeing of the patients who access healthcare services at the PHC facilities as well their out-of-pocket healthcare expenditures. This is because those who could have afforded to take pipe-borne water at the PHC facilities end up buying sachet water because of absence of any water supply system in the facilities. The money spent on buying the sachet water increases their total healthcare expenditures. This additional expenditure could have been avoided if the public water supply system at the facilities has been functional.

5. Recommendations

The first step that needs to be taken in addressing the budgetary concerns raised in this study is to give specific captions to projects in the budgets. For instance, if there are rusted pipes within the **"Alor Water Supply Scheme"**, the budget line item for this scheme should specifically be captioned "Replacement of Rusted Pipes within Alor Water Supply Scheme". This way, any stakeholder that looks at the budget line item can understand what the budget intends to achieve. Apart from the understanding, it makes it easier for monitoring and evaluation of implementation of the project. This calls for advocacy by Community Empowerment Network (COMEN) to ensure that the captions of the line items represent the actual work to be done within the fiscal year.

A second step is to ensure that the capital expenditures budget of Anambra State Primary Health Care Development Agency takes care of these critical details of water and sanitation infrastructures at the PHC facilities. This means that instead of focusing on building new PHC facilities, annual budgets of the Agency should be channelled to providing for these critical infrastructures which tend to limit access to PHC facilities and services. To achieve this step, series of advocacies need to be carried out, especially towards the ANSPHCDA to ensure that their subsequent budgets capture these critical water and sanitation infrastructures of the PHC facilities.

The third step is to emphasise budget implementation higher than and above making budgetary provisions for projects. As discussed in this study, budget performance at macro level of the State Government's budget has been extremely poor over the years. As a result, budgetary provisions of relevant MDAs suffer setbacks during implementation. Probably, revenue estimates have been unrealistic over the years, thereby causing low level of capital expenditures implementation. It is therefore imperative that budget officers be trained with the rudiments of revenue projections so as not to make unrealistic revenue estimates that end up making most of the capital projects budgeted by the State Government not to be implemented. This emphasis also demands advocacy and courtesy calls to the executive and legislative arms of the State Government to present the implications of non-implementation of budgeted capital projects to them. In addition, the advocacies will incorporate a clear discussion on the possibility of ensuring realistic projections for revenues, to halt the reason always given for poor budget implementations.

The fourth step is to create room for improved alternative sources of funding these critical infrastructures at the PHC facilities. One of the tested and proved sustainable means of funding such projects is by encouraging well-off citizens of the State to invest in these critical infrastructures as their individual or corporate social responsibilities. This may take the form of identifying the well-off indigenes of the communities where these PHC facilities are located and approach them with request to cater for those critical infrastructures as a way of giving back to the societies where they are from. This method has been proved over time to be an effective way of providing for those critical infrastructures which tend to limit the functionality of primary healthcare centres across the State.

Annex 1: Submission from the Anambra State Primary Healthcare Development Agency on the recent Interventions across PHCs in the three focal LGAs

Government intervention areas in the improvement of primary health care service delivery in the three targeted local government areas.

Introduction

Facing the realities of the challenges brought by the COVID-19 pandemic in Nigeria, the Federal Government through the Ministry of Budget and National Planning introduced a review strategy of the 2020 approved Budget in other to design and produce a plan that reflects the current realities in the nation as regards sources for revenue, its projections and refocus resources to sectors where they are most needed to assist the country manage the pandemic effectively without intense pressure on the Economy and the Citizens.

This approach was adopted by States at the sub national level including Anambra State – hence the Ministry of Economic planning, Budget and Development Partners, being the Ministry saddled with the management of economic and fiscal activities as well as interfacing with development partners in the State also set out to review the 2020 Budgetary allocations of the State.

In addition to the above measures of the State Government to improve the service delivery of the Health care centers in the communities much better steps have been taking by the Government through the Agency in-charge of the primary Health care Centers in our communities.

