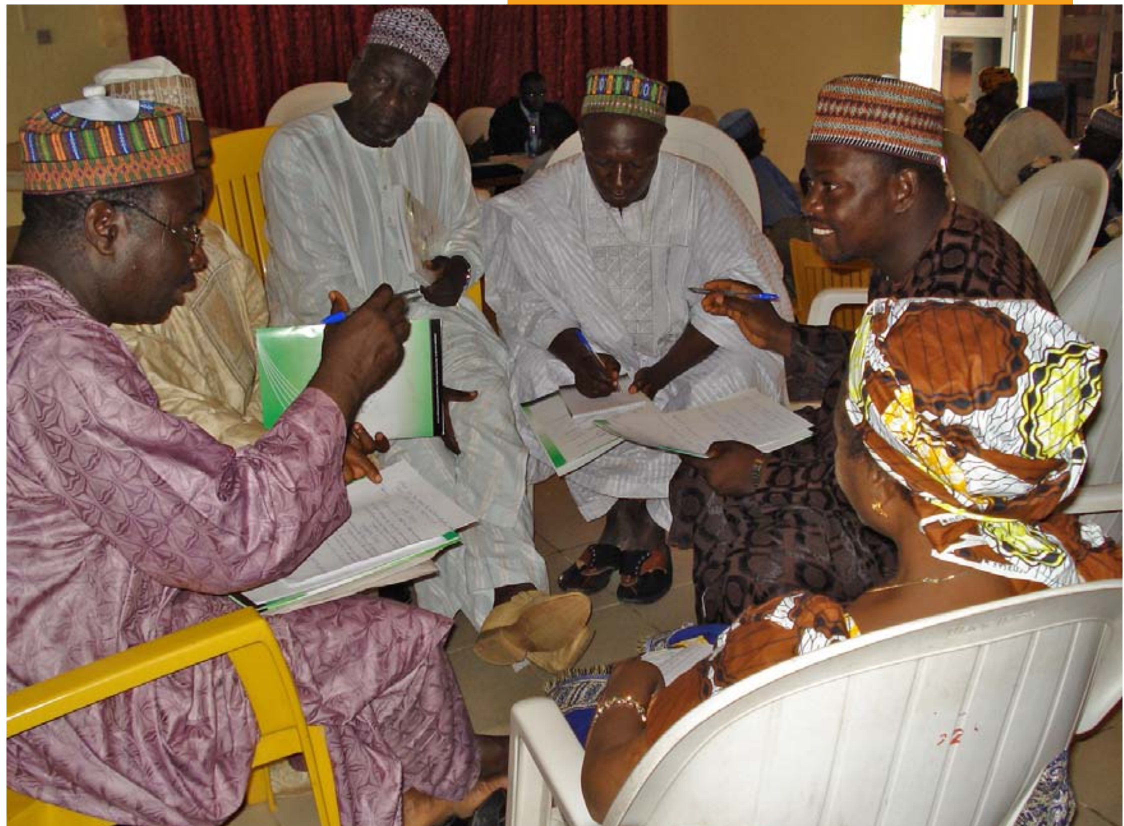
PATHS

Nigeria Partnership for Transforming Health Systems

Technical Brief



Strengthening Planning and Budgeting at State Level

DFID Department for International Development

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Nigeria Partnership for Transforming Health Systems

This technical brief was written by Chris Allison, PATHS Programme Technical Advisor for governance.

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Dr. (Mrs) Adebiyi, a member of FMOH Planning Cell presenting at the Federal Tertiary Health Institutions 2008 Workplan and Federal Health Expenditure Analysis (2006-2007) Workshop, Minna, 2008.

Strengthening Planning and Budgeting at State Level

Summary

In 2002, many of the state planning and budgeting weaknesses could be directly associated with the 'role ambiguities' (both political and administrative) which persisted in the Nigeria Public Health System – between and within the three tiers of government. As a result, there was an absence of systematic links between policies, plans and budgets. Policies and plans were not articulated, with resource availability as a central constraining factor. Inadequate attention was paid in the planning process to public revenues and the ramifications for out-of-pocket payments (OOP) by households[1]. In addition, planning and budgeting were not seen and deployed as core or integral parts of programme implementation and performance management. Plan and budget progress was rarely reviewed, monitored, or reported on.

Strategies to address these systemic weaknesses centred on:

- agreeing with the SMoH and other stakeholders on what might be achieved in the annual (operational or business) planning and budgeting cycle
- supporting strategic planning

1 The 2007 National Health Financing Policy highlights the need to reduce levels of out of pocket payments in Nigeria.

For annual operational planning and budgeting, specific strategies focused on:

- Alignment with State Annual Planning and Budgeting Cycle
- Establishing state planning and budgeting teams to drive the process
- Implementing new Budget Codes and a modified Chart of Accounts
- Developing and applying new planning and budgeting formats
- Preparation of facility and departmental plans and budgets
- Strengthening budget processes: preparation, review, presentation and defence
- Building planning and budgeting capacities and systems
- Linking revenue planning and budgeting

Significant steps were taken in all these areas to strengthen annual planning and budgeting.

Strategic or Medium Term Plans were completed, or were nearing completion, in all states where PATHS was operating by early 2008. Further efforts will be required to consolidate this process as many of the health programmes, including national programmes, were used to planning on their own, without reference to a wider state strategic plan.

These strategic plans were in some cases still only "state health plans". By early 2008, efforts were underway to prepare "health sector" plans that fully encompassed PHC and Local Government responsibilities for this part of the national health system. In states where a DHS approach was operating, the plans were already broader based – down to PHC level.

Further efforts will be required to build, year on year, on the gains that were made between 2004 and 2008. These include:

- Ensuring a single co-ordinated planning framework
- Strengthening the budgeting process
- Strengthening performance monitoring
- Further clarifying role ambiguities and strengthening stakeholder participation.

Introduction

This Technical Brief focuses on support to the health sector for efforts to re-establish effective strategic (or medium-term) planning, along with annual operational (or business) planning and budgeting.

Whilst efforts to enhance state planning and budgeting were on-going throughout the six years of PATHS, these evolved considerably over the last three years of the programme i.e. 2005 to early 2008.[2] Approaches were adapted and strengthened as opportunities emerged. This included taking into account other PATHS interventions (especially those with a 'governance' focus), and changes outside the health sector. Processes were adapted as partnerships with stakeholders matured and in the light of lessons and experience, including sharing learning across states.

Other significant contributions to enhancing planning and budgeting were effected under the auspices of several other PATHS initiatives; including those focusing on management strengthening (e.g. IMPACT/PPRHAA), disease and service specific initiatives (e.g. Routine Immunisation), and communications. These experiences have been documented in other Technical Briefs.

The challenge

The health system and health outcomes in Nigeria declined considerably in the 1990s, although by 2002 there was some encouraging emerging evidence that this decline had halted, and maybe had even reversed. However, there remained a number of major systemic weaknesses, including those besetting planning and budgeting, which could be linked directly to how the health system was established - with public health responsibilities shared across the three tiers of government (local, state and federal).

