Federal Republic of Nigeria
State Ministry of Health, Cross River State

Neglected Tropical Diseases Health Financing Landscape and Fund Flow Analysis in Cross River State

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Neglected Tropical Diseases Health Financing Landscape and Fund Flow Analysis in Cross River State.

Final Report

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FOREWORD

The study on Fund Flow Analysis in Cross River State Landscape, undertaken by the Cross River State (CRS) Ministry of Health with technical and financial support from the United States Agency for International Development's (USAID's) Act to End Neglected Tropical Diseases (NTDs) | East Program and its partner Results for Development (R4D), could not have come at a better time than now, when the prioritization of activities with limited funds has become the order of the day in Cross River State. The state's health sector is privileged to have Act | East intervene in NTDs that have affected underserved and marginalized communities. The utilization of scarce resources to mitigate and eliminate NTDs must be all-embracing and participatory to ensure elimination.

To realize this objective, USAID offered to further invest in this research as a way of coming up with the best approach to managing funds earmarked for the elimination of NTDs in Cross River State and, by extension, Nigeria.

My firm belief is that findings from this study will help to improve domestic funding to NTDs, enhance prudent utilization of scarce resources, and guide further research in financing the elimination and control of NTDs.

The research went through a range of processes:

- Seeking and receiving approval from the Honorable Commissioner for Health, **Dr. Betta Edu,** for the commencement of the research.
- Seeking and getting approval for the certificate of **Ethical Approval**.
- Convening a stakeholder's inception meeting on data gathering for the research.
- Engagement of a consultant by **R4D** with the Director Planning, Research, and Statistics, Ministry of Health, as a co-investigator.
- Holding discussions with heads of Ministries, Departments, and Agencies (MDA) in the Ministry of Health, State Planning Commission, Budget Office, Ministry of Finance, Office of the Accountant General, Ministry of International Development Cooperation, and Finance and Supply Office, Ministry of Health.
- Convening of a focus group discussion (FGD), key informant interviews (KII), civil society organizations (**CSOs**), and six Chairmen of Local Government Areas.

Having gone through these processes, it is my firm belief that the findings and recommendations captured in this report are indeed representative and acceptable.

I therefore seize this opportunity to thank USAID, RTI International, and R4D for the funding, technical support, and research expertise, respectively, without which this research would not have been possible.

Ugbong Casmir A
Director of Planning, Research, and Statistics
Ministry of Health
For: Commissioner for Health

ACKNOWLEDGEMENTS

This research report was a collaborative effort of the lead researcher, Dr. Arowolo Ayoola, and Casmir Ugbong, Director of Planning, Research, and Statistics at the Cross River State Ministry of Health, who is also the principal co-investigator in this study who is also the principal co-investigator in this study. The authors also thank Jose Gonzalez ,Edward Owino, and Simbiat Lawal of R4D, and Dr. Benjamin Obi, Wangeci Thuo Danielle Epps, Okonkwo Chukwuma, and Joseph Mfon of RTI International, for their constructive feedback and sharing of information that helped in preparing this report. Lastly, the authors thank Emmanuel Koledoye, who provided support on data analysis and editing.

Special thanks to Dr. Betta Edu, the Commissioner for Health; Dr. Inyang Asibong, the Commissioner for International Development Cooperation; and Dr. Francis Ntamu, the Chief Economic Advisor to the Executive Governor of Cross River State, for granting the permission and providing needed support throughout the process of conducting this study. The authors also appreciate the input of the Directors of the Department of Public Health, Finance and Accounts, and Budget and Planning Office; the Director of Administration at the Ministry of International Development Cooperation (MIDC); the Statistician General of CRS; and Veronica Mark, the state NTD coordinator, that agreed to participate in the interviews and shared valuable reflections.

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ACRONYMS

COVID-19	coronavirus disease 2019
CRS	Cross River State
CSO	civil society organization
DIDS	Department of International Donor Support
DPB	Department of Budget and Planning
DPH	Director of Public Health
EA	Evidence Action
FAA	Fixed Amount Award
FGD	focus group discussion
FY	fiscal year
HREC	Health Research Ethics Committee
IGR	internally generated revenue
JICA	Japan International Cooperation Agency
KII	key informant interview
LGAs	local government areas
M&E	Monitoring and Evaluation
MDA	Ministries, Departments, and Agencies
MEPB	Ministry of Economic, Planning, and Budget
MIDC	Ministry of International Development Cooperation
MTEF	medium-term expenditure framework
NPHCDA	National Primary Health Care Development Agency
NTD	neglected tropical diseases
OV	Onchocerciasis
PC-NTDs	preventive chemotherapy neglected tropical diseases
PEMR	Public Expenditure Management Review
PHC	primary health care
PRS	Planning, Research, and Statistics
R4D	Results for Development
RTI	RTI International
SHA	State House of Assembly
SMOH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SPT	Sector Planning Team
STH	Soil-Transmitted Helminths
SWOT	Strengths, Weaknesses, Opportunities, and Threats

TAS	Transmission Assessment Survey
UHC	universal health coverage
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WACA	West Africa Coastal Areas Management Program

EXECUTIVE SUMMARY

Twenty NTDs are of public health importance and are broadly categorized into preventive chemotherapy NTDs (PC-NTDs) and intensified disease management NTDs, with four of these NTDs—onchocerciasis, lymphatic filariasis, schistosomiasis, and soil-transmitted helminths—being prevalent in CRS.

In Nigeria, the government is a principal actor in the provision of health care services, and NTD programming falls under public health services and is expected to be funded by the three tiers of government. In CRS, NTD is a unit under the Department of Public Health in the State Ministry of Health (SMOH).

This fund flow analysis in CRS follows up on the Public Expenditure Management Review (PEMR) conducted by USAID in CRS in 2012. It evaluates the health financing landscape and fund flow analysis in the CRS health sector to inform the prospects for strengthening government ownership of the NTD program.

Key Findings

- The CRS budgeting process begins with the "call circular" which outlines policy priorities determined by the executive council through the state budget office. The Public Health Department, which oversees NTDs, is provided with the call circular, which is used as a tool to direct budgeting requests.
- NTD is captured in the CRS 5-year Strategic Health Development Plan (2018–2022) and the medium-term expenditure framework (MTEF), but NTD programs have not received funding from the state government in the past 3 years reviewed.
- At the state level, NTD is a unit under the Department of Public Health in the Cross River SMOH. Hence, the flow of funds to NTDs follows the same channel of administrative command. At the local government area (LGA) level, NTD is under the local government authority, headed by a coordinator. Funding at the LGA for NTD goes through the local government authority. For the past 3 years, no records are available of funding received for NTD programming through the state or local government health authorities. The lack of funding for NTD programming is primarily attributed to the government's low prioritization of the program and heavy reliance on external funding.
- CRS has two fund flow mechanisms based on the funding source, which is unlike other Nigerian states. The state capital or recurrent account appropriates federal allocations, state-generated revenue, and loans. Grants and subventions are appropriated by the MIDC. The MIDC is expected to channel donor funds for NTD interventions; however, awareness and usage of this channel are minimal.
- CRS is largely dependent on federally allocated revenue for health services. The major funding source in the past 3 years has been federal allocations, followed by state internally generated revenue (IGR), loans, and then grants/subventions. In the last 3 years, about 48% of the state's total fund came from federal allocation, 16% from IGR, 30% from loans, and about 6% from grants and subventions, which are domiciled with the MIDC.
- Since the establishment of the MIDC in 2015 by the current state administration, only a few donors in the state have funded programs through this channel because of a lack of awareness and the government's non-insistence on the MIDC channel. However, in the last year, grants from some actors, such as the Japan International Cooperation Agency (JICA), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA), have been appropriated through the MIDC.
- The fund flow through the state's main account is characterized by a bureaucratic structure that starts from the budgeting process to the disbursement of funds, which can delay the implementation of NTD programs. However, establishing the MIDC account was one of the measures to restructure the machinery of governance for effective coordination and implementation of government policies and programs around international collaboration. The MIDC has a flexible fund flow designed and agreed upon by the government and the development partner.
- NTD programs in CRS have been donor-driven. USAID, through the Act | East Program and Evidence Action (EA), have been the major actors supporting the state's NTD program. These donors fund NTD activities directly without passing through the state account.

- Health prioritization in CRS has been relatively constant since 2017, with allocations to primary health care at an average of 4%, except only in 2020 during the COVID-19 (coronavirus disease 2019) pandemic, during which primary health care received up to 6.48% of the state health budget. Although the government is committed to universal health coverage (UHC), the provision of infrastructure is the state's top priority for funding. The political interest of the executives largely influences budgeting actions and appropriations in the state.

Conclusion

The budgeting process, through to the disbursement of funds, is part of a bureaucratic system that defines the financing structure of health programs in CRS. The state's projects and policies are funded by resources generated through the Federal account, IGR, grants and subventions, and loans. The health sector has received budget allocations ranging from 4% to 6% of the total state budget, which is low when compared to other sectors in the state; such allocation remains insufficient due to the state's scope of health projects and programs. Specifically, funds for NTD programming, although captured in the budget, have not been released as a result of government prioritization and bureaucracy in the fund flow system leading to a request apathy from the NTD unit. The MIDC was established to restructure the machinery of governance and to ensure ease of project implementation supported by development partners, but most partners working in CRS have not used the channel, largely due to a lack of awareness and the state government not requiring use of the MIDC channel.

Recommendations

- Increase the proportion of the state capital health budget for NTDs. Two major reasons are behind the lack of appropriation to NTDs in CRS: (1) lack of capacity of the personnel in the NTD unit to prepare a convincing fund release memorandum to the Executive Governor, and (2) NTDs are not a priority health focus in CRS. To address the first issue, capacity building is needed among NTD personnel in fiscal year 2023 (FY23), and to address the second issue, high-level stakeholder engagement and advocacy need to occur on the endemicity of NTDs in CRS, as are the strategies and resources for the engagement/advocacy activities.
- Strategic advocacy to key stakeholders, such as executives of health ministries and affiliated agencies, legislators, and executive council members, is required to mobilize domestic funding for NTDs at the state and federal levels. Therefore, capacity-building activity, along with targeted advocacy activities, should be pursued for FY24. This activity can be jointly led by the NTD state team and the Department for Planning, Research, and Statistics.

1.0 INTRODUCTION

Health financing is a critical element toward achieving positive health outcomes. As a principal actor in the provision of health care services, the government is responsible for healthcare delivery at the primary, secondary, and tertiary levels of care through the three tiers of government: local government area (LGA), state government, and federal government, respectively. Neglected tropical diseases (NTDs) fall under the public health services and are expected to be funded by the three tiers of government. Generally, Nigeria's poor results on key health indicators are usually driven by underinvestment and inefficient management of limited available resources. Although the focus of the health systems in Nigeria aligns with the global goal of universal health coverage (UHC), NTDs have received very limited resources and are almost ignored in the appropriation of public funds. Aside from financing, the efficiency of the fund flow system in the public sector is also key to achieving UHC goals.

The fund flow analysis in Cross River State (CRS) follows up on the Public Expenditure Management Review (PEMR) conducted in 2012 by the United States Agency for International Development (USAID) in CRS. The PEMR study revealed a low investment in health, difficulties coordinating among the fragmented revenue resources, and discrepancies between budgets and spending across all LGAs. These circumstances pose a major challenge toward ensuring UHC and sustained financing for NTD efforts. The fund flow study evaluates the funding landscape, presenting a detailed overview of the health financing mechanisms in CRS, from budgeting and funding sources to disbursement. Critical bottlenecks to budgetary performance are also outlined to understand the feasibility of the Fixed Amount Award (FAA) mechanism and to identify opportunities to mobilize domestic financing for NTDs through existing fund flow mechanisms in the state.