FACING THE REALITIES

COMEN conducted an assessment of the PHCCs (in 3 LGAs as a pilot study) against the minimum standards recommended by the National Primary Health Care Development Agency (NPHCDA). The findings from the assessment among other things showed that the majority of the PHCCs were in terrible conditions albeit worn out infrastructure and equipment (including leaky roofs, damaged water equipment, damaged toilet facilities, rickety walls/building blocks, beddings, tables and chairs, refuse disposal equipment, etc), inadequate supplies (including cleaning tools, detergents, medical gloves, syringes, etc), and inadequate skilled personnel for cleaning and maintenance of facilities.

These issues have combined to leave the PHCCs in a dirty and poorly maintained condition, making it unappealing for use by community members who have pressing health needs. These community members have resorted to patronizing private health care providers at exorbitant costs, further impoverishing them and exposing them to avoidable risks to life due to patronage of quacks.

The Anambra State government in an attempt to address the gaps in the delivery of the Primary Health Care program had commenced a program to rehabilitate a total of 63 PHCCs (springing from 3 PHCCs from each of the 21 LGAs) in the State annually starting with the 2019 fiscal year. However, the program has not achieved its desired effect 2 years down the line due to poor budget performance and a perceived lack of political will by the government to execute allocated resources for the rehabilitation of PHCCs and poor prioritization of the PHC sub sector.

To close this gap, the Anambra State government through the Anambra State Primary Health Care Development Agency (ASPHCDA) is leveraging the Basic Health Care Provision Fund (BHCPF) to support the delivery of the primary healthcare program in the State. The BHCPF is derived from contributions including — an annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF); grants by international donor partners; and funds from any other sources.

To access the BHCPF, the Federal Government put in place key criteria that must be fulfilled by States who desire to utilize this pool of funds. The Anambra State government demonstrated its commitment to address the needs of the sector by fulfilling the set criteria which includes the existence of a functional State Primary Health Care Development Agency.

In the 3 focal LGAs for the SPARK program, 17 out of the 21 Primary Health Care Centers (PHCCs) in SPARK's focal communities have now accessed the BHCPF. Only 4 PHCCs are unable to access the BHCPF.

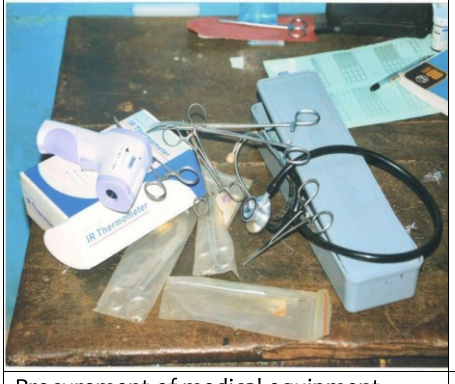
Below are some of the communities and the PHCs that have put in work with the fund.

Akwu-ukwu PHC in Idemili South LGA

Procurement of new locker for storing of the drugs and records

Provided Security Gate at the Entrance Health facility

Akwu ukwu Facility in Idemili South Renovation with the BHCPF



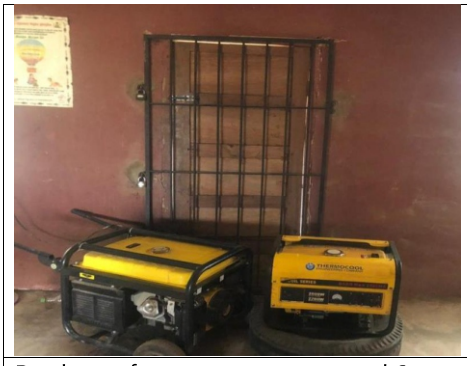
Procurement of medical equipment.

Repairs of Facility Ceiling Board

Uboma Ukpor Ward 6 PHC in Nnewi South LGA

Used to Purchase Mattress and Pillows for the Facility

Used to renovate the Pipe of the Wash Hand Sink



Purchase of new generator sets and Construction Purchase of new power change over of Burglary for the facility at Uboma, Ukpor PHCC, Ukpor.