In simple terms, the division of roles placed the responsibility for primary health care, including PHC financing, with Local Government. State and federal governments had similar obligations for secondary and tertiary care respectively. In practice, the situation was more complex, and there remained a number of "role ambiguities" between and within the three tiers of government. These role ambiguities, which were both political and technocratic, served to slow and limit progress in turning the health system around. For example, the NPHCDA (a federal agency) had overall responsibility for PHC and was responsible for building model PHC centres.

Planning and budgeting itself had an obvious part to play in trying to address and clarify such role ambiguities. Indeed, ensuring that there was effective intra- and inter-government interaction in planning and budgeting can be argued to be central to overall good governance in Nigeria, given its federal system.

At the same time, it was necessary to attempt to reverse other weaknesses and poor practice that had become ingrained. The most serious weaknesses were:

I) **The absence of systematic links between policies, plans and budgets**. Until very recently, policies and (strategic) plans were not articulated, with resource availability as a central constraining factor. The inattention to cost implications related to both public finances and the ramifications for out-of-pocket payments (OOP) by households.

II) Planning and budgeting were not automatically included as an integral part of **programme implementation and performance management**. Plan and budget progress and outputs were rarely reviewed, monitored, or reported on. Arguably this was only one part of a range of weaknesses in health sector supervision, monitoring and evaluation.

Given the above, the key challenges to be tackled with PATHS' support thus included:

- Role ambiguities
- Budget Code and Chart of Accounts weaknesses
- Budget and expenditure disjoints
- Planning and budgeting not used systematically in the health sector
- PHC and Local Government planning and budgeting weaknesses

2 Towards the end of PATHS, more limited efforts were undertaken to support planning and budgeting at federal level. However, the results of this support will only become fully clear once the current 2009-2011 Medium Term Sector Strategy (MTSS) exercise is completed."

- Weak human resource capacity
- Poor Development Partner co-ordination

Role ambiguities

At state level, Governors exercised predominant control over the 'state purse'; as did LGA chairmen over the LGA purse. This distorted the planning and budget process as a whole and limited the roles of other state planning and budgeting actors. These actors included Commissioners and officials in the Ministry of Finance and the Ministry of Planning and Budgeting, as well as those in line Ministries - such as the State Ministry of Health (SMoH).

Within the SMoH, budgeting and costing responsibilities were not shared across the ministry as a whole. The norm was very limited involvement in budget preparation, typically restricted to a few individuals in Departments of Finance and Administration (DFA), and Departments of Planning Research and Statistics (DPRS). Agencies and facilities were rarely involved. An artificial division of responsibilities between the DFA and DPRS often emerged, with the DPRS leading on the capital budget, and the DFA on the recurrent budget. In part this was linked to the different "release" processes that applied to recurrent and capital expenditures, and who, within the SMoH, was involved in these release processes. The almost inevitable consequence was the absence of any linkages between recurrent and capital budgets. The recurrent cost implications of capital budget expenditures were rarely evaluated. In addition, the common practice of including obvious recurrent items (e.g. the procurement of drugs and medical supplies) in the capital budget added to this confusion. Political influence over budgeting was also excessive and undue attention was given to procurement and construction.

In such circumstances, the credibility of the budgeting process inevitably suffered. Within the SMoH, many officials wholly or partially abrogated their responsibilities (as they could not see an alternative). Planning and budgeting was not something to be taken seriously, or something to be 'owned'. This applied especially to those in the SMoH charged with taking the lead in policy and programme implementation. Within the health sector it became commonplace to talk of "resource mobilisation" not in the legitimate sense of internal revenue generation, but in the sense that Ministry of Health staff regarded themselves as 'outsiders', advocating for health resources. As state government officials, SMoH staff had an explicit and direct responsibility for effective health planning and budgeting, as an essential part of health stewardship. Yet this obligation was not always seen and discharged.

Engagement in planning and budgeting by other stakeholders outside the SMoH was haphazard and unsystematic. Many Ministries of Health did not have the sort of relationship with the Ministry of Planning and Budgeting (or the equivalent) that was conducive to effective governance. Ministries of Planning and Budgeting did not hold Ministries of Health in high regard; they did not see their budgets and plans as well constructed and making a persuasive case for an increased share of state resources.

Non-governmental and civil society involvement in budget and planning processes was equally hit-and-miss.

Budget Code and Chart of Accounts weaknesses

In common with other sectors, health planning and budget formats and practices were not formalised, and did not adhere to basic principles. The Budget Code (BC) and Chart of Accounts (COA) in operation in most states was a hindrance to effective budgeting. Problems included:

- No means of making the essential distinction between the necessary 'financial inputs' on the one hand, and the programmes and initiatives towards which these inputs were directed on the other.
- The listing of financial inputs was not detailed enough.
- Misclassification of capital and recurrent budget items was ingrained. In particular, drugs and medical consumables were generally classified as capital expenditure.

With such BC and COA deficiencies, it was almost impossible to use state health budgets (and budget monitoring) as an integral part of policy implementation and programme performance management.

Examples from the Kaduna 2007 Approved Budget

In the table, expenditure is lumped together with no details on allocations to programmes or initiatives. In addition, financial inputs (e.g. transport and travel) are mixed with programmes or functions (e.g. Provision of Free Medical Treatment for Children and Pregnant Women).

NEW CODE	CLASS CODE	DETAILS OF EXPENDITURE	APPROVED ESTIMATES 2007
0001	1	Personnel Cost	2 241 000 000
0111	2	Transport and Travel	5 500 000
0200	3	Utility Services	1 000 000
0301	5	Stationery, Uniforms and Minor Office Expenditure	7 000 000
0310	28	Emergency Medical Service	25 000 000
1501	29	Hospital and Dental Services	228 517 200
1204	30	Insurance of Ambulances and Medical Equipment	20 000 000
1207	31	Establishment of Primary Healthcare Development Agency	200 000 000
1207	32	Establishment of Hospital Management Board and Committees	64 620 000
1207	33	Provision of Free Medical Treatment for Children and Pregnant Women	1 300 000 000