Overview of NTDs in Cross River State

NTDs are a diverse group of infectious conditions prevalent in tropical and subtropical areas. They affect people with low access to safe water, low access to safe water, and poor sanitation and hygiene.[1] More than 20 NTDs exist, broadly categorized into preventive chemotherapy NTDs (PC-NTDs) and intensified disease management NTDs,[2] and four of these NTDs are prevalent in CRS, including onchocerciasis, lymphatic filariasis (LF), schistosomiasis, and soil-transmitted helminths (STH). The mapping for the PC-NTDs has been completed in all 18 LGAs of Cross River State with endemicity distribution as follows: onchocerciasis – 15 LGAs, lymphatic filariasis – 10 LGAs, schistosomiasis – 6 LGAs, and soil-transmitted helminthiasis – 9 LGAs. All PC-NTDs endemic to LGAs in Cross River State are under treatment. Progress has been made in the fight against LF, as 9 LGAs (Abi, Akamkpa, Biase, Boki, Ikom, Obubra, Ogoja, Calabar South, and Bekwarra) have interrupted the transmission of LF, having passed Transmission Assessment Survey 1 (TAS1) in 2019 and 2021, respectively. The state has just one LGA (Yala) that has yet to interrupt LF transmission. At the state level, NTD programming is administered by a unit under the Department of Public Health, headed by a coordinator. The coordinator reports to the Director of Public Health. At the LGA level, NTDs are a unit under the local government health authority, headed by a coordinator who reports to the local government health supervisor.[3]

Overall Objectives of the Study

The objective of this study was to conduct a health financing landscape and fund flow analysis in the CRS health sector that will inform the prospects for strengthening government ownership of the NTD program by using FAAs to support activities at the LGA level through the following sub-objectives:

1. Understand the fiscal context for health financing and health expenditure trends in CRS.

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[1] World Health Organization (2022). Neglected Tropical Diseases. https://www.who.int/health-topics/neglected-tropical-diseases#tab=tab_1

[2] World Health Organization (2022). Control of NTDs. https://www.who.int/teams/control-of-neglected-tropical-diseases/preventive-chemotherapy

[3] CRS Primary Health Care Department Agency

2. Identify the main sources of funding for health and NTDs at the national/state/local levels and understand how funding flows from the state to the LGA level.
3. Identify available channels for using FAAs and assess challenges and opportunities to mobilize domestic financing for NTDs through these channels.
4. Begin engagement with government and provide the basis for dialogue with key stakeholders to identify entry points for NTDs that could result in increased budgetary allocations and expenditure on NTD intervention in CRS.

2.0 METHODOLOGY

The methodological approach for this research was predominantly qualitative and drew upon a range of primary and secondary data. Primary data were collected using focus group discussions (FGDs) and key informant interviews (KII) from key state- and LGA-level actors. The secondary data analysis entailed a thorough review of relevant government documents, such as the annual state budget and budget performance reports, to gain insights into budget allocation and the actual release of funds to the health sector, including specific allocations for NTD activities. Additionally, the review of the state's Strategic Health Development Plan provided valuable information regarding government priorities in the health sector.

- A total of 42 KIIs were conducted, of which 30 KIIs were with LGA-level stakeholders and 12 were with state-level actors.
- At the state level, top government executives directly involved with health programming, health financing, and economic planning were interviewed. At the LGA level, the Director of Planning, Research, and Statistics; Director of Finance and Supply; Director of Local Government Health Areas; NTD focal officer; and health supervisors in the six selected LGAs were interviewed.
- The study involved conducting interviews with stakeholders in six selected LGAs, namely Biase, Odukpani, Obanliku, Yala, Boki, and Ikom.
- FGDs were conducted with civil society organizations (CSOs) for triangulation of findings. The respondents were selected based on their knowledge, experience, interest, and active involvement in health financing. Two FGDs were conducted with CSOs working in health financing, government strengthening, transparency, and accountability.

S/No.	Stakeholder	Data Collection Type	No
State-Level Actors: Ministry of Health			**12 KIIs**
1.	Director, Public Health	KII	1
2.	Director, Primary Health Care Development Agency	KII	1
3.	Director, Planning, Research, and Statistics, Ministry of Health	KII	1
4.	Director, Finance, Ministry of Health	KII	1
5.	State Coordinator for NTD	KII	1
6.	Focal Person for NTD, PHCDA	KII	1
7.	Monitoring and Evaluation (M&E) Coordinator, PRSMOH	KII	1
State-Level Actors: Department of Economic Planning			
8.	Director of Budget, CRS Budget Office	KII	1
9.	Statistician General of the State	KII	1
10.	Chief Economic Adviser to the CRS Governor	KII	1
State-Level Actors: Ministry of International Development Cooperation (MIDC)			
11.	Director of Planning and Research	KII	1
12.	Director of Administration	KII	1
Local Government Actors			**30 KIIS**
13.	Director, Planning, Research, and Statistics LGA	KII	1 per LGA
14.	Director, Finance and Supply LGA	KII	1 per LGA

S/No.	Stakeholder	Data Collection Type	No
15.	Director, Local Government Health Authority	KII	1 per LGA
16.	LGA NTD Focal Officer of the LGAs	KII	1 per LGA
17.	LGA Health Supervisor	KII	1 per LGA
	Civil Society Organizations		
18.	• Budget Accountability and Transparency Initiative • African Dignity Foundation • Centre for Healthworks, Development, and Research (CHEDRES) Initiative • Community Health and Development Advisory Trust (COHDAT) • Positive Care and Development Foundation • Mediatrix Development Foundation • Green Vision for Community Development Initiative • Basic Foundation for Socio-Economic Development of Rural Women and Youths (BF-SEDRWAY)	FGD	2

Ethical approval for this study was obtained from Cross River State Health Research Ethics Committee (CRS HREC) with the Approval Number: RP/REC/2021/215. Verbal informed consent was also obtained from all FGD and KII respondents before the study. One of the primary challenges faced during this study was the difficulty in accessing certain political stakeholders, as the study coincided with the period for election planning. As a result, we had to adapt and engage with the most senior executives present in their respective ministries or agencies as replacements. While this may have posed limitations to our research, it also provided a unique opportunity to gain insights from key decision-makers actively involved in the governance process.

3.0 FINDINGS

Fund Flow Mechanism in Cross River State

CRS maintains two major fund flow systems depending on the funding source. Federal allocations, state internally generated revenue (IGR), and loans are appropriated through the state capital or recurrent account. In contrast, grants and subventions are appropriated through the Ministry for International Development Cooperation (MIDC). Since the MIDC was established in 2015 by the Cross River State administration, a few donors have implemented programs in the state through that channel. However, most recently, funding from some key actors, such as the UNDP, UNICEF, JICA, and UNFPA, has been appropriated through the MIDC. For instance, the United Nations (UN) has been a major multinational agency funding its projects in CRS through the MIDC. In addition, UN projects such as the UN Women Spotlight Initiative and the UNFPA Child and Maternal Healthcare Program have been funded through the MIDC channel. However, major health donors such as USAID, the World Bank, the Global Fund, and the United Kingdom and German governments do not use the MIDC largely due to a lack of awareness and the state government not requiring/promoting the use of the MIDC channel. However, the World Bank recently proposed sponsoring its West Africa Coastal Areas Management Program (WACA) in the state using the MIDC channel.

CRS is largely dependent on federally allocated revenue. In the past 3 years, the major funding source has been federal allocations, followed by state IGR, loans, and grants/subventions. In the last 3 years, about 48% of the state fund came from federal allocation, 16% from IGR, 30% from loans, and about 6% from grants and subventions.[4]

The fund flow mechanism in CRS starts from the budgeting process to the disbursement of funds.[5] The CRS budgeting process begins with the “call circular” outlining policy priorities determined by the executive council through the state budget office. The Ministries, Departments, and Agencies (MDA) are provided with the call

[4] Report of the Auditor-General of the Account of the Government of CRS, Nigeria; 2019, 2020, 2021

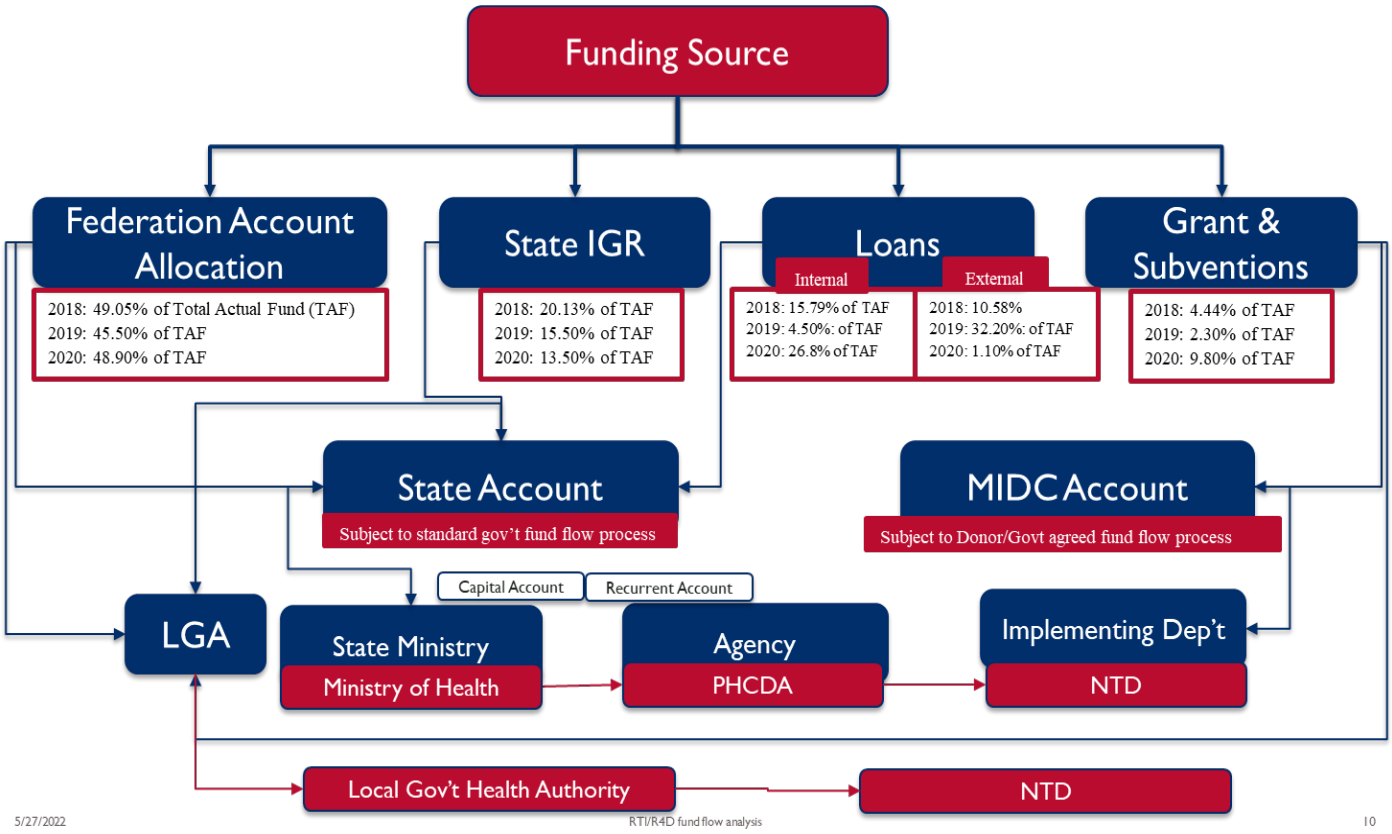
[5] Department of Planning, Research, and Statistics, CRS

circular, which is used as a tool to direct budgeting requests. The disbursement process moves from the requisition for funds by the respective MDA to the disbursement of funds by the Accountant General subject to the approval of the Executive Governor.