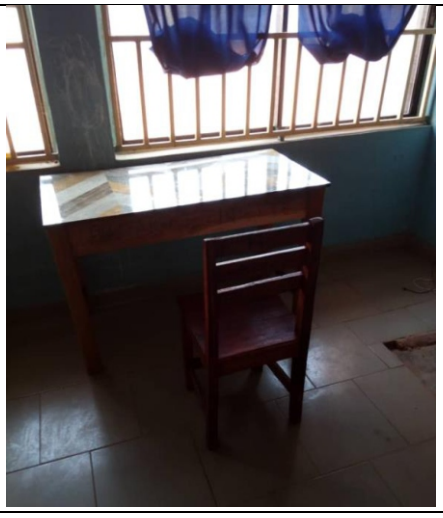
Utuh in Nnewi south LGA

Reconstruction of a Sewage tank at the PHC.

Reconstruction of a new sign post at the PHC in UTUH community.

PHC Ward 1 of Ezinifite Community in Aguata LGA

Construction of window nets at the PHC in Ezinifite in Aguata LGA



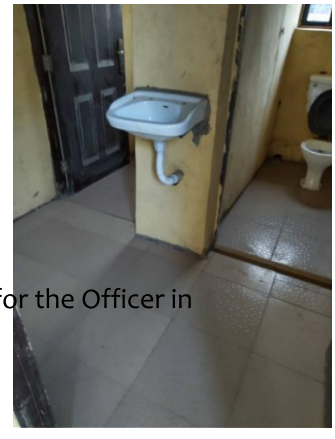
Construction of a new table for the Officer in charge.

Nkpologwu in Aguata LGA	
	
Repaired a Leaking Roof at their Facility	Purchased Generator Set and Fumigating Back-Pack.

<u>Achina Ebele PHC in Aguata LGA.</u>

Construction of window nets at the PHC in Ezinifite in Aguata LGA

Construction of a new table for the Officer in charge.



Construction of Placenta Pit Construction of Ne Benches Renovation of Wash Hand Basin

<u>Oye Achina PHC in Aguata LGA.</u>

Purchased the following:

1. Prepared and arranged a Consultation Room
2. GP Tank
3. Constructed a Burn and Bury Pit
4. Purchased a Cooking Gas Cylinder
5. Paid a Water Vendor for Water supply

This is as reported from the WDC Chairman of Ward 2 Mr Gabriel Ezenwanne.

The list of items to be collected by the Officers – in – charge of the various PHCs from the PHC Agency

S/N	ITEMS	AMOUNT
1	FACILITIES PHONE	25,000
2	FACILITY FIRE EXTINGUSHER	5,000
3	FACILITY DISPOSAL BIN	7,000
4	FACILITY CASH RECIEPT BOOKLETS	10,000
5	FACILITYCASH BOOK	2,000
6	FACILITY BED SHEET	5,000
7	FACILITY DRUGS AND COMMODITIES Q1&Q2	130,000
8	LAB KITS Q1&Q2	130,000
9	PATIENTS FOLDERS AND CARDS	15,000
	TOTAL	**329,000**

While the Government is working so hard to put up so many things in place at the respective facilities under it, the following areas are in dire need of urgent attention though they alternate with different Health facilities, they are;

Fourteen (14) major problems were identified with the primary healthcare facilities across the focal LGAs and they rotate around the following:

1. Absence of Public Electricity
2. Placenta Pits, Disposable Bins, Sewage Tanks
3. Toilets/Bathrooms
4. Solar Refrigerators
5. Mopping Sticks, Mopping Buckets & Disinfectants
6. Water
7. Drug Rooms
8. General Cleanliness
9. Ambulances
10. Waste disposal
11. Drainages
12. Cleaners/Labourers
13. Beds/Beddings
14. Window Blinds/Mosquito Nets/Window Nets

About Centre LSD

AFRICAN CENTRE FOR LEADERSHIP, STRATEGY AND DEVELOPMENT (CENTRE LSD)

... Building Strategy Leadership for Sustainable Development in Africa.