Budget and expenditure disjoints

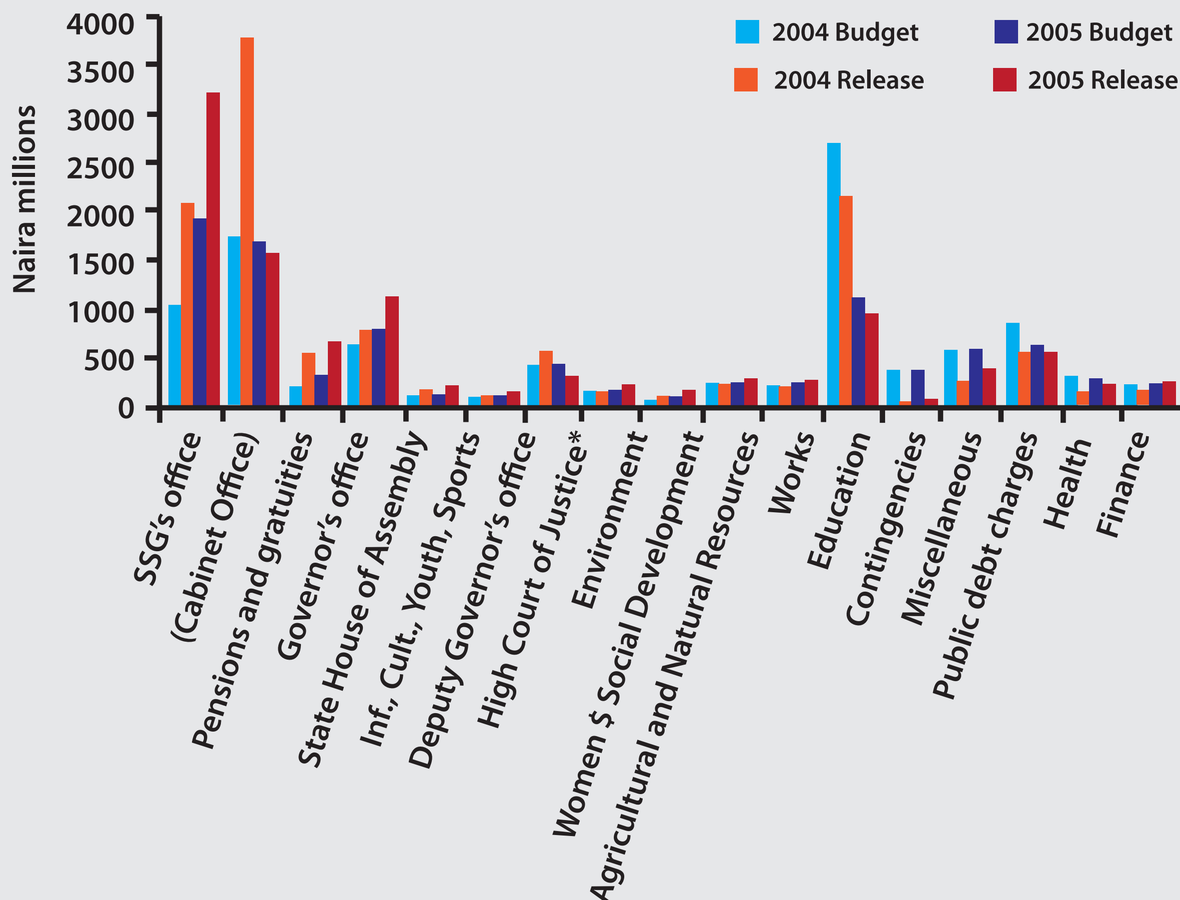
Disjoints between budgets and expenditures further jeopardised the value and credibility of planning and budgeting processes. The allocation of money in a budget was no guarantee that subsequent releases would occur. Whilst some parts of government invariably reported expenditures exceeding budgets, expenditures for others (including typically Ministries of Health and Education) fell short of budget allocations.

Crucially for the health sector, releases were not regular, consistent and predictable. Regular release is essential, especially for the recurrent costs (salary and non-salary) required to run an effective health service. In the face of such unpredictability, planning horizons became very short – days, weeks, and sometimes months (but not years).

Not surprisingly, budget and expenditure tracking remained the exception rather than the rule. It was hardly ever used in relation to a particular policy or programme objective or target.

Budget and Release Amounts in Kano State (2004 and 2005)

Some Ministries (e.g. Secretary to the State Government in both years and Pensions and Gratuities in 2004) spent far more than what was budgeted; while Ministries such as Education and Health received substantially less than was budgeted.



Planning and budgeting not used systematically in the health sector

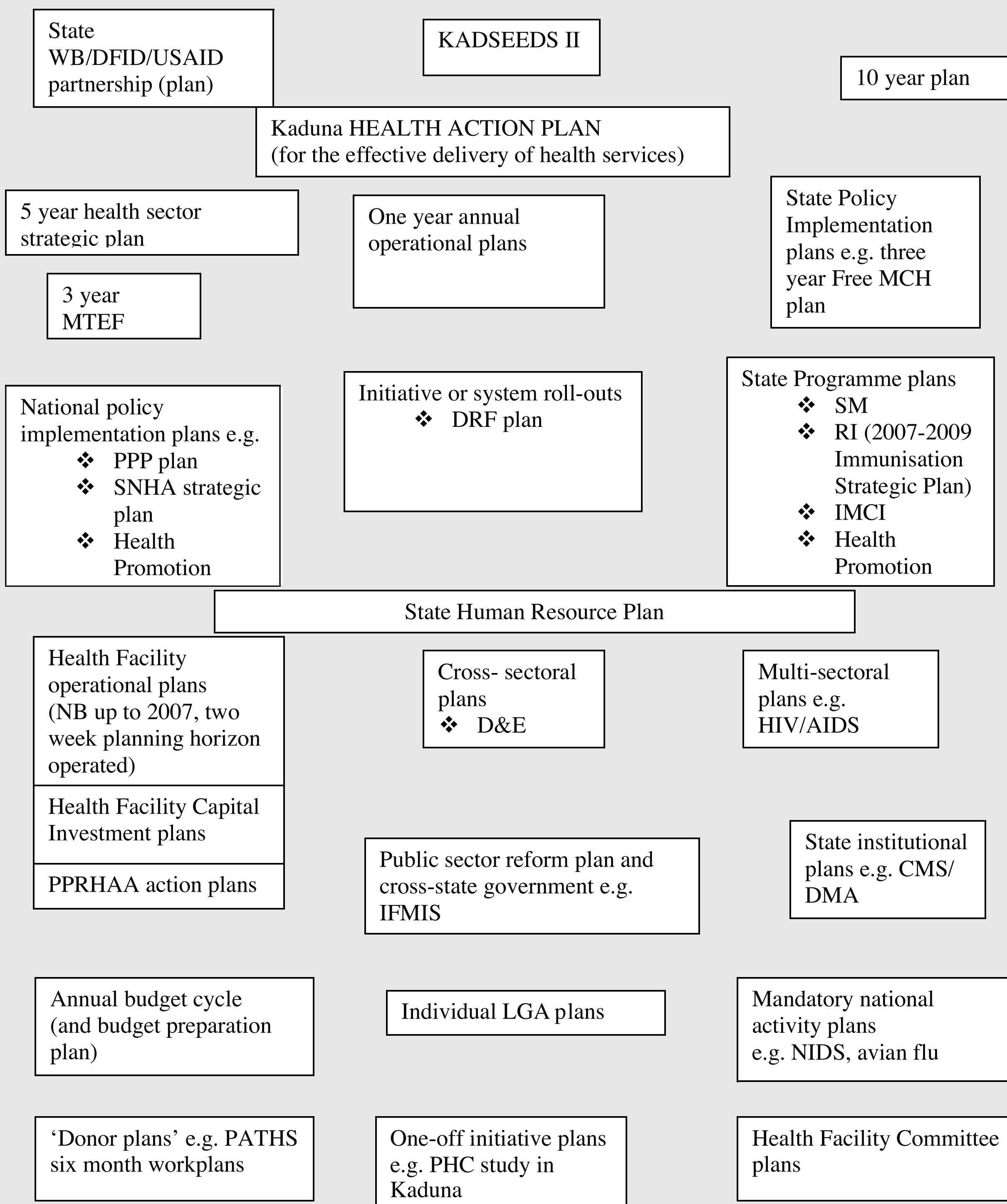
Incremental budgeting became the norm – a certain amount was added to existing budgets each year, rather than systematically thinking through what was actually required. The key practice of routine and systematic health sector annual operational planning, as the foundation around which all other planning (long, medium or short-term) could be built, fell away. Annual planning and budgeting processes built around the annual budget cycle, with deadlines for specific inputs and responsibilities, were no longer systematically adhered to. Some key steps in the budget process, including budget review, were neglected.

