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Budget Resource Evaluation of Primary Healthcare-Based Intervention Funds for Improving Reproductive Health Activities in Ebonyi State Nigeria

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Abstract

The development of reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N) Investment Case (2017-2030) signaled the government of Nigeria's commitment to strengthen commitment in reproductive, maternal, newborn, children, adolescent health and nutrition. Despite seemingly deliberate increase in yearly health budgets, it appears that challenges in the states persist and remain unabated. This study is aimed at determining relevance of the yearly budget releases from 2019-2023 in addressing the increasing challenges in Nigeria. The study adopted the accounting method of cost classification by function to classify all releases into direct and indirect costs/releases. In line with the philosophy and convention, the details adopted by this study are as follows: -All actual capital releases on RMNCAH+N from the health ministry, agencies, and office from 2017-2021 are classified as direct costs. Other capital and special releases that are not within categories A and B are classified as indirect costs. The percentage of the budget released in 2017 stood at 9.42%, in 2018 it moved to 35.64%, in 2019 it got to 47.71%, and continued to 69.53% in 2020 and finally jumped to 89.02% in 2021., while the percentage of the health budget released within these years that relate to direct cost and overheads (releases relating to reproduction, maternal, newborn, child, and adolescent health) shows 0% in 2017, 0.96% in 2018, 0.18% in 2019, 2% in 2020 and 0% in 2021. The fractional percentage increase in 2019 and 2020 was related to emergency and outbreak-related releases including COVID-19 outbreak. There is urgent need for government of Nigeria especially at the sub-national levels to begin to fund RMNCAH+ N related programs and to also make deliberate effort in broadening RMNCAH+ N budget policies, frameworks and procedures towards multi-stakeholders' participation, especially in budget financing, monitoring and in developing yearly evaluation template for the attainment of the RMNCAH + N goal in 2030...

Keywords: Budget performance, Healthcare system, ministry of health, adolescent health, Maternal and child health.

Introduction

The development of reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N) Investment Case (2017-2030) a sub-component of Nigerian National Strategic Health Sector Development Plan 11 in 2017 signaled the government of Nigeria's commitment to strengthen commitment in reproductive, maternal, newborn, children, adolescent health plus nutrition, popularly referred to as RMNCAH + N. The roadmap became necessary due to low coverage of health services such as antenatal care, high unmet need for family planning, low rates of facility-based childbirth, poor quality of health services, and an array of inequities and inequalities (Seddighi et al.,2020; Akpa et.al., 2022; Ogundeji et al. 2019; Bagepally et al.2022; Jakovljevic et al.2020; Ololo et al. 2023). The RMNCAH +N Investment Case further provides and supports improved governance strategies and accountability, especially at the sub-national level; this was identified as an important prerequisite for the attainment of the goal in 2030**.** Globally, there is a growing concern on issues around effective cost resource allocation as being key to the realization of some of the health goals by various governments (Guinness et al. 2023; Belaid et al. 2020; Darnell et al. 2013). In Nigeria, governments at various sub-national levels claim to have made a huge investment in the health sector in recent times regardless of these challenges that appear resistant over the years (Fleming et al. 2012). Improving the health system efficiency is a key strategy to increasing health system performance and accelerating progress toward universal health coverage. In recent times, Kenya transitioned into a devolved system of government granting local government councils 'autonomy over budget and priorities. This however led to an efficient primary health system in most of the local councils (Li Oleribe 2019). Proper financial budgeting for health-related challenges should not be an afterthought in the health budgeting system, rather it should include monitoring and evaluation mechanisms for timely review of objectives (Agu et al. 2022; Farewar et al. 2022). Following the rollout of District Health Information Software (DH1S) 2 the scorecard was reintroduced in 2017 with a shift to achieving its use at the state and local government levels. The rollout of the RMNCAH+N scorecard began as a pilot program in Ebonyi state and Kogi state in 2017. In 2018, the scorecard pilot program was further extended to the states of Niger, Kebbi, Bauchi, Oyo, and Adamawa and later to all other states of the federation. In recent years it appears that state governments and the local government at the sub-national levels have relegated this responsibility to international partners and foreign support. Issues around RMNCAH +N including administration and management appear not to have been given the needed attention and priority they deserve in our society (Baltussen et al. 2006; Sangar et al. 2019; Aregbeshola et al. 2022). The financial budget for the health sector from 2017-2021in Ebonyi State appears impressive. The percentage of budget releases to the general health sector under the period under review also appears progressive. The percentage of the budget released in 2017 stood at about 9.42%, in 2018 it moved to 35.64%, in 2019 it got to 47.71%, and continued to 69.53% and finally jumped to 89.02% in 2021. However, the general health outlook, findings and conclusions in recent studies on reproductive, maternal, newborn, child, and adolescent health costs in Ebonyi State do not measure up with the level of financial commitment in health by the State government. This uncorrelated trend if not properly addressed may result to serious health danger, and also derail the achievement of RMNCAH + N target in Nigeria by 2030 (Ravindran et al. 2020). There is very little financial room for family planning services and contraception in Ebonyi State, according to the United States Agency for International Development (USAID) Working Paper June 2022. It could be improved if the state government honors its commitment to allocate 15% of its budget to the healthcare sector and if family planning services are given priority in the Basic Health Care Provision Fund (Ololo et al.2023). Although major stakeholders appear to be supportive of Adolescent Sexual and Reproductive Health (ASRH) program implementation in Ebonyi State, many significant government and non-government organizations are not involved in policymaking. For greater ownership and sustainability of Adolescent Sexual and Reproductive Health (ASRH) initiatives, there is a need for more purposeful and active involvement of important stakeholders in policymaking (Ezeh et al. 2008; Doctor, 2003). Also, a study on intermittent preventive treatment in pregnancy in Ebonyi State in 2023 suggested that Interventions that reinforce the importance of health professionals carrying out actions aimed at pregnant women and their partners (spousal) to guide them on preventive actions against malaria and other diseases are recommended and should be in place in Ebonyi State (Nmadu et al.2020; Onuoha et al. 2025). This study therefore is an appraisal of the budget of the State health ministry and other health agencies from 2017-2021 via the Audited Financial Statement of Ebonyi State, to determine the budget performance on the realization of RMNCAH +N mandate so far.