The African Centre for Leadership, Strategy and Development (Centre LSD) is a non – profit, non – governmental organization established under Nigerian laws to build strategic leadership for sustainable development in Africa.

The African continent is very rich and diverse. There are abundant human and natural resources in the continent. But the continent has the worst development indices in the world: maternal mortality, infant mortality, literacy rate, HIV/AIDS prevalence, poverty rate, life expectancy etc. More than half of the populations of African people are living in abject poverty. Most country in Sub-Sahara Africa are unlikely to achieve the modest Millennium Development Goals (MDGs) adopted by world leaders at the UN Millennium Declaration in 2000. Many African countries continue to suffer food shortages. Some countries are in conflict. We have experienced democratic reversals in some countries with the military coming into power in Guinea Bissau. All of these make the development of Africa a huge challenge. The continents to grapple with the developmental challenges have been complicated by its colonial history, globalization, leadership failures and adoption of development approaches that have been proved to be inadequate.

The importance of leadership for the success of organizations and nations cannot be overemphasized. Some scholars have pointed out that everything rises and falls on leadership. Despite this recognition, there is scarcity of leaders all over the world. There is a saying that the world is filled with followers, supervisors and managers but very few leaders. There are four kinds of people in the world: those who watch things happen; those who let things happen; those who ask what happen and those who make things happen. Leaders are those who make things happen. A visionless, insecure and incompetent leadership is a killer of organization and nations.

Similarly, strategy is very crucial to the development and performance of any organization or nation. Strategy occupies a central position in the focus and proper functioning of any organization or nation. This is because it is a plan that integrates an organization or nation's major goals, policies and actions into a cohesive whole. A well formulated strategy should therefore help to marshal and allocate an organization or nation's resources into a unique and viable posture based on its relative internal competencies and shortcomings, anticipated

changes in the environment, and contingent moves by others. Strategies help to create a sense of politics, purpose and priorities.

A dynamic and visionary leadership combines with appropriate strategy process will produce a correct development approach that will lead to the prosperity and development of Africa. Centre LSD is poised to contributing to the transformation of Africa through building dynamic and visionary leadership and proposing appropriate strategies and development approaches.

The major focus of work will be in the giant of Africa Nigeria but the centre will work across Africa with a Pan-African perspective with partners in all the sub-regions in Africa. The Centre's strategy, programme and actions will focus on Africa with the operations being run from Nigeria partnering with organizations across Africa. Centre LSD is registered with Corporate Affairs Commission as an NGO in Nigeria.

CENTRE LSD'S VISION

The vision of Centre LSD is an African society with strategic leadership and sustainable development.

CENTRE'S LSD MISSION

The Centre's mission is to work with forces of positive change to empower citizens to transform society.

Centre LSD's Values

The Centre is guided by the following values:

- Diversity
- Integrity
- Feminism
- Dignity of the human person
- Pan-Africanism
- Accountability
- Transparency
- Transformative change

The objectives of the centre include:

1. To promote ideas, policies and actions that will lead to transformative change in Africa.
2. To promote leader development (expanding the capacity of individuals for effective leadership roles and processes) and leadership development (expansion of organizations' capacity to

enact basic leadership tasks including setting direction, creating alignment and maintaining commitment).

3. To develop the capacity for strategic thinking, formulation, implantation and evaluation.
4. To promote human centre and sustainable development with special focus on Governance, Human Centre Development and Environment.
5. To collaborate with individuals, organizations, networks, coalitions and movements that will help in achieving the Centre's objectives

OPERATIONAL APPROACH

The centre carries out its programmes through the following methods:

Research
Think Thank
Capacity Building
Advocacy and Campaign

PROGRAMMATIC APPROACH

The Centre's programme is built on the principles of catalytic partnership and rights based approach.

The programme conception, design, implementation and evaluation are built around four principles:

1. Dynamic and visionary leadership
2. Appropriate strategy
3. Relevant development approaches including the promotion of women's right, citizen participation, ownership, pro-poor orientation and focus on the next generation of youth and children.
4. Building people and institutions.

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