Strategic planning, where this happened, was built around "wish-lists". Even the best strategic plans were effectively medium-term statements of intentions (aims and objectives) and activities. The plans were not costed. Moreover, these plans were rarely truly "strategic" in terms of assessing alternative strategies for attaining a particular health goal.

Within the health sector, a common response was to develop plans (sometimes costed) for specific interventions or initiatives. Where costing occurred, there was no consistency in terms of approach – and minimal attention to working within a resource envelope. A multitude of different plans emerged, with different approaches, formats, and intentions.

Kaduna: Health Planning Jigsaw

The diagram illustrates the multitude of unco-ordinated planning activities within a state.



PHC and Local Government planning and budgeting weaknesses

All the challenges and weaknesses described above for the state level applied in varying degrees to PHC and Local Government planning and budgeting. Indeed, in many ways, the weaknesses in local government planning and budgeting were even more serious and deep-rooted than those at state level. As a consequence, there were no robust local government plans for attaining the Millennium Development Goals (MDGs). There were also few comprehensive well-founded plans for building an effective referral system and process, linking primary and secondary care.

CASE STUDY:

Unco-ordinated Planning Systems for Routine Immunisation (RI) at LGA level in Kaduna

'All the LGAs had developed their micro plans for RI for 2006. All the plans had clear objectives, activities to achieve the objectives, timeline for each activity, measurable indicators, responsible body to overlook activities, and the budgetary requirement for the activities. However, each LGA seem to pursue a different objective. Perhaps the plans for the different LGAs were not prepared based on a common state strategic plan. In addition, the plans did not make provision for linkages between strategies and the actual delivery of services. This implies that there is lack of co-ordination and provision for sustainability in planning and delivery of RI in the state. LGAs being the operational level for RI are suppose to take [their direction] from the state strategic plan in preparation of their plan of action for implementation of RI activities in their respective LGAs.'

Extract from Kaduna Routine Immunisation Report by Dr Umar Muhammad Lawan, March 2007

Weak human resource capacity

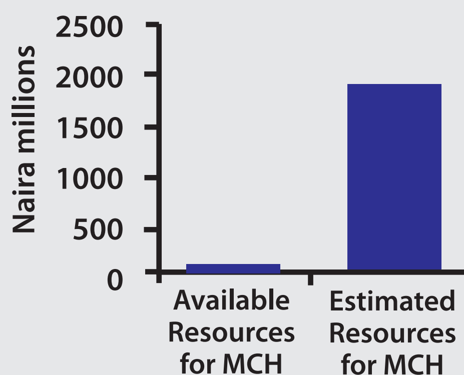
Weak HR capacity was associated with most of the above challenges. However, the over-riding challenge was "the way the system operated". Breaking with the past, and enabling all concerned to envisage and believe in the gains from this, was the major hurdle to overcome.

Poor Development Partner co-ordination

For many years development partner activities compounded many of the above problems, rather than contributing to resolving them. Prior to 2007, there was no evidence of donors paying any interest in, or attention to, a shift towards a 'one-plan' approach - in line with the "harmonisation and alignment principles" set out in the 2005 Paris Declaration. Alignment of donor planning processes with the state annual budget cycle remained the exception rather than the rule. Similarly, there was little attention paid to the political cycle; for example, long-term plans were proposed by development partners in 2006, at a time when significant changes in state government policies and leadership would inevitably take place in 2007, following the national elections.

Resource Gap in Financing Free MCH Services in Kano

The first column identifies the state budget for free MCH services, while the second is the estimated budgetary requirements for free MCH services.



The Response

Over the course of the PATHS programme, strategies were developed and applied to address some, but not all, of the challenges described above. An overall aim was to start "getting some of the basics right"; whilst at the same time seeking and using opportunities to address some of the wider constraints, especially those linked to role ambiguities. In all of this, there was a focus on moving at a pace that would enable as many state stakeholders as possible (or at least a 'critical mass') to modify progressively their systems and ways of working.

An approach evolved which centred on:

1. Agreeing with the SMoH and other stakeholders what might be achieved in the forthcoming annual (operational or business) planning and budgeting cycle. The pace of progress was determined in no small part by factors within and outside the health sector.

2. Supporting strategic planning when the time and place were right, or with short-term expediency in mind. Where feasible, this was linked with State Economic Empowerment and Development Strategy (SEEDS) and SEEDS II exercises.

A general lack of interest by most of the state administrations in the run up to the May 2007 elections limited the pace of progress over that period. By contrast, following the elections, there were greater opportunities and more conducive environments to move forward substantively. This included starting to address some of the organisational and role ambiguities within the health sector.

In both Kano and Enugu, it was only in the latter part of 2007 and early 2008 that progress was made in developing a sound strategic plan; whilst gaining the requisite type and degree of stakeholder participation and ownership. In these states, support for annual operational planning had previously gone ahead in the expectation that this would lead into the strategic planning process.

Jigawa presented a slightly different scenario where a strategic planning process took place in early August 2004. Major implementation challenges included the lack of quality data to monitor the unrealistic targets in the plan, limited stakeholder awareness of the content of the plan, inability of all development partners to buy in to the plan, and weak linkages between operational plans and the strategic plan. However, the document was jealously guarded by the key stakeholders; thus providing evidence that a culture of strategic planning was beginning to be established in the state.

Whilst this overall approach facilitated some significant progress, there remained a substantial unfinished agenda of issues which had not yet been properly addressed.

CASE STUDY:

Strategic Planning in Kaduna

Even though the PATHS programme in Kaduna only began in 2006, it offered an interesting example of how strategic planning could evolve, as needs and circumstances changed. The initial strategic plan developed in early 2006 was the basis for discussing and agreeing the principal PATHS areas of support for the state. Further significant strategic planning work took place in 2007 and 2008; linked first with the introduction of the Free MCH policy (in late 2006), and subsequently with the development of Kaduna SEEDS II (from mid-2007 onwards). In the course of this, in October 2007, the Governor of Kaduna requested a Health Roadmap, to go alongside the state Education Roadmap which had already been developed. These efforts culminated in the draft KADSEEDS II medium-term plan in March 2008. This was comprehensive and linked both projected recurrent and capital expenditures with "strategic specific policy objectives". This plan was of a quality to serve as the foundation on which further sector-wide approach (SWAp) dialogue could be pursued.

