



## Assessment of Kaduna State Primary Health Care Board Financial Management Capacity on Primary Health Care Service Delivery in Kaduna State, Nigeria

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**Abstract.** The establishment of the Kaduna State Primary Healthcare Board was passed into law in 2015 to tackle fragmentation in primary healthcare and ensure preventive healthcare services are accessible and affordable to all. The institutional capacity of the SPHCB is aimed at tackling several issues, including poor release of funding, poor infrastructural services, inadequate health personnel capacity, poor supply of essential drugs and other commodities, poor referral system, poor monitoring, and supervision affecting the PHCs across the state. The paper specifically assesses the financial management capacity of the SPHCB in ensuring the funding of PHC services across the health centres. Both primary and secondary data were used and analysed using descriptive and inferential statistical tools. Linear regression analysis was used in testing the hypothesis postulated. It was revealed that the financial capacity has improved the funding for routine immunisation and family planning programmes at the PHCs in the LGAs. A timelier release of funds is necessary to ensure efficiency and transparency in PHC service delivery.

**Keywords:** Financial management, PHC, service delivery, funding.

### 1. Introduction

Every nation around the globe recognises that a healthy nation translates into a wealthy nation. As such, measures have been taken locally, nationally, and internationally to cater to the vulnerable and prevent and manage diseases and illnesses worldwide.

Nigeria, the most populous country in Africa, has a population of 206 million and 107 million children. The country has one of the world's highest maternal and neonatal mortality rates, with over 40,000 maternal deaths occurring yearly. 1 in every 22 women stands the lifetime risk of dying in pregnancy and childbirth, which is higher than anywhere else in Africa or the world. Despite Nigeria's level of economic development, it has fallen short in saving the lives of women and newborns from preventable deaths during pregnancy and delivery (FMOH, 2018). Disparities in survival rates exist according to children's geographical location and socioeconomic characteristics. The under-5 mortality rate is highest in Kebbi in the Northwest (252 deaths per 1,000 live births) and lowest in Ogun in the Southwest (30 deaths per 1,000). About 32% of children under age five in Nigeria are stunted or too short for their age. Seven per cent are wasted (too thin for height). The 2018 National Demographic Health Survey recorded a maternal mortality ratio of 512 deaths per 100,000 live births, and this means that approximately 5 out of 1,000 women die during pregnancy, childbirth, or within 42 days after childbirth from causes related to or made worse by childbirth. The report also estimated an infant mortality rate of 67 deaths per 1,000 live births, a neonatal mortality rate of 39 deaths per 1,000 live births, and an under-5 mortality rate of 132 deaths per 1,000 live births. To put this into context, this translates into more than 1 in 8 children in Nigeria dying before their 5th birthday. Rural children have higher levels of stunting at 45%, wasting at 8%, and underweight at 28%, compared to urban children at 27%, 5% and 15%, respectively (UNICEF, 2020).

As such, section 17 of the 1999 Constitution of the Federal Republic of Nigeria (as amended) obligates the government to direct its policies to ensure adequate medical and health facilities for all persons, ensure that the health, safety, and welfare of all persons in employment are not endangered or abused. In 2016, the Federal government passed the National Health Bill into law, which seeks to promote accessible, affordable, available, and qualitative access to healthcare services at all levels in Nigeria. Health is on the concurrent legislative list; by implication, the three tiers of government are vested with the responsibility to promote health in the country. According to the Constitution, federal, state, and local governments shall support in a coordinated manner a three-tier of health care: Primary Health Care (PHC) for local governments, Secondary health care for State governments, and Tertiary health care for Federal government. However, this has never been fully operationalised, and tertiary hospitals in Nigeria still manage a large patient load of cases that can easily be managed in primary healthcare centres. Referral pathways are generally underdeveloped (Nigeria Health Watch/CODE 2020).

The states perform the function of providing secondary health care services. The State Ministry of Health is charged with providing PHC support (planning, training, programming, financial and operational support) and other responsibilities in the national health policy. The Federal Ministry of Health, however, acted as a consultant to strengthen the capacity of the state to perform efficiently and effectively and to be reorganised along the lines of maximum efficiency for PHC. (NPHCDA 2012).

The power to provide preventive, curative, and quick health care services is vested in the Local Government through its primary health care centres. This is in line with the Alma Ata declaration in 1978, where representatives of 134 nations declared that PHC is the key to attaining health for all by the year 2000 and that it should be adopted by all member states of the WHO (WHO, 2000). The goal of the National Health Policy is to bring about a comprehensive health care system based on primary health care that is promotive, protective, preventive, restorative, and rehabilitative to all citizens within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living.

The National Primary Health Care Development Agency was established to provide leadership that supports the promotion and implementation of high-quality, sustainable primary health care for all. It is mandated to provide technical and programmatic

support to states and LGAs on developing PHC in Nigeria. In addition to this, partnership and development of community-based systems and functional infrastructure, as well as ensuring that infants are fully immunised against vaccine-preventable diseases before attaining the age of twelve months, are included. To tackle the problem of fragmentation of Primary healthcare services and ensure better articulation of programs, the State Primary Health Development Agency comes up with a series of policies and initiatives to ensure equitable primary healthcare services at the grassroots level.

The Kaduna State Primary Health Care Board was established in 2010 to improve the development of primary health care and primary healthcare facilities (Integrating Primary Health Care Governance in Nigeria 2013). The State agency is given the power to review the existing health policies, particularly regarding their relevance in the development of primary health care, and to ensure effective community involvement and participation in all primary health care activities from inception to implementation stage (NPHCDA 2012). In 2015, the law establishing the agency was reviewed to capture the 2011 PHC Under One Roof (PHCUOR) policy. This policy was formulated as part of the strategy aimed at reducing the problem of fragmentation in the delivery of Primary Health Care (PHC) services by integrating all PHC services under one authority.

The Kaduna State Government has implemented strategies and measures to strengthen and reposition the SPHCB to enhance PHC service delivery in the state. Part of these measures is boosting the financial capacity of the SPHCB by opening a dedicated account for the SPHCB with all the signatories drawn from the SPHCB management team. Also, the State Government Approved Budget for the PHCDB in 2016 stood at N3.687 billion or 28% of the total health budget allocation. In 2017, it was increased to 12.049 billion or 50.5% 2017 to further strengthen the board in overseeing primary health care service delivery. There was a decline in 2018 to N9.645 billion or 27.7% and a further decline to N8,418 billion or 34.2% in 2019 of the total health budget. 2020 saw an increase to N11,707 billion (DRPC, 2021). On average, the percentage of the PHCDB budget to the total health budget in Kaduna state in five years stood at 33.9%. The budget also captures significant amounts allocated to supply essential MCH drugs, immunisation, and other medicines. The percentage was scaled up to 70% against 60% in 2015. The allocation to immunisation to tackle childhood vaccine-preventable diseases such as poliomyelitis, tuberculosis, measles, diphtheria,

pertussis, tetanus, yellow fever, and hepatitis B, was also scaled to an average of 78.8% on an average between 2016- 2019. Cold chains for immunisation exercises were also made functional in the PHCs across the state This shows a steady commitment on the part of the state government to strengthen and reposition the PHCs in the state in the drive for health for all.

Taking into cognisance the poor PHC service delivery in the state, with only 28% of deliveries being supervised by skilled health professionals and only three PHCs operating 24-hour service in the state, this is an essential emergency obstetric care based on the criteria of the agency (Alabi, 2019), this paper seeks to assess the impact of the state PHCB institutional capacity on primary health care service delivery. Specifically, the study examines the SPHCB Financial management capacity and determines its effect on PHC service delivery in the State.

This paper is divided into six sections, excluding the introductory section for analytical progression. The first section provides conceptual reviews, empirical reviews, and theoretical frameworks, and the second section discusses the institutional capacity of the SPHCB and its financial management capacity. The third section discusses the impact of the SPHCB Institutional financial management capacity on PHC service delivery in Kaduna State. The fourth section is the research methodology, while the fifth section provides data analysis and discussion of findings. The last section is the conclusion and recommendations.

## **2. Conceptual Review, Empirical Review and Theoretical Framework**

### **2.1 Primary Health Care**

In the words of Alma Ata (1978), the concept of PHC is cited in Lucas (2006) is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the preventive and curative healthcare services provided at the grassroots level to ensure accessibility to affordable healthcare.

#### **2.1.1 Components of PHC**

There are ten components of the Primary health care. They are as follows:

- i) Health education concerning prevailing health problems. This is an integral part of Primary Health Care. It is an umbrella term used to reorientate health workers' minds towards appreciating the complex nature of health education (Akinsola, 2006). Health promotion comprises efforts to enhance positive health and prevent ill health through health education, prevention, and protection (Downie et al., 1994).
- ii) Promotion of Food supply and Proper Nutrition. In most developing African countries, undernutrition is one of the major factors contributing to infant mortality and morbidity.
- iii) Adequate supply of safe water and basic sanitation
- iv) Maternal and Child Health, including family planning.
- v) Immunization against the major infectious diseases
- vi. Prevention and control of locally endemic diseases;
- vii. Appropriate treatment of common diseases and inquiries;
- viii. Provision of essential drugs;
- ix. Oral health
- x. Mental Health. (NPHCDA 2012)

### **2.2 Financial Management**

Financial management is the process of ensuring optimal procurement, allocation and control of financial resources. It encompasses regular and appropriate provision of funds in the actualization of stipulated goals and objectives. In this regard, it is the process of advocating and mobilising funds to address issues in PHC service delivery.

### **2.3 Empirical Review**

The Financial capacity of the SPHCB in Primary health care is critical in providing PHC services across the state. Riman and Akpan (2012) analysed the linkage between health financing and health outcomes in Nigeria. The study reveals that the infant mortality rate corresponds to high out-of-pocket expenditure and inequitable income distribution. The study further shows that health facilities are concentrated in urban areas to the detriment of rural areas. This implies that financing primary health is crucial in tackling infant mortality and improving the health status of the people, and this study will go further and examine the financial capacity of the coordinating body for PHC service delivery to examine its financial capacity in meeting the 2001 Abuja declaration and overall PHC service delivery.

Anton & Onofrei (2012) argued that a major characteristic of the health sector in less-developed economies is the inadequacy of finance. This is largely due to the poor state of the economy that has caused several governments to adjust the number of resources that go into the health sector. Similarly, Salako (1991), cited in Oyekale (2017), noted that poor funding of the health sector and the purchase of less important expensive drugs has affected healthcare service delivery and availability of drugs at the PHC facilities.

Onisanwa et al. (2018) revealed that government spending on health is a key factor influencing health status in Nigeria. Based on the obtained coefficients, increased government expenditure on health reduced infant mortality. Hence, there is a need for the government to place emphasis on the long-term linkage of health spending and health outcomes by formulating policy and allocating scarce resources to the health sector, thereby resulting in improvement in the quality of health. This will be specific in its assessment of health financing by focusing on the SPHCB in Kaduna by examining its financial capacity in PHC service delivery in Kaduna state.

#### 2.4 Theoretical Framework

Edward Suchman (1967) is often referred to as the founder of the Evaluation Theory. Others include Greenberg (1968), Carol Weiss (1972), Thomas Cook (1978), Peter Rossi (1979) and Lee Cronbach (1980). The justification for this theory is hinged on the fact that the study is an assessment of the institutional capacity of the SPHCB on PHC Service delivery; as such, evaluation theories are considered appropriate. It assists in providing an analytical framework for the analysis of the study.

The idea of Evaluation Theory was first used by Edward Suchman in Colombia to evaluate public health programs in the 1960s. Suchman considered that evaluation must be approached with the logic of the scientific method. He recognizes the role of judgment in evaluation, nothing that values and assumptions affect the formulation of goals. Evaluation is the procedure by which programs are studied to ascertain their effectiveness in fulfilling goals (Greenberg, 1968). It is the systematic, data-based inquiry to determine the merit or worth of a program, product, organization, intervention, or change effort. In essence, therefore, the theory is concerned with the performance evaluation of public institutions or programs. Hatry (2002; 352) asserts that “it is certainly desirable that institutions at any level of government periodically undertake a

comprehensive review of what they are doing and how they are doing it.”

However, Suchman’s Evaluation Theory consists of five performance criteria for assessing organizations or programs. First is the effort, which relates to the quantity and quality of activity, the input/energy, and the attention given with more emphasis on the output. Second is the performance, which deals with effect criteria that measure effort results. Third is the adequacy of performance, which concerns with degree to which performance is adequate to the total amount of need. The fourth is efficiency, which examines the alternative paths or methods in terms of human and monetary costs, and the last criterion is the process, which deals with how and why an organization or a program works or does not work.

The processes, according to Suchman, start with the ‘value formation,’ which he sees as any aspect of a situation, event, or object that is invested with a preferential interest of being good, bad, desirable, or undesirable. The next stage is goal setting, followed by measuring attainment and proper planning stage. The last stage is evaluation; this is where assessment is made to see if the objectives have been achieved.

In relation to this study, the establishment of the SPHCB by the government is the ‘value formation’ because it will go a long way in improving primary health care delivery at the grassroots level, ensuring efficiency and proper coordination of service delivery to tackle alarming rates of maternal and child mortality in the country. The goal-setting in this study is the functions of SPHCB, which covers the area of funding, providing leadership, promoting and supporting the implementation of quality and sustainable PHC service delivery through advocacy and resource mobilisation, partnership, capacity building, and collaboration with relevant stakeholders, and proper community engagement. In measuring attainment, there is a need for proper articulation of functions of the SPHCB through its facilities, both human and material. Participation and involvement of local communities are paramount, and this paves the way for the proper planning stage.

The last stage is the evaluation; this is where assessment is made to see if the objectives and functions of the SPHCB have been achieved. Hence, the relevance of the efforts and initiatives of SPHCB gives room for combating mortality rates, particularly in the rural areas, absence of well-trained health officers, and systematic coordination of Primary health care services.

### 3. SPHCB Institutional Capacity

The State Primary Health Care Board (SPHCB) is responsible for organising, providing, and managing the Primary Health Care System in Kaduna State. The Board delivers its mandate through 3 Zonal Offices, 23 Local Government Health Authority Offices, and 1,068 Primary Health Care Facilities. The institutional capacities of the SPHCB are cut across funding/financial management, infrastructural development, human resource management, and managerial and community participation, amongst others.

#### 3.1 Financial Management Capacity

In 2011, the PHC Under One Roof (PHCUOR) policy was formulated as part of the strategy to reduce fragmentation in the delivery of Primary Health Care (PHC) services, which involves integrating all PHC services under one authority. With the PHCUOR, it is believed that various issues, such as the poor release of funding, inadequate medical personnel, poor referral system, poor monitoring, etc., will be addressed across the state. Kaduna State has consistently met the 15% allocation benchmark recommended by the 2001 Abuja Declaration on Health over the last five years. The SPHCB ensures that resources are adequately mobilized to enhance PHC service delivery. The funding of the capital and recurrent expenditures is captured in the SPHCB budget.

#### 4. Impact of SPHCB Financial Management Institutional Capacity on Primary Health Care Service Delivery in Kaduna State

Financial capacity for primary healthcare in Nigeria has been a topic of concern, and ongoing efforts to improve access and quality of care. Primary healthcare is considered the first point of contact for individuals seeking healthcare services, and it plays a vital role in promoting health, preventing diseases, and providing basic medical treatment. Funding healthcare involves a huge financial outlay for developing countries in an attempt to operate a sustainable health financing system to the benefit of all stakeholders. The state of health outcomes is a function of the nature of healthcare financing and the behaviour of individuals.

In Nigeria, primary healthcare is primarily funded through various sources, including government allocations, health insurance, donor funding, and out-of-pocket payments by individuals. (Olakunde, 2012). According to Oyefabi, Aliyu, and Idris

(2014), healthcare financing mobilises funds for healthcare services. That is, it is the provision of resources in terms of money or funds to various activities, such as medical and related services, by the government to maintain people's health. Alenoghena, 2014 revealed in a study to examine the management of the Primary Health Care Services in Nigeria using both primary and secondary data that the primary health care program was grossly underfunded and has manifested in the low performance of the PHC facilities. Similarly, low coverage and poor utilization of maternal health care services have been attributed to inadequate funding of PHC services. This is because the pattern of financing health is, therefore, closely connected to health service delivery (Riman & Akpan, 2012). Healthcare financing does not only involve raising sufficient resources to finance healthcare needs. It also entails affordability and accessibility of healthcare services, equity in access to medical services as well and guarantees financial risk protection (Usman & Agboola, 2019).

### 5. Research Methodology

The study adopted both qualitative and quantitative research methods; hence it is mixed-method research. Primary data was sourced using questionnaires while secondary sources were sourced using documented research, journal publications, academic papers, newspapers, and internet sources.

#### 5.1 Study Area

Kaduna state covers a land area of 46,053 square kilometres with an average density of about 75 persons per square kilometre. The state shares boundaries with Niger state to the west, Zamfara, Katsina, and Kano to the north, Bauchi, and Plateau States to the east and FCT Abuja and Nassarawa states to the south. Kaduna state provides the meeting point of the earliest histories of Nigeria. According to the 2021 population projection, Kaduna state has a total population of 9.4 million, accounting for 4.3% of Nigeria's total population. Females constitute 4,401,430 of the population while males are 4,499,521. The state is divided politically into three senatorial districts, Kaduna North, Kaduna Central and Kaduna South. The state has 23 local government areas. Inhabitants are mostly Christians and Muslims belonging to different ethnicities. Agriculture and other associated activities constitute the mainstay of the economy of the state

#### 5.2 Population and Sample size

The total population of the study comprise of the staff of KSPHCB, staff and beneficiaries of primary health

care services at the PHCs in (Kaduna North, Kajuru, Zaria, Kudan, Kachia and Kagarko local government areas). Krejcie and Morgan’s formula was used to determine the sample size 384.

A total of 384 questionnaires were distributed and 332 returned duly filled, representing 87% of the entire questionnaires distributed.

**6. Data Analysis and Discussion of Findings**

Data obtained from the questionnaire were analysed in line with the research objectives and research hypothesis formulated for this study. Statistical Packages for Social Science (SPSS) was used to analyse and interpret the responses. Test of

hypothesis test was conducted using the responses provided in simple percentages as contained in the questionnaire item.

The decision rule for the hypothesis test: Accept the null hypothesis when the probability value exceeds the alpha value. If otherwise, we reject it.

H0: There is no significant relationship between SPHCB Financial capacity and PHC service delivery in selected local government areas.

H1: There is a significant relationship between SPHCB Financial capacity and PHC service delivery in selected local government areas.

**7. Discussion of Findings**

Table 1

S/N	SPHCB Financial Management Capacity and PHC service delivery in selected local government areas in Kaduna State.	SD	D	U	A	SA	Total
1.	Funds are made available to manage PHC service delivery?	13 (4%)	20 (6%)	4 (1.2%)	107 (32.2%)	188 (56.6%)	332 (100%)
2.	Funds are made available to carry out immunization programs in the state.	20 (6%)	4 (1.2%)	10 (3%)	186 (56%)	112 (33.8%)	332 (100%)
3.	Vaccines and Drugs necessary for Immunization are provided by the SPHCB	3 (1%)	48 (14.5%)	-	180 (54.2%)	101 (30.3%)	332 (100%)
4.	Family Planning Programs provided have improved due to funds availability	12 (3.6%)	40 (12%)	3 (1%)	130 (39.1%)	147 (44.3%)	332 (100%)
5.	Funds budgeted for are released and expended	74 (22.2%)	46 (14%)	15 (4.5%)	70 (21.1%)	127 (38.2%)	332 (100%)

Source: Researcher’s computation using SPSS Version 21

Table 1 shows the descriptive analysis of the respondents in the research on the impact of SPHCB Financial management capacity on PHC service delivery in Kaduna State. Majority of the respondents agree that funds are made available to fund PHC service delivery in the state. A closer look at the Kaduna health budget and KSPHCB budget further affirms the opinion of the majority of the respondents.

Table 2: Kaduna Total Health Budget vs KSPHCB total Budget

Year	Total health budget (billions)	Total PHCDB budget (billions)	% of PHCDB budget to health budget	Total health Capital budget (in billions)	Total PHCDB Capital budget (in billions)	Total health recurrent (in billions)	Total PHCDB recurrent
2016	13,132	3,687	28	6,661	3,498	6,471	189,582,505
2017	23,856	12,049	50.5	10,490	5,569	13,366	6,480,083,209
2018	34,696	9,645	27.7	17,576	2,600	17,119	7,045,191,210
2019	24,547	8,418	34.2	11,435	4,721	13,112	3,699,352,041
2020	35,788	11,707	29	NA	7,992	NA	3,715,851,234
2021	39,430	11,388	29	NA	NA	NA	NA

Source: DRPC and SPHCB Appropriation laws 2016-2021

Drawing from the table above, the state has consistently allocated above the 15% threshold agreed upon at the 2001 Abuja declaration on PHC, with an average percentage of funds allocated to PHCDB over the years standing at 35%. Hence, the average PHCDB allocation between 2016 and 2019 stood at N8,450 billion, its average capital expenditure for the same period was 4,097 billion (40.3%), and its recurrent was 4,353 billion (30.1%). This shows that the majority of the budget was allocated to capital expenditure covering renovation and purchase of medical equipment for the 255 PHCs in the State. The PHC board is committed to enhancing primary health care service delivery in Kaduna state.

In addition to the forgone, about 3.8 million children have been immunised in Kaduna State against poliomyelitis. This was done with the United Nations Children’s Fund (UNICEF) and other development stakeholders. In 2019, over 5.8 million children were targeted for immunisation in the state, and about 5.3 million were immunised.

**Table 3: Routine Immunization Budget Estimates (in Millions of Naira)**

Year	Counterpart Funding Under the SPHCB Capital Budget	Amount	Other RI allocations Under the Recurrent SPHCB Budget	Amount
2016	State Counterpart Fund on Routine Immunisation RI and System Strengthening	255	Nil	-
2017	State Counterpart Fund on Routine Immunisation RI and System Strengthening	285	Nil	-
2018	Provision of Counterpart Funding	720	Immunization Plus Days RI & System Strengthening	41
2019	Provision of Counterpart Funding	550	Immunization Plus Days RI & System Strengthening	26
2020	Provision of Counterpart Funding	1,946	Immunization Plus Days RI & System Strengthening	10
2021	Provision of Counterpart Funding.	817	RI & System Strengthening	Nil

*Source: Approved 2018, 2019, 2020, 2021 Kaduna State Budgets and SPHCB, 2022.*

From the table above, counterpart funding accounts for the majority of the budget estimates for routine immunization in the state. A steep decline was, however, recorded in 2021. Similarly, a gradual increase in the RI budget estimates, as captured in the SPHCB capital budget, is seen. A decline was recorded in 2019 and 2021, respectively. There was, however, an allocation of N41 million and N26 million under recurrent expenditure for Immunization Plus Days in 2018 and 2019. This confirms budget allocation to immunisation under the SPHCB budget to be significant. However, there is a need for a timelier release of funds to enhance the immunisation exercise and the financial management capacity of the SPHCB.

The table below shows the routine immunisation budget allocation 2022 under the Kaduna state budget.

**Table 4: Routine Immunization Budget Estimates 2022**

Budget line	Amount allocated
Immunization plus day	1,905,025.00
Routine Immunization and system strengthening	3,459,192.00
Total	5,364,217
RI % to SPHCB Budget	0.04
RI % to total health budget	0.01

*Source: DRPC 2022 and Kaduna State Budget 2022.*

The table above shows that routine immunisation has less than 1% of the total health budget for the state and 0.04% of the SPHCB budget. The immunisation plus day, which allows vaccinators to go from house to house to conduct vaccination on eligible children who may not have been exposed to the vaccine at the routine immunisation level, is quite minimal.

The board has two dedicated budget lines for routine immunisation in the state, the Immunisation plus Day and Routine Immunisation and System Strengthening. Mechanisms have been deployed to ensure immunisation is conducted in all PHCs weekly. Though the allocation is less than 1% of the entire budget of the board, nonetheless, immunisation against childhood killer diseases remains critical in the realisation of the board’s mandate

Secondary data generated from appropriation laws of the state between 2016 and 2019 reveal that poor release of funds leads to large variances between appropriation and releases, translating to a low percentage budget execution rate. The table below shows the SPHCB approved and released capital and recurrent budget allocation.

**Table 5** Total KSPHCB Approved and Released Budget Allocation 2016-2019

Year	Approved budget	Actual release	utilized sum	% approved sum released	% approved sum utilized
2016	3,687,892,321	2,588,085,413	2,588,085,413	70	70
2017	12,049,352,021	4,419,268,834	4,419,268,834	36	36
2018	9,645,462,412	5,657,492,336	5,657,492,336	59	59
2019	8,418,707,913	6,257,413,107	6,257,413,107	74	74

*Source: Author Compilation from Kaduna Appropriation Laws, 2016-2019*

From the table, 2017 records the lowest percentage release in the approved budget. 36% of the entire approved budget was released for PHC services. 2018 recorded a 59% approved sum release, and 2019 recorded a 74% approved sum release. The actual released amount is in synchronization with the utilized sum. The need to encourage regular stakeholder meetings to review and monitor the financial commitment of the state government and the SPHCB, in particular to PHC service delivery, is critical in ensuring optimal budget performance.

**Test of Hypothesis**

H0: There is no significant relationship between SPHCB Financial capacity and PHC service delivery in selected local government areas.

Table 6: Linear Regression Result (Model Summary) between SPHCB Financial capacity and PHC service delivery across programs

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.	Durbin-Watson
1	.793 <sup>a</sup>	.630	.629	.62439	649.298	.000 <sup>b</sup>	.188

Predictors: (Constant), SPHCB Financial capacity (Independent Variable)

Dependent Variable: PHC Service delivery (Dependent Variable)

*Source: SPSS Version 20.0 output.*

Table 7 above showed that the SPHCB Financial Capacity has accounted for about 62.9% (adj. r = 0.635) of the PHC service delivery. The implication is that other factors outside the model can explain the remaining 38.1% of the PHC Service delivery. It also shows a strong relationship between the SPHCB Financial capacity and PHC Service delivery ( $r^2 = 0.629$ ). The F = 649.298, indicating the model's fitness, while the Durbin-Watson statistics is 0.188, indicating the absence of serial auto-correlation and fitness of the model.

**Table 7:** Linear Regression Result (Coefficients<sup>a</sup>) between SPHCB Financial capacity and PHC service delivery

Model	Unstandardised Coefficients		Standardised Coefficients	t	Sig.	95.0% Confidence Interval for B		
	B	Std. Error	Beta			Lower Bound	Upper Bound	
1								
	(Constant)	.091	.129		.702	.000	1.669	2.118
	SPHCB Financial capacity (Independent Variable)	.825	.030	.785	25.769	.000	.642	.769

Dependent Variable: PHC service delivery (Dependent Variable)

Independent Variable: SPHCB Financial capacity (Independent Variable)

The table above shows the overall result of the tested hypothesis. The model contributes about 62.9% of SPHCB's Financial capacity to PHC service delivery. The hypothesis, which states that There is no significant relationship between SPHCB Financial capacity and PHC service delivery in selected local government areas, is significant at a 1% level (P = 0.000) with a positive relationship (Beta = 0.785), which shows that the P value is less than the level of significant. The study, therefore, rejected the null hypotheses and concluded that there is a significant

relationship between SPHCB financial capacity and PHC service delivery in selected local government areas in Kaduna State.

This further proved a significant relationship between `SPHCB financial capacity` as the independent variable and `PHC service delivery` as the dependent variable. This means that funds budgeted and allocated to PHC programs such as routine immunisation, essential medicines, reconstruction, and renovation by the SPHCB have strengthened

routine immunisation, increased the number of immunised children in Kaduna state, and ensured the availability of drugs and vaccines in the PHC centres, and by extension improved PHC service delivery in selected Local Government Areas.

### 8. Conclusion and Recommendation

The study revealed that the financial capacity of the SPHCB in funding PHC programs is above the 15% threshold agreed upon in 2001 at the Abuja declaration. This aligns with the submission by Alonge (2020) and Oyekale (2017) that funding PHC is critical for health system strengthening and achieving sustainable development goals. Similarly, funds appropriated are sometimes not released accordingly. There is a delay in the release of funds, which sometimes affects PHC service delivery. In addition to this, there are differences in the actual amount budgeted for and the actual amount released for PHC service delivery. Data from qualitative and quantitative analysis agreed with the above finding. This aligns with the components of evaluation theory, which states that there is a need for goal setting, which captures the need for adequacy in funding for efficiency and effective performance as demonstrated in the theoretical framework. As found out by Uzochukwu (2015), there is a need for transparency and accountability in financial management to enhance PHC service delivery.

### Recommendations

- The funding of PHC Programs in the state already above the 15% Abuja 2001 declaration be applauded. Strict policy statements should be made to ensure continuity.
- The paper recommends a timelier release of funds to ensure budget execution and operational efficiency.

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