Funding Sources for Health and NTD in Cross River State

The state's health programs and policies are funded through the resources generated from the federation account, IGR, grants and subventions, and internal and external loans.[6]

Figure 1: Shows Funding Sources and Accounts in Cross River State, Nigeria



The funds generated through the federation account, IGR, and loans are appropriated through the state account and subject to government fund flow processes. In contrast, funds generated through grants and subventions from donors are appropriated through the MIDC account, subject to the donor/government-agreed fund flow process. The funding for the NTD program is organized along the three tiers of government (federal, state, and LGA), with the units of operation being the health facilities at the LGAs.

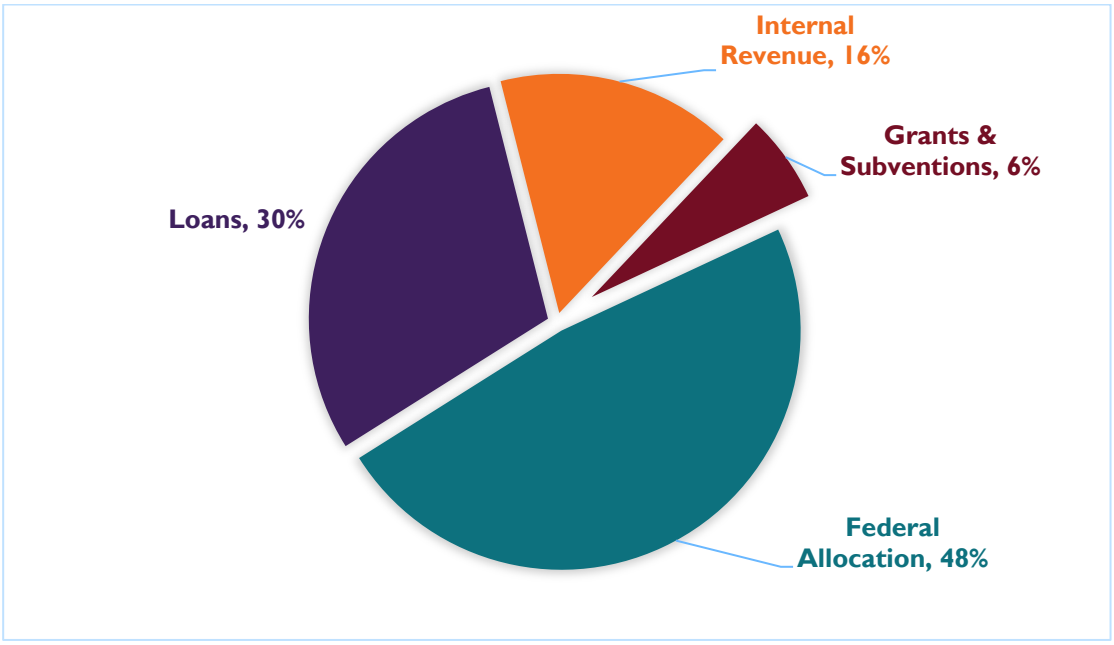
At the state level, the NTD unit functions as a department under the State Ministry of Health (SMOH), specifically under the Department of Public Health, with the state NTD coordinator leading the department. The request and approval of funds for NTDs at the state level also follows that chain of command. Although NTD programs are captured in the 5-year Strategic Health Development Plan (2018–2022)[7] and in the medium-term expenditure framework (MTEF), in the past 3 years, the NTD unit has not received funding through state appropriation.[8] Other sources of funds, such as the internal and external loans of the government, are particularly driven by a targeted project, resulting in the inability of such funds to be directed to other programs.

[6] Report of the Auditor-General of the Account of the Government of Cross River State, Nigeria; 2018, 2019.
[7] Cross River State Strategic Health Development Plan, 2018–2022
[8] Report of the Auditor-General of the Account of the Government of Cross River State, Nigeria; 2019, 2020, 2021

In the LGAs, NTDs are under the local government authority, headed by a coordinator. Funding at the LGA level for NTDs goes through the local government area. Also, in the past 3 years, no records are available of funding received for NTD programming through the local government health authority.

From the state capital and recurrent accounts, NTD program funding goes through the Department of Public Health to the unit implementing the NTD program. In the LGAs, the funding goes from the local government to the local government health authority and then to the unit implementing the NTD program headed by the NTD focal person. However, NTD programs have recently not received funding through the state account. Similarly, the MIDC account, an alternative channel for donor-sponsored projects, has not been used by the previous sponsors of NTD programming in the state, because the state government did not mandate the donors to use the channel, and no information campaign was made to program sponsors.

Figure 2: Shows Income Generated in Cross River State by Type (2019–2021)



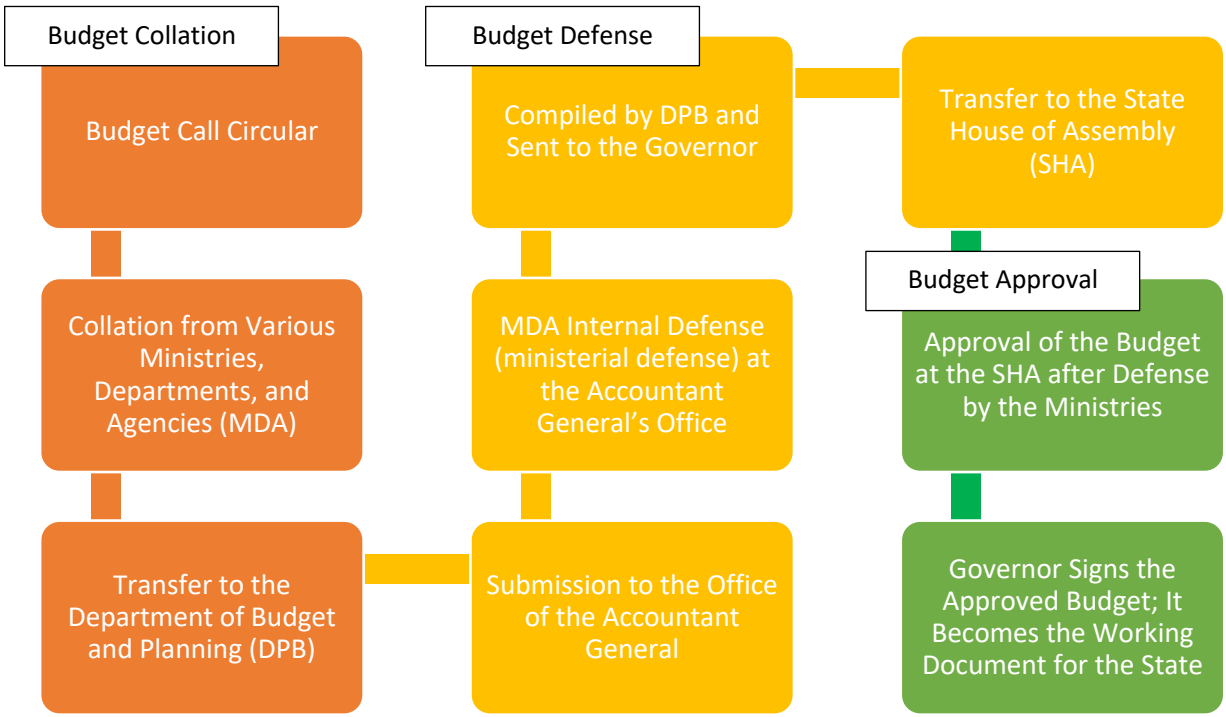
CRS is largely dependent on federally allocated revenue for health. In the past 3 years, the major funding source has been from federal allocations, followed by state IGR, internal and external loans, and then grants/subventions. NTD programs in CRS have not been considered in federal and state government financing, but have mainly been funded through grants/subventions by donor partners.

Budget Preparation Mechanism

The Department of Planning coordinates the budget planning, research, and statistics (PRS) of the SMOH with inputs from the various units, departments, and facilities under the ministry. The CRS Strategic Health Development Plan outlines the 5-year strategic direction, which informs the MTEF. The MTEF was adopted in 2006 as an integrated budgeting and public financial management approach. The MTEF is a multiyear strategic and budget planning tool to ensure that health sector budget preparations are based on actual performance benchmarks.

The SMOH prepares its budget with the assistance of its Sector Planning Team (SPT) and in consultation with relevant stakeholders. All directors within the SMOH are members of the SPT. Each secondary health facility prepares its own budget in consultation with the SMOH and the SPT's assistance. The budget preparation follows a sequence of activities, beginning with a call circular providing policy priorities determined by the executive council through the state budget office. Budgets from the various ministries in CRS are submitted to the state's Ministry of Finance Budget Office for harmonization.

Figure 3: Shows budgeting process in CRS



The budget preparation and approval process can be summarized into three phases:

1. **Budget Call Circular and Collation:** MDA are notified about the budget preparations and are mandated to prepare the budget using a bottom-up approach. The budget preparation takes input from all the units in the ministry. In the case of the SMOH, budget inputs are taken from all the health facilities, agencies, and units administered by the ministry. The NTD unit also sends the budgetary input through the State Primary Health Care Development Agency (SPHCDA), which is then harmonized at the SMOH in the Department of Planning, Research, and Statistics. While the call circular occurs between July and August, collation from various MDA occurs before the end of September annually.
2. **Budget Defense:** The annual budget defense starts after the budget has been announced by November. The budget is defended by the units first at the SMOH, followed by defense at the state budget office, and then the SHA Budget Committee. The budget defense is the responsibility of the commissioner and/or the executives of the MDA; the budget is then adjusted to fit the expected revenue for the year. Less than 50% of the funds requested by MDA are allocated, and not all requests are funded. For small agencies under health, allocations are even lower.[9] The CRS budgeting process is the same for the health financing by the SMOH and the SPHCDA. The SPHCDA, on the other hand, benefits from donor grants for the implementation of health projects and services delivered at the primary care level, freeing up additional resources to support primary healthcare delivery.[10] Contrary to the African Heads of States agreement (Abuja Declaration)[11] that 15% of the total budget should be allocated to health across the board, CRS government allocation to health has, over the years, been suboptimal.[12] Except during the COVID-19 pandemic in 2020, the annual budgetary allocation to the health sector has been below 10% over the years.[13] Although the CRS strategic health plan has been a

[9] Report of the Auditor-General of the account of the Government of CRS, Nigeria; 2018, 2019, 2020.
[10] Cross River State Ministry of Health Sub-National Health Accounts Report, 2015–2017.
[11] World Health Organization (WHO, 2010). Abuja Declaration: Ten Years On. https://au.int/sites/default/files/decisions/9536-1991_ahg_res_201-205_xxvii_e.pdf
[12] Report of the Auditor-General of the Account of the Government of Cross River State, Nigeria; 2018, 2019.
[13] Report of the Auditor-General of the Account of the Government of CRS, Nigeria; 2018, 2019, 2020.

tool used to inform budgeting for health, annual constraints still occur with budgetary allocations for health.[14]

3. **Budget Approval and Signing:** Approval of the budget occurs after the budget defense. After the heads of MDA have successfully defended their respective budget proposals, the SHA approves the budget with some modifications, then sends it to the Executive Governor. The governor signs the approved budget, and it becomes the working document for the state. Signing of the annual budget by the governor in CRS is usually between December and January each year.