Annual operational planning

KEY STEPS:
Strategies Used to Strengthen Annual Operational Planning:

- Alignment with State Annual Planning and Budgeting Cycle
- Establishing planning and budgeting teams
- Implementing new Budget Codes and Modified Chart of Accounts
- Developing and applying new planning and budgeting formats
- Preparation of facility and departmental plans and budgets
- Strengthening budget processes: preparation, review, presentation and defence
- Building planning and budgeting capacities and systems
- Linking revenue planning and budgeting

Alignment with the State Annual Planning and Budgeting Cycle

Strengthening annual operational planning and budgeting within the context of the budget cycle started in 2005. Initially, the majority of inputs were timed to coincide with the start of the budget cycle in July/August. This proved too late to make any significant impact – although in Ekiti there was substantive progress in changing the budget structure (building on earlier state health accounts work). In 2006, inputs commenced in April/May to allow two to three months preparation. From 2007, inputs started in January. Recognition that earlier and more extensive preparation was essential was a shared learning process – for state stakeholders and PATHS.

Establishing planning and budgeting teams

In all states, except Kaduna (and earlier in Ekiti), the Ministry of Health established a formal planning and budgeting team (or budget core group) to drive the planning and budgeting process. Whilst the core members of these teams were drawn from the DPRS and DFA, there was also representation from one or more spending or implementation Departments. For example, in Enugu, the team had representatives from the Pharmacy Department in the State Health Board, and from one of the District Health Boards, and by early 2008 consideration was being given to adding a Local Health Authority representative. In Jigawa, some representation was also drawn from the Ministry of Joint State Planning, Budgeting and Expenditure Control (MJSPBEC) and the health training institutions. This mix of staff proved invaluable in facilitating a mix of perspectives (and roles) as part of the planning and budgeting process.

PATHS consultants initially served as the secretariat for this team. However, this responsibility was gradually taken on by the team itself. In Enugu, the 2008 schedule of activities (i.e. covering the period up to the start of the 2009 budget cycle in July) was locally managed and implemented with only limited external inputs.

Implementing the new Budget Codes and Modified Chart of Accounts[3]

The decision by state governments to introduce a modified state BC and COA started, in 2006 in Kano, and subsequently, in 2007 in Jigawa and Enugu.[4] This served as an invaluable opportunity to facilitate other broader enhancements to state planning and budgeting processes. The new BC and COA was vital in:

- re-establishing comprehensive and appropriate codes for recurrent and capital budgets and expenditures, as well as for government revenues;
- re-establishing institutional and organisational codes for all entities within the health system;

3 The BC and COA changes are being followed, after a period of about a year, by the introduction of state public sector Integrated Financial Management Information Systems (IFMIS)."

4 The new COA anticipated in Kaduna in 2007 (for the 2008 budget) was delayed by a year.

- starting a process (in Kano) of linking budget capital expenditures with MDG and state SEEDS goals, and specific programmes (e.g. MCH);
- enabling all stakeholders to understand the different sources of funding.

The modified BC and COA was an opening for the health sector (and the respective state governments) to approach planning and budgeting in a different way. Annual operational plans and budgets could now be based on a full list of potential financial inputs; and, equally importantly, not be muddled by mixing financial inputs (e.g. materials and supplies) with programmes or functions (e.g. child health and monitoring and evaluation). In particular, more accurate comprehensive and uniform estimates of the 'overhead' (i.e. non-salary recurrent) costs entailed in delivery of specific health activities could be prepared. In addition, there was much greater scope for establishing a clear hierarchy of initiatives and activities.

In Kano and Enugu, the Ministry of Planning and Budget set out strict guidance on eligible expenditures for inclusion in each of the recurrent and capital budgets. With this, it was possible to correct previous poor practice – so that recurrent items (including materials, training and services) were all in the recurrent budget, and the capital budget and plan were reserved for major capital investments (e.g. the construction or major rehabilitation of a hospital, or primary health care facility). Some SMoH staff took time to adapt to this shift. For example, the draft Kano strategic plan retained some of the previous confusion in classification of financial inputs. This could be linked to another view which was taking time to dissipate – that the DPRS had lead responsibility for the capital budget, whilst the DFA took charge of the recurrent budget.

The new organisational coding proved equally important. In Enugu, each entity within the District Health System (including DHBs and LHAs) had its own individual organisational code. This consolidated and formalised recognition and understanding of the structural changes that were central to the introduction of the DHS. Similar organisational coding changes were in place in Jigawa for the Gunduma system, and were planned for Kano for the establishment of a zonal health system.

In this, one key contribution by PATHS was to ensure that codes for 'welfare or benefits' payments were retained within the list of potential economic inputs. The Federal Ministry of Finance had introduced such codes when introducing the amended BC and COA in 2005, but some states then omitted these when adapting their own Chart of Accounts. PATHS and SLGP helped in identifying and rectifying these omissions. Such codes are essential for state governments wanting or intending to make future welfare, social benefit, child benefit, disability benefit, "demand side financing" or cash transfer payments to the poor and disadvantaged. In the health sector, these codes are needed for budget allocations for deferrals and exemptions payments.

CROSS CUTTING:

Links with other DFID Programmes

The lead support for bringing in the BC and COA changes was the DFID-funded State and Local Government Programme. However, PATHS contributed to their introduction. For example:

- Draft BC and COA were reviewed initially by, and sometimes piloted in, SMoHs.
- Health case studies and examples were incorporated in State Budget Users Manuals.

Developing and applying new planning and budgeting formats

The BC and COA changes enabled new planning and budgeting templates and formats to be developed and applied.[5] These formats varied from state to state, and were evolved from year to year (according to the preference of the planning and budget team). However, the overall guiding principle was to work towards a format which allowed:

- objectives and activities to be clearly specified within a hierarchy of aims and intentions;

5 These templates and formats are available on the CD accompanying this series of Technical Briefs.

- all objectives and activities to be clearly and comprehensively articulated within a framework of "strategic policy objectives" (Kaduna and Jigawa) or "core health functions" (Enugu and Ekiti – the specification of health functions was more detailed in Enugu). This ensured an appropriate link between the annual operational plan and the strategic plan.
- development of individual departmental and facility plans and budgets.

In Enugu, the core functions undertaken by each part of the district health system in the state were agreed – from the highest policy level down to community level outreach. The main activities associated with each function were mapped out – with each activity costed in line with the new Enugu BC and COA. The result was an assessment of the cost of delivering the entire state and local public health system.[6]

There is scope for further development of the planning formats. The Enugu format, for example, already had scope for adding in 'policy linkages' (or 'policy markers'). Through these, the expected contributions (via a particular objective and activity) to both national and state policies could be identified and highlighted.