Method

This study is an evaluation of the performance of actual budgets on RMNCAH + N in Ebonyi State Nigeria. The focus of the study is the state ministry of health and other public health agencies and offices in the state that are adjudged responsible for the promotion of the RMNCAH+N agenda. The data were all extracts from the Audited Financial Statements of Ebonyi State Government from 2017-2021. The study is part of the evaluation of the performance of RMNCAH +N Investment Case (2017-2030) a sub-component of Nigerian National Strategic Health Sector Development Plan II to operationalize the Global financing facility and accelerate results for reproductive, maternal, newborn, and child adolescents' health and nutrition in Nigeria. The study focused on the performance evaluation of strategic government agencies with the responsibility to improve the result of RMNCAH+N via budgetary performance and to generally provide primary healthcare services to the generally of people of Ebonyi State, These agencies are the Ministry of Health (MoH), State Hospital Management Board (SHMB), Primary Healthcare Development Agency (PHDA), Agency for the Control of Aids (ACA), School of Health Technology Ngbo (SHTN), School of Nursing and Midwifery Uburu (SNMU), and Office of the special Adviser on Primary Health (OSAPH). The study extracted the capital and other RMNCAH + N-related releases made to these agencies from Audited Financial Statements of the Ebonyi State government from 207-2021. By the mandate establishing these agencies, their core responsibility is to improve RMNCAH+N as the target the primary health care services. The study adopted the accounting method of cost classification by function to classify all releases into direct and indirect costs/releases. In line with the philosophy and convention, the details adopted by this study are as follows: -

A. All actual capital releases on RMNCAH+N from the above-named ministry, agencies, and office from 2017-2021 are classified as direct costs.
B. All non-capital direct releases or targeted costs for various programs relating to RMNCAH+N within the period under review are also classified as direct costs.
C. Any other capital and non-capital-capital releases or costs that are not within the category A and B are classified as indirect costs.

Therefore, the cost model for direct cost classification based on function was adopted as follows: TDC = TR on RMNCAH+N in MoH + TR on RMNCAH +N in SHMB+ TR of RMNCAH+N in PHDA+ TR on RMNCAH + N of ACA+ TR on RMNCAH +N of SHTN + TR on SNMU+ TR on RMNCAH + N in OSAPHC

Results

Table 1 Classification of Capital Releases and Extracts from 2017-2021.

2017	Budgeted N	Actual N	%	Cost Classification (RMNCAH +N}
MoH	4,360,762,500.00	459,298,760.56	11%	Indirect
SHMB	41,672,500.00	0	0%	Direct
PHDA	292,275,500.00	0	0%	Direct
ACA	44,330,000.00	0	0%	Direct
SHTN	150,000,000.00	0	0%	Indirect
SNMU	1,157,501,337.00	110,362,031.31	9.53%	Indirect
OSAPHC	117,722.500.00	0	0%	Direct
Total	6,046,541,837.00	569,660,791.87	9.42%	Direct=0%, % Indirect= 9.42%
2018				
MoH	2,591,943,643.64	1,093,225,413.77	42%	Indirect
SHMB	181,000,000.00	0	0%	Direct
PHDA	283,500,000.00	0	0%	Direct

ACA	-	0	0%	Direct
SHTN	52,000.000.00	9,783,085.58	18.81%	Indirect
SNMU	691,431,125.58	232,915,369.11	33.68%	Indirect
OSAPHC	-	0	0%	Direct
Total	3,747,874,769.22	1,335,923,868.46	35.64%	Direct=0%, Indirect=35.64%
2019				
MoH	7,050,000,000.00	5,933,707,706.24	84%	Indirect
SHMB	74,150,000.00	0	0%	Direct
PHDA	5,100,000,000.00	0	0%	Direct
ACA	50,000,000.00	0	0%	Direct
SHTN	100,000,000.00	0	0%	Indirect
SNMU	530,000,000.00	228,100,000.00	43%	Indirect
OSAPHC	10,000,000.00	0	0%	Direct
Total	12,914,150,000.00	6,161,807,706.24	47.71%	Direct=0%, Indirect= 47.71%
2020				
MoH	25,238,687,701.44	17,549,100,599.04	69.53%	Indirect
SHMB	23,300,000.00	0	0%	Direct
PHDA	559,600,000.00	0	0%	Direct
ACA	112,000,000.00	0	0%	Direct
SHTN	48,000,000	0	0%	Indirect
SNMU	28,000,000.00	0	0%	Indirect
OSAPHC	0.00	0	0%	Direct
Total	**26,009,587,701.44**	**17,549,100,599.04**	69.53%	Direct=0%, Indirect=69.53%
2021				
MoH	13,435,636,800.00	12,420,686,578.31	92.44%	Indirect
SHMB	3,830,000.00	0	0%	direct
PHDA	136,950,000.00	0	0%	direct
ACA	77,000,000.00	0	0%	direct
SHTN	155,000,000.00	0	0%	Indirect
SNMU	143,000,000.00	0	0%	Indirect
OSAPHC	-	0	0%	direct
Total	13,951,416,800.00	12,420,686,578.31	89.02%	Direct=0%, Indirect= 89.02%

Source: Extracts from Ebonyi State Audited Financial Statement 2017- 2021

Table 2 Schedule of Yearly Direct and Indirect costs in Naira [N]

	2017	2018	2019	2020	2021
Direct Costs = RMNCAH+N	0	0	0	0	0
Specific Direct Costs for NPI, Malaria & COVID-19	0	800,000.00	11,350,000.00	296,773,813.00	0
Indirect Costs	569,660,791.87	1,335,923,868.46	6,161,807,706.24	17,549,100,599.04	12,420,686,578.31
TOTAL	569,660,791.87	1,336,723,868.46	6,173,157,706.24	17,845,874,412.04	12,420,686,578.31

Source: Computed from Ebonyi State Audited Financial Statements 2017-2021

Table 3 Schedule of Yearly Direct and Indirect Costs in Percentage

	2017	2018	2019	2020	2021
Actual Capital Costs Directly Related to RMNCAH+N (0%)	0%	0%	0%	0%	0%
Other Actual Direct Cost for NPI, Malaria &COVID 19(0.44%)	0%	0.06%	0.18%	2%	0%
Actual Capital Costs Not Related to RMNCAH+N (99.56%)	100	99.94	99.81	98	100

Source: Computed from Ebonyi State Audited Financial Statements 2017-2021

Result

Table 1 above shows the actual performance evaluation of RMNCAH+N of the core ministry, agencies, and offices of the state with the core mandate of improving reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH+N). In 2017, the evaluation result shows that only 10.53% of the MoH capital budget was released for implementation. Other critical health agencies for the improvement of RMNCAH+N like SHMB which oversees up to 13 general hospitals in the state received no capital funds in 2017. The PHDA supervises over 540 primary healthcare centers in the state did not also get any release. The same was the case of ACA and OSAPHC which are very critical in the realization of RMNCAH+N objectives. Only SNMU which is classified as indirect cost received 9.53% of their capital releases for the year 2017. The year's result shows a 0% direct cost and a 9.42% average indirect cost in 2017. In 2018, ACA was not budgeted for. Indirect cost centers represented by MOH SHTN and SNMU got their capital budgets released to the tune of 42.17% 12.81% and 33.68% respectively while direct cost centers like SHMB, PHDA, ACA, and OSAPHC all received 0% of their annual capital budgets as actual releases for the year. However, capital releases of MOH increased from 10.53% in 2017 to 42 17% in 2018. Also looking at the general health budget performance of the state which grew from 9.42% in 2017 to about 35.64% in 2018 shows that the government has made significant spending in the health sector. Table 2: Shows the summary of the budget performance direct costs and indirect costs of these critical health ministries, agencies, and offices from 2017 to 2021. SHMB, PHDA ACA OSAPHC are classified as critical agencies for the realization of RMNCAH+N at both the primary and secondary levels of health services in the state. However, these agencies received 0% of capital releases from (2017-2021) MOH received over 95% of all the released in the health sector.

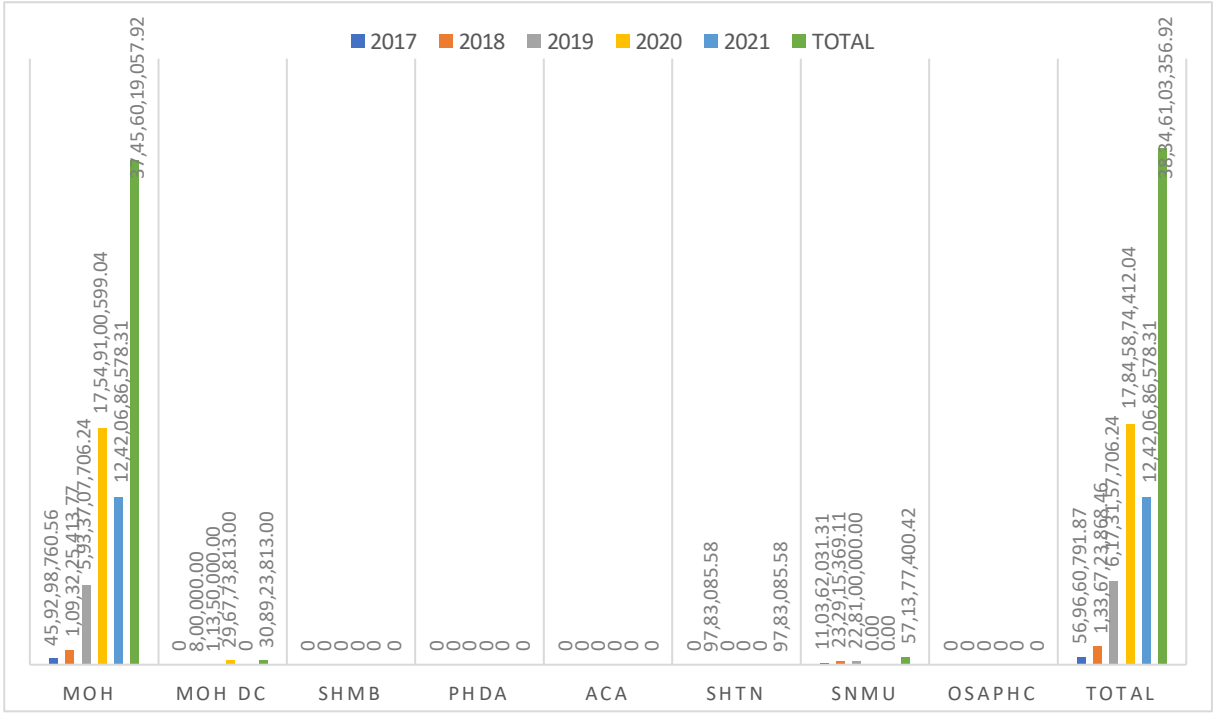
Table 3 shows that from 2017 to 2021; actual capital budgets directly related to RMNCAH + N received 0%. The agencies and cost units under this category include SHMB, PHDA ACA OSAPHC. But in 2018 other direct cost interventions for NPI malaria via MoH received the sum of N800,000.00, while cost centers not related to RMNCAH+N intervention received 100%, 99.94% in 2018, 99.94% 99.82% in 2019, 98% in 2020, and 100% in 2021. Other direct costs in the form of interventions through MoH in 2019 included N11,350,000.00 and N296,773,813.00 in 2020 specifically for COVID-19. These interventions caused a rise in other direct cost interventions to 0.06% in 2018, 0.18% in 2019, and 2% in 2020, This is the opposite of what the government budget is intended to achieve.

Discussion

Capital Budgets Releases and Impact on RMNCAH +N

An effective healthcare system is the pride of any society if the future must be secured. Therefore, exploring the effectiveness of different health financing methods may be needed going forward. It will not be good to follow a financing strategy that has not been effective over the years. A government budget is expected to drive every strategic health plan and reform (Dahiru et al. 2015). This was the idea of RMNCAH strategic plan 2030, but policy inconsistency, corruption, and lack of effective monitoring and evaluation among other vices make the government budget weak in driving its purpose**.** Table 1 above shows the actual performance evaluation of RMNCAH+N of the core ministry, agencies, and office of the state with the core mandate of improving primary healthcare (PH) and reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N) In 2017, the evaluation result shows that only 10.53% of MOH capital budget was released for implementation. Other critical health agencies for improvement of RMNCAH+N like SHMB which is in charge of over 13 general hospitals in the state received no capital fund in 2017. The PHDA supervises over 540 primary healthcare centers in the state. The same was the case of ACA and OSAPHC which are very critical in the realization of RMNCAH+N objectives. Only SNMU which is classified as indirect cost received 9.53% of their capital releases for the year 2017. The year's result shows a 0% direct cost and a 9.42% average indirect cost in 2017. In 2018, ACA was not budgeted for. Indirect cost centers represented by MOH SHTN and SNMU got their capital budgets released to the tune of 42.17% 12.81% and 33.68% respectively while direct cost centers like SHMB, PHDA, ACA, and OSAPHC all received 0% of their annual capital budgets as actual releases for the year. However, capital releases of MOH increased from 10.53% in 2017 to 42 17% in 2018. Also looking at the general health budget performance of the state which grew from 9.42% in 2017 to about 35.64% in 2018 shows that the government has made significant spending in the health sector. But facts on the ground in terms of worsening health conditions and indicators especially as it affects the realization of RMNCAH. Despite this significant increase in total health budget releases, releases to direct cost centers and units that affect RMNCAH+N improvement remained at 0% in 2017 and 0% in 2018 respectively. The government funding challenge here is obvious but may be managed in a better way that critical health budgets should be prioritized (Douglas et al. 2023). But also, that political will to spend a little in line with the prevailing health situation in the state is Key in addressing other challenges. In 2019 releases for MOH grew to 84% from 42.17% in 2018. In 2019 no only MOH and SNMU received 84% and 43.04% of their capital budgets which were all indirect costs as shown in Table 1. Still, critical agencies for RMNCAH+N received zero in terms of capital releases. 2020 and 2021 maintained the pattern of previous years through the total budget for health. Increased from 69.53% in 2020 to 89% in 2021. These budgets appear not to have been targeted towards the RMNCAH+N intervention nor primary healthcare services which is the core mandate of the MOH and other health agencies at the state level (Ikpor et al. 2019; Uzochukwu et al. 2015). MOH received 69.53% and 92.44% of its capital budget in 2020 and 2021 respectively. Critical government agencies like SHMB PHDA ACA and OSAPHC received 0% capital budgets for 2020 and 2

Figure 1 Actual Capital and special Fund Release Pattern and Amount in Naira to Ministry of Health and Agencies, 2017-2021



Source: Computed from Ebonyi State Audited Financial Statements 2017-2021

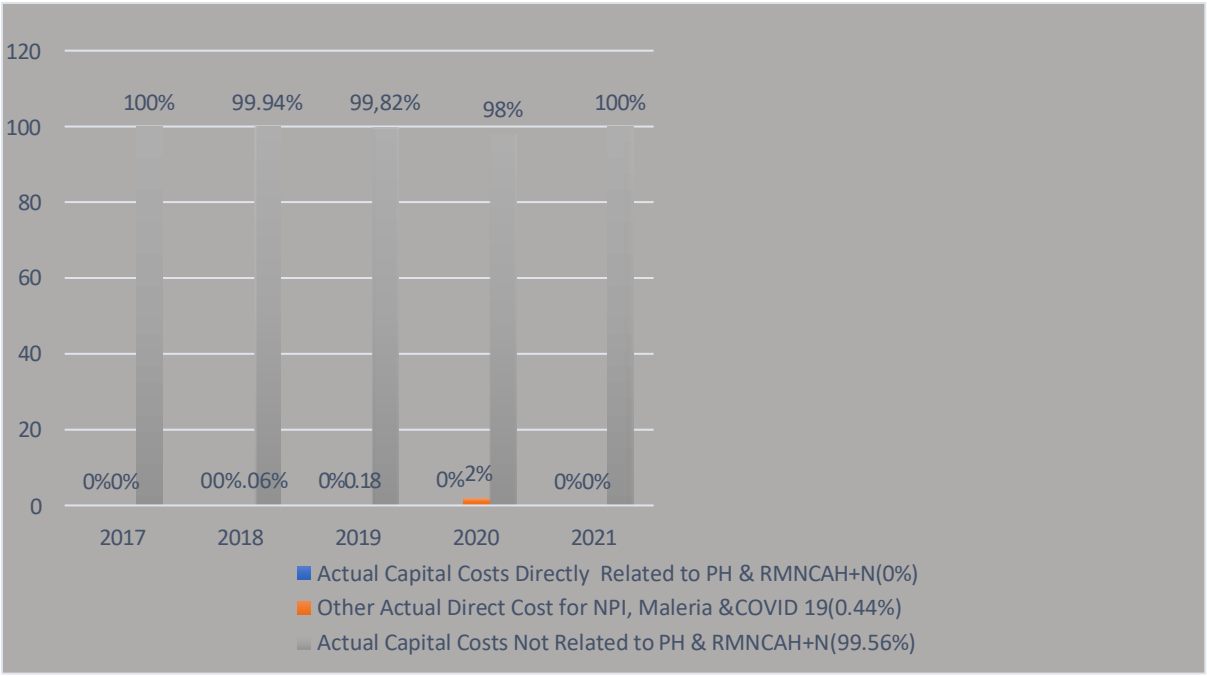
Budget Efficiency Releases: Direct and Indirect costs

Table 2: Shows the summary of the budget performance direct costs and indirect costs of these critical health ministries, agencies, and offices from 2017 to 2021. SHMB, PHDA ACA OSAPHC are classified as critical agencies for the realization of RMNCAH+N at both the primary and secondary levels of health services in the state. However, these agencies received 0% of capital releases from (2017-2021) MOH received over 95% of all the released in the health sector.

Yet there is no trace of direct investment in RMNCAH-related challenges within the period under review except few sums like N800,000.00, N11,350,000.00, and N296,773,813 released as NPI, malaria, and COVID-19 intervention funds in 2018,2019 and 2020 respectfully.
The State Ministry of Health is a ministry charged with the responsibility of developing and planning health policies and supervising their implementation. It provides health services to the people of the State through the services rendered at the health facilities. There are a lot of policies but these policies do not reflect in the budgets (Ambach et al. 2022). Budgeting of healthcare spending should be a multi-stakeholder approach. The conceptualization of health spending may be politically initiated but should be subjected to societal needs and perspectives via expert advice (Edward,2022; Ololo et al. 2023).
The responsibility of health experts and civil society organizations should not end in budget preparation, rather they should further seek to guide the release of budgeted funds more efficiently (Ogunkola et al. 2021; Onwujekwe et al. 2019). Government authorities should always pay attention to proper analysis of facilities and services at the primary healthcare level which is the closest to the people. (Ooms et al. 2023)

Interventions for RMNCAH +N-related programs and Budgets Performance.
Table 3 shows that from 2017 to 2021; actual capital budgets directly related to RMNCAH + N received 0%. The agencies and cost units under this category include SHMB, PHDA ACA OSAPHC. But in 2018 other direct cost interventions for NPI malaria via MoH received the sum of N800,000.00, while cost centers not related to RMNCAH+N intervention received 100%, 99.94% in 2018, 99.94% 99.82% in 2019, 98% in 2020, and 100% in 2021. Other direct costs in the form of interventions through MoH in 2019 included N11,350,000.00 and N296,773,813.00 in 2020 specifically for COVID-19. These interventions caused a rise in other direct cost interventions to 0.06% in 2018, 0.18% in 2019, and 2% in 2020. Government public expenditure should reflect government policy priority (Lateef et al. 2022). The infant mortality rate is the risk that a kid will die before reaching the age of one. According to the MICS 2021 report, the national infant mortality rate in 2021 was 63 per 1,000 live births. Sokoto state had the greatest infant mortality rate for weighted children at 104 per 1,000 live births, while Ebonyi state had the lowest at 3 per 1,000 live births. This progress made so far is a result of several intervention programmes by donor agencies and nongovernmental organizations (NGOs) Government especially in most instances does not make adequate provisions during budgeting (USAID, 2022). Government at every level should remove all known gaps impeding the smooth implementation of reproductive, maternal, newborn, child, and adolescent health policies (Guindo et al. 2012). Health data mapping and analysis should be incorporated into health decision-making; also, efficient allocation of scares resources to areas of urgent need should be encouraged (Jokovljevic et al. 2020). COVID-19 exposed the lack of preparedness of the Sub-Saharan and
Several other nations in addressing issues around antenatal and essential emergency healthcare services and other primary healthcare challenges (Sangar et al. 2019; Brent, 2023).

Figure 2. Graphic Representation of Percentages of Actual Capital Budgets of Ministry of Health and Other Health Agencies Releases to RMNCAH+N, Other Direct Activities and None RMNCAH+N Related Activities 2017-2021



Source: Computed from Ebonyi State Audited Financial Statements 2017-2021

Conclusion

The Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH +N) related Sustainable Development Goals (SDG) Targets for 2030 are not being met in many Low and Medium-Income Countries (LMICs), particularly those in sub-Saharan Africa. This is despite the unprecedented progress made in maternal, neonatal, and child health outcomes globally over the past ten years. RMNCAH + N health burden was shown to be significant, with unacceptable mortality and morbidity rates for mothers, newborns, kids, and teenagers.

Empirical evidence abounds that in some Low and Medium-Income Countries (LMICs), funds are primarily allocated through budgeting procedures, however, these funds are not made available in terms of releases to efficiently address the purpose for which funds were budgeted. In some other cases, resource allocation policies do not give adequate allocation commensurate with the level of financial attention needed to address reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH +N) related challenges (Doshmangie et al. 2022; Barasa et al. 2021). while the most vulnerable are left to bear the financial burden of treatments that appear to have been provided for in the budget (Guinness et al.; Menon et al. 2022; Nnachi et al. 2024; Nnachi et al. 2024; Bhatia et al. 2022; Ololo et al. 2023; Eneogu et al. 2021). Priority setting of health interventions needs a multi-sectorial and multi-criteria decision-making analysis (Joshua et al. 2021; Ikpor et al. 2023). This approach will ensure that the right decisions are taken including financial allocation. From Table 1, the percentage of the budget released in 2017 stood at 9.42%, in 2018 it moved to 35.64%, in 2019 it got to 47.71%, and continued to 69.53% in 2020 and finally jumped to 89.02% in 2021. On face value, it is so interesting to see the percentage of budget releases move up at that rate within 5 years- from 9.42% in 2017 to 89.02% in 2021. Notwithstanding this seeming outlook where it can be said the government appears to have been making practical efforts to release more funds to the health sector, the other side of the coin shows the opposite. For instance, the percentage of the health budget released within these years that relate to direct cost and overheads (releases relating to reproduction, maternal, newborn, child, and adolescent health) shows 0% in 2017, 0.96% in 2018, 0.18% in 2019, 2% in 2020 and 0% in 2021. The fractional percentage increase in 2019 and 2020 was related to emergency and outbreak-related releases including COVID-19 outbreak (Brent et al. 2023; Adelekan et al. 2021).

Ideally, budget allocation is traditionally a lead to budget implementation. But in recent time, especially in Nigeria, the opposite is the case. The gap appears wider at a careful look at the budgets at the sub-national level. The yearly

defense of appropriation bill at state level has become a ritual across many states of the federation. Ministries, statutory government agencies and departments appear to only spend personnel costs while other components of the budgets are largely unimplemented or highjacked politically to non-relevant areas. Non-governmental organizations, foreign partners, civil society organization and the general public should begin to hold government at all levels accountable, especially the elected leader through sensitization exercises, deliberate engagement on good governance strategies, community engagement programs in order to hold our leaders to account and also to avert imminent brake down of law and order by individuals who are entrusted with the resources of the states. The misalignment in government policies is key to discrepancy between the increasing total health budget percentages and the minimal allocation or release for RMNCAH+N. The Rhetorics of policies articulation without commensurate implementation strategies in Nigeria is becoming worrisome. The yearly rituals in budget preparation, budget defense, budget allocation and approval without a commensurate releases/implementation in most cases especially for primary healthcare activities are pointers to a deranged governance priorities which favors physical projects that are not directly impactful to health and livelihood of the people. We need to get our budget implementation right. It should center more on the peoples need and not what the political class want to achieve. lack of visionary leadership, political will, character and empathy in governance result to deranged expected outcomes in budget performance despite evidence of substantive financial appropriations in the budget. Ebonyi State appears to be one of the states mostly affected by high maternal mortality rate. This has remained high, the same with other primary healthcare related diseases.

The underlying causes of these funding gaps include lack of visionary leadership, lack political will, lack of character and empathy in governance. Political consideration in strategic appointment, tribalistic tendencies and mis-match of personnels in-charge of the healthcare delivery. These has deranged expected outcomes in budget performance despite evidence of substantive financial appropriations in the budget. Ebonyi State appears to be one of the states mostly affected by high maternal mortality rate. This has remained high, the same with other primary Healthcare related diseases. The low release of fund significantly impacts negatively on the delivery and the outcome at the primary healthcare level. Health service expectations are not met, especially at the primary healthcare level. Ebonyi State appears to be one of the states mostly affected by high maternal mortality rate. Infant mortality rate. The same with other primary Healthcare related diseases, despite the political noise about budget approvals. To improve budget performance, the following considerations must be of a great interest to all stakeholders: -

-Citizenship engagement in primary Healthcare budget design, in the state.

-Citizenship engagement in primary healthcare budget monitoring and implementation.

-Bottom top feedback strategies

- Stakeholders including and professional bodies in state's budget cycle.

There is urgent need for government of Nigeria especially at the sub-national levels to begin to fund RMNCAH+ N related programs and to also make deliberate effort in broadening RMNCAH+ N budget policies, frameworks and procedures towards multi-stakeholders' participation, especially in budget financing, monitoring and in developing yearly evaluation template for the attainment of the RMNCAH + N goal in 2030.

Abbreviations of Key Agencies and Programs

USAID =United States Agency for International Development
MOH = Ministry of Health
SHMB =State Hospital Management Board.
PHODA = Primary Healthcare Development Agency
ACA =Agency for the Control of Aids.
SHTN =School of Health Ngbo
SNMU =School of Nursing and Midwifery Uburu
OSAPHC = Office of the Special Assistant for Primary Healthcare
TDC =Total Direct Cost
TR = Total Releases
RMNCAH+ N = Reproductive, Maternal, Newborn, Child, Adolescent Health plus Nutrition
DHIS = District Health Information Software (DH1S)

ASRH =Adolescent Sexual and Reproductive Health (ASRH)

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Competing interests

The authors declare that they have no competing interests in the study

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