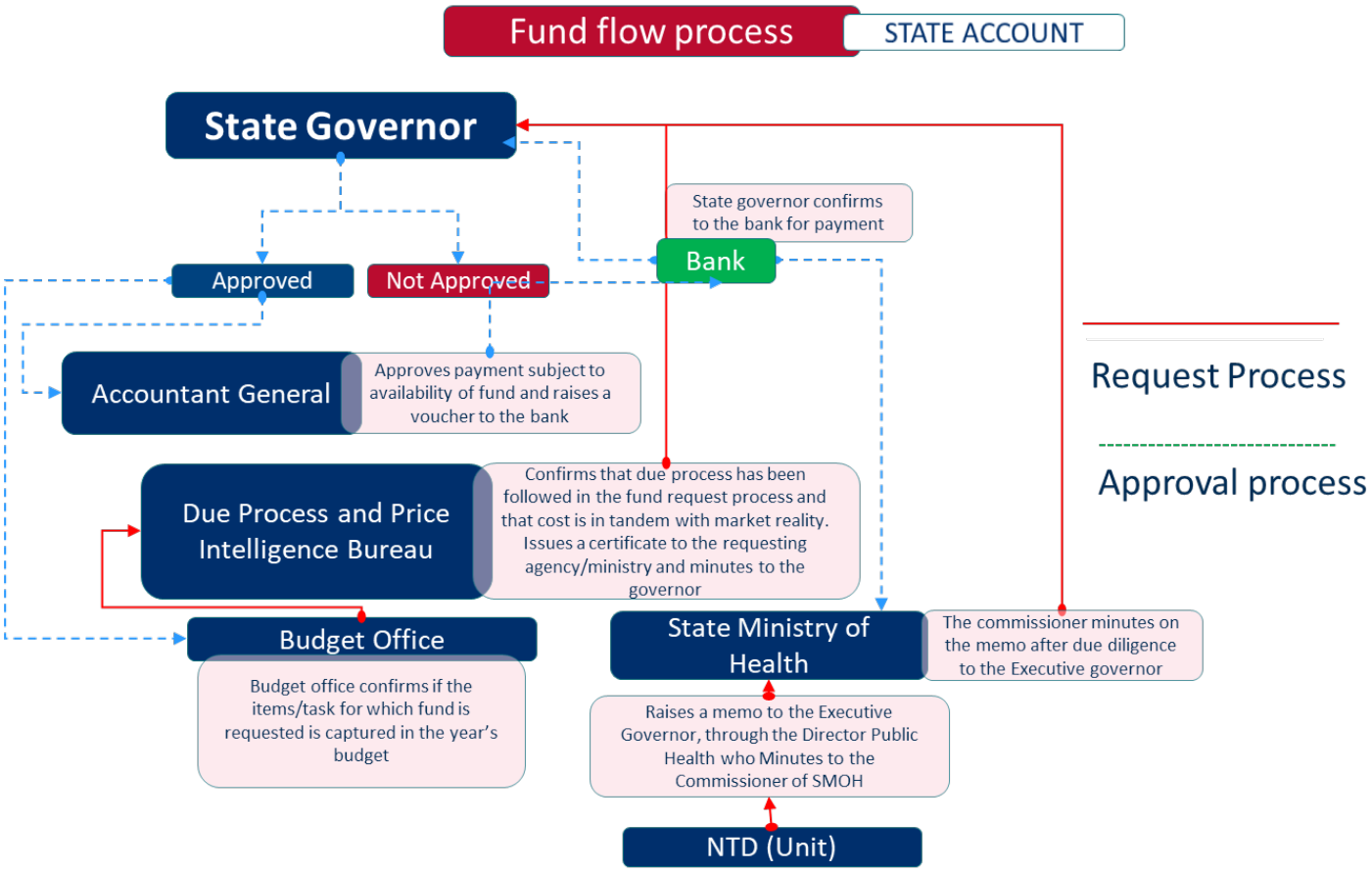
Fund Approval Process for Health and NTD in Cross River State

The fund approval process in CRS depends on the funding source, and bottlenecks and risks are associated with each fund approval process.

NTD fund approval through the state account

The fund approval process for NTD through the state account starts with the unit (NTD) raising a fund request memorandum to the Executive Governor through the Director of Public Health and the Commissioner of Health.

Figure 4: Shows Fund Approval Process from the State Account in CRS for NTDs

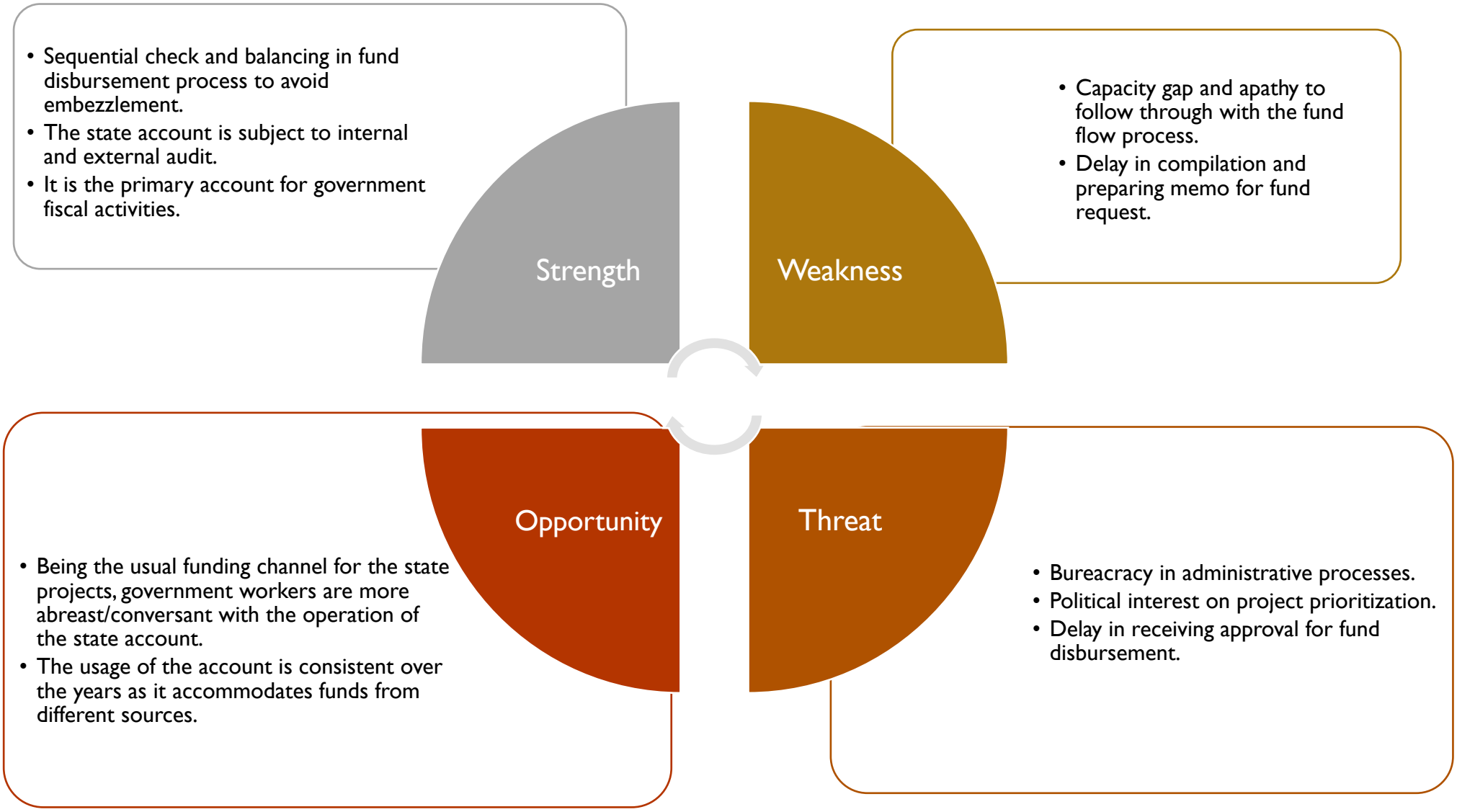


If approved by the governor, this request is sent to the budget office for verification. The budget office confirms that the items/tasks for which the fund is requested are captured in the year's budget. After that, the Due Process and Price Intelligence Bureau confirms if due process has been followed in the fund request and confirms if the quoted cost is in tandem with market reality. The Due Process and Price Intelligence Bureau issues a certificate to the requesting agency/ministry.

[14] Cross River State Strategic Health Development Plan, 2018–2022.

The due process certificate and fund request memo is returned to the Executive Governor, who, after due consideration, communicates to the Accountant General for fund release. The Accountant General approves payment subject to the availability of funds and raises a voucher to the bank. Finally, the Executive Governor needs to again confirm this payment order in the bank before funds are disbursed to the account of the Department of Public Health for appropriation to the NTD unit.

Figure 5: Strengths, Weaknesses, Opportunities, and Threats (SWOT)Analysis for the State Account



Bottlenecks associated with the fund flow through the State Account

- Delays in:
  - Preparing the fund request memo at the implementing department (NTD) because of capacity gaps and apathy to follow through with the fund flow process.
  - Receiving proposal verification from the due process office
  - Receiving approval from the governor's office due to the number of requests the office attends to.
- Compilation of memos at the SMOH for submission to the governor's office.
- Raising and compilation of payment vouchers at the office of the Accountant General.
- Confirmation of payment voucher to the bank by the Executive Governor.

Risks associated with the fund flow through the State Account

- *Political interest/pressure on project prioritization*: Health prioritization in CRS has been relatively constant since 2017, with allocation to primary health care at an average of 4%, except for in 2020 during the COVID-19 pandemic, when primary health care received up to 6.48% of the state health budget. Although the government is committed to UHC, provision of infrastructure, such as roads and factories for economic stimulation, is the state's top priority for funding.
- *Budgetary discrepancies:* The annual budget faces challenges in terms of realism, mainly due to the existing MTEF system. Within the state, certain budgetary provisions may not align with the actual, feasible revenue collections per annum, leading to discrepancies in financial planning.
- *Inequitable budget allocations:* Because of contending interests on limited financial resources, allocations to the state sectors have not been evenly distributed. More specifically, allocations to the SMOH have not been equitably distributed to the departments under the supervision of the ministry, which means that even while the health ministry received a relatively fair share of the budget, no equitable budgetary allocation was made for the NTD programs in the state.
- *NTD programs not prioritized:* NTD has not been a top priority as a result of low awareness among critical stakeholders, and NTD programs have not been well captured in the budgetary allocations.
- *Bureaucratic structures:* The state account encounters obstacles, primarily due to the presence of an extensive bureaucratic structure, leading to notable delays in the release of funds. This bureaucratic process, although intended for proper control and oversight, inadvertently hinders the timely allocation of resources to essential projects and initiatives. Therefore, crucial programs can face setbacks and limited progress, impacting the state's ability to efficiently execute its developmental plans.
- *NTD unit-level apathy for fund requests:* The NTD unit did not make any budgetary requests for the years 2021 and 2022. This decision appears to have stemmed from a prevailing belief that raising such memos is futile, as they rarely receive approval. The reluctance to seek budgetary allocations from the government may also be attributed to the established pattern of external support that stakeholders, including the NTD unit, rely upon, which inadvertently perpetuates a dependency on external aid without adequately addressing the unit's need to mobilize domestic funding.

NTD fund approval through the MIDC account

The MIDC was formerly a unit in the Cross River State Planning Commission, known as the Department of International Donor Support (DIDS). This unit was upgraded to a full ministry and renamed as the Ministry of International Development and Donor Cooperation in 2015, with a mandate to provide "a platform for coordinating all development assistance, diplomatic relations, and socio-economic cooperation for the state government. This ministry provides a flexible fund flow for development partners coming into the state. The creation of MIDC was one of the measures to restructure the machinery of governance for effective coordination and implementation of government policies and programs pertaining to international

collaboration" and to upscale the gains of development partnership through an institutionalized, cutting-edge coordination framework.

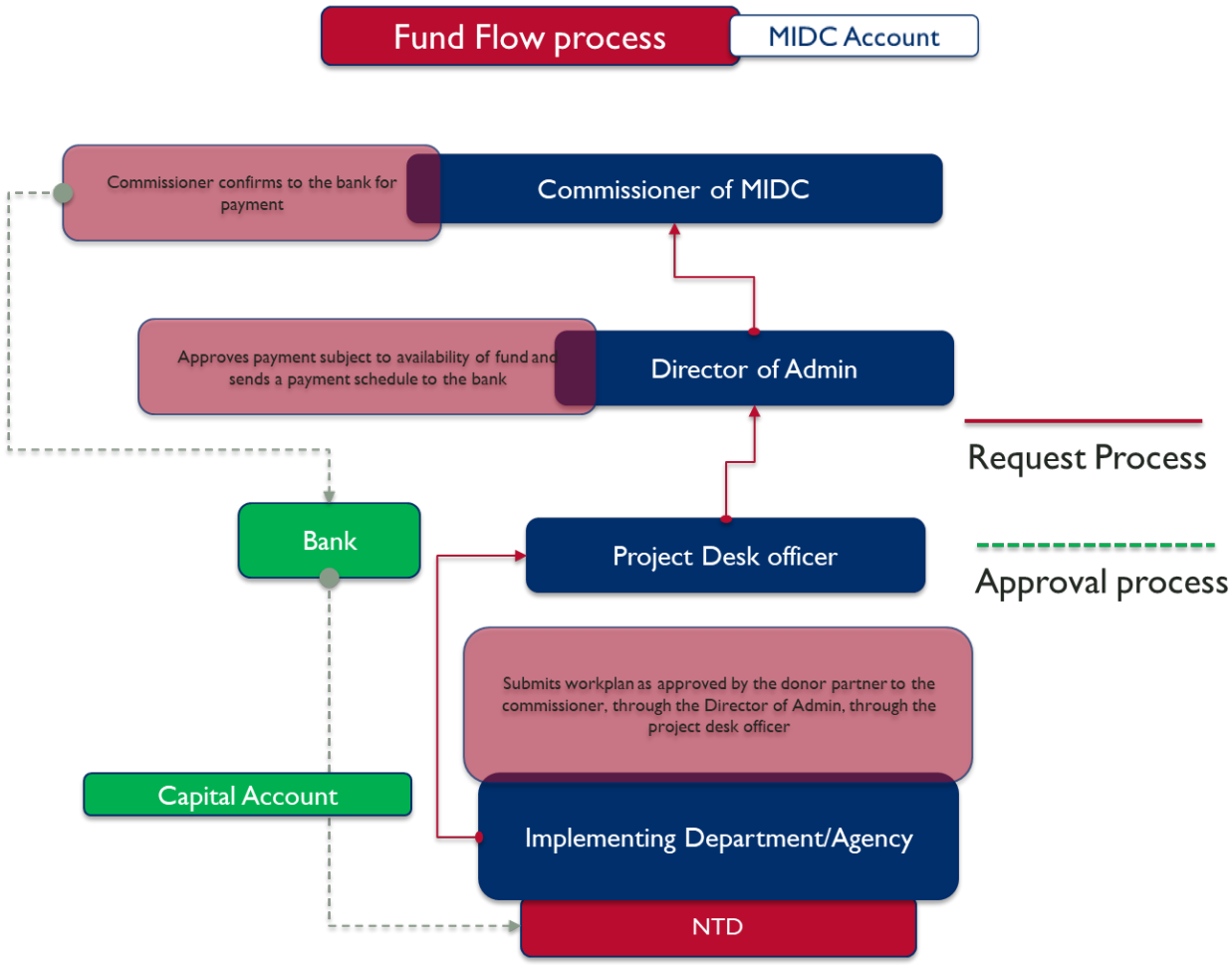
Using the MIDC account, the partner organization signs an agreement with the ministry in collaboration with the implementing department or unit, detailing program objectives, a work plan, and a fund release mechanism. Generally, the fund approval process starts with the submission of a work plan as approved by the donor partner from the implementing department or unit to the state commissioner of MIDC through the Director of Administration of MIDC.

The director approves the payment, subject to the availability of funds, and sends the payment schedule to the bank. Payment is made by the bank subject to the commissioner's confirmation. Although the system provides a flexible fund flow that is agreed upon with the development partner, the efficiency of the MIDC fund flow system when many donors are involved has not been tested (See Figure 6 below).

Delays to the project implementation also occur, especially where counterpart funding is required from the government.

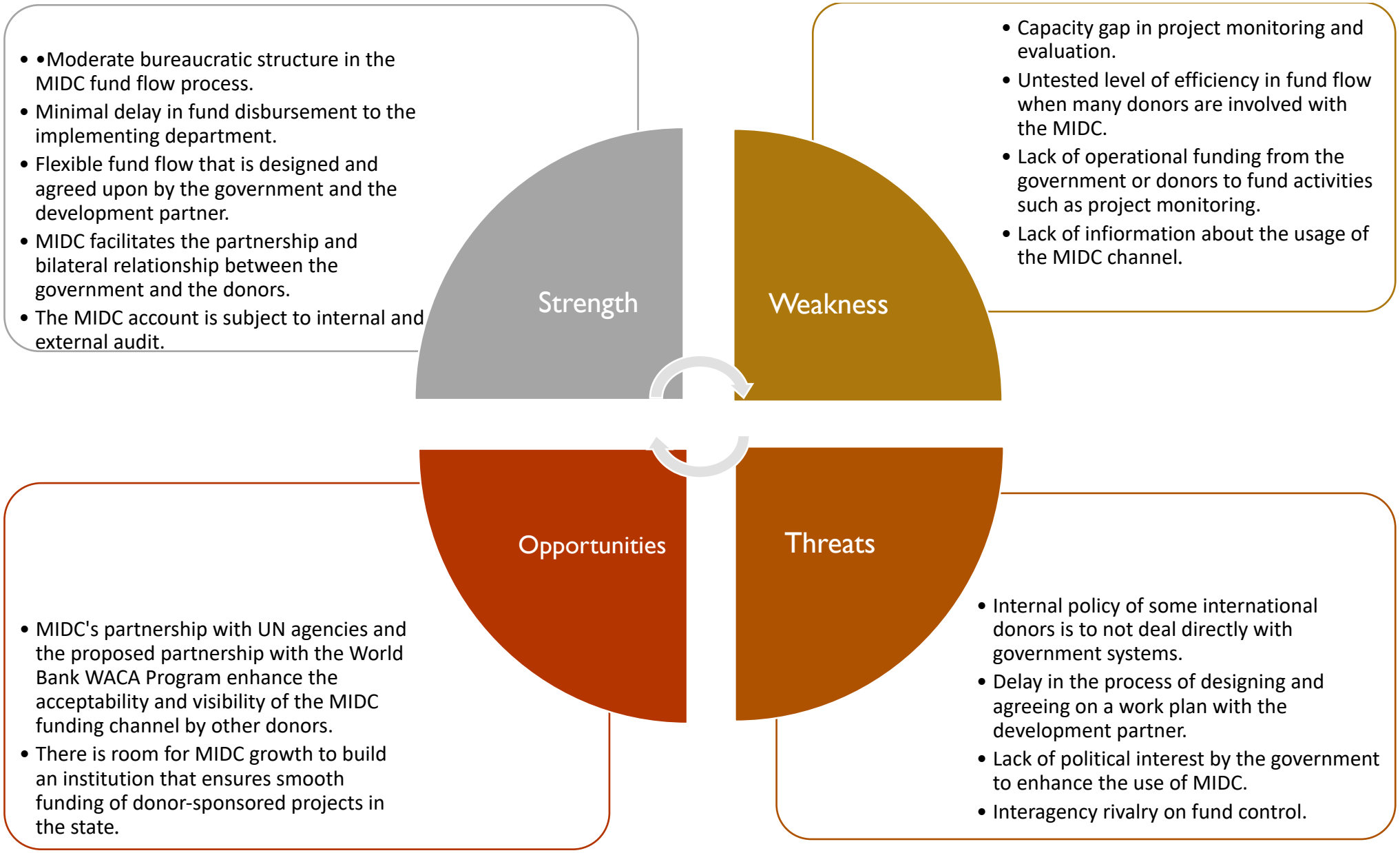
> *"The fund approval process from the MIDC special account starts from [when] the implementing department/agency submits a work plan as approved by the donor partner to the commissioner, through the Director of Administration, through their project desk officer. The Director of Admin approves the work plan and fund request, subject to the availability of funds, and sends a payment schedule to the bank, while the commissioner of MIDC gives the authorization to the bank before the funds are disbursed"* (Director of Administration, MIDC, CRS).

Figure 6: Shows Fund Approval Process from the MIDC Account in CRS for NTDs



Using the MIDC account, the requisition for funds is made by the implementing agency (NTD) to the commissioner, through the project desk officer, through the Director of Administration of MIDC. Fund disbursement is subject to the approval of the commissioner; then, the bank makes the payment to the implementing agency for project execution.

Figure 7: Shows SWOT for MIDC Accounts



Bottlenecks associated with the fund flow through the MIDC Account

- Time required to design and sign a work plan with the donor, MIDC, and the implementing department.
- Fund released delayed by the donor or government where counterpart funding is required.
- Implementing department/unit sending in not timely reports to access more funds.
- Project monitoring not efficient due to a lack of operational funding.

Risks associated with the fund flow through the MIDC Account

- Inter-ministry rivalry: The MIDC is at the same level of authority with other ministries, such as the SMOH. The other ministries prefer direct funding instead of going through the MIDC. Both the MIDC and the implementing ministry have similar hierarchical heads, making the implementing ministry reluctant to succumb to the leadership of the MIDC and funding of their projects through the MIDC account.
- Lack of consistent budget allocations for ministry operational costs from the government: This poses a risk on the cost element for daily operations, such as project monitoring, especially when using the MIDC.
- Capacity gap in project monitoring and evaluation: Project monitoring has not been effective in the SMOH, because no specific team or department is saddled with this responsibility.

"There is no special department in the Ministry of Health that is assigned with the responsibility of monitoring the project embarked on by the ministry; when the implementation of a project is ongoing, the director may go with one of two staff in the department to inspect the project" (Director of Finance and Account, SMOH, CRS).

Implications of the Fund Flow Mechanism in CRS on the Implementation of NTD

The bureaucracy in the fund flow process may result in delays in implementation of NTD activities. The channel through which funds are generated and disbursed currently in the state suggests that there is limited likelihood of changing the status quo as the annual budget to the health sector remains below the benchmark of 15% of the total budgetary allocation. Similarly, the allocation of funds to NTD programs by the state government has been grossly inadequate. Although NTD is captured in the Strategic Health Development Plan and MTEF, there has been no release of funds. The NTD state team will need capacity building in preparing convincing fund request memos in this regard.

There is no evidence of disbursement of funds from the state account for NTDs in recent years.[15] This results in the undertreatment of those affected by NTDs as it impacts the budgetary allocation to the State Primary Health Care Development Agency (SPHCDA), which is saddled with the responsibility of ensuring prevention and treatment of communicable diseases in CRS. By implication, as shown in Figure 8 below,4.38%, 3.77%, 6.48%, and 3.77% of the state health budget was appropriated for primary health care (PHC) for 2018, 2019, 2020, and 2021 respectively.[16] This implies that the amount budgeted for PHC in CRS has been relatively low over time. Also, only a meagre 0.26% and 0.28% of the budgetary allocation for the PHC was budgeted for the NTD programs in 2018 and 2019, respectively,[17] yet none of the budgeted fund has been released for NTD programs. The implication of this is that 0.01% of the state health budget was allocated toward addressing NTDs for the same period. Meaning,

"Allocation toward curtailing the NTD, which is one of the PHC focal points, has been grossly insignificant over the years" (State Coordinator, NTD, CRS).

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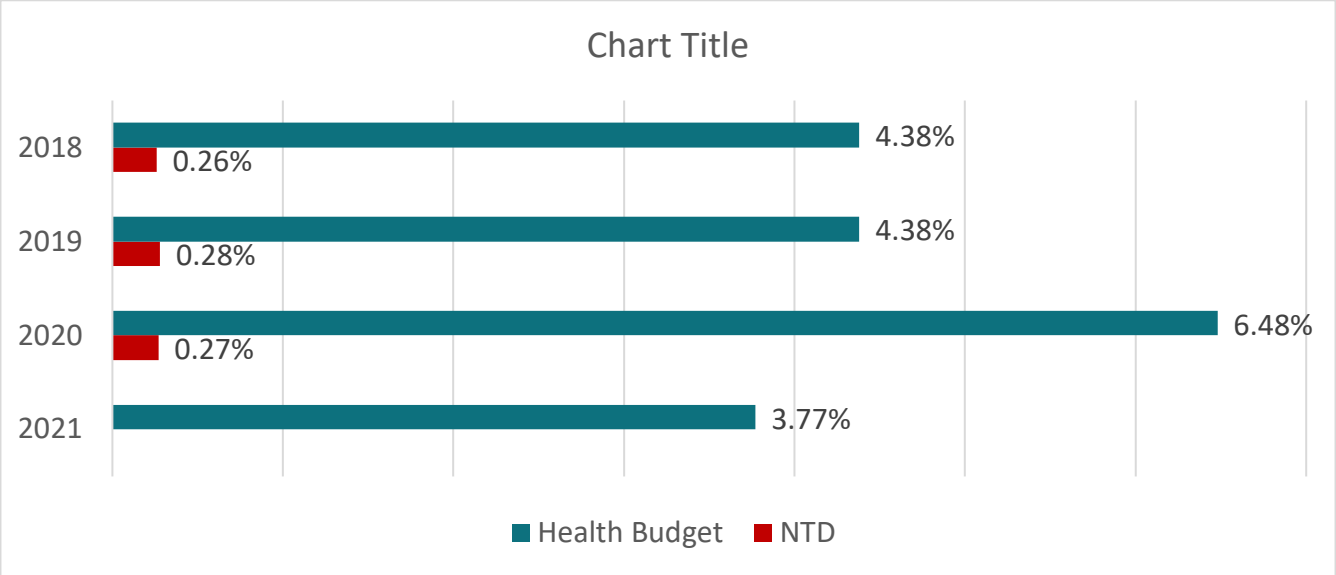
[15] Cross River-State approved budget summary, 2018, 2019.
[16] 2018-2021 Cross River-State approved budget summary
[17] Cross River-State approved budget summary, 2018, 2019.

Figure 8: Shows the percentage of Health Financing to PHC in CRS



Source: Cross River State's approved budget (2018 – 2021), Budget Archives - Cross River Internal Revenue Service (crirs.ng)

To effectively mobilize domestic funding for NTD programming, a strategic approach involves enhancing the knowledge and understanding of key stakeholders in the state about the endemicity of NTDs. This effort will be instrumental in garnering the necessary political interest and support. A contributing factor to the failure of obtaining domestic funding for the state's NTD program was identified as the lack of capacity among individuals responsible for advancing fund request memos. These personnel lacked the necessary skills and knowledge to advocate effectively for the program's funding needs. From the interviews with NTD stakeholders, it was apparent that the last capacity-building support provided to the staff of the NTD unit by Cross River State dates back to 2010.

Nonetheless, the existing CRS health financing policy and strategy plan[18] states that the government aims to establish at least one primary healthcare center per ward in keeping with the national policy of the National Primary Health Care Development Agency (NPHCDA) and the Federal Ministry of Health. The strategy has rekindled the drive for better health sector investment in the state through the provision of infrastructure for PHC and procurement of drugs, commodities, and basic medical equipment. Also, keeping with the directives of the NPHCDA, CRS has set up a PHC board with a mandate to ensure availability of quality health care at the PHC level to all residents of the state. This is to reduce fragmentation in PHC funding and service delivery and to ensure an integrated approach aimed at improving quality care. The government aims at augmenting this drive for good health care in the state with the support of donor agencies.

> *"Effort has been made to approach the state governor and to seek for partners, though they have a very limited number of partners assisting them; RTI and Evidence Action (EA) are also interested. EA has applied to see how they can come back, because their funding was cut short at a point because of some internal delays"* (Director of Public Health, CRS).

Donor funds have been the major source of funding for NTD programs in Cross River State. Specifically, EA and RTI, through USAID's Act | East Program, have been the major partners working with the state on NTD interventions. In 2016, EA began supporting the government of Cross River State for school-based deworming programs for STH and schistosomiasis as a part of the state's integrated NTD control program. These partners have worked directly with the implementing NTD department without going through the MIDC.

[18] Cross-River State Ministry of Health: Cross-River health financing policy and strategy, November 2018.

Implications of the Fund Flow on FAA Funding

With an FAA, the entire award sum is negotiated up front. The "pass-through" entity must be aware of both the actual cost and the anticipated number of tasks to be done so as to use this mechanism.

> *"Fixed amount (fixed price) awards are appropriate when the work that will be performed can be priced with a reasonable degree of certainty; ……. to establish an appropriate price include the non-Federal entity's past experience with similar types of work for which outcomes and their costs can be reliably predicted, or the non-Federal entity can easily obtain price estimates"* (USAID, 2014).[19]

For an FAA to be appropriate, a similar entity must have adopted the FAA medium of funding for similar purposes in the past.[20] This is not employed among the states' governments with similar NTD profiles in Nigeria. Therefore, estimating the amount appropriate for the tasks may be difficult. More so, from the investigations on the current fund flow mechanism in CRS via the state and MIDC accounts, there is no evidence that FAA or any similar funding mechanism has been employed in the state in the past. Also, the current CRS budget template, as reviewed, does not include any section for fixed-amount awards. This implies that the use of FAA has not been planned into the state's current fiscal provisions.

USAID (2020)[21] identified the main FAA eligibility checklist for a recipient of the award as "organizational integrity, organizational capacity to achieve the proposed FAA activity, past performance in the sector, FAA activity implementation viability, and FAA pre-award financial review checklist applicable for authorizing advances of funds." Considering this checklist, the capacity gap exists in the current organizational framework of the NTD program as revealed in the fund flow process, especially in the area of preparing memos for the requisition of funds. Also, past health sector performance has been low over the years due to low funding. While the annual fiscal allocation to the health sector of CRS has been below 10% over the years, except during the COVID-19 outbreak in 2020, only 0.01% of the fiscal provisions of the health sector was allocated for the NTD program in the state.

4.0 CONCLUSION

The funding landscape in CRS is characterized by a bureaucratic structure that starts from the budgeting federation account process to the disbursement of funds. The state's projects and policies are funded by resources generated through the allocation, IGR, grants and subventions, and loans. Despite a relatively fair share of funds (4% to 6%) allocated to the health sector compared to other critical sectors of the state, such allocation remains insufficient due to the state's scope of health projects and programs. Funding for NTD initiatives from the state government's account remains insignificant, with the unit relying heavily on donor agencies' involvement to address NTDs in the state. Despite the establishment of the MIDC to enhance governance coordination and policy implementation for international collaboration, most development partners operating in CRS (the state) have not used this channel. The primary reasons for this are the lack of awareness regarding the MIDC and the state government's limited insistence on its usage.

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[19] USAID (2014). Fixed Amount Awards to Non-Governmental Organizations: an Additional Help Document for ADS Chapter 303.

[20] USAID (2014). Fixed Amount Awards to Non-Governmental Organizations: an Additional Help Document for ADS Chapter 303.

[21] USAID (2020). Fixed Amount Award Entity Eligibility Checklist, a Mandatory Reference for ADS Chapter 303. https://www.usaid.gov/sites/default/files/documents/303mak.pdf

5.0 RECOMMENDATIONS

The following recommendations are provided:

- **Conduct strategic advocacy to key stakeholders**, such as executives of health ministries and affiliated agencies, legislators, and executive council members, to mobilize domestic funding for NTDs at the state and federal levels. To support this activity, pursue capacity-building activities and targeted advocacy activities for FY24.
- **Strengthen personnel capacity in the NTD unit**. To overcome the challenge of insufficient funding due to the inability to present convincing fund release memos to the Executive Governor, it is crucial to build the capacity of the NTD personnel in FY24. By providing comprehensive training and support, these personnel can enhance their advocacy skills and effectively communicate the significance of NTD programs in addressing public health challenges within the state. This capacity-building effort will bolster their ability to make compelling funding requests and secure the necessary resources to combat NTDs effectively.
- **Advocate for NTDs as a priority health focus in CRS**. To address the issue of NTDs not being considered a priority health focus in CRS, proactive engagement with high-level stakeholders is essential. By emphasizing the endemicity and impacts of NTDs within the state, along with the resources required to address them, it is possible to create awareness and garner support from decision-makers. Advocating for increased recognition of NTDs as a critical health concern can lead to a more favorable allocation of funds in the state capital health budget. This can be achieved by organizing dissemination workshops, bringing the high-level stakeholders together to co-create solutions for the funding of NTDs in the state. Through sustained efforts to engage stakeholders and raise awareness about the importance of NTD control, the state can take significant strides toward curbing the prevalence and impact of neglected tropical diseases.

ANNEXES

Data Collection Tool for State-Level Actors- Ministries of Health, Finance and Planning.

General Information

This interview guide will be used to conduct key informant interviews (KIIs) with policy makers, leadership of key agencies and departments within the State Ministry of Health (SMOH), other relevant Ministries, Departments and Agencies (MDA) that work with the health sector and development partners. The purpose of the interview is to confirm and provide further information on secondary data sources that will be useful for the assessment on the state's health finance landscape and fund flow analysis. The interview will last between 1 hour to 1 hour 30 minutes. This interview will be recorded on a recording device and later transcribed.

Section 1: Introduction

1. Please confirm that you have read and understood the consent form and give your written/verbal consent to be interviewed?

2. What is your name and position in this organization?

3. What is the name of your department, unit or agency, organization (development partners)?

4. What are the essential roles and responsibilities of your department, unit or agency or organization (development partner)?

5. Are you aware of the Cross River State Neglected Tropical Disease (NTD) Program? If yes, what was your experience, or general opinion about the program?

6. If you are not aware of the NTD Program, have you worked on any other disease program? Which one and what was your experience, or general opinion about the program? Are you aware of any challenges experienced during the implementation of the project and are there lessons learned?

Section 2: Health financing landscape

1. Has there been any previous assessment of the health financing landscape in the state?
    a. Probe: If yes, what were the goals and objectives, lessons learned, gaps and challenges faced? Who conducted the assessment? Who funded the assessment? When was the assessment conducted?
    b. Probe: If no, can you please explain the current health finance structure and how money flow (from fund approval to release for implementation of programs)
2. What are the factors that determine or influence how the health sector is funded?
    a. Probe: In your opinion, do you think the health sector is given priority in funding compared to other sectors? Or ask, do you know what percentage of the state budget is allocated to health sector?
    b. Probe: If health is not given priority, ask: "What do you think is responsible for the poor funding of the health sector?"

3. What are some recommendations to improve funding of health programs and interventions?

4. How are health data and statistics provided to the Ministry of Economic, Planning, and Budget (MEPB) for inclusive planning and budgeting for health?
    a. Probe: Is there a state strategic health development plan?
    b. Probe: If yes, does the ministry prepare an annual operational plan that informs the health budget preparation? Who is involved in the process of developing the annual operational plan?
    c. Probe: If no, how does the MEPB, SMOH and its agencies allocate funds to disease programs?

5. For State Ministry of Health, and parastatals, how much money is the state and disease programs spending on Neglected Tropical Disease (Lymphatic Filariasis, STH, Schistosomiasis and Onchocerciasis) activities?

a. Probe: How important are investments in these activities and the health system generally?

6. What are the constraints that inhibit the ability of the health system to increase funding of priority interventions such as NTD-related programs?

7. How much more of the total government budget could feasibly be allocated to the health sector, given the competing priorities and constraints in the budget?

a. Probe: Are there mechanisms to accumulate and redistribute health funds across different pools—geographic areas, administrative levels, and revenue sources?
b. Probe: To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?
c. Probe: Is there a system to track and monitor how health budget is disbursed and used annually for priority population, programs, and services? Who is responsible for monitoring the implementation of the health budget?
d. Probe: What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?

8. To what extent have donors been supporting the implementation of priority health programs in the state, including NTD programs?

Section 3: Fund flow within the government sector

1. How is the health sector budget allocated to different program areas?

a. Probe for how the budget is prepared within the SMOH and agencies; does each program area develop costed annual workplans that is used to determine the budget allocations? Is budget development limited to the SMOH or also includes the local government and PHCDA?

2. What is the % of annual budget that should/can be allocated to the health sector in line with the 15% Abuja Declaration?

a. Probe: What is the ideal quantity of resources (funds) required to implement priority health and the estimate of the funding gaps within the health budget?
b. Probe: What is the average (in %) allocation to the health sector on an annual basis? (Looking at the past 3 to 4 years)?

3. How does funding cascade from the State Ministry of Health to the local government health authorities and finally to the primary healthcare facilities?

4. What is the process of release of funds to the local government level from state for project implementation and monitoring?

5. How does the state go about allocating funding for the NTD Program?

a. Probe: How does the NTD program budget for LF and OV?
b. Probe: What % goes to NTD offices at LGA level?
c. Probe: who monitors budget implementation to NTDS across the different levels?

6. What additional result do you think additional funding to the health sector especially for NTD programs will bring?

a. Probe: How do aid inflows (additional funding) affect the health budget (macroeconomic and fiscal context)?
b. Probe: How are aid inflows managed and monitored?

7. Is there any mechanism for holding health sector agencies accountable for health expenditure or funding received from donor partners for health programs?

Section 4- Fixed Amount Award (FAA) related questions

1. Have you heard of Fixed Amount Award (FAA) mechanism?
    a. Probe: If yes, what are your thoughts on the mechanism?
    b. If no, interviewed to give a brief description of the FAA mechanism using one of the illustrative examples in the training brief.
2. Are local government entities able to receive/manage U.S. government funds directly?
    a. Probe: If yes, ask what type of programs have been supported through U.S. Government funds and how this was implemented. Then ask if they experienced any challenges in managing those funds?
    b. Probe: If no, how does the state ensure that funds for health programs are allocated to the LGA/PHCDA to implement the activities they are earmarked for?
3. Has the ministry ever received donor funding for NTDs or health that is a results/milestone based?
    a. Probe: If yes, what has been the experience of the ministry to implement such donor funding, what are some challenges and lessons learned? which account were the funds held in? Who manages that account and what were the pros and cons of that management approach?
    b. Probe: If no, do you think the ministry can implement the FAA mechanism within its existing structure? Provision of reports based on milestones, preparation of invoice document (signed, stamped, and dated) for payment and storing of relevant document for the stipulated period-minimum of 3 years.
4. What are modalities for keeping financial records within the ministry, and does the ministry have the infrastructure and capacity to store documents for a period of 3-5 years?
5. How would you ensure that NTD program is better prioritized in terms of allocation and releases?

Data Collection Tool for LG-Level Actors

General Information

This interview guide will be used to conduct key informant interviews (KIIs) with policy makers, leadership of key agencies and departments within three select LGAs in the three geopolitical zones of the state that work with the health sector and development partners. The purpose of the interview is to confirm and provide further information on secondary data sources that will be useful for the assessment on the health finance landscape and fund flow analysis. The interview will last between 1 hour to 1 hour 30 minutes. This interview will be recorded on a recording device and later transcribed.

Section 1: Introduction

1. What is your name and position in this organization?
2. Are you aware of the Cross River State Neglected Tropical Disease (NTD) Program? If yes, what was your experience, or general opinion about the program?

Section 2: Health financing landscape

Can you please explain the current health finance structure and how money flow (from fund approval to release for implementation of programs) from the state to local government level and to activities.

3. What are the factors that determine or influence how the health sector is funded?
4. In your opinion, do you think the health sector is given priority in funding compared to other sectors? Or do you know what percentage of the LGA budget is allocated to health sector?
5. For your Local Government, how much money is spent on Neglected Tropical Disease (Lymphatic Filariasis, STH, Schistosomiasis and Onchocerciasis) activities?
6. What are the constraints that inhibit the ability of the health system to increase funding of priority interventions such as NTD-related programs?

Probe: Is there a system to track and monitor how health budget is disbursed and used annually for priority population, programs, and services? Who is responsible for monitoring the implementation of the health budget?

a. Probe: What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?

7. To what extent have donors been supporting the implementation of priority health programs in the state, including NTD programs?

Section 3: Fund flow within the government sector

1. How is the health sector budget allocated to different program areas?

a. Probe for how the budget is prepared within the SMOH and agencies; does each program area develop costed annual workplans that is used to determine the budget allocations? Is budget development limited to the SMOH or also includes the local government and PHCDA?

2. What is the % of annual budget that should/can be allocated to the health sector in line with the 15% Abuja Declaration?

a. Probe: What is the ideal quantity of resources (funds) required to implement priority health and the estimate of the funding gaps within the health budget?
b. Probe: What is the average (in %) allocation to the health sector on an annual basis? (Looking at the past 3 to 4 years)?

3. How does funding cascade from the State Ministry of Health to the local government health authorities?

4. What is the process of release of funds to the local government level from state for project implementation and monitoring?

5. How does the state go about allocating funding for the NTD Program?

a. Probe: How does the NTD program budget for LF and OV?
b. Probe: What % goes to NTD offices at LGA level?
c. Probe: who monitors budget implementation to NTDS across the LGA levels?

6. What additional result do you think the additional funding to the health sector especially for NTD programs will bring?

a. Probe: How do aid inflows (additional funding) affect the health budget (macroeconomic and fiscal context)?

7. Is there any mechanism for holding health sector agencies accountable for health expenditure or funding received from donor partners for health programs?

Section 4- Fixed Amount Award (FAA) related questions

1. Have you heard of Fixed Amount Award (FAA) mechanism?

a. Probe: If yes, what are your thoughts on the mechanism?
b. If no, interviewed to give a brief description of the FAA mechanism using one of the illustrative examples in the training brief.

2. Are local government entities able to receive/manage U.S. government funds directly?

3. Probe: If yes, ask what type of programs have been supported through U.S. Government funds and how this was implemented. Then ask if they experienced any challenges in managing those funds?

4. Probe: If no, how does the state ensure that funds for health programs are allocated to the LGA/PHCDA to implement the activities they are earmarked for?

5. Has the ministry ever received donor funding for NTDs or health that is a results/milestone based?

   a. Probe: If yes, what has been the experience of the ministry to implement such donor funding, what are some challenges and lessons learned? which account were the funds held in? Who manages that account and what were the pros and cons of that management approach?
   b. Probe: If no, do you think the ministry can implement the FAA mechanism within its existing structure? Provision of reports based on milestones, preparation of invoice document (signed, stamped, and dated) for payment and storing of relevant document for the stipulated period-minimum of 3 years.

6. What are modalities for keeping financial records within the ministry, and does the ministry have the infrastructure and capacity to store documents for a period of 3-5 years?

7. How would you ensure that NTD program is better prioritized in terms of allocation and releases?

Data Collection Tool for Primary Care-Level Actors

General information

This interview guide will be used to conduct key informant interviews (KIIs) with policy makers, leadership of key agencies and departments within the Primary Health Care Agency, Select Public and Private facilities that work with the health sector and or development partners. The purpose of the interview is to confirm and provide further information on secondary data sources that will be useful for the assessment on the health finance landscape and fund flow analysis. The interview will last between 1 hour to 1 hour 30 minutes. This interview will be recorded on a recording device and later transcribed.

Section 1: Introduction

1. Please confirm that you have read and understood the consent form and give your written/verbal consent to be interviewed?

2. What is your name and position in this organization?

3. Are you aware of the Cross River State Neglected Tropical Disease (NTD) Program? If yes, what was your experience, or general opinion about the program?

4. If you are not aware of the NTD Program, have you worked on any other disease program? Which one and what was your experience, or general opinion about the program? Are you aware of any challenges experienced during the implementation of the project and are there lessons learned?

Section 2: Health financing landscape

1. Has there been any previous assessment of the health financing landscape in the state?

   a. Probe: If yes, what were the goals and objectives, lessons learned, gaps and challenges faced? Who conducted the assessment? Who funded the assessment? When was the assessment conducted?
   b. Probe: If no, can you please explain the current health finance structure and how money flow (from fund approval to release for implementation of programs) to the PHCDA and facilities?

2. What are the factors that determine or influence how the health sector is funded?

   a. Probe: In your opinion, do you think the health sector is given priority in funding compared to other sectors? Or ask, do you know what percentage of the state budget is allocated to health sector?
   b. Probe: if yes, what percentage of that approved budget is given to the PHCDA? How is the percentage determined?
   c. Probe: If health is not given priority, ask: “What do you think is responsible for the poor funding of the health sector?”

3. What are some recommendations to improve funding of health programs and interventions?

4. How are health data and statistics provided to the Ministry of Economic, Planning and Budget (MEPB) for inclusive planning and budgeting for health?

a. Probe: Is there a state strategic health development plan?
b. Probe: If yes, does the ministry involve the PHCDA and facilities when preparing an annual operational plan that informs the health budget preparation?
c. Probe: If no, how does the MEPB, SMOH and its agencies allocate funds to disease programs?

5. For PHCDA, and facilities, how much money is the state and disease programs spending on Neglected Tropical Disease (Lymphatic Filariasis, STH, Schistosomiasis and Onchocerciasis) activities?

a. Probe: How important are investments in these activities and the health system generally?

6. What are the constraints that inhibit the ability of the health system to increase funding of priority interventions such as NTD-related programs?

7. How much more of the total government budget could feasibly be allocated to the health sector, given the competing priorities and constraints in the budget?

a. Probe: Are there mechanisms to accumulate and redistribute health funds across different pools—geographic areas, administrative levels, and revenue sources?
b. Probe: To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?
c. Probe: Is there a system to track and monitor how health budget is disbursed and used annually for priority population, programs, and services? Who is responsible for monitoring the implementation of the health budget?
d. Probe: What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?

8. To what extent have donors been supporting the implementation of priority health programs in the state, including NTD programs?

Section 3: Fund flow within the government sector

1. How is the health sector budget allocated to different program areas?

a. Probe for how the budget is prepared within the SMOH and agencies; does each program area develop costed annual workplans that is used to determine the budget allocations? Is budget development limited to the SMOH or also includes the local government and PHCDA?

2. What is the % of annual budget that should/ can be allocated to the health sector in line with the 15% Abuja Declaration?

a. Probe: What is the ideal quantity of resources (funds) required to implement priority health and the estimate of the funding gaps within the health budget?
b. Probe: What is the average (in %) allocation to the health sector on an annual basis? (Looking at the past 3 to 4 years)?

3. How does funding cascade from the State Ministry of Health to the primary healthcare facilities?

4. What is the process of release of funds to the PHCDA from state for project implementation and monitoring?

5. How does the state go about allocating funding for the NTD Program?

a. Probe: How does the NTD program budget for LF and OV?
b. Probe: What % goes to NTD offices at LGA/PHC level?
c. Probe: Who monitors budget implementation to NTDS across the facilities?

6. What additional result do you think the additional funding to the health sector especially for NTD programs will bring?

   a. Probe: How do aid inflows (additional funding) affect the health budget (macroeconomic and fiscal context)?

7. Is there any mechanism for holding health sector agencies accountable for health expenditure or funding received from donor partners for health programs?

Section 4- Fixed Amount Award (FAA) related questions

1. Have you heard of Fixed Amount Award (FAA) mechanism?

   a. Probe: If yes, what are your thoughts on the mechanism?
   b. If no, interviewed to give a brief description of the FAA mechanism using one of the illustrative examples in the training brief.

2. Is the PHCDA able to receive/manage U.S. government funds directly?

3. Probe: If yes, ask what type of programs have been supported through U.S. Government funds and how this was implemented. Then ask if they experienced any challenges in managing those funds?

4. Probe: If no, how does the state ensure that funds for health programs are allocated to the LGA/PHCDA to implement the activities they are earmarked for?

5. Has the ministry ever received donor funding for NTDs or health that is a results/milestone based?

   a. Probe: If yes, what has been the experience of the ministry to implement such donor funding, what are some challenges and lessons learned? which account were the funds held in? Who manages that account and what were the pros and cons of that management approach?
   b. Probe: If no, do you think the ministry can implement the FAA mechanism within its existing structure? Provision of reports based on milestones, preparation of invoice document (signed, stamped, and dated) for payment and storing of relevant document for the stipulated period-minimum of 3 years.

6. What are modalities for keeping financial records within the ministry, and does the ministry have the infrastructure and capacity to store documents for a period of 3-5 years?

7. How would you ensure that NTD program is better prioritized in terms of allocation and releases?

Data Collection Tool for CSOs and Donors/Partners

General Information

This interview guide will be used to conduct key informant interviews (KIIs) with policy makers, leadership of key agencies and departments within the State Ministry of Health (SMOH), other relevant Ministries, Departments and Agencies (MDA) that work with the health sector and development partners. The purpose of the interview is to confirm and provide further information on secondary data sources that will be useful for the assessment on the state's health finance landscape and fund flow analysis. The interview will last between 1 hour to 1 hour 30 minutes. This interview will be recorded on a recording device and later transcribed.

Section 1: Introduction

1. Please confirm that you have read and understood the consent form and give your written/verbal consent to be interviewed?

2. What is your name and position in this organization?

3. What is the name of your department, unit or agency, organization (development partners)?

4. What are the essential roles and responsibilities of your department, unit or agency or organization (development partner)?

5. Are you aware of the Cross River State Neglected Tropical Disease (NTD) Program? If yes, what was your experience, or general opinion about the program?

6. If you are not aware of the NTD Program, have you worked on any other disease program? Which one and what was your experience, or general opinion about the program? Are you aware of any challenges experienced during the implementation of the project and are there lessons learned?

Section 2: Health financing landscape

1. Has there been any previous assessment of the health financing landscape in the state?
    a. Probe: If yes, what were the goals and objectives, lessons learned, gaps and challenges faced? Who conducted the assessment? Who funded the assessment? When was the assessment conducted?
    b. Probe: If no, can you please explain the current health finance structure and how money flow (from fund approval to release for implementation of programs)

2. What are the factors that determine or influence how the health sector is funded?
    a. Probe: In your opinion, do you think the health sector is given priority in funding compared to other sectors? Or ask, do you know what percentage of the state budget is allocated to health sector?
    b. Probe: If health is not given priority, ask: "What do you think is responsible for the poor funding of the health sector?"

3. What are some recommendations to improve funding of health programs and interventions?

4. How are health data and statistics provided to the Ministry of Economic, Planning and Budget (MEPB) for inclusive planning and budgeting for health?
    a. Probe: Is there a state strategic health development plan?
    b. Probe: If yes, does the ministry prepare an annual operational plan that informs the health budget preparation? Who is involved in the process of developing the annual operational plan?
    c. Probe: If no, how does the MEPB, SMOH and its agencies allocate funds to disease programs?

5. For State Ministry of Health, and parastatals, how much money is the state and disease programs spending on Neglected Tropical Disease (Lymphatic Filariasis, STH, Schistosomiasis and Onchocerciasis) activities?
    a. Probe: How important are investments in these activities and the health system generally?

6. What are the constraints that inhibit the ability of the health system to increase funding of priority interventions such as NTD-related programs?

7. How much more of the total government budget could feasibly be allocated to the health sector, given the competing priorities and constraints in the budget?
    a. Probe: Are there mechanisms to accumulate and redistribute health funds across different pools—geographic areas, administrative levels, and revenue sources?
    b. Probe: To what extent is it possible to develop, disburse, and account for health sector budgets based on priority populations, programs, and services rather than inputs?
    c. Probe: Is there a system to track and monitor how health budget is disbursed and used annually for priority population, programs, and services? Who is responsible for monitoring the implementation of the health budget?
    d. Probe: What accountability measures can be put in place to ensure that funds are being used effectively for priority populations, programs, and services?

8. To what extent have donors been supporting the implementation of priority health programs in the state, including NTD programs?

Section 3: Fund flow within the government sector

1. How is the health sector budget allocated to different program areas?
    a. Probe for how the budget is prepared within the SMOH and agencies; does each program area develop costed annual workplans that is used to determine the budget allocations? Is budget development limited to the SMOH or also includes the local government and PHCDA?

2. What is the % of annual budget that should/can be allocated to the health sector in line with the 15% Abuja Declaration?

a. Probe: What is the ideal quantity of resources (funds) required to implement priority health and the estimate of the funding gaps within the health budget?
b. Probe: What is the average (in %) allocation to the health sector on an annual basis? (Looking at the past 3 to 4 years)?

3. How does funding cascade from the State Ministry of Health to the local government health authorities and finally to the primary healthcare facilities?

4. What is the process of release of funds to the local government level from state for project implementation and monitoring?

5. How does the state go about allocating funding for the NTD Program?

a. Probe: How does the NTD program budget for LF and OV?
b. Probe: What % goes to NTD offices at LGA level?
c. Probe: who monitors budget implementation to NTDS across the different levels?

6. What additional result do you think additional funding to the health sector especially for NTD programs will bring?

a. Probe: How do aid inflows (additional funding) affect the health budget (macroeconomic and fiscal context)?
b. Probe: How are aid inflows managed and monitored?

7. Is there any mechanism for holding health sector agencies accountable for health expenditure or funding received from donor partners for health programs?

Section 4- Fixed Amount Award (FAA) related questions

1. Have you heard of Fixed Amount Award (FAA) mechanism?

a. Probe: If yes, what are your thoughts on the mechanism?
b. If no, interviewed to give a brief description of the FAA mechanism using one of the illustrative examples in the training brief.

2. Are local government entities able to receive/manage U.S. government funds directly?

a. Probe: If yes, ask what type of programs have been supported through U.S. Government funds and how this was implemented. Then ask if they experienced any challenges in managing those funds?
b. Probe: If no, how does the state ensure that funds for health programs are allocated to the LGA/PHCDA to implement the activities they are earmarked for?

3. Has the ministry ever received donor funding for NTDs or health that is a results/milestone based?

a. Probe: If yes, what has been the experience of the ministry to implement such donor funding, what are some challenges and lessons learned? which account were the funds held in? Who manages that account and what were the pros and cons of that management approach?
b. Probe: If no, do you think the ministry can implement the FAA mechanism within its existing structure? Provision of reports based on milestones, preparation of invoice document (signed, stamped, and dated) for payment and storing of relevant document for the stipulated period-minimum of 3 years.

4. What are modalities for keeping financial records within the ministry, and does the ministry have the infrastructure and capacity to store documents for a period of 3-5 years?

5. How would you ensure that NTD program is better prioritized in terms of allocation and releases?

Certificate of Ethical Approval

GOVERNMENT OF CROSS RIVER STATE OF NIGERIA
MINISTRY OF HEALTH, CALABAR
HEALTH RESEARCH ETHICS COMMITTEE

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CRS/MH/HREC/2021/Vol.V/221 14th December, 2021

Benjamin Chukwuemeka Nwobi
Research Triangle Institute (RTI) International

CERTIFICATE OF ETHICAL APPROVAL

The Cross River State Health Research Ethics Committee (CRS-HREC) having reviewed your application for Ethical Approval of the Research titled **"Assessment of the Health Financing Landscape and Fund Flow Analysis in Cross River State, Nigeria"** *with REC No. RP/REC/2021/215* has granted **FULL ETHICAL APPROVAL**.

This approval is valid for **ONE YEAR** from the date of its issuance.

You may proceed with your study in accordance with the protocol. You are requested to abide by every professional and ethical code for the conduct of this research, including advising the CRS-HREC of any changes to your protocol in advance.

The CR-HREC reserves the right to request an audit of this research at any time during or post implementation. ***A copy of the completed research (Results) should be submitted*** *to* the Department of Clinical Governance, SERVICOM and E-Health for policy and decision making in the State Ministry of Health.

Yours sincerely,

Dr. Bassey Ikpeme
Chairman CR-HREC