Preparation of facility and departmental plans and budgets

Facilities and departments were not full cost-centres by the time PATHS ended in mid 2008. However, the scene was set for individual Departments and facilities to prepare plans which:

a) specified their primary functions and initiatives;

b) indicated which of the main state health strategic objectives and strategies they had some responsibility for (in a lead or a supporting role);

c) identified which targets and milestones would be used to judge their performance;

d) showed the resources (recurrent and capital) at their disposal;

e) could be used as a basis for preparing rough (e.g. quarterly) 'cash flow' projections throughout the year.

The initial effort focused on a comprehensive specification of activities, whilst at the same time achieving the right degree of detail.

Initial progress was at departmental level. In Kano, this resulted in one department (Primary Health Care and Disease Control) specifying up to 90 recurrent activities, whilst others proposed more modest lists of between 10 and 20 main tasks. A similar result emerged from the Department of Public Health in Enugu. Excessive numbers of activities was partly linked to the way that the Federal Ministry of Health liaised with states around national programmes. Each national programme appeared to generate a significant number of activities at SMoH level - even when some of these activities would be more appropriately implemented by others in the state health system. In addition, monitoring was often planned as a distinct activity for each programme, rather than as part of integrated supervision. The exercise highlighted role ambiguity and mis-specification.

Similar plans were to be developed at facility level, again ideally encompassing both facility functions (with delivery of an "essential package" as the core function, but with other functions also clearly articulated) and expected facility roles and contributions in relation to key health strategic objectives. However, at facility level an added complication was that more than one budget projection would be required since Drug Revolving Funds (DRFs) ran as separate and ring-fenced cost-centres. Facilities needed distinct DRF and non-DRF budgets. By early 2008 the processes for preparing these had not been fully worked out.

6 In reality, it was not possible to get a full cost because no figures were made available for the salaries budget at LGA level.

Strengthening budget processes: preparation, review, presentation and defence

A key aim of working within the budget cycle was to allow intervention at the appropriate juncture when annual (and/or medium term) health budget ceilings were established. The State Ministry of Budget and Planning (or equivalent) typically circulated budget ceilings to all line-ministries in July or August; any dialogue about the level of health sector ceilings (recurrent and capital) had to precede this. For example, in Kaduna the proposed 2009 budget ceilings were initially issued in March 2008. Ideally, in preparing for this dialogue, it would be feasible for states to put forward estimates for alternative levels of (health) budget, along with an indication of what each of these levels would imply in terms of key state and national targets. However, this stage was not reached. Current costing work (as part of the medium term planning) was still focused on preparing indicative figures.

Nevertheless, the earlier preparation allowed more robust adaptation of budgets and plans, once the budget ceilings had been circulated. For the 2008 budget in Enugu for instance, this meant scaling up some of the initial estimates to meet the higher than anticipated budget ceilings.

More rigorous approaches were also applied in the PATHS-supported states for budget review and defence. In common with other PATHS efforts, a significant element of peer review was built into preparation for the review and defence. In Jigawa and Kano, each department was required to present and justify their initial plans and budgets, and to review their departmental performance in front of other departmental heads.

In this, and in any SMoH presentations to the SMoBP and subsequently to the State Assembly, one important gain was that any given activity and cost in the operational plan and budget could be fully explained and justified.

Building planning and budgeting capacities and systems

Capacity and system-building activities were organised to back up these changes. Training programmes were devised, and applied in Kano and Jigawa, to enable a much wider range of health staff to participate in planning and budgeting processes. By early 2008, such training was also underway in Enugu.

Planning and Budget Manuals were to be prepared in Enugu and Jigawa. In addition, the initial steps were made to computerise the planning and budgeting process, since to date, the overwhelming majority of financial planning and management activities had been paper-based. One part of the training concerned working with spreadsheet budget formats.

Standard presentations (for 'hard copies' of the health plans and budgets) were also devised.

Linking revenue planning and budgeting

Although revenue projections were part of budget preparation, most attention was paid to health expenditures. There was some focus on revenues and revenue projections. For example, harmonised and uniform Internally Generated Revenue (IGR) tariffs were agreed in Kaduna state. (IGRs are the "sales of services" income which facilities can attract.)

The modified revenue codes in the BC and COA were reviewed in each state. Arguably though, these deserved further attention - there were questions about the appropriateness of the current codes for both IGR and the "fees and licences" income which accrued as part of the state government role in regulation (inspection, licensing and re-licensing).

Building Capacity in Kano

Key achievements of the step-down training include:

- 'For the first time, all members of the various zonal management committees had an opportunity to meet together to share ideas and experiences around health planning and budgeting.'
- An "Action Plan" was drawn up jointly by the zonal management teams for preparation/submission of their plans as well as step-down the training to their facilities.
- For the first time, participants realised that all of them have a role in operational planning and budgeting.'

Extract from Report "Provision of ongoing support to strengthen the budget system in Kano State health sector" by Ate Wombu in July 2007

State strategic planning

The strengthening of strategic planning varied considerably between states. For example, the 2004 Jigawa Strategic Plan led on to the development and implementation of the Gunduma policy. In 2005-6, preparation of a strategic plan was supported in Ekiti. Otherwise, it was only during the second half of 2007 and early 2008 that significant progress was made in developing sound state strategic plans in the other PATHS-supported states (Enugu, Kano and Kaduna).

Prior to this, there was not the broad-based interest, leadership, or scope for effective engagement required to pursue a health sector strategic planning process with serious purpose. In Enugu, in 2003 a strategic plan was prepared but not followed though. In 2006, an attempt was started to develop a revised strategic plan – once the District Health System had been inaugurated. However, this exercise was postponed until the desired degree of engagement could be guaranteed.

A key factor in later progress was the change of administration in 2007. This made it possible to promote more constructive and extensive engagement in the planning process and to highlight the necessary policy and programme issues on which strategic choices had to be made.

Health sector reform and strategic policy objectives

The Kano and Kaduna strategic plans followed similar courses in mapping out broad reform and strategic policy objectives. The objectives covered the core areas of stewardship; access to health services and care; client and consumer awareness, participation and voice; resource availability and resource management; health systems; and health information. The table illustrates the direction of the main policy objectives.

Strategic Policy Objectives – Kano and Kaduna

	Kano	Kaduna
Stewardship	Ministry of Health assuming a stewardship role in the context of a reformed organisational structure and improved co-ordination among providers	To highlight the role of government and individuals in managing resources for health service delivery and in making sure all health sector actors (public and private) fulfil their respective responsibilities
Access to Services	Kano health system offering quality health care based on global best evidence	To ensure the provision of quality and affordable health care services in priority health areas especially at PHC level
Consumer and client participation, voice and awareness	Individuals, groups and networks socially empowered to demand increased access to quality services for all, including the very poor and especially women and children	To strengthen consumer and client partnership on health issues
Resources and resource management	Appropriate mechanisms for health care financing and resource allocation in place, based on the principle of equity Improved supply of health workers in an appropriate professional mix	To develop and ensure an effective and sustainable health resource management function within the health sector
Systems	Effective systems for planning and management of services in place, based on a principle of continuous improvement	*Covered in resources above*
Health Information	*Included in systems*	To have complete, accurate, consistent, reliable data for informed decision making by stakeholders

The Kaduna plan went a stage further and mapped out a series of 'targets' (really strategic sub-objectives and strategies) under each of the main headings. For example, Target 1.1 was to have prepared departmental and facility plans for all facilities by end 2008.

The Kano and Kaduna strategic plans included some costings. However, this part of the medium-term planning was not completed with the same degree of rigour and comprehensiveness as the budget estimates included in the annual plans. In Kaduna's case, the delay in introducing the modified BC and COA was one factor limiting the costing process; another was the ambivalent costing guidance in the KADSEEDS manual. For Kano, a narrow and limited costing approach was adopted.

The main gains from the strategic planning to date were not so much from the plans themselves, but from the process of engagement and involvement. Crucially, there was much wider acceptance and recognition of the need and value of the plans.

Other planning

Other extensive planning inputs occurred in the context of the many and varied other initiatives that PATHS supported. This embraced:

- the *action plans* which were an integral part of the IMPACT/PPRHAA process;
- the *programme plans* which were developed for such programmes as Routine Immunisation, Safe Motherhood and TB;
- the *policy implementation plans* and strategic frameworks which were developed for rolling out such initiatives as the National Human Resources and Public Private Partnership Policies;
- *investment and system plans* to move towards state-wide coverage for such initiatives as Free MCH and DRFs.

Whilst the overwhelming majority of these plans were robust in their own right, a key failing was the lack of attention paid to ensure that such plans were consistent, both in themselves and with other state plans.

One particularly important aspect of this inconsistency remained the continuing confusion between "recurrent" and "developmental" activities and efforts. As a result, not all of these other plans were in a form that could feed directly into the strategic or annual operational planning, and the annual budget cycle. Equally, costs did not always differentiate between the implications for the Recurrent and Capital budgets.

It was not possible during the timeframe of PATHS to introduce and apply the necessary "multi-year, adaptive, trial and error" approaches at a Local Government level; or at least not with sufficient consistency and coverage to be able to draw robust conclusions. The greatest progress was achieved in Enugu and Jigawa, within the context of the DHS and Gunduma systems, where decentralised planning was extended down to Gunduma, District, Local Health Authority and PHC facility levels.

Results

The table overleaf outlines the main results of the changes to state planning and budgeting. Beyond these results, the main gains were the wider engagement and participation in the planning and budgeting processes, and the beginning of re-establishing the credibility of planning and budgeting as an essential government function.

Substantive progress was made in addressing some, but not all, of the planning and budgeting weaknesses. None of the strategic plans really addressed the challenge of exploring strategic alternatives. Opportunities, threats, assumptions and risks were also not systematically identified and assessed. However, what was encouraging was that the annual operational planning and budgeting formats were developed in a way that made such genuine strategic planning a potentially realistic prospect.[7]

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7 An attempt was made to assess the impact of introducing a Free MCH policy in Enugu using a genuine strategic approach (i.e. exploring different options, including, for example, free EOC or a free MCH policy targeted to the very poor). However, the state team (charged with preparing and costing the new policy) preferred a simpler approach. This applies equally to Kaduna. Different options were explored, but rejected by the Free MCH Committee.

Results : State Operational Planning and Budgeting, and Strategic Planning

ANNUAL PLANNING AND BUDGETING	State				
	Ekiti	**Enugu**	**Jigawa**	**Kaduna**	**Kano**
Plans linked to budgets		From 2008	From 2008 for Gundumas	From 2007 for Free MCH, and from 2008 for all state health activities	From 2008 for SMOH and HMB
Alignment with annual budget cycle	Since 2005	Since 2006	Since 2006	Since 2006	Since 2006
2008 plan for planning and budgeting actions and strengthening		Through to June 2008	Action plan developed to cover June 2008		Action plan developed to cover June 2008
Planning and budgeting team established		From 2007	From 2005		From 2007
Decentralised planning		Departmental, District, LHA and facility plans from 2008	Gunduma plans from 2008	Some progress on facility plans, and early drafts of LHA plans	SMOH and HMB Departmental plans. Zonal plans in preparation.
Budget Codes and Chart of Accounts	Not introduced before the closure of PATHS.	Successfully introduced in 2007. Reflects DHS.	Introduced in 2007. Reflects Gunduma system	To be introduced in 2008. Agreed that new BC and COA to be piloted in health facilities for 2007 plans	Introduced in 2006. SMOH did not adapt initially
Operational and Business Plan and Budget methodologies	Broad functional analysis format introduced in 2005. Refined LG formats developed for 2006.	Business plans first developed in 2004. Refined and expanded in 2005, 2006, and 2007 – when explicit budget links, and planning and budgeting by "function" were firmed up.	Departmental and facility budgeting introduced in 2007. Gunduma budgets prepared from 2007.	Activity Based Budgeting (ABB) introduced in 2007.	Simplified departmental activity budgeting introduced in 2007.

	Ekiti	Enugu	Jigawa	Kaduna	Kano
Budget Format and Presentation	Budgets by State Health Account Function and old COA (Implicit Departmental budgets)	Budgets by: • functions • new COA • departments • facilities • Districts and Local Health Authorities	Budgets by : • new COA • Gundumas	Budgets by : • old COA • some departmental estimates as part of ABB • facility budgets being prepared as pilots with new COA	Budgets by: • New COA • SMoH Departments • Activities within SMoH Departments • SHMB zonal offices
Explicit Budget Policy and Programme Linkages		In plan/budget template, but not yet applied		Free MCH explicitly costed in Recurrent and Development budgets	From 2007, Capital budget (but not recurrent) had explicit coding for policies and targets (including MDGs)
Budget Ceilings		Adjusted to budget ceilings in 2007	Budget ceilings introduced in 2006	Engagement with MoBP on budget ceilings	Budget ceilings introduced in 2007
Budgeting capacities		Further and step-down training underway in 2008	Training processes established and formalised from 2007. Annual update training being planned at time of writing		Training processes established and formalised from 2007. Annual update training being planned at time of writing
Budgeting systems		Computerisation initiated	Computerisation initiated		Computerisation initiated
Planning and budget manual		To be developed.	Guidelines developed – but needed to be refined		Guidelines developed – but needed to be refined
Feed through with expenditure tracking		Limited expenditure tracking	Expenditure tracking for secondary facilities from 2006		Expenditure tracking for SMoH expenditures from 2007

STRATEGIC/MEDIUM TERM PLANNING	Ekiti	Enugu	Jigawa	Kaduna	Kano
Strategic plan	Developed in 2005	Completed during 2007-8.	Completed in 2004 and reviewed in 2007/2008. with support from PRRINN as part of the ongoing collaboration The revised plan has six main strategic objectives	Completed during 2007-8. Five "strategic policy objectives"	Completed during 2007-8 Six "key strategic areas"
Strategic plan leadership and engagement		Led by Policy Development and Planning Directorate	Led by PS SMoH and Gunduma Health System Board	Led by PS and Department of Planning Research and Statistics	Led by Commissioner and PS, with broad engagement and participation
Strategic plan costing		None yet undertaken (except for some limited estimates associated with Free MCH policy introduction) – but can use annual plan and budget formats for this.	Not covered in depth	Provides both recurrent and capital indicative cost estimates - based around annual plan, Free MCH, and Essential Systems and Services Package costing. (Still some questions about consistency of costing.)	Limited costing – focusing narrowly on specific costs.
Cost implications assessed for Out-of-pocket payments by individuals and families		Not yet	Not yet	Not yet	Not yet
Evaluated policy and strategy alternatives		Not yet	Not yet	Not yet	Not yet
Planning "integration" i.e. all plans linked to strategic/medium term and annual operational plans		Strategic and annual planning links still to be strengthened	Linking annual plans with strategic health plan still needs strengthening		Strategic and annual planning links still to be strengthened

Lessons Learned

Based on the activities supported in the states, the key lessons are:

1. Strengthening state planning and budgeting is an ongoing process, with inputs over a number of years required to bring systems back to a minimum level of effectiveness.

2. Alignment with the planning and budget cycle is crucial, and all too often forgotten (e.g. by development partners). The nature of the alignment will however be shaped by stakeholder dialogue, and may vary according to needs and circumstances.

3. Through-the-year inputs will generally be required so that a SMoH is appropriately positioned before the annual budgeting round formally commences in July, or an MTEF is updated in June.

4. Where the Budget Classification and Chart of Accounts has become badly flawed (as was the case in Nigeria), the entire budget process will suffer. It will generally be impossible to complete the strengthening of planning and budgeting systems effectively whilst a seriously flawed BC and COA is in place – as the Kaduna experience shows.

5. Equally, the introduction of a new BC and COA offers opportunities including:
    - the chance to take account of the full range and mix of "financial inputs" required for the health system to operate effectively;
    - the chance to estimate accurately both recurrent and capital inputs; and how the latter will have implications for the former;
    - the option of introducing more rigorous activity, functional, or programme based budgeting approaches (and to be able to review, with stakeholders, the pros and cons of each of these);
    - the option of moving towards departmental and facility based budgeting;
    - the chance to enhance budget tracking; and
    - the chance to build new items into the budget (e.g. IGR).

6. The BC and COA changes were directly linked to the introduction of state public sector Integrated Financial Management Information System (IFMIS) capacity building. With such systems, planning and budgeting (monitoring) will be able to take its place as an essential element of programme management and policy implementation.

7. The process of engagement and involvement re-created the culture of planning at all levels. There was much wider acceptance and recognition of the need and value of the plans and associated budgets.

Further Challenges and Potential Strategies

The process of strengthening planning and budgeting systems at state level requires on-going support. Further efforts will be required to:

1. Ensure a single co-ordinated planning framework

    - Harmonise and align all state plans – working with and from the strategic policy objectives mapped out in the state SEEDS II, medium-term strategic plans. This will have major implications across the health sector, as most initiatives have yet to show any strong interest in using (and potentially compromising with) a standard state planning format. This will inevitably require alignment of national programme plans e.g. the national TB plan with the state strategic plan, and vice versa.
    - Work towards state health sector plans which span all primary and secondary care, and the referral system linking the two. This will involve State Ministries of Health and Local Government working together. It will also require significant capacity building and changes in ways of working at LGA level. As new agencies such as State Primary Health Care Agencies are established there will be a need to clarify what planning roles, if any, these will take on.
    - Complete the process of departmental and facility planning and budgeting (including making regular plan and budget reviews an integral part of departmental, facility, and programme monitoring and management).

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Kaduna PPRHAA Planning of August 2006

2. Strengthen the budgeting process

    - Ensure that standardised public sector costing processes are used. These should be based around the state Chart of Accounts, and specify recurrent and capital inputs separately. Again, this will have implications for state-federal dialogue; for example, to ensure that state costing processes are compatible with the Ward Minimum Health Care Package costing by NPHCDA.[8]
    - Ensure that planning and budgeting increasingly takes account of the entire financing implications of a particular action - and not just the capital (or recurrent) public sector costs associated with this. Eventually this should cover the out-of-pocket financial ramifications – for different communities and families, and especially the poorest.
    - Pay appropriate attention to revenue trends. Current policy and strategy shifts such as the introduction of Free MCH policies (with alternative variants being applied in Kaduna in 2006, and in Enugu and Jigawa in 2007), and the re-establishment of Drug Revolving Funds provide good examples. In both cases, there are significant revenue implications, including both 'foregone' revenue (when specific MCH services are free, or when drug sales revenues are wholly retained in the DRF accounts), and also potentially increased revenues through other forms of IGR.

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8 The WMHCP costing has been applied in Jigawa for the Gundumas; this provides some uniformity in cost estimates.

- Consolidate a set of 'real-life' unit costs which can be used uniformly.

3. Strengthen performance monitoring

    - Ensure that plans and budgets are linked with performance measurement. This has already been initiated in Enugu, with 2008 facility budgets being adjusted according to patient usage (as recorded in the state HMIS), and in Jigawa, with facilities being accorded an "efficiency" rating.

4. Present the case for State Health Investments to attain given health outcomes (e.g. MDG targets).

    - This should become part of state MTEF discussions and will ensure that the necessary dialogue takes place before state budget ceilings are established.

5. Clarify role ambiguities and strengthen stakeholder participation

    - Continue to use planning and budgeting to resolve the pervasive role and responsibility ambiguities – including, but not only, those between the three tiers of government. As Ministries of Health re-organise, following the examples of Enugu, Jigawa and Kaduna, this will require ensuring that departmental plans and budgets are prepared in line with the functional responsibilities of the revised organisational structure.
    - As part of this, continue to support DPRS in their lead planning role.
    - Promote greater involvement by the users and consumers of health care in budget analysis. This would include extending the current early efforts to strengthen "budget literacy" on the part of CSOs and others who are taking on a voice and accountability role on behalf of health consumers.
    - Broaden the engagement to include state assemblies, which have a key role to play in budget review and ratification.
    - Continue to institutionalise the annual planning and budgeting system. In particular, this will include ensuring greater involvement of middle-level management staff, alongside Departmental Directors.

6. Complete the planning and budgeting manuals.

7. Ensure that planning and budget strengthening is harmonised with other Public Financial Management (PFM) strengthening – including expenditure tracking and reporting. This would embrace future Public Expenditure Financial Analyses (PEFA).[9]

9 PEFA have been completed in a number of states for the education sector, but not yet for the health sector.

Partnership for Transforming Health Systems (PATHS)

PATHS is a programme of collaboration with Nigerian partners to develop partnerships for transforming health systems in Nigeria. It is funded by the UK Department for International Development (DFID).

The PATHS Programme is managed by an international consortium on behalf of DFID. Members of the consortium are: