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Human Capital Public Expenditure and Institutional Review

An analysis of financing and governace constraints for the delievry of basic education and primary health care in Nigeria

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List of Acronyms

ARI	acute respiratory infection
ANAR	adjusted primary school net attendance rate
ANC	ante natal care
ASER	Annual Status of Education Report
ASC	Annual School Census
BECE	Basic Education Certificate Examination
BESDA	Better Education Service Delivery for All
BPHCF	Basic Primary Health Care Fund
BIR	Budget Implementation Report
CRF	Consolidated Revenue Fund
CSO	Civil Society Organization
DEA	data envelopment analysis
DFF	direct facility finance
DHIS	District Health Information System
DHS	Demographics and Health Survey
DP	development partners
DQA	data quality assurance
ECD	Early childhood development
EMIS	Education Management Information System
ESSPIN	Education Sector Support Program in Nigeria
FCT	Federal Capital Territory
FEC	Federal Executive Council
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
GDP	gross domestic product
GMS	grant management system
HCI	Human Capital Index
HH	household
HLO	Harmonized Learning Outcomes
HMIS	Health Management Information System
HOPE	Human Capital Opportunities for Prosperity and Equity
HRH	human resources for health
IGR	internally generated revenue
IPT	intermittent preventive treatment
ITN	insecticide-treated net
JSS	junior secondary school
LGA	local government area
LGC	local government council
LGEA	local government education authority
LGHA	local government health authority
MDA	ministries, departments, and authorities
MICS	Multiple Indicator Cluster Survey
MLA	Monitoring Learning Achievement
MoC	Ministry of Commerce
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	memorandum of understanding
NALABE	National Assessment on Learning Achievement in Basic Education
NASS	National Assembly of Nigeria
NBS	National Bureau of Statistics
NCDC	Nigeria Center for Disease Control
NCE	National Certificate of Education
NDHS	Nigeria Demographic & Health Survey
NEC	National Economic Council
NEDS	Nigeria Education Data Survey
NEMIS	National EMIS
NEMTC	National Emergency Medical Treatment Committee
NGF	Nigeria Governors' Forum
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NICS	National Immunization Coverage Survey
NLA	National Learning Assessment
NLSS	National Living Standards Survey
NPA	National Personnel Audit
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NYSC	National Youth Service Corps
OOS	out-of-school
OOSC	out-of-school children
ORS	oral rehydration solution
PHC	primary health care
PPP	purchasing power parity
PTR	pupil-teacher ratio
RISE	Research on Improving Systems of Education
RMNCH	Reproductive, maternal, newborn, and child health
SBA	skilled birth attendance
SDI	Service Delivery Indicators

SHIA	State Health Insurance Agency
SHIS	State Health Insurance Schemes
SIF	Special Intervention Fund
SMoE	state ministries of education
SMoH	state ministries of health
SPC	students per classroom
SPHCB	State Primary Health Care Boards
SPHCDB	State Primary Health Care Development Board
SUBEBs	State Universal Basic Education Boards
TIMSS	Trends in International Mathematics & Science Study
TFR	total fertility rate
TESCOM	Teaching Service Commission
U5MR	under-5 mortality rate
UBE	Universal Basic Education
UBE Fund	Universal Basic Education Intervention Fund
UBEC	Universal Basic Education Commission
UHC	universal health coverage
UNESCO	United Nations Education, Scientific & Cultural Organization
UIS	UNESCO Institute for Statistics
WASH	water, sanitation, and hygiene
WDI	World Development Indicators

Acknowledgments

The report is a final product of a long and useful engagement with partners and stakeholders on the constraints for delivery of basic education and primary health. We thank the State Health, Education, and Local government commissioners; the State Basic Education and State Primary Care Development Boards, and State Health Insurance Authorities; the Federal Ministry of Health and the Federal Ministry of Education; the National Primary Care Development Agency and the National Health Insurance Agency; and the Universal Basic Education Commission. We also would like to thank development partners whose engagement with the task team has enriched the report.

While the report is a final product, the engagements had a significant impact in shaping the pipeline (and portfolio). The findings of this report have generated three interrelated operations that collectively improve service delivery at the subnational level. These operations are sequenced so that the first one is focused on key system-related issues that cut across both health and education sectors, while the second and third ones are focused on the health and education sectors, respectively. These operations collectively are labeled as: Human Capital Opportunities for Prosperity and Equity (HOPE).

The report was prepared under the guidance and supervision of Shubham Chaudhuri (Country Director for Nigeria), Trina Haque (HD Regional Director for West and Central Africa)., and Dena Ringold (Directors, Strategy and Operations, Human Development). The team expresses gratitude for the strategic guidance they provided throughout the engagement and preparation of the report. The team is grateful to the peer reviewers, Christophe Rockmore Samer Al-Samarrai and Maxwell Bruku Dapaah, for their valuable comments and feedback. The team gratefully acknowledges constructive suggestions and invaluable feedback received from colleagues, partners, and participants in the many consultations and discussions: state officials including Oyo, Kano, Katsina, Enugu and Gombe states; commissioners of health, education, and local government; chairs of SUBEBs, SPHCDAs, SHIAs, and LGA officials; at the federal level, Federal Ministries of Health, Education, UBEC, NPHCDA, and NHIA; the Human Capital Core Working Group secretariat; and NGF, CSOs, and development partners. The report has benefited from financial support from the Bill and Melinda Gates Foundation.

The engagement and the resulting report task team included multi-sectoral members from Health, Education, Governance, and WASH. The team is led by Tekabe Belay (HD Program Leader) and included Martin Elias De Simone (Education Specialist), Dilip Parajuli (Senior Education Specialist), Olumide Olaolu Okunola (Senior Health Specialist), Mahesh Dhal (Education specialist), Ayodeji Gafar (Senior Health Specialist), Elina Pradhan (Senior Health Specialist), Deborah Isser (Lead Governance Specialist), Ikechukwu John Nweje (Senior Public Sector Specialist), Stella Nneka Eze (Team Assistant), and Aisha D.A. Kaga (Senior Program Assistant).

CHAPTER 1.

Introduction: Human Capital, Its Importance and Constraints to Improvement

Human capital, the sum of a population's health, skills, knowledge, and experience, constitutes a fundamental pillar in the sustainable development and economic growth of nations (World Bank 2018). It represents not just the capacity of individuals to contribute productively to society, but also the potential for countries to achieve higher levels of economic development and social well-being. This report focuses on identifying the constraints to and solutions for improving human capital outcomes in the Federal Republic of Nigeria, a country with significant untapped potential in this critical area.

Investing in human capital yields significant benefits both for individuals and society at large. At an individual level, each additional year of education typically leads to an increase in average earnings. The value of education becomes even more pronounced amidst technological advancements, as those with greater human capital are quicker to adapt to new technologies. Healthier individuals also tend to be more efficient at work. These personal gains from investing in human capital contribute to substantial economic advantages—nations see wealth accumulation as the level of human capital among their populations increases. Human capital not only enhances physical capital during production but also plays a crucial role in driving technological innovation and sustained economic growth.

Consequently, differences in human capital account for 10 to 30 percent of the variation in per-capita GDP across countries, a figure that might rise when factoring in the quality of education or the synergy among workers with diverse skill sets. Moreover, in pre-demographic-dividend countries, human capital plays a pivotal role in speeding up the demographic transition necessary to materialize the dividend. It also lays the foundation for social capital, as more educated individuals tend to exhibit greater trust in others, a linkage that is critical in a country like Nigeria, which suffers a myriad of challenges related to fragility and conflict.

As Africa's most populous nation and one of its largest economies, Nigeria faces a considerable human capital deficit that is hindering its development prospects. According to the World Bank's Human Capital Index (HCI), Nigeria scores a mere 0.36, positioning it substantially below the average for Sub-Saharan Africa (0.40) and for lower-middle-income countries worldwide (0.48). This implies that the average child born in Nigeria today will be only 36 percent as productive in adulthood compared to a scenario with complete education and full health. In other words, Nigeria's economy could be up to 2.77 times larger if comprehensive education and health services were provided. To put this into perspective, this represents an additional growth of approximately 2.06 percentage points annually over the next five decades.

This report aims to identify key governance and financing challenges to improving human capital outcomes in Nigeria. By examining the drivers of the current poor state of education and health services, the report seeks to provide actionable insights and recommendations for policy makers. Nigeria's health and education sectors face significant challenges that contribute to suboptimal human capital outcomes. These challenges can be broadly categorized into three types: *supply-side constraints, demand-side issues*, and *systemic issues*.

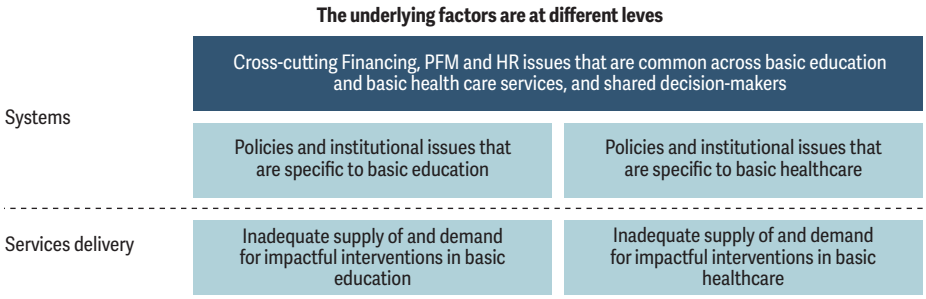
Supply-side constraints encompass limitations in infrastructure, resources, and personnel, leading to inadequate provision of health and educational services. For instance, shortages of medical personnel and essential medicines restrict access to quality health care, while insufficient schools, teachers, and educational materials hamper the delivery of effective education.

Demand-side issues relate to the willingness and ability of the population to access available services. Cultural norms and beliefs, as well as economic status, can deter individuals from seeking health care or prioritizing education, even when these services are available. For example, poverty- and gender-related norms are found to be key determinants of investment in the education of girls in Nigeria. Similarly, traditional beliefs may lead to lower rates of delivery [at health facilities.

Systemic issues—the other set of challenges that the health and education sectors face—are less understood. These include overarching constraints in financing and governance that affect both sectors, including the size and quality of spending in health and education. Inefficiencies in the allocation and utilization of resources, lack of accountability at all levels, and lack of transparency in fund flow arrangements, as well as planning, budgeting, and governance structures that fail to adequately support the sectors' needs, all impact the actual resources that reach front-line service providers and the quality and volume of services provided. While some systemic challenges are common to both health and education—stemming from similar decision-making bodies and budgetary processes—other challenges are unique to each sector or involve different stakeholders, albeit with analogous impacts.

FIGURE 1-1.

Analytical framework for analyzing service delivery challenges



Source: Authors

Focusing on systems is relevant because while improving human capital services based on interventions backed by evidence is important, it is not enough in contexts where the system itself does not work. As Pritchett (2015) claims, any review of the empirical literature on the proximate determinants of learning, for instance, finds that impacts vary widely across contexts. Smaller class sizes, higher teacher salaries, more textbooks, and better teacher training tend to be associated with better learning outcomes; but there are always rigorous empirical examples of null effects. In these cases, the efficiency of the implementation tends to be small because of systemic issues. This is partly what occurs in Nigeria, where in spite of many years of multiple interventions, outcomes are still far from ideal. When systems reach a critical level of incoherence and dysfunction, the empirical findings might invert the conventional wisdom.

This report aims to disentangle some of those systemic problems and propose potential avenues to address them. The ultimate objective is to make significant improvements in human capital investments in Nigeria, thereby unlocking the full potential of its people and fostering a prosperous future for all Nigerians. The report delves into the financing and governance constraints that critically undermine the performance of Nigeria's health and education systems. By examining these systemic challenges, it seeks to shed light on the underlying factors that perpetuate the low levels of health and educational outcomes. The report proposes recommendations to address these foundational issues and improve basic service delivery. It analyses different areas where reforms are needed, what type are needed, and what agencies/levels of government are relevant to implement the reforms. Beyond simply identifying reforms, the report also explores how they can be implemented in the Nigerian context, where a multiplicity of institutions and agencies is common.

The report is organized as follows. Chapter 2 focuses on the state of basic health services and basic education services. Chapter 3 presents an analysis of state-level expenditures in health and education. This analysis complements the recently completed public finance review, in which detailed analysis of health and education expenditures is missing. A closer look at the federal-state fiscal transfer for health and education is presented in Chapter 4, which focuses on the two key flagship programs in health and education: the Basic Health Care Provision Fund (BHCPF) and the Universal Basic Education (UBE) Fund. Chapter 5 examines human resources, with a particular focus on teacher development, recruitment, deployment, and performance management. Chapter 6 focuses on information systems that are needed to improve accountability and transparency in the health and education sectors. Finally, Chapter 6 provides recommendations.

Why a focus on under-5 mortality rates and out-of-school children?

While this report acknowledges the broad variety of outcomes that are related to human capital accumulation, the focus here will be on two specific outcomes: the *under-5 mortality rate* and the number of *out-of-school children*. Selecting these two key indicators to assess human capital in Nigeria is both strategic and insightful, given the profound implications these factors have on the country's developmental trajectory.

The under-5 mortality rate serves as a crucial indicator of the overall health and well-being of a population, reflecting the effectiveness of health care systems, child health, nutrition, and access to clean water and sanitation facilities. High under-5 mortality rates often signal underlying deficiencies in these areas, which are vital for nurturing a healthy and capable workforce. In Nigeria, where health care challenges are prevalent, this metric can highlight critical areas for intervention to improve the health outcomes of the youngest and most vulnerable segment of the population. By reducing under-5 mortality, Nigeria can ensure a healthier start to life for its children, laying the foundation for a more robust and productive human capital base in the future.

The number of out-of-school children, by contrast, is a direct measure of educational access and quality. Education is a cornerstone of human capital development, equipping individuals with the knowledge, skills, and competencies necessary to participate effectively in the economy. In Nigeria, where educational disparities exist due to factors such as geographic location, gender, and socioeconomic status, focusing on reducing the number of out-of-school children can address inequities and unlock the potential of the country's youth. Ensuring that all children have access to quality education not only enhances individual life chances but also contributes to broader economic and social development.

More importantly, the selection of these two indicators is also driven by the magnitude of the problems they represent. As will be explained below, Nigeria has the largest number of out-of-school children in the world and the largest number of children under 5 who die every year in any country globally. Globally, one in every 6 deaths of children under 5 are in Nigeria, and one of every 12 children out of school globally are Nigerian as well. Addressing these issues will not only contribute to improving Nigeria's human capital and, therefore, its economic prospects; it will also significantly contribute to improving regional and even global results.

Together, these indicators offer a comprehensive view of the state of Nigeria's human capital. By addressing the systemic drivers of high under-5 mortality rates and the high number of out-of-school children, Nigeria can make significant strides in improving the state of human capital. This, in turn, will foster sustainable economic growth and development. Given that Nigeria's main asset is its population, especially its youth, addressing these issues is not only a moral imperative but a strategic investment in the country's future prosperity.

CHAPTER 2.

The State of Human Capital in Nigeria: Primary Health Care and Basic Education

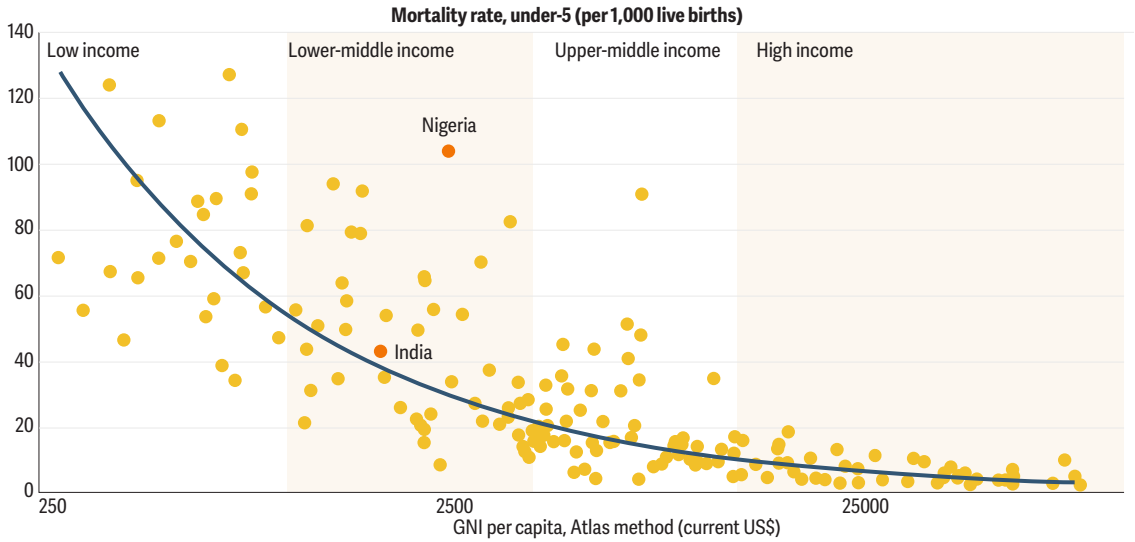
The state of human capital in Nigeria calls for urgent action. The most recent global estimate of the World Bank's Human Capital Index (HCI) shows that Nigeria scores 0.36, which compares very poorly to the average for Sub-Saharan Africa (0.40) and much worse than lower-middle-income countries worldwide (0.48). Looking at certain components of HCI, in particular at the under-5 mortality rate (U5MR) and expected years of schooling, the picture is rather stark. More than 844,000 children die every year in Nigeria before they reach their fifth birthday. This constitutes the largest number registered anywhere in the world. In Nigeria, a child who starts school at age 4 can expect to complete only five years of education when factoring what the child actually learns.

The state of basic health care services

Nigeria's health outcomes are low and have been stagnant for some time. Compared to its structural peers, Nigeria performs poorly in health outcomes. Even compared to Sub-Saharan countries alone, Nigeria is performing much lower than most and lower than what its income level would predict (Figures 2-1 and 2-2). Data from the World Development Indicators show that Nigeria recorded approximately 844,321 under-5 deaths in 2020, accounting for 30 percent of under-5 deaths in Sub-Saharan Africa (17 percent globally).[1] Not only is this rate high, but the rate at which it is declining is slowing and almost stagnating. A large number of children who do survive their early years face chronic malnutrition and stunting, a factor that further predisposes them to disease and other ill health. What is more, Nigeria is also the largest contributor to maternal deaths in the world (34 percent); for a Nigerian woman, the lifetime risk of dying during pregnancy, childbirth, postpartum, or after an abortion is one in 22, compared to one in 4,900 in high-income countries. Compared to Nigeria's income peers, its rates of under-5 mortality, life expectancy at birth, and stunting in children under age 5 are all worse than the average among lower-middle-income countries as well as Sub-Saharan Africa as a whole (Figures 2-2, 2-3, and 2-4).

FIGURE 2-1.

Under-5 mortality rates and national income, 2020

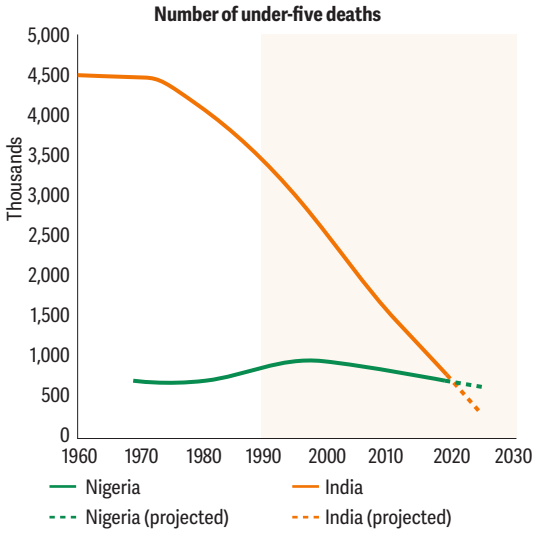


Source: World Development Indicators.

1 It has overtaken India as the country with the highest absolute number of under-5 deaths in the world, despite India's population being seven times larger (Figure 2-2).

FIGURE 2-2.

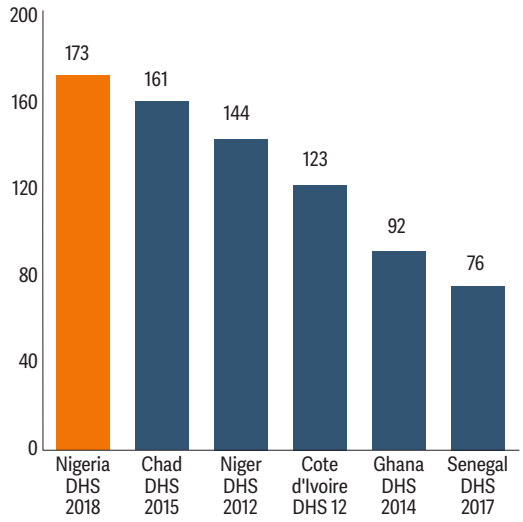
Absolute number of under-5 deaths in India and Nigeria, 1960–2020 and projected



Source: World Development Indicators.

FIGURE 2-3.

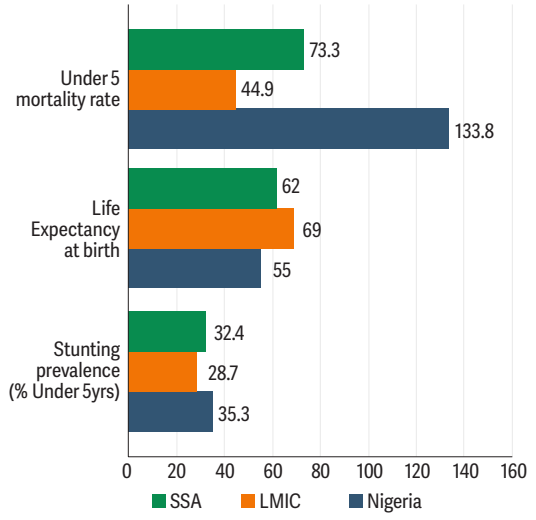
Child health outcomes in Nigeria, low-middle income countries, and Sub-Saharan Africa



Source: Demographic and Health Surveys.

FIGURE 2-4.

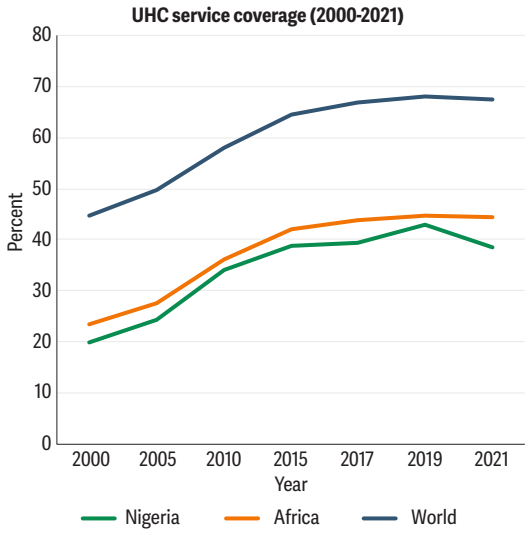
Under-5 mortality rates, Nigeria and poorest income-quintile countries



Source: World Development Indicators.
Note: LMIC = low–middle income countries; SSA = Sub-Saharan Africa.

FIGURE 2-5.

UHC service coverage in Nigeria, Sub-Saharan Africa, and the world, 2000–2021



Source: World Development Indicators.

Not only is Nigeria's U5MR high, but it is also very inequitable. Among children in the poorest income quintile, Nigeria's U5MR is the highest in West Africa (figure 4), twice the rate of Ghana or Senegal. Within Nigeria, children from the poorest quintile die at a rate that is 3.3 times higher than U5MR from the richest quintile. Both in relative and absolute terms, poor children in Nigeria are faring badly.

Nigeria has made progress toward universal health coverage (UHC) in the past two decades, but it still lags the region and the world. Using the measure of service coverage, coverage in Nigeria has increased from the lower 20 percent in the 2000s to close to 30 percent as of 2021 (Figure 2-5). While this is remarkable progress, the level of coverage is still very low and lower than the Sub-Saharan African average. Nigeria's UHC journey in the past two decades has been uneven. Rapid progress during the first half of this period (2005 to 2015) has been followed by either stagnation or even decline. A closer look at the access, quality-of-care, and equity dimensions can provide more insight into this uneven progress.

Access to health care

Coverage of basic maternal and childcare services is low across the country. Coverage of basic health services that improve maternal and child health outcomes, such as vaccination against common childhood illnesses, use of oral rehydration solution (ORS) and zinc during episodes of diarrhea, use of insecticide-treated nets (ITN) to prevent malaria among under-5 children and pregnant women, intermittent preventive treatment (IPT), and so on, is still very low in Nigeria. Data from the most recent national survey[2] indicate that only 36 percent of children ages 12–23 months received all recommended vaccines; less than a third (30 percent) of children with diarrhea, 33.4 percent of those with symptoms of pneumonia, and 63 percent of those who had fever sought care from a health provider. In terms of maternal health, about 60 percent of pregnant women completed their fourth antenatal visit; 51 percent and 49 percent of women were attended to by skilled providers at delivery and delivered at facilities, respectively. Only about 40 percent of the demand for family planning has been met, and nearly 22 percent of women use any method of contraception. All these conditions, combined with the high fertility rate, significantly increase the proportion of women at risk of pregnancy-related morbidity and mortality.

Physical access is limited, especially in some parts of the country. Although not equitably distributed, the Health Facility Registry shows that there is no local government area (LGA) in the country that does not have the presence of government-owned primary health facilities and at least one secondary facility. However, data from household surveys show that households use private facilities for a number of reasons. For example, the MICS 2021 reported that treatment at private facilities is more commonly sought for common childhood sicknesses like malaria (40.2 percent), acute respiratory infection (ARI) (39 percent), and diarrhea (34 percent). One area to look into is the availability and distribution of human resources for health (HRH). Already, there is both a shortage of and inequitable distribution of HRH in the country. Given the current brain drain among health workers, there are concerns that a health workforce crisis may be looming in the nearest future, thereby worsening the already bad situation.

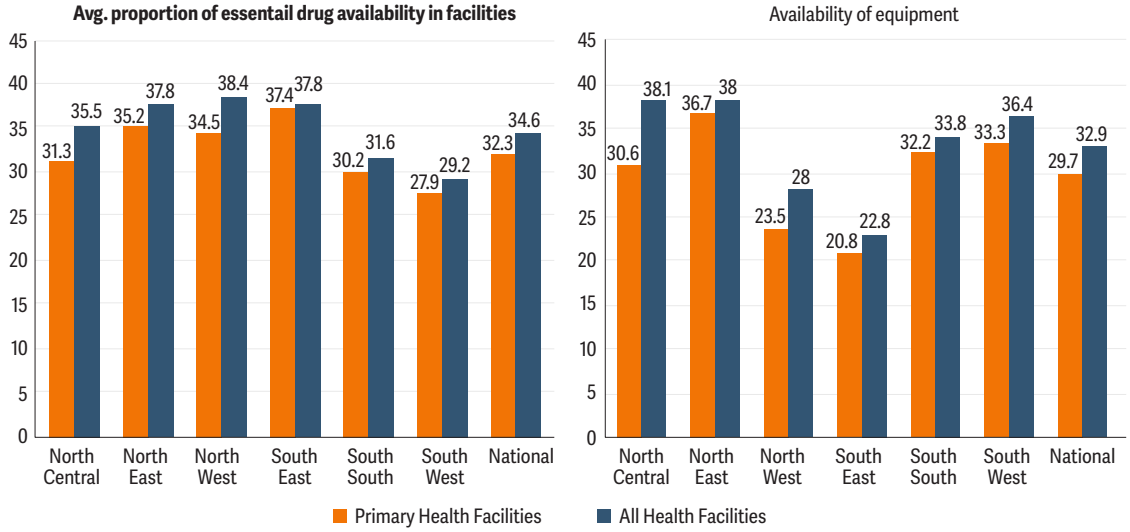
Financial access is a major challenge for Nigerians to access health care. Out-of-pocket expenditure contributes about two-thirds to overall health expenditure in Nigeria and remains a major challenge and a large section of the population forgo health service due to financial barriers. . Recent efforts to address this challenge and improve access to health care, especially at the primary level, incudes the enactment of the National Health Act and the National Health Insurance Act. These acts enable the implementation of the BHCPF to ensure access to a defined basic minimum package of health services with reduced financial burden on the citizens. The implementation of this program is in the early stages, with coverage for only about 2.7 percent of the population (MICS 2021).

Insecurity has exacerbated the already limited access to health. Increases in insurgency, banditry, and kidnappings have had a significant impact on access to health care services in different parts of the country, especially in the North. Disruption in health supply chains, forced imposition of curfew, restriction of movement have discouraged of health workers from taking up roles and resuming appointment in insecurity-prone areas. Other incidents of insecurity have reduced access to food and water, sanitation, and hygiene (WASH). The impact is not limited to areas that are insecure, because as people move to relatively safe places, this increases the pressure on service providers in those areas.

2 The 2021 Nigeria Multiple Indicator Cluster Survey (MICS) and the National Immunization Coverage Survey (NICS).

FIGURE 2-6.

Availability of essential drugs and equipment, by geopolitical zone, 2016



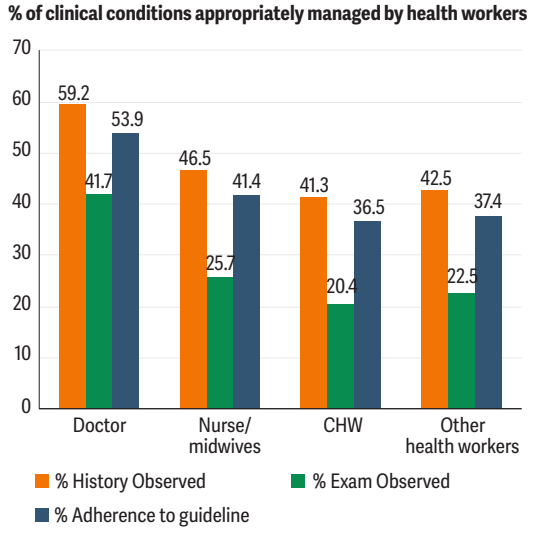
Source: National Health Facility Survey 2016.

Quality of care

When services are available, the quality is poor. Poor quality of care may account for more deaths than lack of access to care. The National Health Facility Survey 2016 shows that health facilities lack basic commodities and supplies needed to provide services (Figure 2-6). Furthermore, the knowledge and effort of health workers is such that the quality of services they provide may not improve health outcomes: the same survey shows low levels of "diagnostic accuracy" and "adherence to clinical guidelines." Overall, levels of accuracy and adherence are low but there are large regional variations (Figures 2-7, 2-8, 2-9, and 2-10).

FIGURE 2-8.

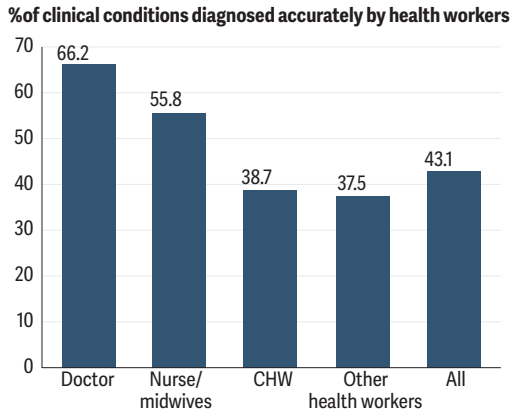
Adherence to clinical guidelines, by type of health worker, 2016



Source: National Health Facility Survey 2016.

FIGURE 2-7.

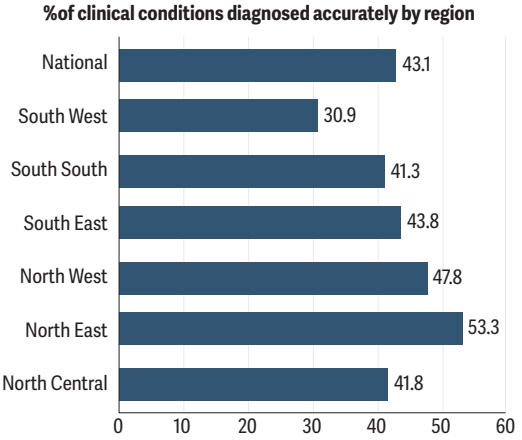
Diagnostic accuracy, by type of health worker, 2016



Source: National Health Facility Survey 2016.

FIGURE 2-9.

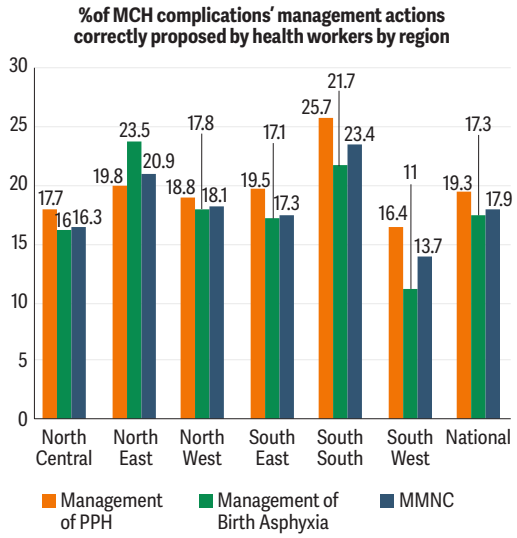
Diagnostic accuracy, Nigeria, by region, 2016



Source: National Health Facility Survey 2016.

FIGURE 2-10.

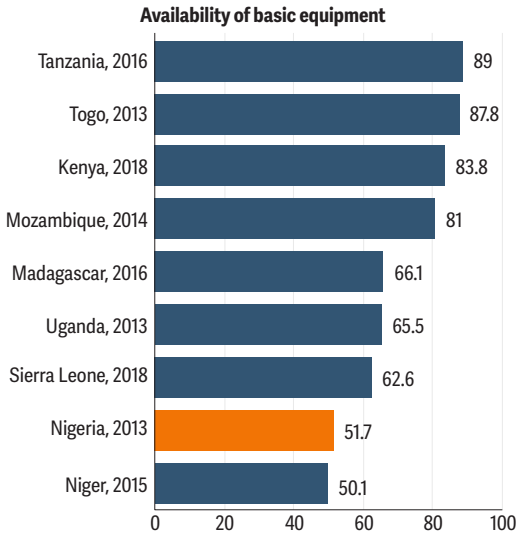
Adherence to clinical guidelines, Nigeria, by region, 2016



Source: National Health Facility Survey 2016.

FIGURE 2-11.

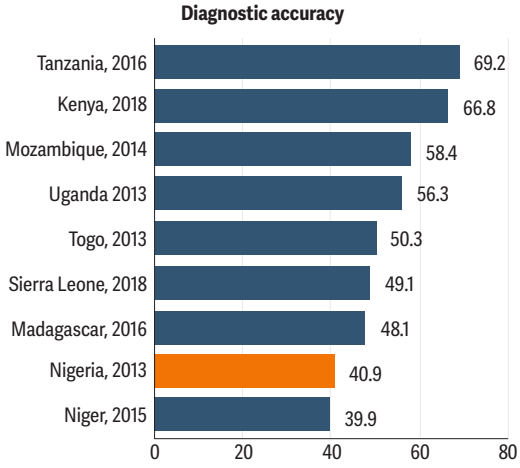
Availability of basic equipment, other African countries

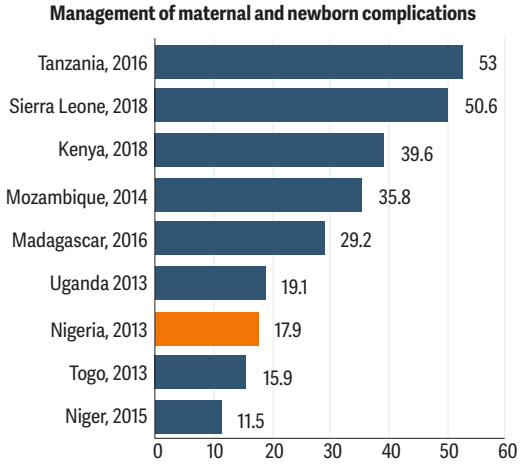


Source: Service Indicator Survey.

FIGURE 2-12.

Diagnostic accuracy, other African countries



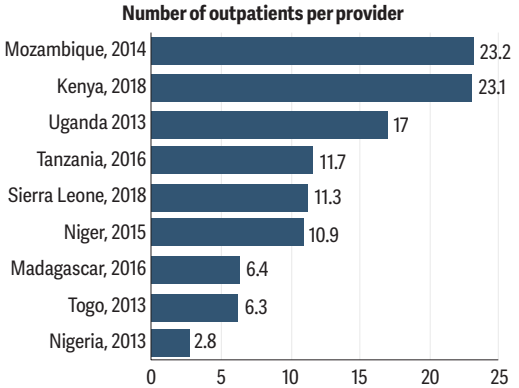


Source: Service Indicator Survey.

The quality of care provided varies widely within health facilities in the country and by type of health care professional (Figures 2-7, 2-8). Overall, health care quality in Nigeria is lower than in most Sub-Saharan African countries (Figures 2-11, 2-12, and 2-13).

FIGURE 2-13.

Number of outpatients per provider, other African countries



Source: Service Indicator Survey.

Equity in access to health care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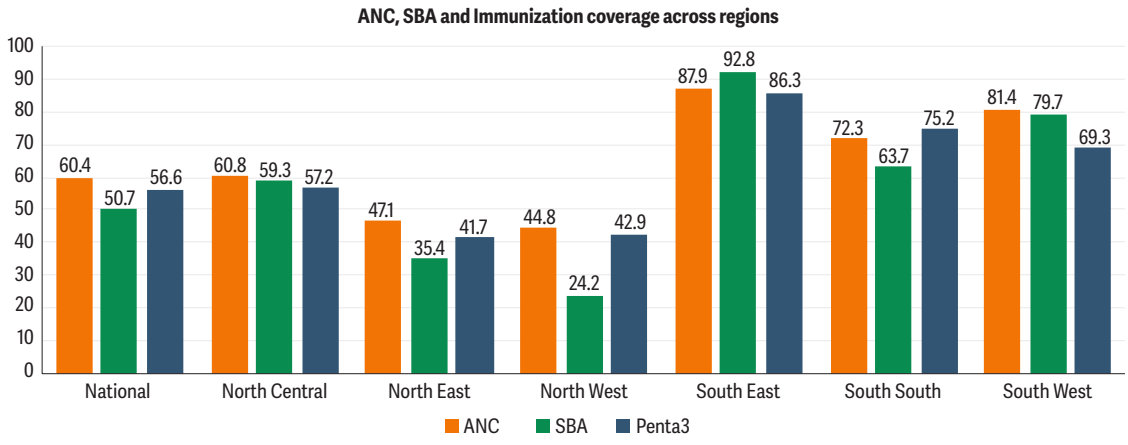
Access to essential maternal and child health services is very inequitable across the country and across population groups. ANC-4 coverage, that is, coverage of at least four antenatal visits, reaches just 49 percent of pregnant women in rural areas as compared to 80 percent in urban areas, while the rates of skilled birth attendance (SBA) are 35.5 percent and 77.3 percent in rural and urban areas, respectively. ANC and SBA are also disproportionately lower among women with no education (37 percent ANC and 21 percent SBA) and those from the poorest wealth quintile (34 percent ANC and 22 percent SBA). Similarly, vaccination coverage is lower for children living in rural areas (47.5 percent), those whose mothers had no education (36.2 percent), and those who come from the poorest households (38.7 percent). Only 22 percent in the poorest wealth quintile (compared to 89 percent of those in the highest quintile) delivered in a health facility. Similarly, 19 percent of those with no education (compared with 91 percent of those with higher education) delivered in a health facility. Likewise, use of modern contraception varies widely among women, with those living in rural areas, those with no education, and those from the poorest households reporting lower uptake rates than their counterparts in other groups. Generally, wide disparities in coverage for maternal and child health services persist across the geopolitical zones in the country, with the North East and North West having the poorest rates (Figure 2-14).

Not surprisingly, the inequality in health service coverage is manifested in inequality in health outcomes. Poor health outcomes such as increased under-5 mortality are higher among children whose mother had no education (142 per 1,000 live births), live in rural areas (123 per 1,000 live births), are from the two lowest wealth quintiles (133 per 1,000), and/or are in the North East (114 per 1,000) and North West (158 per 1,000) regions of the country. According to the Nigeria Demographic & Health Survey (NDHS) 2018, children who are stunted are more likely to come from the poorest families (55.4 percent), to live in rural areas (44.8 percent), and to live in the North West (56.8 percent) or North East (49 percent) regions.

FIGURE 2-14.

Maternal and child health services coverage, by region, 2021



Source: Multiple Indicators Cluster Survey (MICS) 2021.

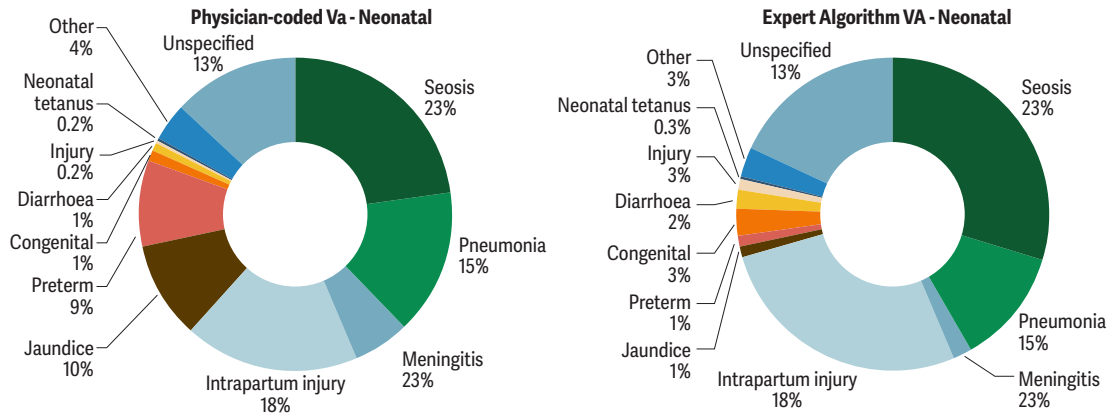
The Solutions are not simply technical

Despite the fact that the technical solutions to addressing these poor health outcomes are well understood, the country has made little progress mainly due to the Financing and governance challenges.

Most of the proximate causes of Nigeria's poor health outcomes are easily prevented or treated. Most may be controlled by existing high-impact technologies, vaccines, and medicines that are already available. Excluding neonatal mortality, under-5 mortality in Nigeria is due to malaria, pneumonia, diarrhea, and three other vaccine-preventable diseases: measles, pertussis, and meningitis. Much of neonatal mortality is due to infections and hypothermia. Additionally, these illnesses can cause disabilities. Malaria, for instance, can be the reason for hearing loss or deafness, meningitis can lead to intellectual disability, and measles can leave a child deaf or with intellectual disability. Fortunately, there are high-impact and cost-effective technologies available to control these diseases, including some new vaccines that prevent diarrhea and pneumonia. These interventions are relatively simple to implement and benefit from strong evidence coming from numerous randomized trials. However, the delivery of basic health services continues to be a challenge in the country. Most maternal deaths occur close to or during delivery, which underscores the importance of access to timely medical interventions by personnel with the requisite skill and equipment.

FIGURE 2-15.

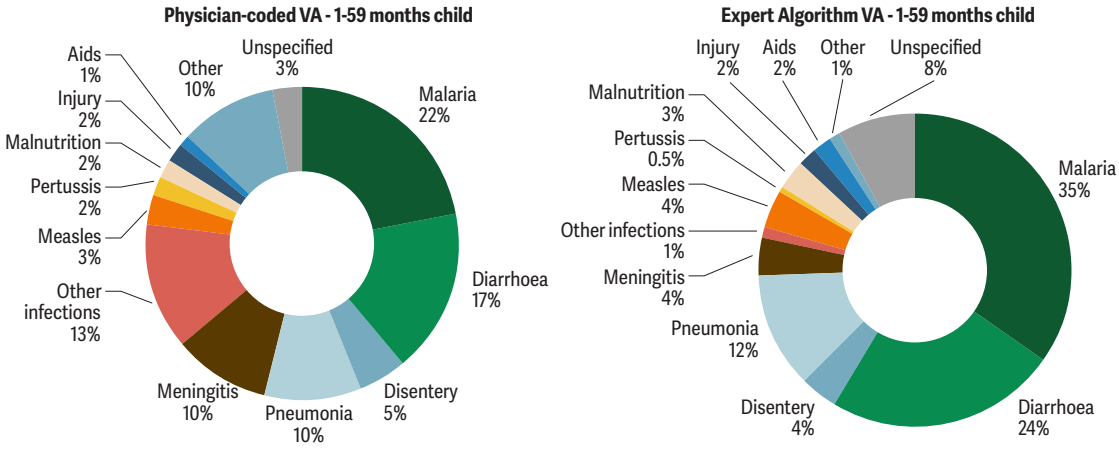
Leading causes of neonatal deaths in Nigeria, 2020



Source: NPC and CIRCLE 2020..

FIGURE 2-16.

Leading causes of under-5 deaths in Nigeria, 2020



Source: NPC and CIRCLE 2020..

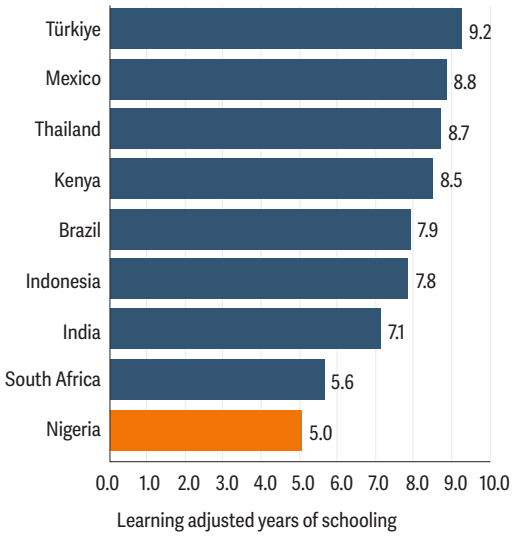
Beyond the availability/quality of health services and the demand-side constraints, there are poorly understood challenges of inadequate transparency and accountability, incentive structures between the three levels of government, and overall financing. Improving the delivery of basic health services would require a good understanding of these issues to ensure that incentives are aligned across the different actors. Chapter 5 in this report looks into these issues ranging from the systems of financing and fund flow arrangements, to systems of accountability, to enabling laws and institutions engaged in service delivery.

The state of basic education services

Nigeria performs poorly in basic education outcomes. This is clear when Nigeria is benchmarked against structural and aspirational peers. For example, in 2020 Nigeria's learning-adjusted expected years of schooling was 5.0, compared to 7.8 in Indonesia, 8.5 in Kenya, and 9.2 in Türkiye (Figure 2-17). The out-of-school (OOS) rate among primary-school aged children was 26 percent in Nigeria—the highest among the comparator countries (Figure 2-17). Despite the significant increase in primary school enrollment in the last 22 years, what is perhaps most striking is that Nigeria has made only marginal progress in reducing its OOS rate (which decreased from 33 to 26 percent over the same time). India, which had a similar OOS rate to Nigeria's in 2000, has made significant progress since then (its rate is now under 10 percent). Ethiopia and Pakistan—both with much higher OOS rates in 2000—have also made impressive improvements over time.

FIGURE 2-17.

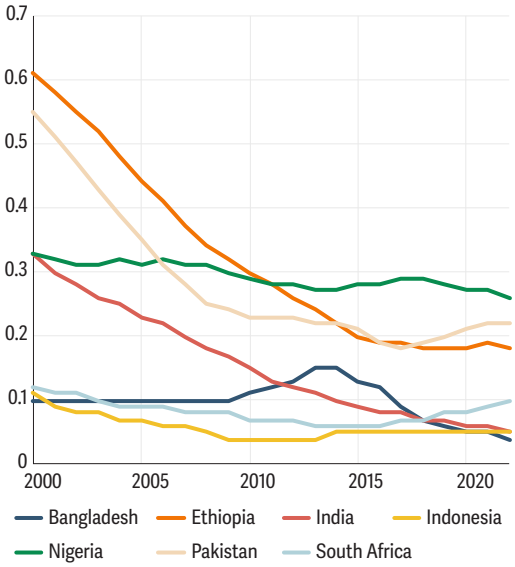
Learning-adjusted years of schooling for Nigeria and structural/aspirational peers, 2020



Source: World Bank 2020, Human Capital Project (https://www.worldbank.org/en/publication/human-capital).

FIGURE 2-18.

Out-of-school rate among primary-school-age children, 2000–2022

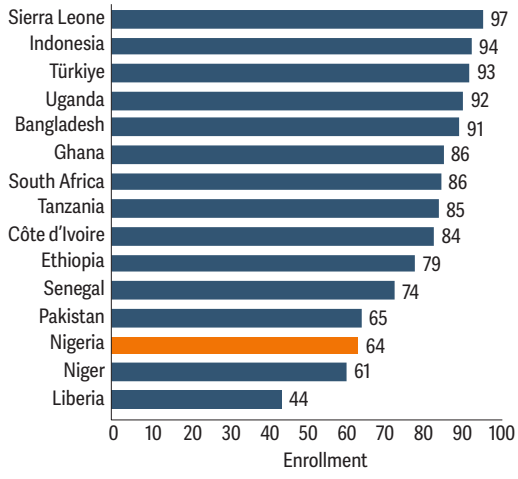


Source: UNESCO, Visualizing Indicators of Education for the World (VIEW) 2022 (https://education-estimates.org/out-of-school/data/).

Similarly, Nigeria has a much lower net primary enrollment rate—which measures both coverage and internal efficiency. For instance, the net primary enrollment rate for primary-school-age children in Nigeria is only 65 percent. This is much lower than the net enrollment rates of 97 percent for Sierra Leone, 94 percent for Indonesia, 91 percent for Bangladesh, and 86 percent for Ghana (Figure 2-19).

FIGURE 2-19.

Net primary enrollment rates in Nigeria and selected comparable countries, 2022



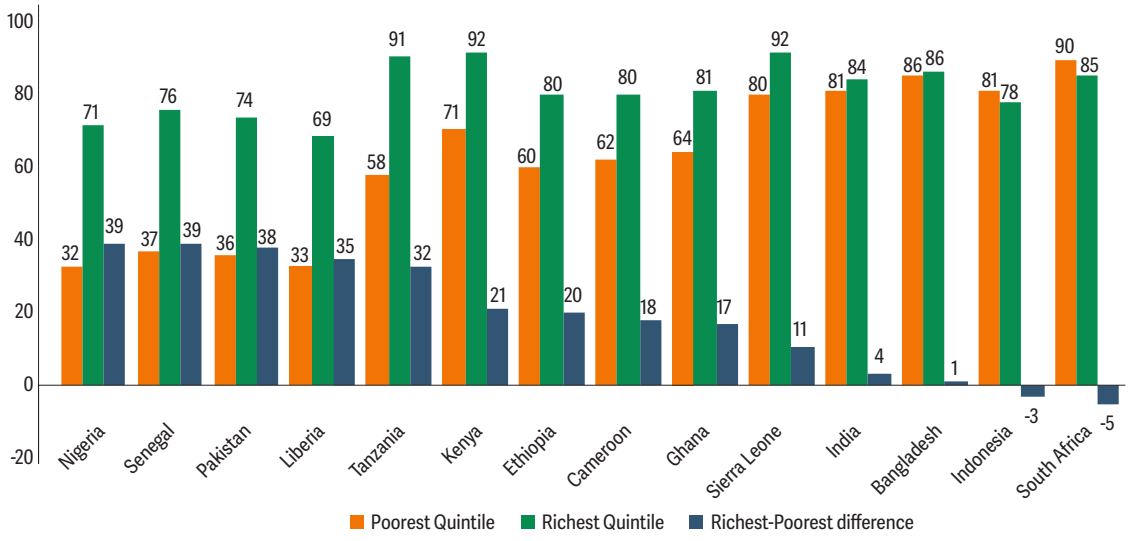
Source: World Development Indicators 2022.

Equity

Nigeria has among the most unequal educational outcomes. For example, the net primary school attendance gap between children from the richest and the poorest quintiles of the welfare distribution is among the widest gaps among comparable countries (Figure 2-20).

FIGURE 2-20.

Net primary school attendance for children from the poorest and richest household wealth quintiles



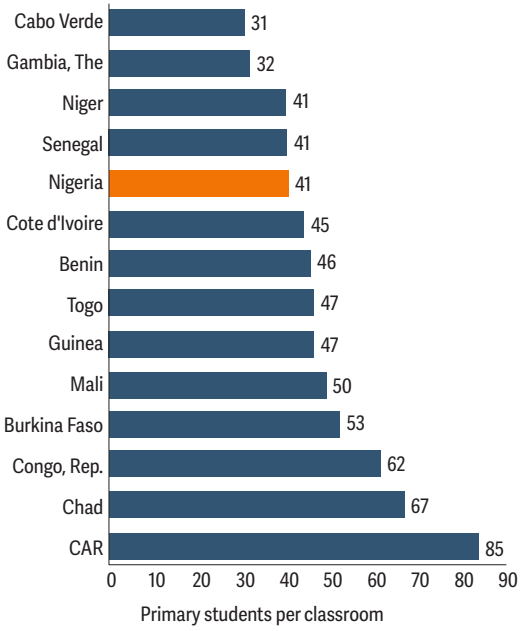
Source: Demographic and Health Surveys.

Shortage of classrooms and teachers

Nigerian children often attend school in extremely overcrowded classrooms that are not conducive for learning. While the average student-to-classroom ratio of 40:1 is better than the ratio in most Sub-Saharan African countries (Figure 2-21), it masks the large variation across Nigerian states (Figure 2-22). It is estimated that Nigeria will need to build at least 458,000 new classrooms by 2025 to accommodate all school-age children in schools and maintain a student-classroom-ratio of 40:1 (Figure 2-23). These estimates are lower bound for the number of classrooms that will be required to enroll all school-age children and maintain a student-classroom-ratio of 40:1, as these estimates do not consider that the existing classrooms are already overcrowded and that students are not uniformly distributed across geographic locations.

FIGURE 2-21.

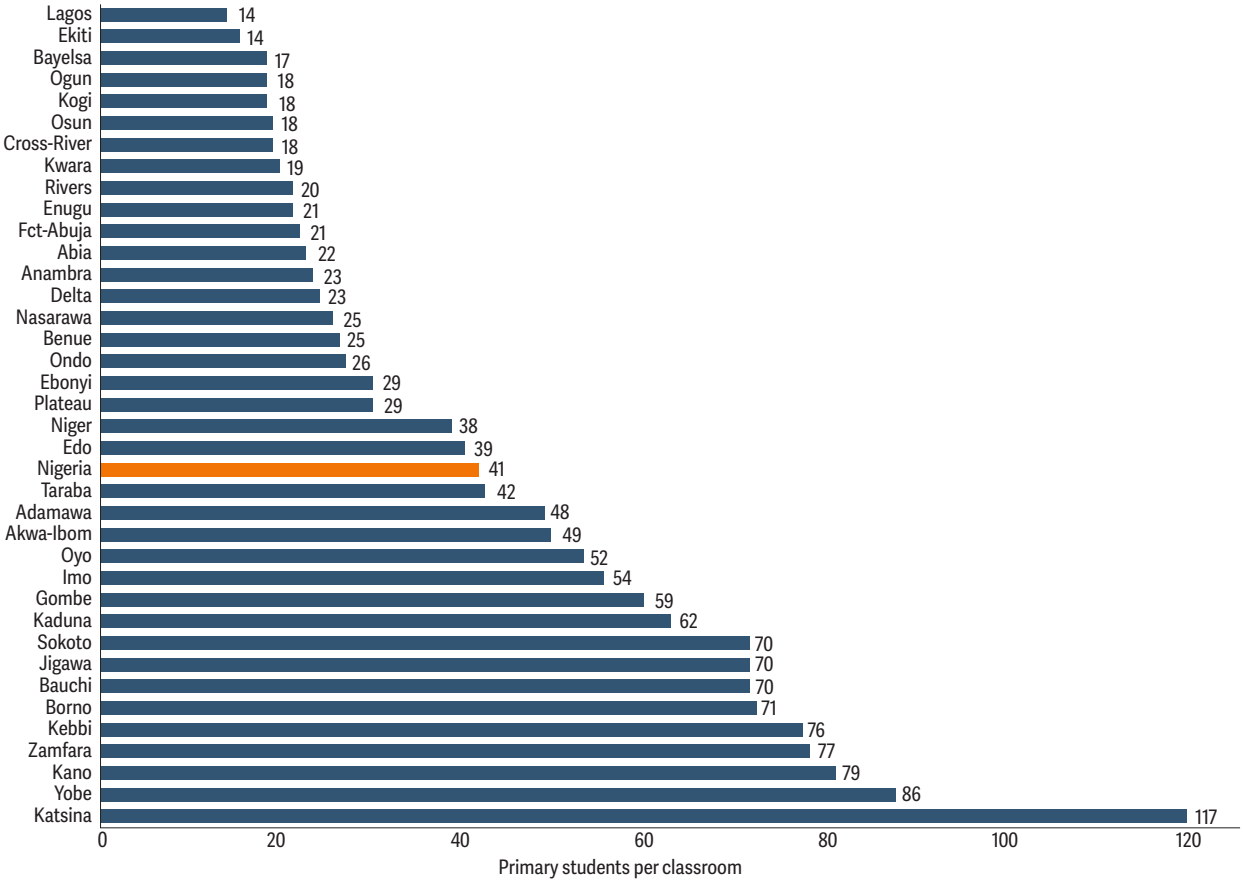
Primary students per classroom, Nigeria and selected countries in West and Central Africa



Source: NPA 2022 for Nigeria and UNESCO Institute for Statistics (UIS) for all other countries.

FIGURE 2-22.

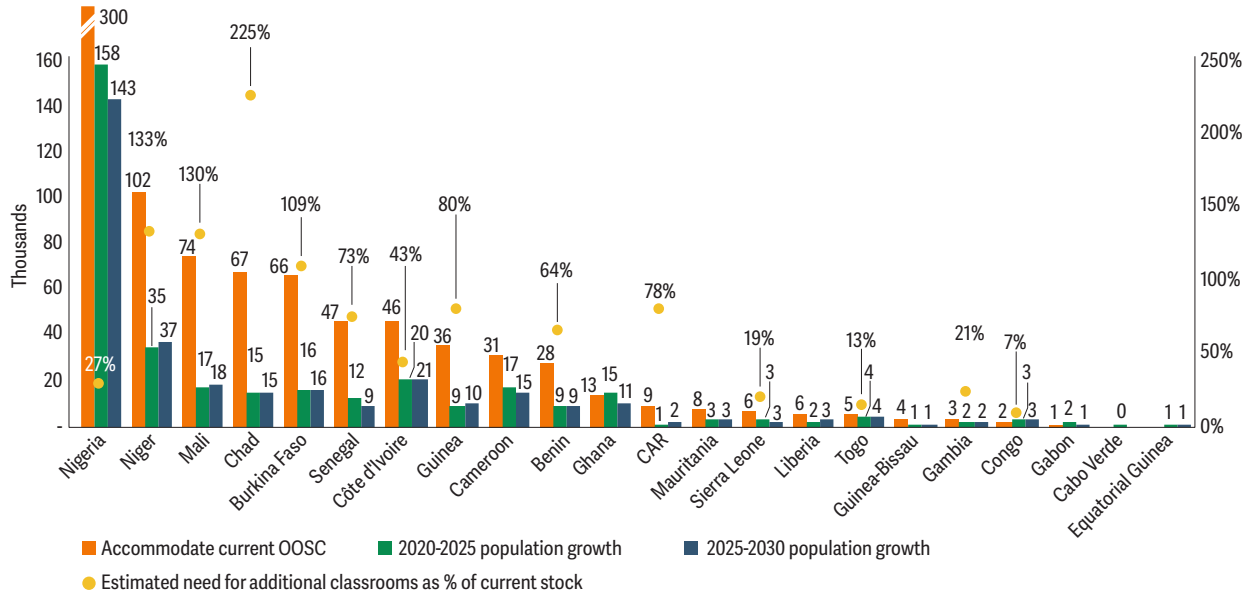
Primary students per classroom in Nigeria, by state, 2022



Source: NPA 2022.

FIGURE 2-23.

Estimated number of classrooms required to accommodate current out-of-school children (OOSC) and estimated additional children ages 6–15 as a result of population growth in 2020–25 and 2025–30



Source: World Bank estimates based on population estimates for 2020 from United Nations (2019); rates of OOS children based on analysis of microdata from Demographic and Health Surveys (Benin 2018, Cameroon 2018, The Gambia 2020, Guinea 2018, Liberia 2019, Mali 2018, Senegal 2019, and Sierra Leone 2019); Living Standards Measurement Surveys (Burkina Faso 2014, Gabon 2017, Niger 2014, and Nigeria 2018); and Multiple Indicators Cluster Surveys (Central African Republic 2019, Chad 2019, Congo 2015, Côte d'Ivoire 2016, Ghana 2017, Guinea Bissau 2019, Mauritania 2015, and Togo 2017).

Out-of-school children: Magnitude and trends

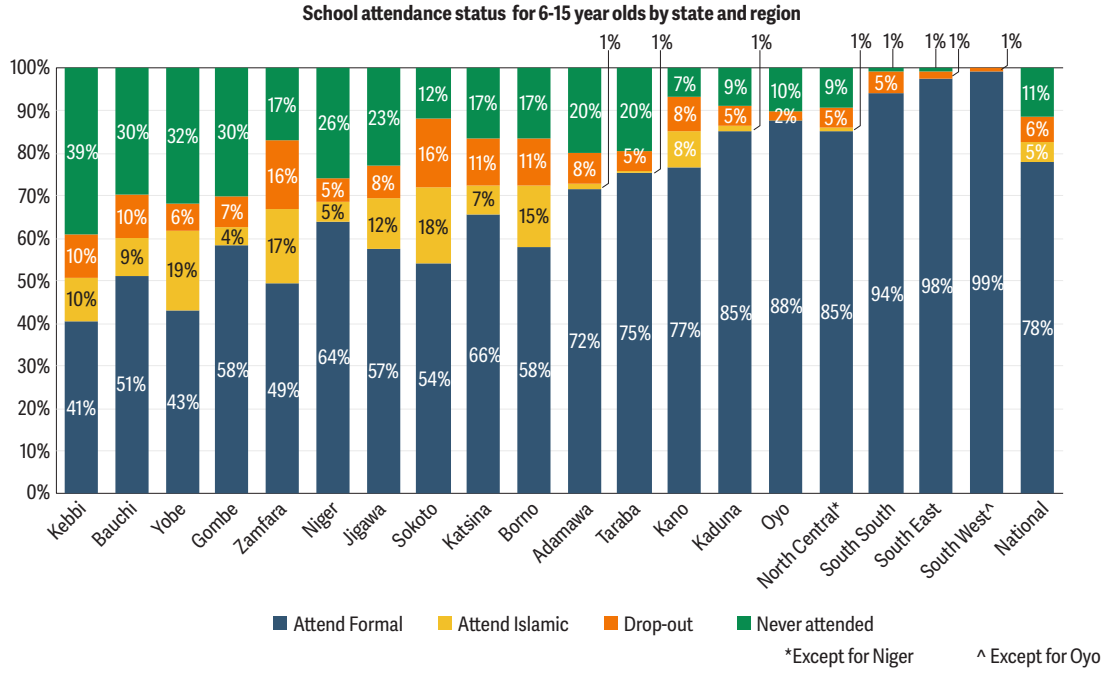
According to UNESCO (2022),[3] 14.6 million Nigeria children between ages 6 and 14 (basic education age group) were out of school in 2020. This number represents one in eight of all OOS children globally and close to 30 percent of all children in this age group in the country. Despite the notable increase in the number of in-school children in basic education in the last 20 years, the total number of OOS children among school-age children grew from 9.1 million in 2000, to 9.9 million in 2010, to 14.6 million in 2020. Other sources provide different estimates, but they all coincide in the severe magnitude of the problem. For instance, an analysis based on the Nigeria Education Survey—on which the analysis in this chapter relies—estimates approximately 11 million children out of school, and more recent surveys show approximately 13.5 million children (World Bank 2022).

The OOS rate for this age group experienced no notable improvement during the same period (hovering close to 30 percent). The stagnation in the OOS rate and the increase in the absolute number of OOS children are closely associated with the high fertility rate. Nigeria's OOS challenge, therefore, is a race that can only be won if the rate of increase of the in-school child population is much higher than the rate of increase of the school-age child population overall (World Bank 2022).

At the same time, there is a large cross-state variation in the number and type of OOS children (Figure 2-24). About 90 percent of all OOS children in Nigeria come from the Northern states. These children can be divided into three groups: about half of them have never attended any schooling; one-quarter are drop-outs; and the remaining quarter attend traditional non-formal Islamic learning centers.

FIGURE 2-24.

School attendance status for children ages 6–15, by state and geopolitical zones, 2020



Source: Nigeria Education Data Survey (NEDS), 2020.

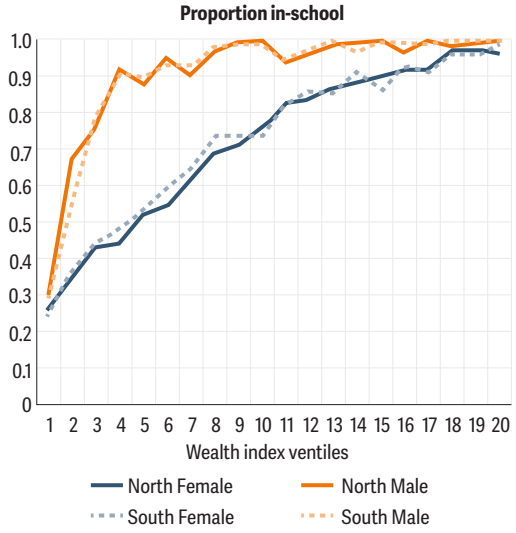
3 UNESCO, Visualizing Indicators of Education for the World (VIEW) (https://education-estimates.org/out-of-school/data/).

What are the main drivers of school attendance?

Household poverty and geography are two of the main drivers of school attendance in Nigeria. Four out of every 5 OOS children ages 6–15 come from households in the bottom two quintiles of the welfare distribution. As Figure 2-25 shows, OOS status is largely associated with geography and wealth, and gender gaps in school attendance are minimal. Children in Nigeria face significant challenges associated with both the direct cost and the opportunity cost of attending schools. The Compulsory, Free Universal Basic Education Act of 2004 mandates basic education shall be provided to children for free; however, as seen in Table 2-2, more than half (52 percent) of children ages 6–15 attending public schools report paying for school attendance, about 1 in 6 report paying tuition fees, and about 1 in 4 report paying examination, school registration, or other official fees charged by the school. About 4 in 10 children report paying for school uniforms, and slightly more than 4 in 10 children report paying for textbooks or other learning materials. The average out-of-pocket expenditure per public school student is about N5,700. In terms of opportunity costs, about 21 percent of rural children and 17 percent of urban children mention domestic obligations and the need to work in a household enterprise or farm as the main reasons for not attending school. Many poor rural families in Northern states who cannot afford formal schooling send their children, mostly young boys, to distant locations to acquire Qur'anic education under the Almajiri system. Almajiri children account for almost 1 in 4 Nigerian children ages 6–15 who are denied a formal education. Given the very low income levels of families in the bottom quintiles, these costs associated with education represent important bottlenecks to access education.

FIGURE 2-25.

Relationship between household wealth and formal school attendance, by gender and region, 2020



Source: NEDS 2020.

TABLE 2-2.

Average annual per-child out-of-pocket education expenses for children ages 6–15 attending public schools

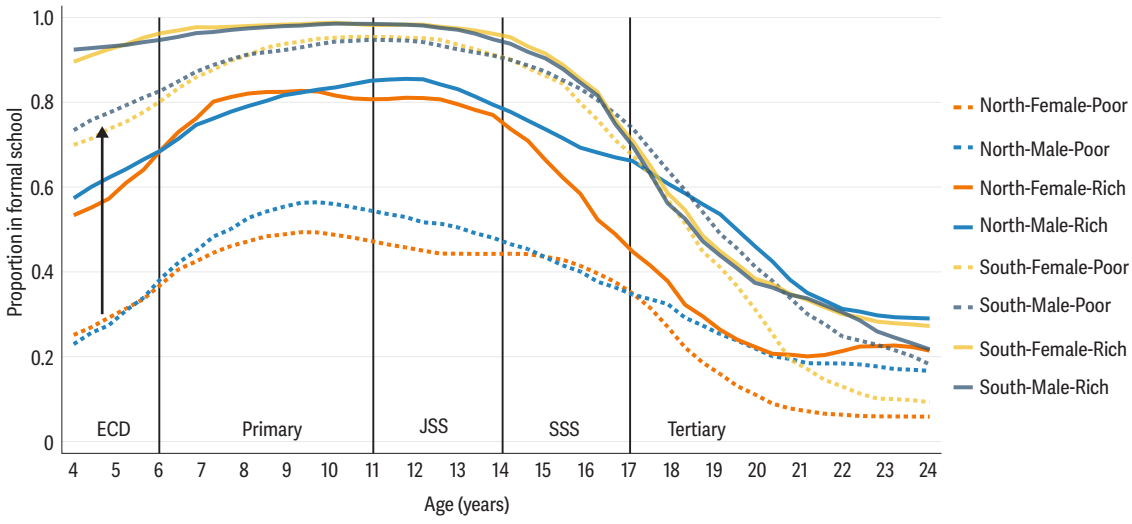
Fee items	Average out-of-pocket expenditure in 12 months (naira)	Share of children who report paying out-of-pocket expenses (%)
Tuition/school fees	911	16
Exam, registration and other official fees	370	24
Other contributions to school (PTA, SMC, school fund, in-kind contributions)	325	32
Other contributions to school (fees for canteen, boarding, transport organized by school, health services)	125	2
Uniform and other required clothing	831	39
Textbooks and other learning materials	1,052	41
School meals and transport purchased outside educational institutions	943	14
Other categories (music and arts lessons, gifts, extra-curricular activities, and so forth)	993	9
Private tutoring	124	3
Total out-of-pocket expenditure in education	5,674	52

Source: World Bank calculations based on the National Living Standards Survey (NLSS), 2018/19.

Prevalent sociocultural norms also contribute to low school attendance, especially for girls. The high prevalence of practices such as early marriage, which results in teen pregnancies and increased domestic obligations, also contributes to low school attendance and performance for girls at the secondary education level. The social norms that place a low value on formal school education in general, and in particular on girls' education, are cited as important drivers of low outcomes. In some cases, lack of information on returns to education may be an issue.

FIGURE 2-26.

In-school rate by age, gender, household income, and geographic region, 2020



Source: NEDS 2020.
Note: ECD = early childhood development; JSS = junior secondary school; SSS = senior secondary school.

Key interventions that help prepare children for retention and foundational learning in basic education, such as early childhood development (ECD), have limited and highly unequal coverage. For instance, the ECD participation rate gap between children from poor households in the North and those from poor households in the South is about 50 percentage points (Figure 2-26).

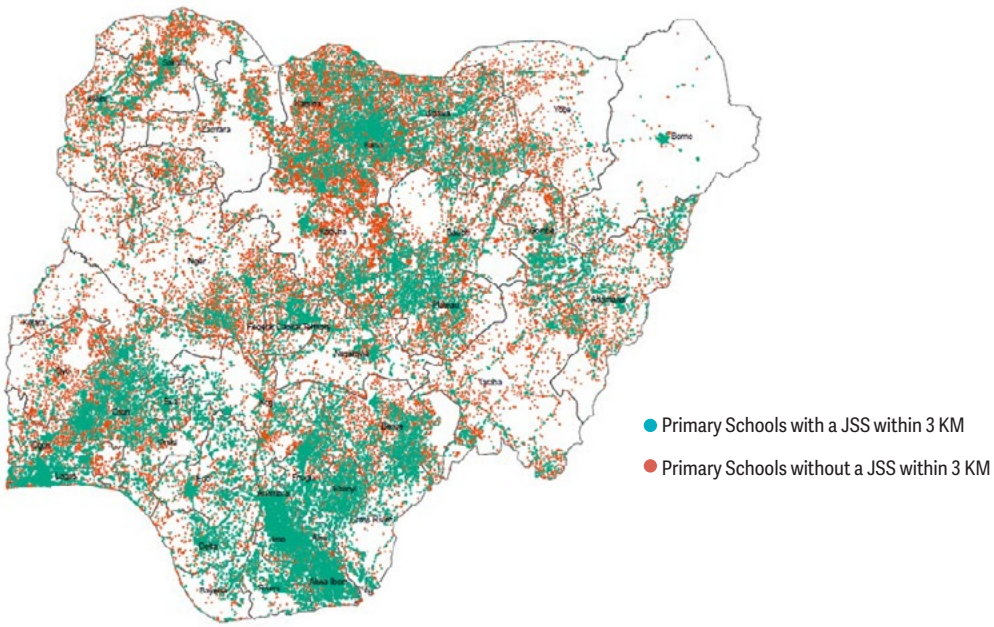
Safety in and around schools is another important driver of enrollment rates. The number of attacks on educational facilities in Nigeria has increased significantly (De Simone and Teixeira 2021), from 22 in 2010 to 116 in the first half of 2021. In particular, school kidnappings have skyrocketed. In the first six months of 2021, Nigeria recorded three times the number of people kidnapped in or around schools than in any previous year, and four times more kidnapping incidents. School closures due to safety issues impacted an estimated 1.3 million children in the 2020/21 academic year, and prolonged school closures tend to create permanent dropouts. Additionally, a recent study has shown that, in Nigeria, one additional conflict event within a 5 km radius of a child's village during the previous academic year reduced the child's probability of school enrollment by two percentage points (Bertoni et al. 2019). This suggests that even attacks not directly targeted at schools affect educational outcomes.

Inadequate access to schools remains a critical supply-side bottleneck. The lack of schools is more prevalent in the North of the country and, while it affects all levels of education, it tends to be more severe for secondary school. About 23 percent of rural school-age children who have never attended school mention the absence of a school nearby as the main reason for their lack of education. Mapping exercises show that around 4.2 million children between ages 5 and 9 do not have access to a primary school within 2 km, and 6.7 million children between ages 10 and 14 do not have access to a junior secondary school within 3 km (Figure 2-27). Lack of schools also affects the transition to secondary schools. For instance, in Katsina state there is only one junior secondary school for every 10 primary schools.

Even when schools are available, learning conditions are usually poor. Classrooms in many states are extremely crowded. On average, there are 60 students per classroom in public primary schools and 68 students per classroom in public junior secondary schools. Classrooms in the North East and North West regions are much more crowded, with 80 and 92 students per classroom respectively. In addition to being crowded, classrooms are in dilapidated condition. About 48 percent of all public primary classrooms and 44 percent of all public junior secondary school classrooms are reported to be dilapidated (NPA 2022). On average, only about 31 percent of public primary schools report having a drinking water facility, and just 43 percent report having a toilet facility.

FIGURE 2-27.

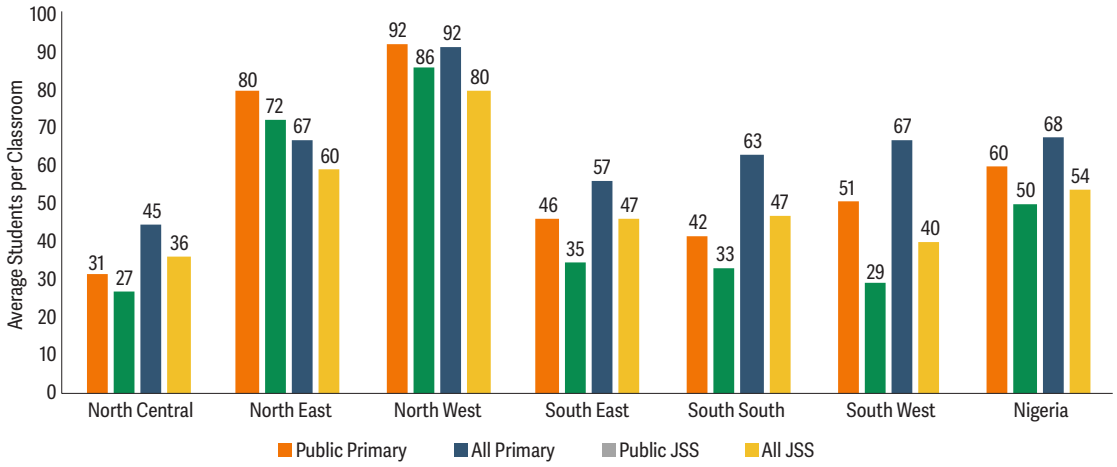
Primary schools situated within or beyond 3 km of the nearest junior secondary school, 2018



Source: Based on National Personnel Audit (UBEC 2019.
Note: JSS = junior secondary school.

FIGURE 2-28.

Average students per classroom in primary and junior secondary schools. 2022



Source: Based on UBEC 2022.

Not surprisingly, the inadequate supply and quality of teachers is also a major challenge. The number of available teachers is much lower than that required to maintain a pupil-teacher ratio (PTR) of 40, as stipulated in the Minimum Standard for Basic Education guidelines of the Universal Basic Education Commission (UBEC). The average PTR in primary public schools was 49 (UBEC 2022), with large variations across the country, including nine states with an average PTR in public primary schools above 60. Furthermore, a significant share of teachers in public primary and junior secondary schools lack formal qualifications as well as required content knowledge and skills for effective teaching. In 2022, on average, 20 percent of teaching staff in primary education (14 percent in public primary schools), and 43 percent in junior secondary education (44 percent in public junior secondary schools) lacked required formal qualifications (UBEC 2022).

Systemic challenges in the governance and financing of basic education are a key driver of low performance and yet are not well understood. Challenges include inadequate accountability; overlapping roles and responsibilities; politicization of teacher management; lack of commitment to addressing inadequate, inefficient, and inequitable financing; weak coordination among the various ministries, departments, and authorities (MDAs) involved in basic education at the state level; and weak capacity for planning, implementation, monitoring, and evaluation. Underfunding of the basic education sector deprives federal and state agencies, schools, and teachers of the resources they need. At the same time, there are institutional overlaps and gaps in core oversight and accountability functions at the state and local government level, and between the three tiers of implementing agencies: UBEC, the State Universal Basic Education Boards (SUBEBs), and Local Government Education Authorities (LGEAs). Overall, basic education in Nigeria needs both a substantially greater resource mobilization and a more effective use of the resources mobilized.

CHAPTER 3.

Public Spending in Primary Health and Basic Education: Inadequate and of Poor Quality

Institutions

There are overlapping roles across three tiers (federal, state, and local) of government, but no national framework that encompasses budgets at all levels of government, and no mechanism for proper coordination. Nigeria is a federal system made up of the federal government at the center, 36 state governments, a Federal Capital Territory administration (FCT), and 774 local government councils (LGCs). The Constitution[4] assigns powers, resources, and responsibilities to the different tiers of government. States and local governments enjoy a considerable degree of political and fiscal autonomy. No national framework encompasses budgets at all tiers of government and no statutory accountability mechanisms ensure proper coordination of state plans and fiscal arrangements to achieve national goals in any sector (World Bank 2015a). With respect to budget reporting arrangements, each tier of government carries out its own reporting with little coordination, standards for reporting on plans and performance or reporting to the federal government. Yet, most states and all local governments rely heavily on revenues collected at the federal level and shared with states on a monthly basis by the Federal Account Allocation Committee. A relatively small proportion of revenues is generated internally by states.

While there is some ambiguity in functional assignments, the Constitution stipulates that the functions of local government councils include (i) the provision and maintenance of primary education and (ii) the provision and maintenance of health services. In fact, ownership and management of primary health and education facilities have operated at the level of local governments for decades. Over the last 20 years, there has been a de facto recentralization of these functions due to introduction of two vertical funding mechanisms and their attendant administrative agencies. In 2004, the Federal Compulsory, Free Universal Basic Education Act established a statutory fund of no less than 2 percent of the Federal Consolidated Revenue Fund (CRF). The Act further established a vertical system of administration: the Universal Basic Education Commission (UBEC) at the federal level, the State Universal Basic Education Boards (SUBEBs), and the Local Government Education Authorities (LGEAs).

The health sector followed with the National Health Act of 2014, establishing the Basic Health Care Provision Fund (BHCPF) with no less than 1 percent of CRF as the main source of funds for the implementation of its health programs. The BHCPF is shared across four gateways: (a) the National Primary Health Care Development Agency (NPHCDA) gets 45 percent of the fund, (b) the National Health Insurance Agency administers 48.75 percent, (c) the National Emergency Management Committee administers 5 percent, and (d) the National Center for Disease Control gets the remaining 1.25 percent. Similar to the basic education sector, these agencies have cascaded the implementation of their policies and programs to the end users through similar structures at the state and local government levels. Consequently, it is now common to find State Primary Health Care Boards/Agencies (SPHCB/As), which have in turn created the Local Government Health Authorities (LGHAs), parallel to the Local Government Health Secretariats for the execution of basic health care services. Similarly, there are also State Health Insurance Agencies as well as State Emergency Medical Treatment Committees.

In effect, delivery of services in the basic education and primary health care sectors are mainly carried out by the state governments based on programs and projects rolled out at the federal tier of government. Local Government Councils (LGCs), are ordinarily the tier of government closest to the citizens and often believed to be responsible for the delivery of basic services. Currently, however, LGCs have little or no role in formulation or delivery of basic education or primary health care service. The responsibilities for both basic education and primary health care service have in practice been taken over by the State Primary Health Care Boards (SPHCB) and SUBEB, respectively, both agencies of the state governments. The SPHCB and SUBEB exclude the LGCs by creating their own extension at the local level—that is, LGHAs and LGEAs. As a result, although the primary health care facilities and primary schools are owned by the local governments, they are rarely accountable to the local governments; their operational directives and programs originate from the institutions created at the federal and state levels.

The institutional landscape for basic education and primary health service delivery thus cuts across all three tiers of government in both vertical and horizontal directions. The legal and de facto roles of the main agencies are laid out in Annex 3A.

4 Constitution of the Federal Republic of Nigeria 1999 as amended, particularly section 4 and the Legislative Lists in the Second Schedule.

Financing

For basic education the local government provides the largest share of financing at 42 percent, followed by federal and state government with 35 percent and 22 percent respectively. The remainder is contributed by development partners. The largest part of public sector finance is supported by the local government area (LGA) budget. As per the 1999 Constitution, the provision of salaries for teaching and nonteaching staff in government primary schools (which may represent up to 90 percent of all public spending at the primary education level) is the responsibility of LGAs. With the adoption of the Universal Basic Education (UBE) Act in 2004, this responsibility was extended to basic education, which covers primary through junior secondary education. However, the practice varies by state. Some states split the financial responsibility for junior secondary school (JSS) salary payments between LGA and state governments (for example Kano and Kogi states), while in other states salaries are fully under state responsibility (for example, Lagos and Edo states). In addition to salary payments, LGAs also dedicate some funds to capital spending, albeit a relatively small contribution. Furthermore, some JSSs are physically located on the state secondary school premises, so it is impossible to distinguish between state capital spending on junior secondary and upper secondary schools.

Similarly, health is financed by the three tiers of government, with the largest spending at the subnational level. Nigeria's 1999 Constitution empowers all three tiers of government (federal, state, and local) to mobilize and deploy resources to provide health care in their jurisdiction (Hafez 2018; Onwujekwe et al. 2019). The Nigerian government has put in place various policies and plans addressing health care financing. The National Health Insurance Scheme (NHIS) plays a critical role in the financing of the sector. The National Health Financing Policy, adopted by the Federal Ministry of Health (FMOH) in 2006, seeks to promote equity and access to quality and affordable health care and to ensure high efficiency and accountability in the system by developing a fair and sustainable financing system.

The focus on the analysis here is public spending at the subnational level. As such, household-level spending as well as spending by the federal government are not included in the analysis. This analysis will complement the recently completed public finance review, which covered federal-level spendings.

The analysis harnesses secondary data on budget and expenditures from both federal and state governments in Nigeria, sourced from the Boost database. To enrich this data, a comprehensive review of pertinent financial documents has also been conducted. Budget and expenditure information at the state level is available for 25 of Nigeria's 37 states. Additional data sources include UBEC Audit reports, along with administrative and financial information from the Federal Ministry of Education (FMOE), state Ministries of Education (MOEs), and the Federal Ministry of Finance, Budget, and National Planning. Household survey data, statistics from the UNESCO Institute for Statistics (UIS), and data collected directly from various states further augment this analysis, providing a robust and multifaceted view of the fiscal landscape across Nigeria's education sector.

The following sections focus on the level of spending on human capital, given the needs (adequacy); whether spending is on the right interventions to achieve the desired objectives; and how well the resources address current gaps among different groups.

Adequacy of spending: Overall public spending in health and education

The overall public spending, at merely 12 percent of GDP, falls short of the threshold necessary to underwrite fundamental public services. This compares to the Sub-Saharan African average of 17.2 percent and the lower middle-income countries average of 18.5 percent. Over the past five years, Nigeria's health and education expenditure has fluctuated between 10 and 12 percent of GDP (Figure 3-2). When measured against international standards, it becomes evident that this level of investment is insufficient for delivering adequate essential public services. As a result, a large proportion of spending, especially health spending, is out of pocket, which excludes a significant segment of the society from accessing health services.

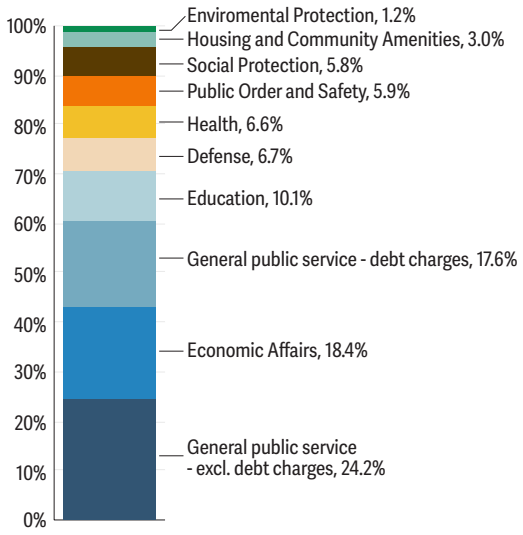
At US$23 and US$15 per capita, public expenditure on education and health in Nigeria, respectively is inadequate by any standard. Of the US$23 per capita spending on education, states spend US$14 and the remainder is spending by the federal government. Similarly, of the US$15 per capital spending on health, states spend US$8.[5] This level of spending compares poorly to Nigeria's peers (Figures 3-4, 3-5, and 3-6). It is far more inadequate given the need to tackle significant issues such as the high rates of out-of-school children and child mortality.

Spending in health and education are low mainly because of overall of level of public spending which is constrained by the very low overall revenue.[6] As a share of budget, allocations to education and health were 10.1 percent and 6.6 percent of overall spending (federal plus state)[7] in 2021, respectively (Figure 3-1). The two largest shares of the budget were spending for General Public Services (24.2 percent) and Economic Affairs (18.4 percent). Debt charges within General Public Services were the third largest expenditure item at 17.6 percent of the general government (federal and state) budget. Social sectors—education, health, and social protection—received together less than one-quarter of the national budget in 2021.

The states spend more than the federal government on both primary health and basic education. In absolute terms, states spent N1,299 billion on education and N731 billion on health, compared to federal spending of N773 billion and N610 billion, respectively. Thus, education constituted the third-highest spending for state governments, followed by spending on health.

FIGURE 3-1.

General government (federal and state) budget allocations across government functions, 2021 (% of the total national budget)

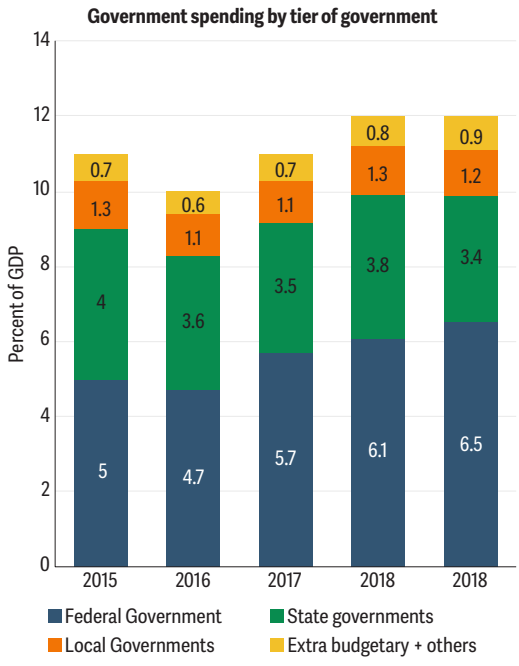


Source: World Bank 2022a.

Note: Estimates exclude FCT, local governments, federal government-owned enterprises, and extrabudgetary funds receiving federation account allocations.

FIGURE 3-2.

Nigeria's government spending by tier of government, 2015–2019 (% GDP)



Source: World Bank 2022a.

5 The figures are budgeted amounts. Details are in the recently completed "Nigeria Public Finance Review" (World Bank 2022a).
6 Nigeria has one of the lowest revenue to GDP ratio at 8%.
7 LGA budgets are not included in the estimate due to the unavailability of data.

TABLE 3-1.

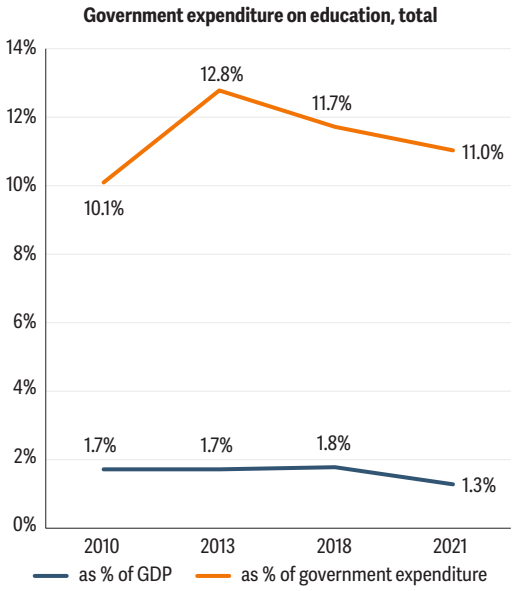
State government spending by sector, 2021

Function	State gov't average (% of total 2021 budget)	Average state gov't budget allocation per capita (US$)
General public service	37	34.5
Economic affairs	24	21.7
Education	16	14.6
Health	9	8.0
Housing and community amenities	7	6.2
Public order and safety	3	2.5
Environmental protection	2	2.0
Recreation, culture and religion	2	1.5
Social protection	1	0.6
Total state gov't budgeted expenditure	100	92

Source: World Bank 2022a.

FIGURE 3-3.

Total government expenditure on education (federal and state) as a share of GDP and proportion of total government expenditures, 2010–21



Sources: For 2021 data, World Bank (2022a); for other years, UIS.

Low levels of execution mean that actual spending per capita is as low as US$4 and US$7.3, respectively. On average, states dedicated 16 percent of their 2021 budgets to education and 9 percent to health, yet this varied significantly across states (as detailed in Table 3-1). This budget allocation equates to a per capita spending of US$14.6 for education and US$8.0 for health. However, due to an average budget execution rate of only 50 percent by the states, the effective per capita expenditure drops to approximately US$7.3 for education and US$4 for health, highlighting a substantial gap between budgetary allocations and actual spending.

Public spending in education is not only low but it is also decreasing, making Nigeria one of the lowest spenders in Sub-Saharan Africa

Nigeria spends 1.3 percent of its GDP on education and has been decreasing. This is a decrease from the 2010–18 average, which fluctuated between 1.7 percent and 1.8 percent (as shown in Figure 3-3). Looking at a longer timeframe—from 2001 to 2017—the country's annual average allocation to education was 1.97 percent of GDP. Notably, between 2001 and 2010, education spending dropped from 3.2 percent to 1.7 percent of GDP, despite an increase in the proportion of school-age children during this period. However, this is due to an overall reduction in public spending. Otherwise, education's share of the national budget actually increased from 10.1 percent in 2010 to 12.8 percent in 2013, before decreasing to 11.7 percent in 2018 and eventually to 11.0 percent in 2021. This suggests that the reduction in education expenditure is more attributable to a decrease in overall government spending rather than a diminished prioritization of education.

This level of spending places Nigeria behind West African nations such as Senegal, Ghana, and Côte d'Ivoire, as well as East African countries like Kenya and Zambia, as illustrated in Figure 3-4. This is in stark contrast to the ambitious pledges made by Nigeria's political leaders to boost education funding to 4 percent of GDP by 2025, which would represent 22.5 percent of the national budget. In reality, education accounted for only 10.1 percent of total government expenditures in 2021, falling short of both international standards such as the Incheon Declaration (4 percent of GDP and 15–20 percent of budgets) and Nigeria's own commitments.

For its income level, Nigeria can afford to spend the equivalent of at least 2.4 percent of its GDP on education. That would be a level similar to that of Pakistan (Figure 3-5). Many countries in the Sub-Saharan African region devote a much higher share of GDP to education. For example, neighboring Cameroon spends equivalent to 3.2 percent of its GDP. Tanzania and Côte d'Ivoire spend a similar amount, 3.3 percent and 3.4 percent, respectively. At 5.5 percent, Senegal spends the highest share of its GDP on education in Western Africa. Despite large differences in the level of income, Nigeria spends almost at the same level of Sudan.

FIGURE 3-4.

Government expenditure on education as a share of GDP in Nigeria compared to Sub-Saharan African countries, 2021 or the latest available year (%)

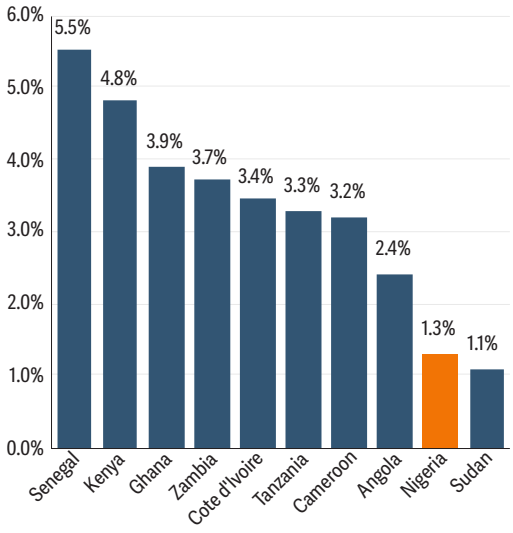
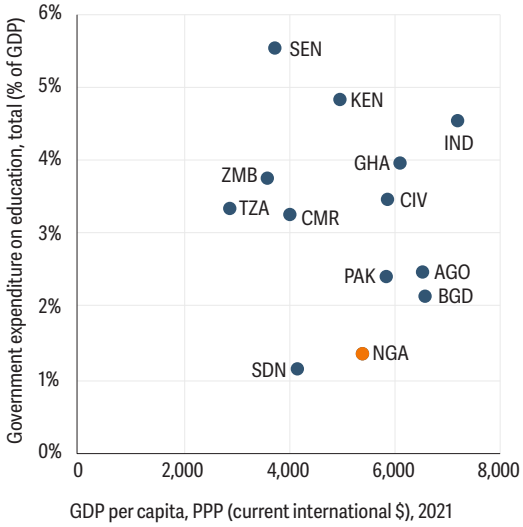


FIGURE 3-5.

Distribution of countries by government expenditure on education as a share of GDP, 2021 (%)

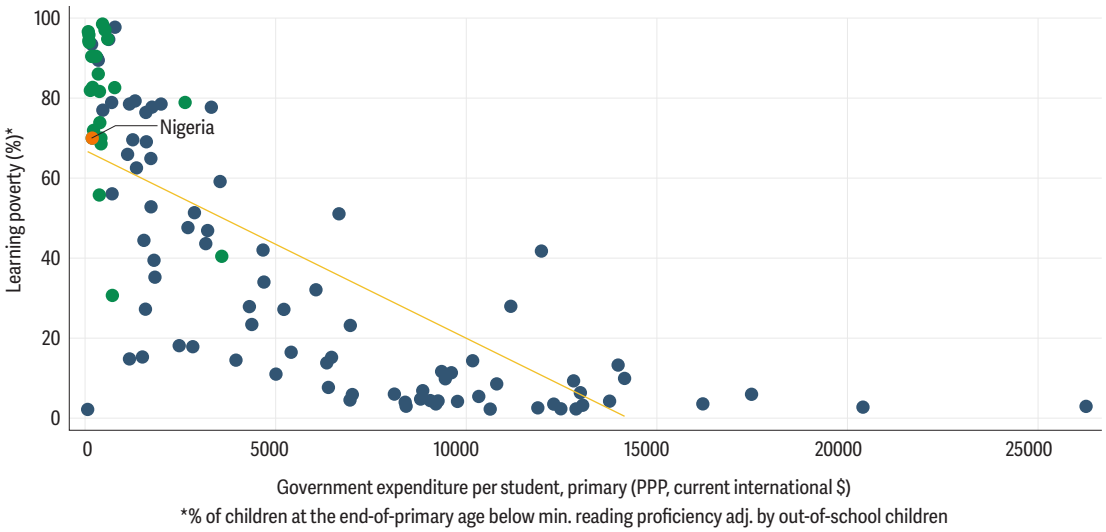


Source: World Bank, using UIS data.

More importantly, Nigeria's low level of learning requires a level of investment much higher than the current one. Nations that boast lower levels of learning poverty (quintiles Q1–Q3) allocate approximately 20 percent of their GDP per capita for each primary school student. In stark contrast, Nigeria's expenditure is a mere 3.3 percent of its GDP per capita per primary student. Considering its stage of economic development, Nigeria should ideally be investing at least US$1,000 per primary student, which means increasing the per-student expenditure sixfold. Moreover, with a significant number of children not attending school and a rapidly growing school age population, by 2030 Nigeria would need to increase its investment in basic education ninefold from its 2022 level to achieve Sustainable Development Goal #4.

FIGURE 3-6.

Distribution of world countries by level of government spending per primary school student and learning poverty, 2020 or latest available year



Source: World Bank using data from the World Bank Learning Poverty Global Database (https://datacatalog.worldbank.org/search/dataset/0038947) and UIS Database.
Note: Spending measured in PPP in international $; red dots represent Sub-Saharan countries.

TABLE 3-2.

Average learning poverty and government spending on education in 124 countries by learning poverty quintile

Learning poverty quintile	Av. learning poverty (%)	Government expenditure per student, primary (% of GDP per capita)	Government expenditure on education, total (% of GDP)	Government expenditure per student, primary (PPP, current international $)
Q1 (low)	3.8	19.5	5.0	11,572
Q2	13.5	21.1	4.8	7,672
Q3	36.7	18.5	4.6	4,404
Q4	67.3	12.4	4.4	1,342
Q5 (high)	89.6	11.5	3.9	493

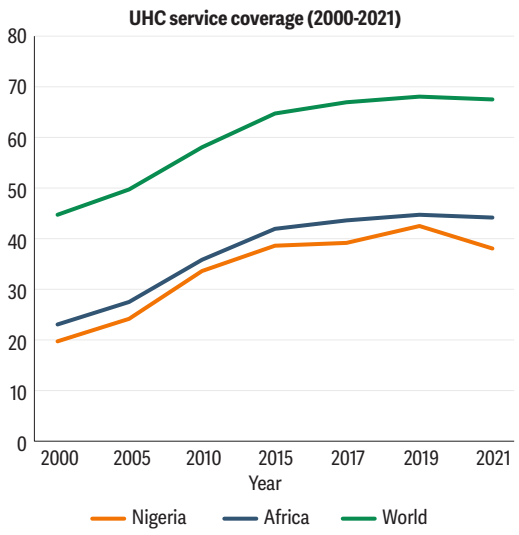
Source: World Bank, using data from the World Bank Learning Poverty Global Database (https://datacatalog.worldbank.org/search/dataset/0038947) and UIS Database.

The low level of financing is in part responsible for the low level of universal health coverage

Nigeria ranks near the bottom in Africa in Universal Health Coverage. With a score of 44, Nigeria's Universal Health Coverage (UHC) index has seen some improvement over time but still ranks among the lowest in the Africa region. The coverage of essential health services remains limited, and the proportion of health expenditures financed by out-of-pocket payments is the highest in the region, which is indicative of the country's poor health outcomes. Despite some progress in recent years, the pace of improvement in Nigeria's health indicators lags behind that of other African nations. For example, the increase in life expectancy in Nigeria has been more gradual compared to other countries on the continent.

FIGURE 3-7.

Scores on universal health coverage, Nigeria, Africa, and the world, 2000 to 2021



Source: World Development Indicators.

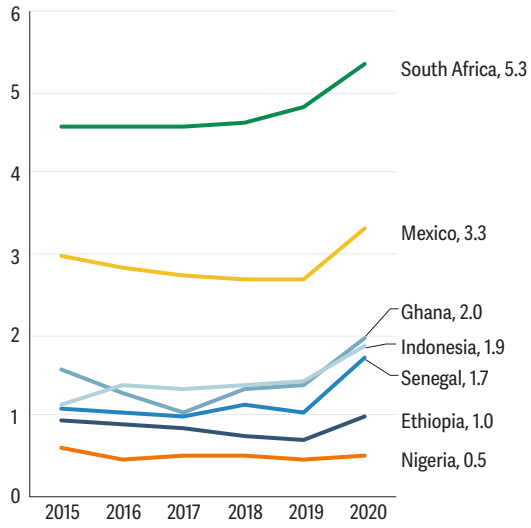
Nigerian government's health expenditure of just 0.5 percent of GDP, ranking it among the lowest globally (as shown in Figure 3-8). Out-of-pocket payments dominated Nigeria's health care financing, accounting for 77 percent of total health expenditures. Such a high reliance on out-of-pocket payments has several adverse effects, one of the most significant being the financial burden it places on households. On average, health-related expenses push more than 1 million Nigerians into poverty each year. Additionally, the prohibitive cost of care leads many to forego necessary medical treatments. For those who manage to avoid falling below the poverty threshold, a substantial number still face catastrophic health expenditures, with a quarter of Nigerians experiencing such financial strains annually.

The limited public funds allocated to health in Nigeria are predominantly directed toward secondary and tertiary care facilities, with a significant portion of the budget being spent on curative services within these higher-level hospitals. This allocation strategy overlooks the crucial areas of prevention, public health, and primary health care, which are both cost-effective and have a high impact on overall health outcomes. The implications of this skewed spending pattern are twofold. First, it results in scarce resources being unavailable for essential preventive and promotive health services that could yield significant health benefits. Second, it leads to high out-of-pocket expenses at the point of service. These costs deter service utilization and pose a substantial barrier to accessing care, particularly for economically disadvantaged populations.

Nigeria is among the countries with the lowest health care spending globally, with public health expenditure barely reaching 0.5 percent of its GDP, as illustrated in Figure 3-8. This level of investment in health is one of the lowest worldwide. When compared to countries with similar economic profiles, Nigeria's health expenditure is notably insufficient.

FIGURE 3-8.

Domestic general government health expenditure as share of GDP in selected African countries and Mexico, 2015–20 (%)



Source: WHO Global Health Database.

FIGURE 3-9.

Domestic general government health expenditure per capita in selected African countries, Mexico, and Indonesia, 2020 (US$)

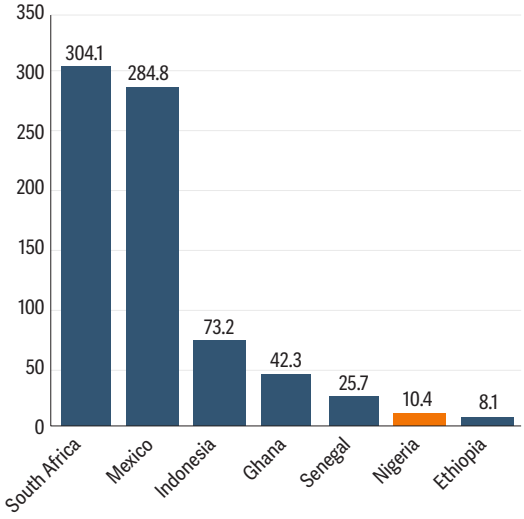
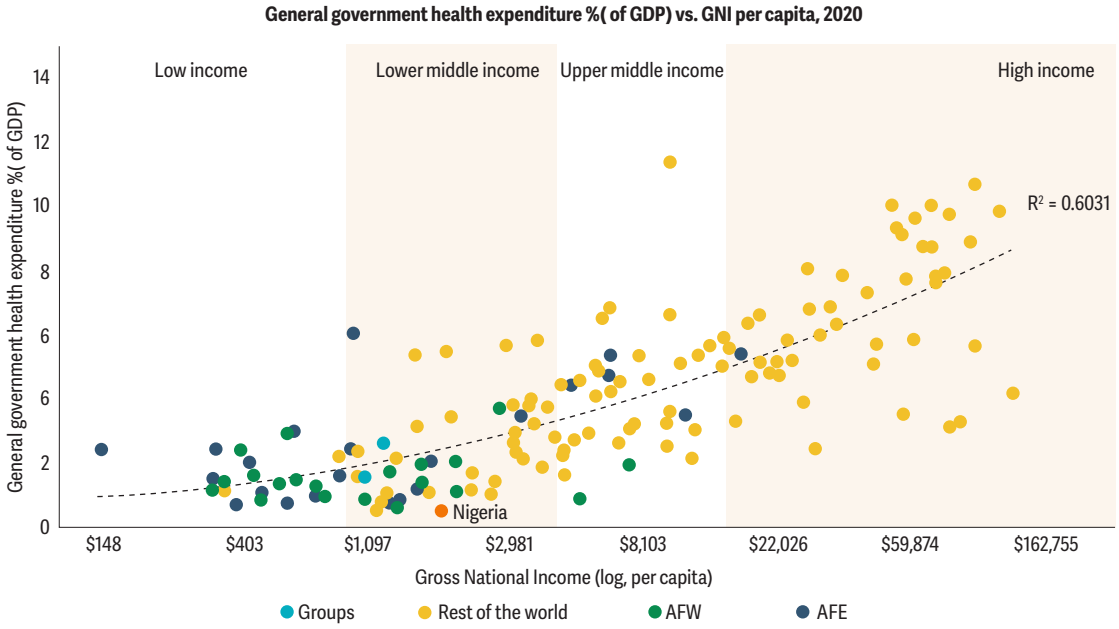


FIGURE 3-10.

General government health expenditure (% of GDP) versus GNI per capita, world countries, 2020



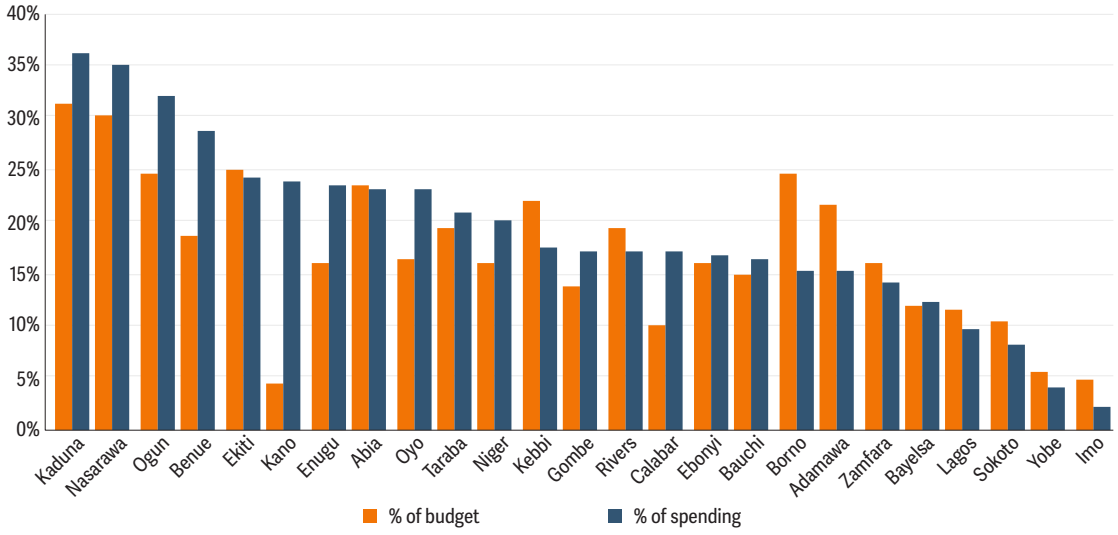
Source: WDI state spending on education and health.

On average, Nigerian states allocate 17.2 percent of their budgets to education and about 9.0 percent to health. However, there is a wide variance in the proportion of budgets dedicated to education across different states, ranging from a low of 5.2 percent in Imo to a high of 31.5 percent in Kaduna, as shown in Figure 3-11. Notably, 11 states invest over 20 percent of their budgets in education and health, with Kaduna, Nasarawa, and Ogun allocating more than 30 percent in education and only Kaduna, Sokoto, and Benue spending more than 12 percent in health (Figure 3-12).

Budget execution also varies significantly across states. Some states' budget execution rates are more than 100 percent while others were able to execute barely 50 percent of their budgets (Figure 3-13). In both cases, spending

FIGURE 3-11.

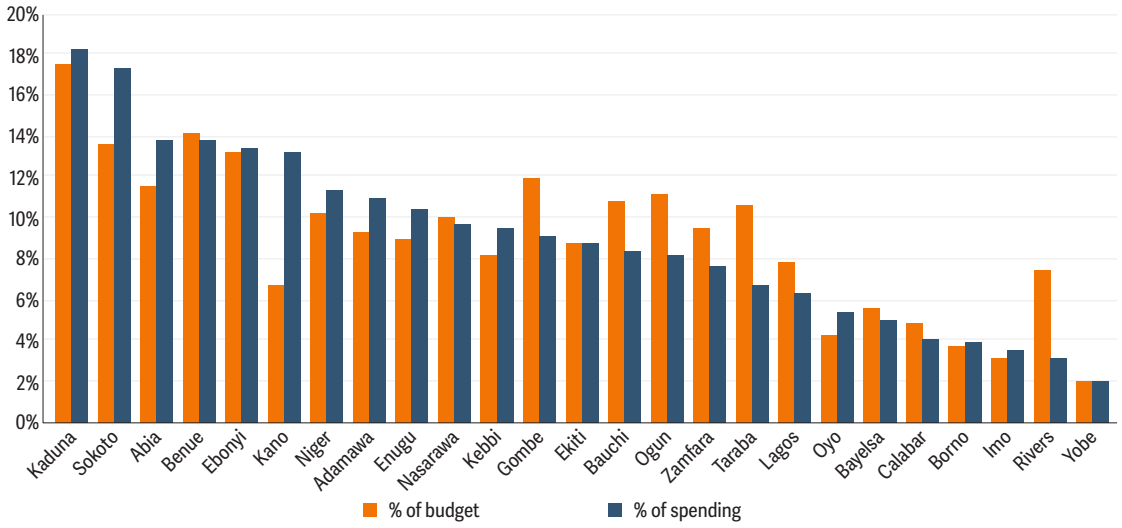
Education as a share of total expenditure and budget, by state, 2021 (%)



Source: World Bank, using state 2021 expenditure data.

FIGURE 3-12.

Health as a share of total expenditure and budget, by state, 2021 (%)



Source: World Bank, using state 2021 expenditure data.

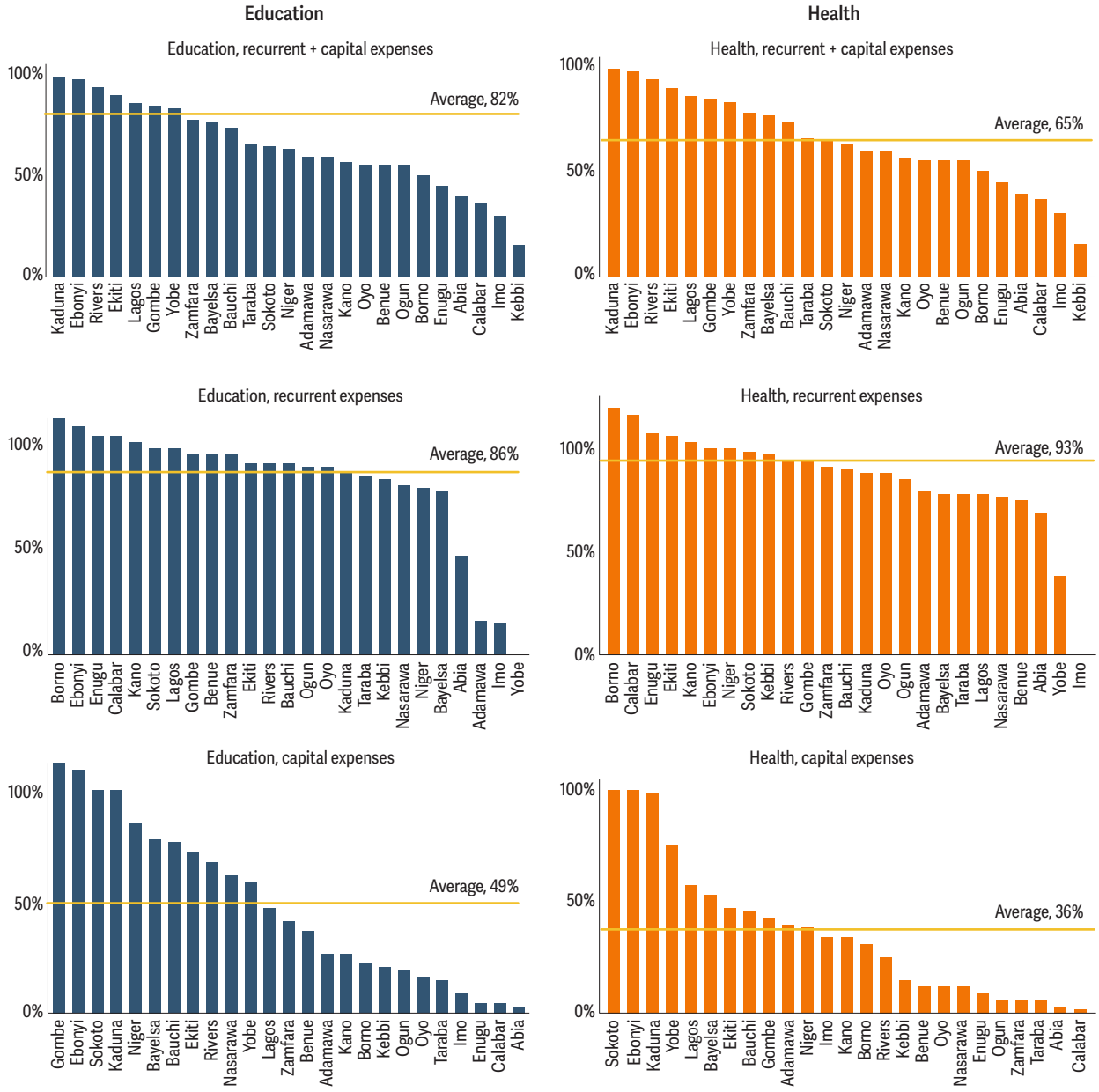
either more than the budget or less (underspending) is a reflection of systemic problems in the public financial management systems, including the overall budgeting, planning, and execution capacity of the states.

The overall budget execution rates for education and health across Nigeria's states are relatively modest at 82 percent and 65 percent, respectively (Figure 3-14)**.** These averages mask significant disparities in budget execution rates among the states. For instance, in the education sector, Kebbi (in the North West) utilized only 15 percent of its budget, whereas Kaduna (in the North) fully expended its education budget. States like Katsina, Gombe, Enugu, and Bauchi executed half or less of their allocated education budgets in 2021. A similar pattern is observed in health budget execution, with Kaduna nearly achieving full expenditure and Kebbi lagging at around 15 percent. Across the board, recurrent budget has a higher execution rate than capital budget.

State budgets on education and health predominantly cover recurrent expenses. In education, recurrent expenses such as wages and salaries account for about 74 percent of the spending, while capital spending takes the back seat. Despite states planning for a more significant portion of their budgets (an average of 39 percent in 2021) to go toward development activities, the actual allocation to development expenditures tends to decrease due to the under-execution of capital expenditures. Similarly in health, recurrent spending accounts for around 65 percent of the total. This is in contrast to what is in the budget: there's a substantial gap between planned and actual spending, as states, on average, intend to allocate 40 percent of their budgets to recurrent expenses and 60 percent to capital projects.

FIGURE 3-13.

Budget execution: Ratio of expenditures to budgets in education and health in states of Nigeria, 2021

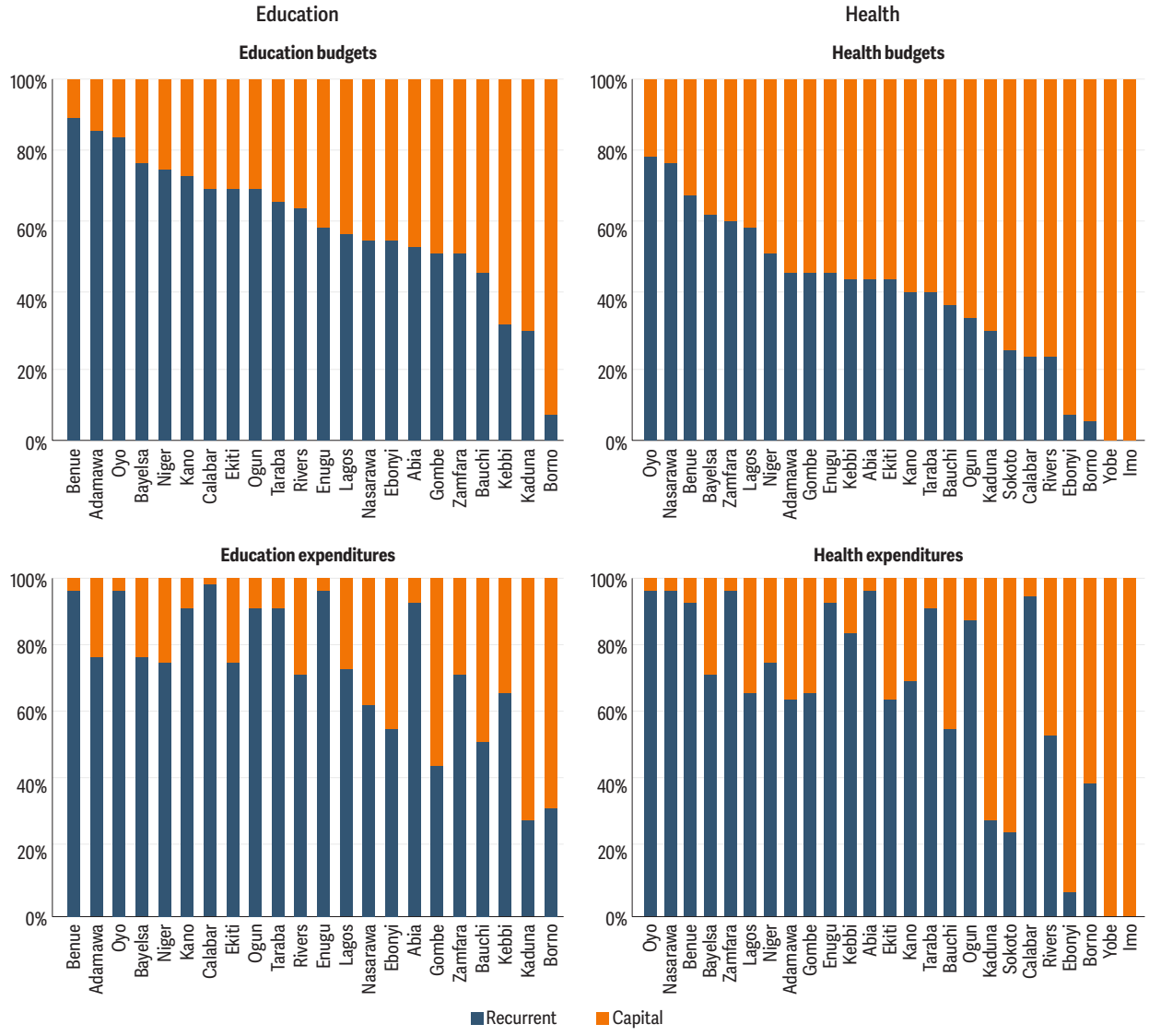


Source: World Bank, using state expenditure data.

The space to increase spending in health and education varies across states. The level of spending in health and education as a percentage of overall spending is a demonstration of how much these two sectors are prioritized by the state. Overall spending as a percent of GDP, on the other hand, can proxy the ability to spend. Plotting these two gives a picture of the space available to increasing spending in health and education, if states are inclined to do so. For states that are already spending more than 25 percent (Benue, Kaduna, and Nasarawa) of their budgets on education, increasing education expenditures by reprioritizing education could be challenging (Figure 3-15). Any increase in state expenditure on education must come from an overall increase in state spending, which would require mobilizing more resources either from internally generated revenue or any other external sources. On the other hand, states such as Abia, Adamawa, Lagos, Sokoto, and Bayelsa still have space to prioritize education within the current level of overall state spending. Similarly, regarding health, some states still have space to increase health spending through reprioritization within the current level of overall spending. States spend, on average, 0.3 percent of their GDP on health, with Kaduna's spending being the highest and Rivers' the lowest. But among states that with a similar overall level of spending, the priority for health varies significantly (for example, Benue versus Lagos, or Sokoto versus Rivers).

FIGURE 3-14.

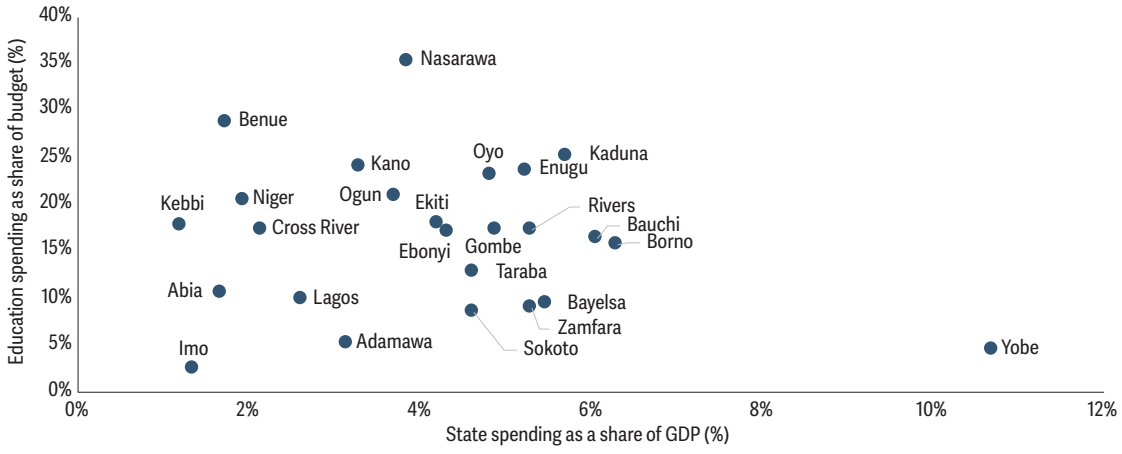
Breakdown of the education and health budget and expenditures in selected states of Nigeria, 2021 (%)



Source: World Bank using state expenditure data.
Note: The reported data for Imo is incomplete, with only capital expenditures reported.

FIGURE 3-15.

Education as a share of total government budget and government spending as a share of GDP, by state, 2021 (%)



Source: World Bank, state expenditure data.

BOX 3-1.

Low domestic resource mobilization constrains investments in human capital

The reasons for the low levels of investments in human capital are multiple. Some of the reasons are economywide. The following excerpt from the recently completed Public Finance Review (World Bank 2022a) describes the state more clearly.

"Nigeria suffers from a very large and broad-based tax gap. During 2017-19, Nigeria's median tax-to-GDP ratio was only 4.5 percent, the 167th lowest level out of 175 countries. Nigeria's tax gap is estimated at 14-15% of GDP, and it spans all elements of the tax system. Over the past decade, VAT revenues hovered between 0.8 and 1% of GDP, far below the average for Sub-Saharan Africa, which stands at 8 percent; corporate taxes remained below 1% of GDP; and customs and excise duties varied from 0.4 to 0.6% of GDP. The internally generated revenues (IGR) of State Governments have been limited to less than 1% of GDP, through recent efforts have been made to shore up subnational resources. Nigeria's weak tax effort—defined as the revenue collected relative to the potential revenue that could be collected—reflects the government's failure to develop a modern, simple, and efficient tax policy.

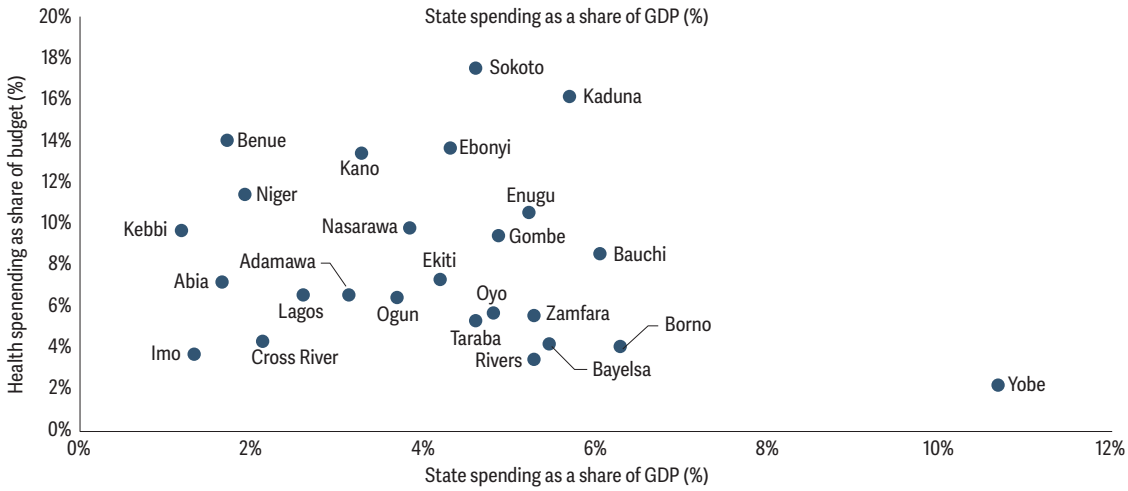
"Low tax rates are a major obstacle to accelerating non-oil revenue mobilization. The standard VAT rate was increased from 5% to 7.5% in 2020, but it remains by far the lowest in Sub-Saharan Africa. Excise rates are also extremely low: for example, the 20% excise rate on tobacco and alcohol products is less than half the median for peer countries and far below the level recommended by the Economic Community of West African States. Moreover, Nigeria does not impose dedicated taxes on environmentally damaging goods (e.g., plastic bags and bottles), and in defiance of international best practices, petrol is exempt from VAT.

"Sizeable tax incentives mean that Nigeria is foregoing revenues that could finance basic service delivery: tax expenditures impose a large cost in terms of forgone revenues. Although forgone revenues are difficult to estimate and compare across countries, Nigeria's tax expenditures cost the government at least at ₦ 5.8 trillion, or 3.7% of GDP, one of the largest shares among countries in Sub-Saharan Africa for which comparable estimates are available. VAT accounts for the bulk of forgone revenue, as a significant part of the tax base is exempted from the base rate and compliance is low. In 2020, if all commodities in the VAT system had been taxed, Nigeria could have generated about ₦ 6 trillion from the existing tax structure. However, it only collected ₦1.8 trillion, with a significant part of the revenue loss related to exemptions. The CIT base is being narrowed due to the use of exemptions, which cost the government ₦ 457 billion (0.3% of GDP) in 2020 alone, compounding Nigeria's low CIT collection efficiency. The cost of customs exemptions reached an estimated ₦780 billion in 2020, equaling more than 80% of the collected customs revenue, which totaled ₦ 932 billion."

Source: World Bank 2022a.

FIGURE 3-16.

Health as a share of total government budget and government spending as a share of GDP in states of Nigeria, 2021 (%)



Source: World Bank, state expenditure data.

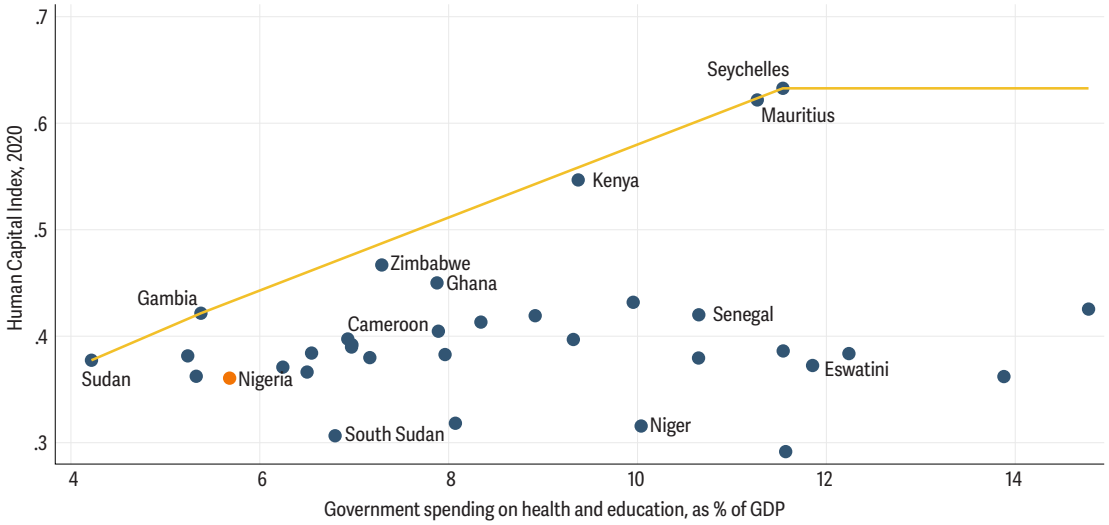
Efficiency of spending

This section aims to explore the efficiency of public spending in health and education. This is done using a simple Data Envelopment Analysis (DEA) to quantify the inefficiency level in key spending categories comparing Nigeria with select African countries. Efficiency in the DEA is measured in relation to the performance of the best units in the population of countries used. Efficiency of spending at the state level is also examined.[8]

HCI: The quality of overall spending in health and education is low. Using the HCI as an overall measure of human capital outcome, there is a large efficiency gain that can be made. With the current level of public spending on health and education, Nigeria should have a Human Capital Index of 0.44 as opposed to its current level of 0.36. This is a significant difference: to put this in context, the HCI for Nigeria has moved from 0.34 in 2018 to 0.36 in 2020.

FIGURE 3-17.

Efficiency frontier of public spending in education and health (as % of GDP) in terms of human capital development (Human Capital Index) in Sub-Saharan African countries



Source: World Bank estimations, based on data from UIS, WHO, and World Bank.

Enrollment. There are significant efficiency gains to be made in public spending in primary education in Nigeria. A partial analysis of enrollment reveals that only slightly more than three-fifths of the potential has been attained. In other words, at the current level of spending, student enrollment could be significantly increased (Figure 3-18). At the spending level of Nigeria, the most efficient countries have gross enrollment ratios in primary education 1.6 times higher than those in Nigeria. Nigeria ranks 36th on the measure of the efficiency of public spending in primary education out of 42 Sub-Saharan African countries for which data are available. Thus, Nigeria could increase its gross enrollment ratio from the current 85.3 percent to more than 100 percent with the same level of spending per school-age child.

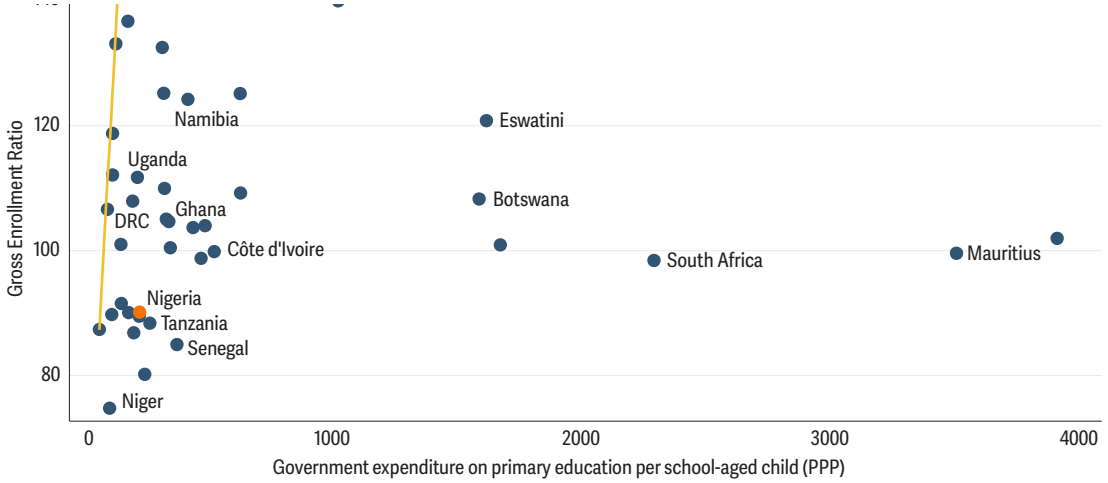
Quality of education. The best-performing countries achieve learning scores that are 31 percent higher than those of Nigeria, which is equivalent to 138 Harmonized Learning Outcomes (HLO) points (Figure 3-19). An equivalent to 5–6 years of schooling is lost due to the low quality of education. Hence, even with the existing meager resources spent on education, the education system in Nigeria has significant scope for improving learning outcomes by improving the quality of spending.

Health outcomes. In the health sector as well, there is a large scope to improve the quality of spending. Using the outcome indicator *"survival rates to age 65,"* Nigeria stands at the bottom of Sub-Saharan African countries (Figure 3-20). In fact, Nigeria ranks 44th on the measure of the efficiency of public spending in the health sector out of 48 Sub-Saharan African countries for which information is available. Countries such as Chad and the Central African Republic have similar health outcomes, despite spending only half of what Nigeria spends on a per capita basis. In other words, countries with similar levels of spending have a probability of surviving to age 65 at 66 percent, while in Nigeria it stands at only 45 percent.

8 It must be mentioned that interpreting results from a DEA requires careful consideration of several caveats. Firstly, a DEA is sensitive to the choice of inputs and outputs, meaning that the inclusion or exclusion of certain variables can significantly impact the efficiency scores derived. Secondly, a DEA assumes that all decision-making units (DMUs) are operating in a similar environment and under comparable conditions, which may not always be the case. External factors not included in the analysis can lead to misleading efficiency assessments. Furthermore, DEA results are relative and do not provide absolute measures of efficiency; a DMU deemed efficient is only so in comparison to others in the dataset, potentially masking suboptimal performance if the entire set operates at low efficiency levels. Lastly, a DEA's non-parametric nature means it doesn't account for statistical noise, leading to overestimation of efficiency scores, especially in small sample sizes. Understanding these limitations is crucial for a nuanced interpretation of DEA outcomes.

FIGURE 3-18.

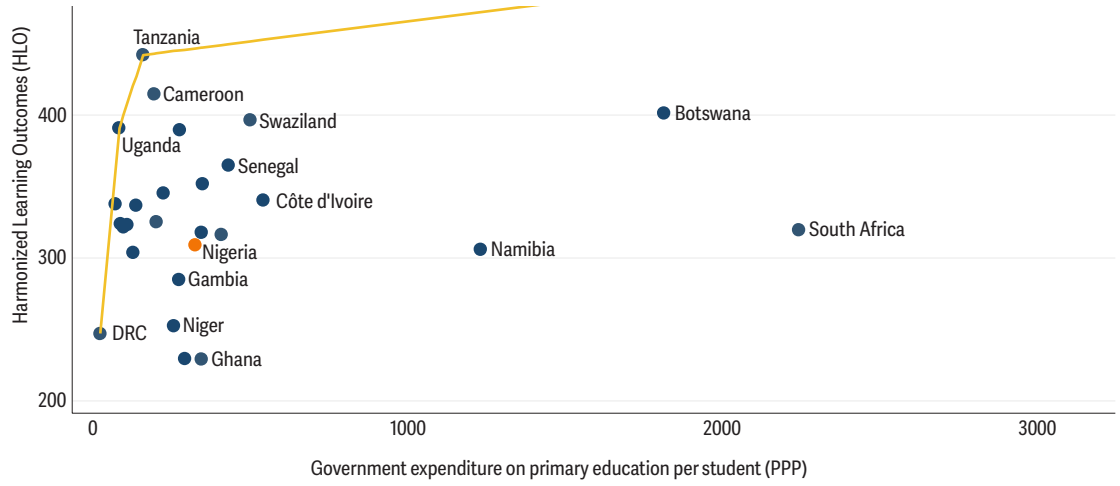
Efficiency frontier of public spending in primary education in terms of educational coverage in Sub-Saharan African countries



Source: World Bank, using UIS data and public spending data from (Budget implementation report, 2021).

FIGURE 3-19.

Efficiency frontier of public spending in primary education in terms of educational quality in Sub-Saharan African countries



Source: World Bank, using UIS data.

Efficiency of state-level spending. This section examines inter-state variations in the efficiency of public spending on education and health. For education outputs, both net enrollment and out-of-school children are used, while under-5 mortality is used as an output measure in assessing the efficiency of health spending.

Education coverage. The average net attendance rate (adjusted[9]) in Nigeria was 68.4 percent, including 81.6 percent in urban and 59.6 percent in rural areas (Figures 3-22 and 3-23).[10] The net attendance rate varies significantly among the states: from 38.2 percent in Bauchi to 88.3 percent in Abia. According to the same survey, a quarter (25.6 percent) of primary-school-age children are out of school in Nigeria. The rate varies from 0.6 percent in Imo to 64.8 percent in Kebbi.

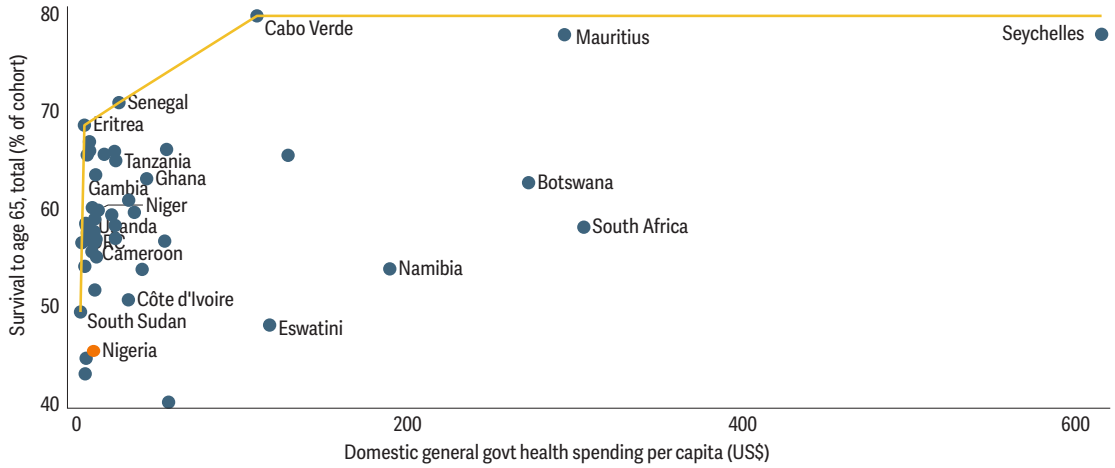
Based on the DEA analysis, Imo, Abia, and Lagos are the best-performing states in terms of efficiency in education spending. With an annual spending of N1,701 per child, Imo enrolls and retains in school 86 percent of school-aged children living in the state, while Abia enrolls 88 percent of school-aged children spending N6,228 per child. Lagos

9 The adjusted primary school net attendance rate (ANAR) is the percentage of children of primary school age (as of the beginning of school year) who are attending primary, lower, or upper-secondary school. Children of primary school age at the beginning of the school year currently attending primary, lower, or upper-secondary school (ED10A=1, 2 or 3) are included in the numerator (attendance at secondary school is included to take into account early starters). Children that did not attend school in the current school year but have already completed primary school are also included in the numerator (ED9=2 and ED5A=1 and ED5B=last grade of primary school and ED6=1). All children of primary school age (at the beginning of the school year) are included in the denominator.

10 According to the MICS conducted by UNICEF in Nigeria in 2021.

FIGURE 3-20.

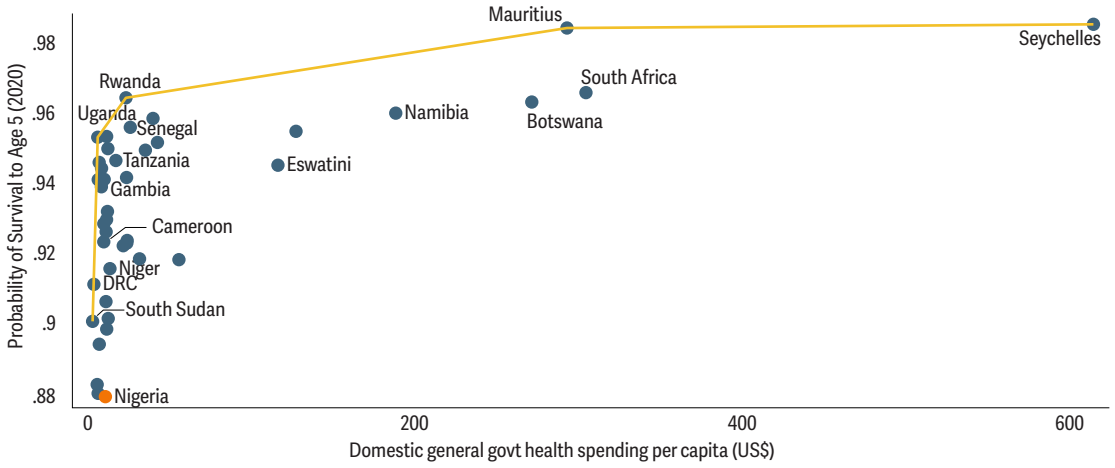
Efficiency frontier of public spending on health in terms of outcomes: survival rates to age 65 (%)



Source: World Bank, using data from BIR (2021) and the WHO Global Health Database.

FIGURE 3-21.

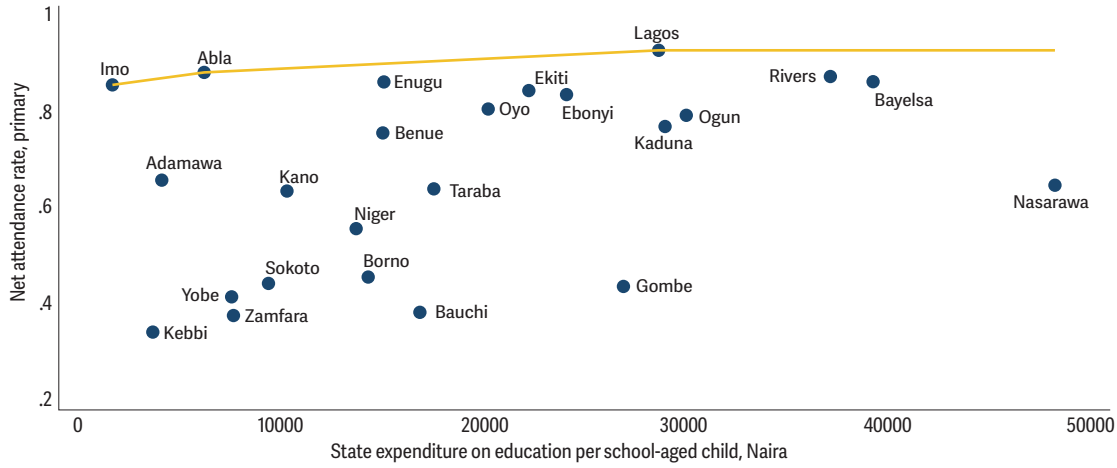
Efficiency frontier of public spending on health in terms of outcomes: probability of survival to age 5 (%)



Source: World Bank, using data from BIR (2021) and the WHO Global Health Database.

FIGURE 3-22.

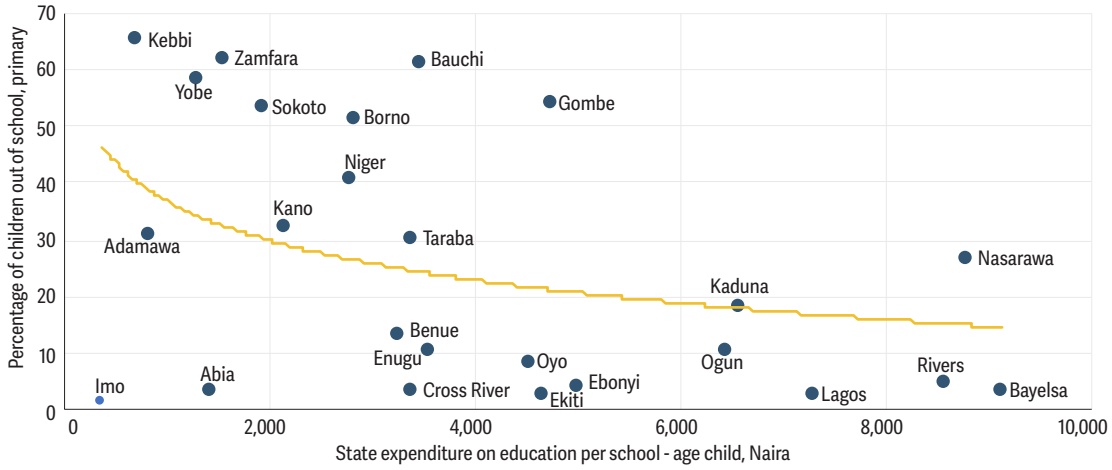
Efficiency frontier of public spending in primary education in terms of education coverage, by state, 2021



Source: World Bank, using data from (BIR 2021) and MICS 2021.

FIGURE 3-23.

Distribution of states of Nigeria by the level of public spending per school-age child and primary out-of-school rates, 2021



Source: World Bank, using data from (BIR 2021) and MICS 2021.

state has the highest net attendance rate among all the states of Nigeria, with annual spending of N28,661 per school-age child. The worst in terms of quality public spending on education include Kebbi, Bauchi, and Zamfara, with efficiency indices of 0.39, 0.42, and 0.42, respectively. These states enroll around a third of their school-age population—34 percent in Kebbi, 37 percent in Zamfara, and 38 percent in Bauchi state (Table 3-3).

TABLE 3-3.

Efficiency of public spending on education in terms of coverage, by state, 2021

	State spending per school-aged child, Naira	Net attendance rate (%)	Efficiency index	Efficiency quintile
Imo	1,701	86	1	5
Abia	6,228	88	1	5
Lagos	28,661	93	1	5
Enugu	15,098	86	0.96	5
Rivers	37,136	87	0.94	4
Bayelsa	39,243	86	0.93	4
Ekiti	22,253	85	0.92	4
Ebonyi	24,113	84	0.91	4
Oyo	20,246	81	0.88	4
Ogun	30,022	79	0.85	3
Benue	15,045	76	0.84	3
Kaduna	28,975	77	0.83	3
Adamawa	4,136	66	0.76	3
Kano	10,315	64	0.71	3
Taraba	17,564	64	0.71	2
Nasarawa	48,220	65	0.7	2
Niger	13,728	56	0.62	2
Borno	14,323	46	0.51	2
Sokoto	9,401	44	0.5	2
Yobe	7,583	41	0.47	1
Gombe	26,921	44	0.47	1
Zamfara	7,674	37	0.42	1
Bauchi	16,874	38	0.42	1
Kebbi	3,693	34	0.39	1

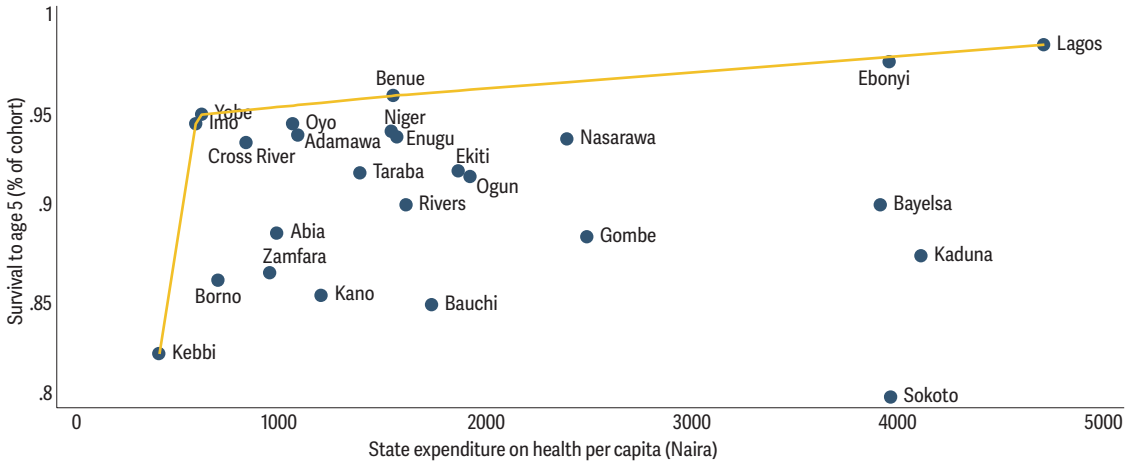
Source: World Bank state expenditure data and MICS 2021

Both Kebbi and Imo allocate approximately 1.2 percent of their GDP to public sectors. Kebbi spends 17.6 percent of all public resources on education, while Imo spends only 2.3 percent. However, measured in terms of expenditure per school-age child, they spend similar amounts. The significant difference in the net attendance rate in primary education has to do with the quality of spending, among other things. A similar pattern is observed for Abia and Benue states: they both spend 1.7 percent of their GDP on public sectors; Abia spends 10.4 percent of its state budget on education, while Benue spends 28.8 percent (which means that Benue prioritizes spending on education). Thus, despite some states prioritizing spending on education by allocating a higher share of their budgets and even spending more per school-age children, they achieve lower outcomes in terms of education coverage, partly due to the quality of their spending.

Health outcomes. Nigeria has the highest number of under-5 deaths of any country, more than 850,000 children dying every year.[11] The under-5 mortality rate varies significantly between states, from 15 deaths (per 1,000 live births) in Lagos to 202 deaths in Sokoto.

FIGURE 3-24.

Efficiency frontier of public spending in health terms of under-5 mortality rates in Nigeria, 2021



Source: World Bank, using data from BIR (2021) and the WHO Global Health Database.

Based on the DEA analysis, the best performing states include Imo, Benue, Lagos, and Kebbi. The worst performing states include Sokoto, with an efficiency index of 0.81.

The above analysis shows that there are large inefficiencies country wide both in terms of education and health spendings. It also shows significant variation across states in the quality of spendings in health and education. The analysis, however, does not identify the sources of the inefficiencies. It is well documented in the previous works that the reasons include: (i) the composition of allocation and actual spending which is skewed toward recurrent at the expense of capital spending. Although budgetary allocation is made to capital expenditures, the execution rate is low with an average spending rate of 30 percent with some variation across states. This is despite a lack of schools/classrooms to accommodate the ever-growing school age population. Even the available schools/classrooms are in bad shape and need repairs/maintenance; (ii) the way the sectors are financed, including budgeting with no explicit link between allocation and expected results; (iii) absence of accountability both at the federal and state levels; and (iv) poor overall sector governance, public finance management in particular, subjecting the sector to significant leakages. Below we try to measure the cost of one particular area where accountability can easily be established—reducing absenteeism of health works and teachers.

11 While the global target calls for reducing under-5 mortality to at least as low as 25 deaths per 1,000 live births, in Nigeria this indicator stood at 102 deaths per 1,000 live births as of 2021.

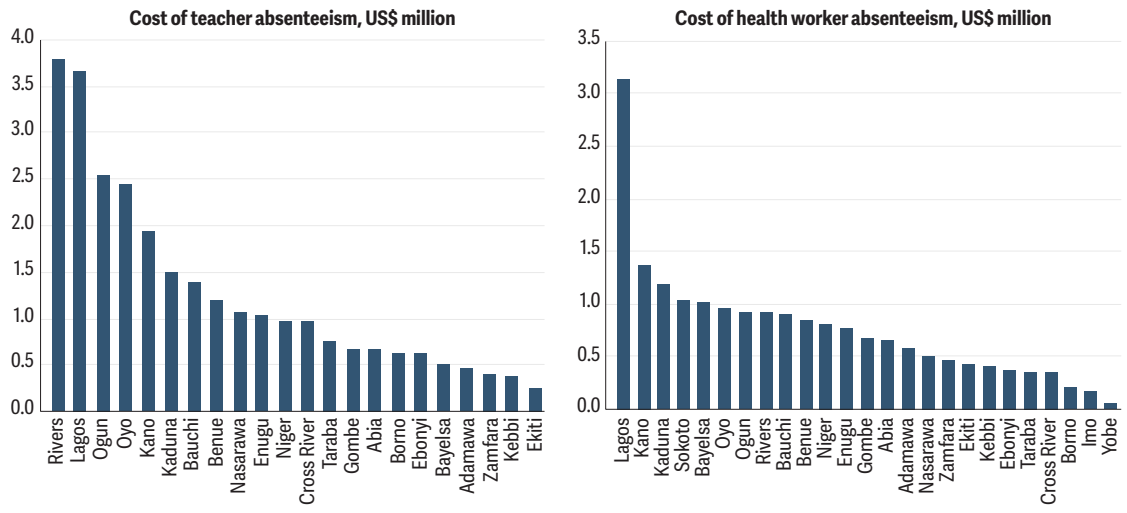
Cost of absenteeism: Health workers and teachers

The level of absenteeism[12] of health workers and teachers is a critical factor affecting the quality of spending in education and health in Nigeria. According to the Service Delivery Indicator Survey (World Bank 2015b), on average, 13.7 percent of teachers were found to be absent from school. Of those at school, about a fifth (19.1 percent) were not in the class teaching. While at school, teachers spent on average about 20.7 percent of their time on non-teaching activities. Combining the absence from school and the classroom with the time engaged in non-teaching activities, the results indicate that teachers spend less than three-quarters of the scheduled teaching time on actual teaching activities. Even when absence is sanctioned, the observed level of over 86 percent of teachers absent is very large. Similarly, absenteeism among health workers is common. According to the same survey, a third (31.7 percent) of the randomly selected health providers who were supposed to be at work were absent during an unannounced visit. Higher absence rates were observed in urban facilities at 34.2 percent, compared to 30.0 percent at rural facilities. Absence rates also differed by the type of health facility, with health centers displaying the highest overall absence rates at 33.6 percent, and the lowest at health posts at 24.3 percent. Absence rates among nurses were the highest at 40.9 percent.

Due to the absenteeism of teachers and health workers, up to 13 percent of public expenditures in education and 21 percent of public expenditures in health are lost. Using available expenditure data from state and LGAs and data on absenteeism from the Service Delivery Indicator (SDI) Survey (World Bank 2015b),[13] the leakages from the health and education systems are estimated for each state (Figure 3-25). According to the estimates, leakage in Lagos state is as high as US$6.7 million from the health and education systems (US$3.6 million from the education and US$3.1 million from the health systems) in 2021.

FIGURE 3-25.

Cost of health care personnel and teacher absenteeism in US$ millions (state and LGA spending on health and education), 2021



Source: World Bank, state BIR (2021).

12 Absenteeism measures absence from duty when the person is expected to be on duty. That means absence with administrative leave and other reasons that were documented are excluded.

13 The education module of the SDI was implemented in four states of Nigeria (Anambra, Bauchi, Ekiti, and Niger). The health module was conducted in 12 states. For states that didn't take part in the SDI survey, we apply weighted averages calculated for states that took part in the survey.

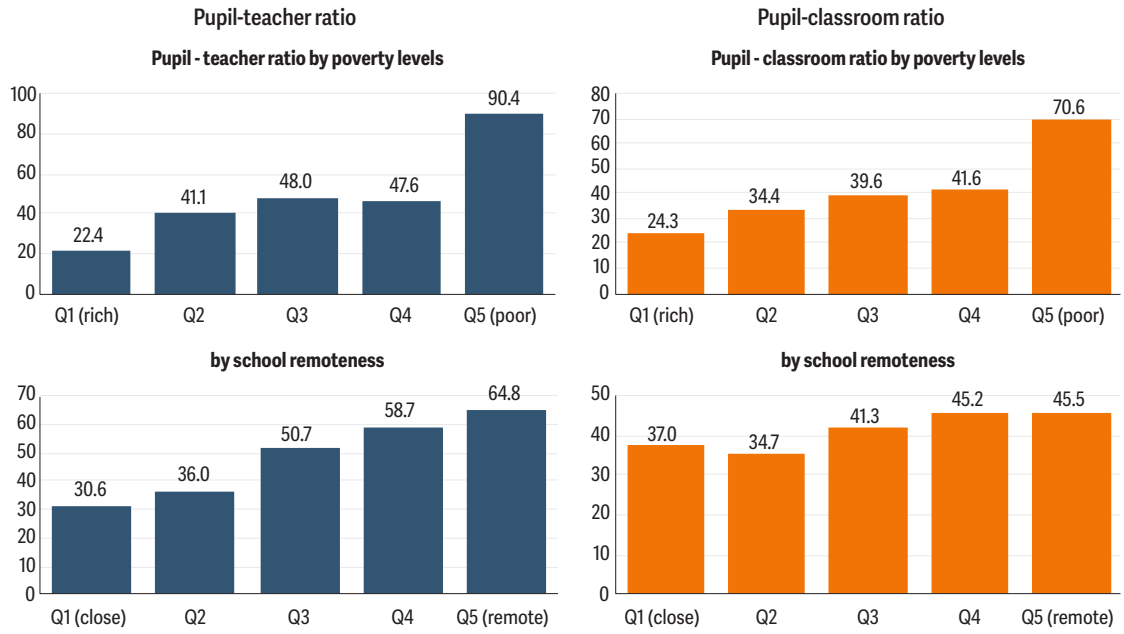
Equity of spending

Distribution of schools, teachers, health facilities, health workers and other inputs

Distribution and availability of teachers in schools. The question of teacher distribution is acute in Nigeria. In the context of rapidly rising enrollment, Nigeria is struggling to post primary school teachers to the schools where they are most needed. School pupil-teacher ratios (PTRs) vary significantly across and within states; between localities with different levels of amenities; and, within localities, between schools with better facilities. This means that severe local shortages of teachers in some schools alongside relative surpluses in others, in some cases within the same small geographic area. PTRs are higher in rural areas than in urban schools. There are several factors that drive this rural/urban divide, including the lack of amenities in rural areas and better employment prospects for families in urban areas (only 25 percent of teachers in rural public primary schools are female, whereas 63 percent of urban public primary teachers are female), and the lack of incentives for teachers to move to rural areas to teach in rural schools (UBEC 2019).

FIGURE 3-26.

Pupil-teacher and pupil-classroom ratios at the school level by poverty levels around school and school remoteness from urban centers



Source: World Bank estimates using data from UBEC (2019).

The uneven distribution of teachers between schools, however, means that the most understaffed schools are severely deprived of teachers: the top 10 percent of schools by PTR have ratios of 112:1 or more, while the bottom 10 percent have ratios of 7:1 or less. As a result, the investment in students for primary education varies widely. A typical student at a school with bottom-decile PTR benefits from investment in teacher salaries of US$1,400 per year of schooling, versus just US$31 in schools in the highest decile.[14] Boys, on average, benefit from more resources (by 5.2 percent) compared to girls.

Availability of classrooms in schools. The 2013 Service Delivery Indicator (SDI) survey in four states in Nigeria found that only 55 percent of schools were equipped with the minimum stock of teaching and learning materials and equipment (pens, pencils, notebooks, textbooks, blackboards, chalk, and so forth) and met the minimum standards for infrastructure. Only 33.6 percent of pupils have a mathematics textbook, and only 38.1 percent have English textbooks. Only 27 percent of school toilets were clean, 44 percent of toilets provided privacy, and only 38 percent were accessible. A 2017 study comparing findings from an SDI study across several countries found that, in Nigeria, only 24 percent of teachers had the minimum knowledge in language, and 31 percent had the minimum knowledge in mathematics (Bold et al., 2017).

14 According to a study (Evans et al. 2022) that examines micro-data on teacher pay and on pay for other workers in 15 African countries, the average monthly teacher salary is US$460 (PPP), which is equivalent to 0.9 percent of GDP per capita. The study utilizes school-level data from UBEC Audit 2018 (UBEC 2019) to estimate pupil-teacher ratios.

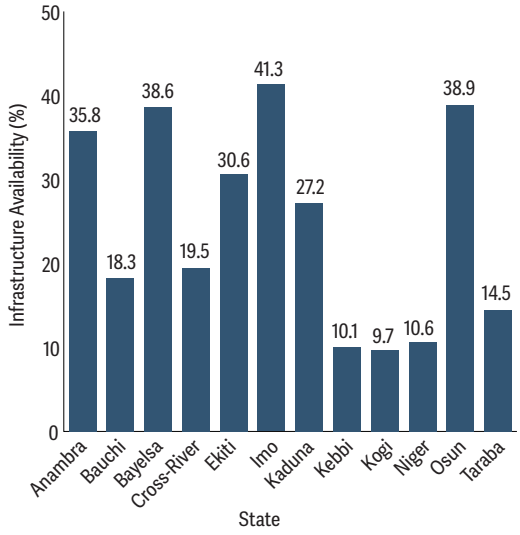
Distribution and quality of health workers varies across states significantly. Nigeria has one of the largest stocks of human resources for health in Africa. For instance, its doctor-population ratio is 39 per 100,000, as compared to the Sub-Saharan African average of 15 per 100,000 (Oreh 2023)[15]. Similarly, the country's nurse/midwife ratio of 148 per 100,000 population far surpasses the regional average of 72 per 100,000 (Oreh 2023). Although Nigeria's ratio of health workers is better than many other countries in Sub-Saharan Africa, its health workers are inequitably distributed. Most health professionals are concentrated in major urban areas and the South of the country, leaving acute shortages in the North and in rural areas. For example, the ratio of health workers to population in Borno state in North Eastern Nigeria is 34 per 100,000, while Lagos state has 120 health workers per 100,000 citizens (Dan -Nwafor et al. 2020).

Within states, the distribution of health workers varies across LGAs and between urban and rural areas. Even in the most well-resourced state—Lagos—the distribution of health personnel and facilities is not equitable, with evident variation between rural and urban areas. The ratio of nurses to general medical practitioners in the state is 2.2:1 in urban areas and 2.7:1 in rural areas (Obubu et al. 2023). In contrast, the ratio of nurses to specialist medical doctors is 1.3:1 in the urban areas and 1.5:1 in the rural areas. Alimosho LGA in Lagos state has the highest population of medical and specialist doctors, with a ratio of 68 general and specialist medical doctors per 100,000 population. At the same time, Epe LGA in Lagos state has only 7.1 doctors per 100,000 population. The ratio of nurses/midwives to 100,000 population also varies within Lagos state, from 16 in Epe LGA to 161 in Ikeja LGA.

There is a severe shortage of health infrastructure, which is also inequitably distributed. According to the results of the 2013 SDI survey of health facilities, less than a quarter of health facilities in Nigeria (23.8 percent) met the minimum infrastructure requirements. Only 4.1 percent of health posts met the minimum infrastructure requirements compared to first-level hospitals (57.2 percent) and health centers (23.8 percent). While the average estimates of individual components of infrastructure were relatively high (80.7 percent of all facilities had clean water, 55.0 percent had access to electricity, and 33.8 percent had an improved toilet), only 23.8 percent of facilities had all three inputs available in the same facility simultaneously. In rural areas, electricity and improved toilets were important infrastructure constraints: only 45.0 percent of rural facilities had access to electricity and 26.5 percent had access to improved toilets. Availability of infrastructure was higher in the southern states than in the Northern states (Figure 3-27). Imo state had the highest infrastructure availability at 41.3 percent of health facilities, followed by Osun (38.9 percent) and Bayelsa (38.6 percent). However, infrastructure availability in other Southern states was weak at only 10.1 percent in Kogi, and 19.5 percent in Cross River. Infrastructure availability in the Northern states was almost consistently weak, with Kaduna having the highest infrastructure availability in the North (27.2 percent).

FIGURE 3-27.

Availability of infrastructure, by state, 2013



Source: World Bank 2013.

Similar inequities are observed in other structural indicators of quality of care. Health facilities in Nigeria had only half (49.2 percent) of the priority drugs[16] available. The highest level of priority drug availability was seen in Anambra state (South), with 64.4 percent of all priority drugs available at facilities. Drug availability was lowest in Kebbi state (North) at 16.6 percent. As to the availability of equipment, less than a quarter of all health facilities (21.7 percent) met the requirements that make up the equipment indicator. The rural-urban gap was especially large: 35.1 percent in urban facilities compared to 13.9 percent at rural facilities. Equipment availability also varied by facility type, with 56.4 percent of first-level hospitals meeting the minimum equipment requirements (which also included sterilizing equipment and refrigerators), followed by health centers (17.0 percent) and health posts (19.2 percent). Equipment availability was higher in the Southern Nigerian states compared to the Northern states, although still relatively poor. In Bayelsa (South), 54.3 percent of facilities met minimum equipment requirements, followed by Ekiti (40.3 percent) and Anambra (36.1 percent), also in the south. Bayelsa state also had among the highest rates of diagnostic

15 These numbers do not consider the recent out-migration of health workers. The migration of health workers mainly to Europe and North America has reached an alarming level in recent years, which warrants the attention of policy makers.

16 This indicator is defined as the number of drugs of which a facility has one or more available, as a proportion of all the drugs on the list. The drugs have to be unexpired and have to be observed by the enumerator. The drug list contains tracer medicines for children and mothers identified by the World Health Organization (WHO) following a global consultation on facility-based surveys.

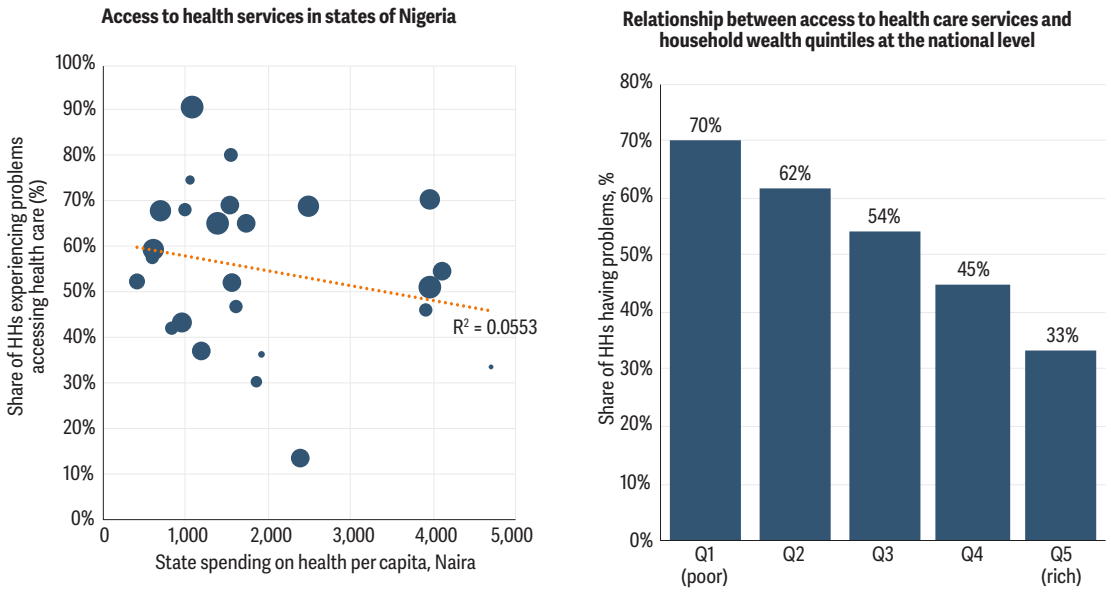
accuracy, at 51.3 percent. The Northern state with the highest equipment availability was Kaduna, with 26.9 percent of facilities meeting minimum equipment requirements. Niger (North) had the lowest equipment availability (8.4 percent), followed closely by Taraba (North) at 11.6 percent.

The shortage and inequitable distribution of appropriate cadres of the health workforce in Nigeria between urban and rural health facilities, and even between states, is a fundamental barrier to access to essential health care services where they are most needed. This has led to poor utilization of thousands of health facilities in the country that were established to provide essential services.

While access to health services varies by income, there is no observable pattern in state health spending to address it. A comparison of health expenditures per capita between states with different economic development statuses reveals that richer states (those with higher GDP per capita) don't necessarily allocate and spend more resources on health per citizen. However, there is a large variation in per-capita expenditures across states. For instance, the per-capita health expenditure in Lagos is almost 12 times higher than that in Kebbi. Part of the difference may be reflective of the cost of production of health services, which also varies across states.

FIGURE 3-28.

Distribution of Nigeria's states by public expenditures on health per capita (Naira) and access to health services in states of Nigeria (left panel) and the relationship between access to health care services and household wealth quintiles at the national level (right panel), 2018



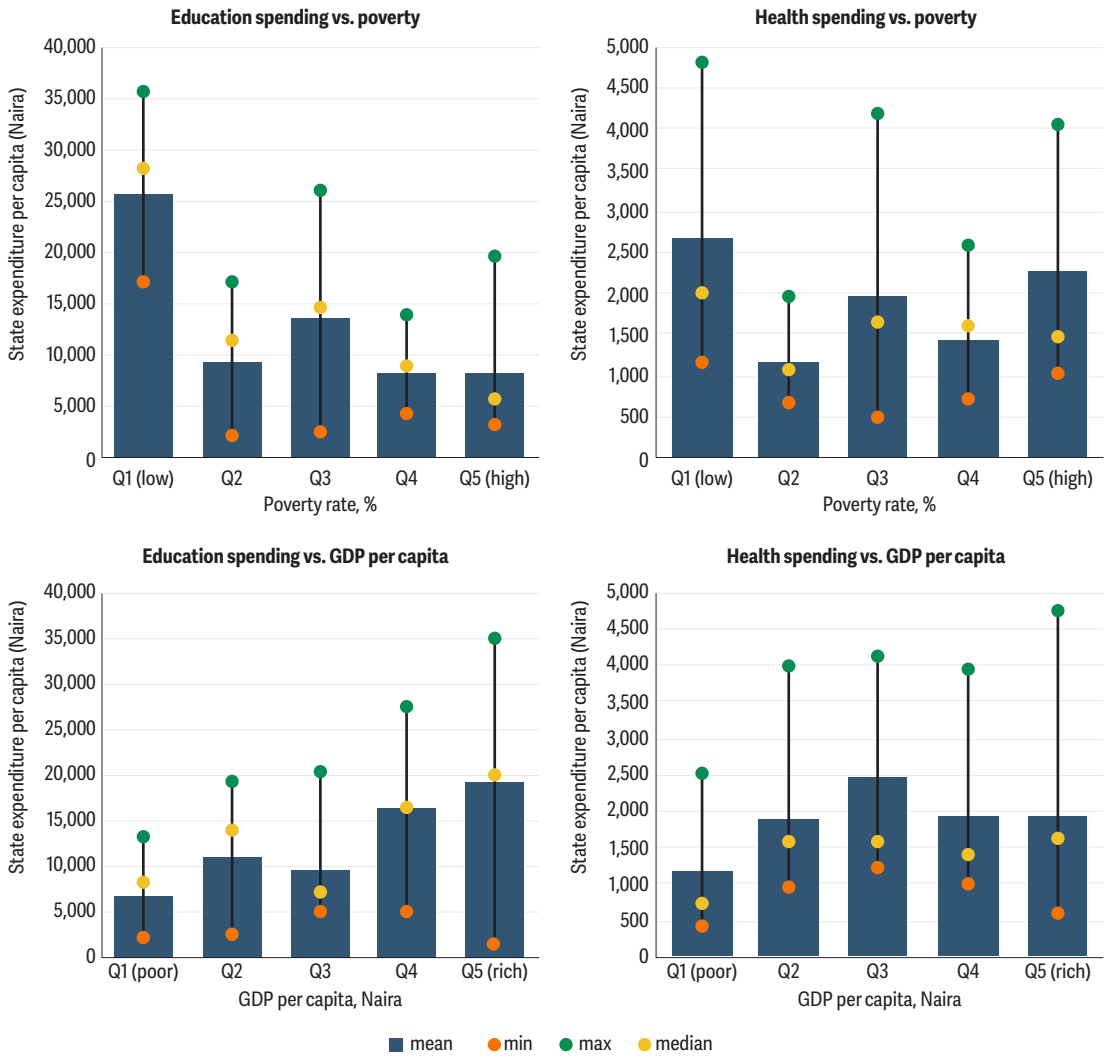
Source: World Development Indicators and Nigeria's Standard DHS, 2018.
Note: The bubble size represents poverty levels in states.

Health spending is not sensitive to the level of poverty, while education spending is. Five states with the highest poverty rates (top 20 percent) spend almost the same amount of resources on health per capita as the top 20 percent of states by household wealth (that is, with the lowest poverty rates). By contrast, states with the lowest poverty (at the top 20 percent) spend more than five times on education (per capita) what those with high levels of poverty (the bottom 20 percent) spend.

Spending by the Basic Health Care Provision Fund Spending The allocation of BPHCF resources does consider the disparities in population distribution, to some extent. Each ward receives an allocation for one health facility, resulting in states that have more wards (which usually means larger populations) receiving a greater share of resources. While this approach may be politically acceptable, it does not fully address the existing inequities in access to health services. Crucially, it overlooks significant factors such as the varying poverty levels among states and within states among LGAs as well as the uneven distribution of health facilities, not to mention the varying disease burden across the country. These factors are among the key drivers behind the disparities in health outcomes observed between different states, and their omission from the allocation criteria undermines efforts to achieve equitable health care access. (More detail on the BPHCF is discussed in Chapter 4).

FIGURE 3-29.

Average state spending on health per capita by state poverty rate quintiles and state GDP per capita, 2021



Source: UBEC 2019, WDI, and MICS 2021.
Note: The bars represent average state-level spending on health and education.

Spending by the Universal Basic Education Commission (UBEC). UBEC resources are distributed equally across all states, irrespective of the needs and challenges each state faces, leading to significant variation in the per-capita across states. This way of allocating resources is at odds with the fact that enrollment rates, the size of the school-age population, and the prevalence of out-of-school children differ markedly from one state to another. By not accounting for these variations, the allocation process inherently becomes inequitable, as it does not prioritize areas with greater educational needs. Compounding this issue is the funding model UBEC employs, which mandates states to provide matching funds to unlock approximately 50 percent of their allocated UBEC resources, intended primarily for infrastructural development like school construction and renovation. This requirement, while it was meant to increase education financing, may end up exacerbating inequity as poorer states struggle to raise the necessary counterpart funds there by accessing part of the UBEC funds. What is not clear is how the UBEC resources are allocated within states across the various LGAs. On the surface it looks like the state has a significant say in how to allocate resources among the LGAs, and this may have a larger effect in terms of addressing equity.

Predictability, timeliness, transparency, and accountability

The quality of public spending is impacted by the predictability, timeliness, transparency, and accountability of funding. Predictability refers to the degree of certainty that the spending agent has over the total amount of funds they can use in a given year. This is important to enable effective planning and implementation based on a realistic budget. Weak predictability means that plans and budgets are not credible, and it is difficult to hold the spending agent to account. Timeliness refers to the regularity of fund releases and transfers, which enables spending units to implement on schedule, avoid delayed payments, and deliver in response to need. Transparency refers to the extent to which key spending information is communicated to the public in a way that enables monitoring, including information on budgets and budget performance reports; the amount, timing, and recipients of transfers; and the outputs of spending. Transparency can also contribute to accountability to the extent it generates public questioning that elicits an effective response. Accountability for public spending is generally checked through an effective and independent audit process, where spending agencies are held to account by the legislature.

The predictability and timeliness of non-salary funding for basic education and primary health service delivery is compromised by weak public financial management at the state level as well as some design of features of UBEC and BHCPF. For education, the UBEC transfer for infrastructure depends on the amount the state puts up as counterpart funding, and this matching grant can be accessed at any time, including in later years. The amount of the transfer also depends on the actual revenues flowing into the CRF, and this fluctuates on a monthly basis. The timing of transfers also depends on the time it takes for the state to get approved plans from UBEC. On the health side, the amount of the NPHCDA gateway transfer to facilities is more certain as it is a fixed amount per quarter for one PHC facility per ward. However, the timeliness of this transfer has been problematic. This is in part due to late releases of funds to the gateways, and to the time it takes for facilities to develop business plans and have them approved by the SPHCDA and aggregated for approval by NPHCDA. Weak financial management capacity has also delayed facilities in acquitting their funds, which is required before they can receive the next quarterly transfer. The predictability and timeliness of state funding is weakened by chronically unrealistic budgets and a tendency to prioritize politically attractive spending ahead of other items.

Despite progress made in recent years in fiscal transparency, significant work remains to improve overall transparency and data quality. There has been progress in fiscal transparency in recent years, with all states publishing approved budgets and audited financial statements, and most states regularly publishing quarterly budget implementation reports. However, the quality of the fiscal data remains poor. Although states have adopted the national chart of accounts, there is insufficient granularity to track expenditure in the basic education and primary health subsectors. There is a functional classification of Primary Education, but this does not capture JSS, which is part of basic education. The health sector does not have functional subsector classifications at all. Moreover, the reliability of the data in the budget implementation reports is wanting.

There is a lack of transparency for key aspects of spending. State investment plans for the UBEC infrastructure transfer are not public. Nor is the amount and timing of the transfer from UBEC to each state. For several years following the establishment of UBE program, the finances and expenditures of the UBEC and SUBEBs were not audited. UBEC funds are legally public funds under the Constitution, and thus under the legal mandate of the Office of the Auditor General of the Federation. However, the process of auditing the funds only commenced when such audits became disbursement conditions under the Better Education Services Delivery for All (BESDA) lending program of the World Bank in Nigeria. Consequently, the first set of audit reports prepared on UBEC funds were for the 2019 calendar year. There is no evidence that the UBEC audits were submitted to the NASS and they are not published. From 2020 to 2022, the SUBEBs of the 17 states that implemented BESDA were audited to fulfill another disbursement condition of the program. Even then, the quality of the audits was poor and they were not submitted to the State House of Assembly or made public, thus limiting citizens and stakeholders' exercise of oversight over the use of such huge resources. Little is known so far about the status of fiduciary control over such a huge pool of funds in the remaining 19 states and the federal capital territory. The first audit of the BHCPF covering the period from its inception through 2022 was undertaken in 2023, but is yet to be finalized.

Summary: Key messages

Spending levels are inadequate

- Overall spending in health and education is far from adequate by any standards, even those of Sub-Saharan Africa. This is true at both the federal and subnational levels.
- Of the meager spending, only a small portion is actually spent, due to low budget execution, and even from that only a small fraction reaches the frontline service providers.

What can be done:

- Direct-facility financing and school grants will increase resources available to frontline service providers.
- In the medium to long term, increasing state budget execution rates and increasing federal as well as state allocations will be key to ensure that health and education services are adequately financed.

Spending is unequal

- There are large inequalities across and within states in health and education pending. This is partly due to income differences across states whereby richer states are able to spend more.
- But it also partly the way federal programs allocate resources among states where the standard practice is to provide equal amount to all states irrespective of the need and performance.

What can be done:

- Allocation of current and future federal transfers should be based on both need and performance.

Inefficiencies in spending are large

- The meager amounts spent on health and education are spent poorly.
- The quality of spending varies across states.
- Leakages from the system due to teachers' and health workers' absenteeism are large.

What can be done:

- Institute digital health workers/teachers' attendance for increased transparency and accountability.
- Institute performance-based transfer/pay at all levels.

Poor predictability and timeliness

- Some design features of UBEC and BHCPF undermine the ability of states to effectively plan and execute for better service delivery.
- State budgets are chronically unrealistic and releases are subject to political priorities.

What can be done:

- Streamline the approval processes for releasing UBEC and BHCPF transfers.
- Strengthen facility level capacity to account for funds.
- Ensure a regular schedule of releases.

Weak transparency and accountability

- Revise the chart of accounts to enable more granular capture of sub sector spending.
- Hold public consultations for annual investment plans (basic education) and publish a citizen-friendly version as well as periodic implementation reports.
- Publish the timing, amount, and recipient of all UBEC and BHCPF transfers.
- Publish audited financial statements and performance audits of UBEC, BHCPF, SUBEBs, and SPHCDAs.

Annex 3A. Overview of key MDAs/ institutions

TABLE 3A.1.

Overview of key MDAs/institutions contributing to the different outcomes

Tier	Federal	State	LGA	Facility
Basic Education				
Regular bodies	Federal Ministry of Education	State Ministry of Education	Local Government Education Secretariat	Schools
UBE specific	Universal Basic Education Commission (UBEC)	State Universal Basic Education Board (SUBEB)	Local Government Education Authority (LGEA)	
Other	National Council on Education	Teacher Service Commission		▸ School Based Management Committees ▸ Parent-Teacher Association ▸ Alumni networks
Primary Health				
Regular bodies	▸ Federal Ministry of Health	▸ State Ministry of Health	▸ Local Government Health Secretariat ▸ Ward Development Councils	▸ Primary Health Care Facilities
BHCPF specific	▸ National Primary Health Care Development Agency (NPHCDA) ▸ National Health Insurance Scheme (NHIS)	▸ State Primary Health Care Development Agency/Board (SPHCDA/B) ▸ State Health Insurance Agency (SHIA)	▸ Local Government Health Authority/ Primary Health Care Coordinators	

CHAPTER 4.

Understanding Intergovernmental Transfers for Human Capital: The Basic Health Care Provision Fund and the Universal Basic Education Fund

This chapter provides an analysis of two flagship federal programs designed to enhance human capital development across the nation: the Basic Health Care Provision Fund (BHCPF) and the Universal Basic Education (UBE) Fund. These programs represent the government's commitment to improve the well-being and the intellectual capital of its citizens. Despite the good intentions, however, both the BHCPF and UBE Fund are yet to materialize their full potential. They face multifaceted challenges that hinder their efficacy. Through an exploration of the intricate governance structures, management processes, and implementation strategies, this chapter aims to dissect the complexities and pinpoint the critical bottlenecks that compromise the impact of these funds. By identifying these challenges, the aim is to set the stage for a dialogue on actionable solutions to optimize resource allocation, improve the quality of spending, enhance operational transparency, and ultimately, to fulfill the promise of universal health coverage and basic education for all Nigerians.

Intergovernmental interaction and its challenges

In Nigeria, the delivery of primary health care and basic education are shared responsibilities between the federal, state, and local governments. The absence of a clear demarcation of roles and responsibilities among the three tiers of government, particularly with respect to program implementation and expenditure management, leads to duplication of efforts and at times rivalry, which undermine the effectiveness of service delivery (World Bank 2022a).

At the national level, in the education sector the key institution engaged in delivery of basic education across Nigeria is the Universal Basic Education Commission (UBEC). In the health sector, the national-level institutions include the National Primary health Care Development Agency (NPHCDA), National Health Insurance Authority (NHIA), and Nigeria Center for Disease Control (NCDC).

At the state level, there are State Universal Basic Education Boards (SUBEBs). Similarly, in the health sector, the state-level institutions include the State Primary Health Care Development Board (SPHCDB) and State Health Insurance Agency (SHIA).

At the local level, in both health and education there are the Local Government Education Authorities and Local Government Health Authorities for the LGCs. At the LGA level these institutions are responsible for implementation of UBEC and BHCPF.

In the absence of clearly defined authority and function, the potential for duplication and rivalry is significant. The critical institutional challenges are between MDAs within the state, which are manifested in a number of ways, including ambiguous arrangements between the Ministries of Education/Health and the SUBEBs/SPHCDBs and SHIAs. Formally, each state education/health ministry is directly responsible for its SUBEB/SPHCDB. In practice, the chairman of the SUBEB/SPHCDB reports directly to the governor. Though the underlying rationale for creating SUBEBs/SPHCDBs was to establish semi-autonomous agencies that are more efficient and effective than traditional ministries, SUBEBs/SPHCDBs operate completely independently of the state ministries of education/health. The Commissioner of each state ministry of education or health is the principal authority for the sector and is responsible for the sector's general policy direction, yet does not always have authority over the SUBEBs/SPHCDBs. What is more, the SUBEBs/SPHCDB and SHIA receive fund transfers from UBEC/NPHCDA and NHIA, especially through UBE/BHCPF intervention funds. They only rely on the state ministries for administrative expenses, including salaries and operating costs.

At the subnational level, the responsibilities for both basic education and primary health care service have been, in practice, taken over by the SUBEBs and SPHCDBs. SUBEBs and SPHCDBs sidestep the LGCs by creating their own extensions at the LGC level: a Local Government Health Authority (LGHA) and a Local Government Education Authority (LGEA). The primary health care facilities and primary schools are owned by the local governments, just as the local health care workers and teachers are legally personnel of the local governments. However, these entities are rarely accountable to the local governments, because their operational directives and programs originate from

the institutions created at the federal and state levels. In practice, the powers of appointment, promotion/reward, and discipline of these teachers and health workers are vested in each state's SUBEB and SPHCDB, which is an agency of the state tier.[17]

Robust coordination mechanisms at the state level that would bring both the education sector and the health sector under a coherent sectoral plan and budget for each sector could mitigate the duplication and rivalry within the sectors. This would require a higher level of coordination within the state. The various MDAs within the health sector including the SMoH, SPHCDB, and SHIAs, need to coordinate at the level of the office governor to develop a single sectoral plan and budget needs. A similar level of coordination is required to get SUBEBs to work together to develop a single sectoral plan and budget.

The Basic Health Care Provision Fund

The BHCPF is a relatively new fund, compared to UBE fund. The 2014 National Health Act established the BHCPF to improve access to primary health care with four financing sources: (1) the federal government, contributing an annual grant of not less than 1 percent of its consolidated revenue fund; (2) grants by international donor partners; (3) counterpart funding from states and local governments equivalent to 25 percent of the total funds; and (4) any other funds. In terms of fund management, the BHCPF has two primary gateways as well as two additional windows that claim a very small proportion of the fund: the NHIS and the NPHCDA. In addition, the NCDC and emergency care services are other gateways. The NHIS purchases a basic minimum package of health services for citizens from eligible primary and secondary health care facilities. The NPHCDA covers the cost of essential drugs, vaccines, consumables, and other for eligible PHC facilities. Figure 4-1 illustrates the flow of BHCPF funds.

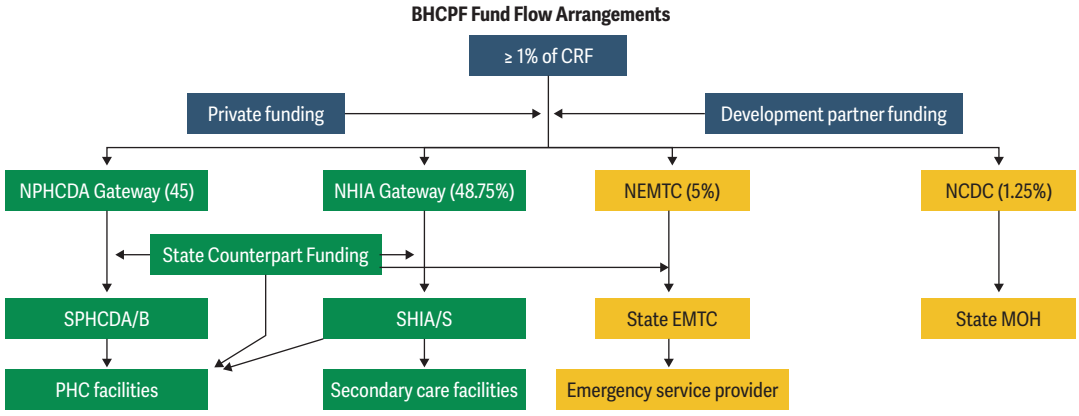
The actual implementation of the BHCPF fund began in 2018 with detailed operational guidelines. The redesign and revision of its implementation in 2019 resulted in some critical changes with significant implications. Some of these changes, especially those related to the fund's management, had eroded confidence in using the system to channel external funding. In addition, the services that the BHCPF is supposed to finance have evolved through time from a tightly defined basic package of services to a broader, at times unaffordable, list of services. In its current form, the BHCPF is distributed through four main gateways in Nigeria. These gateways are the NPHCDA, the NHIA, the National Emergency Medical Treatment Committee (NEMTC), and the NCDC.

- **NPHCDA gateway:** Accounts for 45 percent of the funds. The money then flows to the SPHCDBs (State Primary Health Care Development Boards) and subsequently to the PHC facilities. (See Figure 4-2.)
- **NHIA gateway:** Comprises 48.75 percent of the funds. The funds are directed to the SHIAs (State Health Insurance Agencies) and State Health Insurance Schemes (SHISs), with 25 percent of this funding being matched by state counterpart funding. This money goes to participating secondary facilities. (See Figure 4-3.)
- **NEMTC gateway:** 5 percent of the funds are allocated here and then flow to the emergency providers.
- **NCDC gateway:** Receives a relatively small portion of funds, 1.25 percent, and directs them to the state ministries of health (SMoH).

17 A survey conducted more than a decade ago in Enugu and Kaduna (World Bank 2008) showed that head teachers, directors of local government authorities, and directors of local government education authorities have no shared understanding about who has the power to make, and consequently is accountable for, key decisions for primary education. This is consistent with the interviews conducted on the ground. These ambiguous arrangements ultimately create a serious lack of accountability, especially when it relates to expenditures.

FIGURE 4-1.

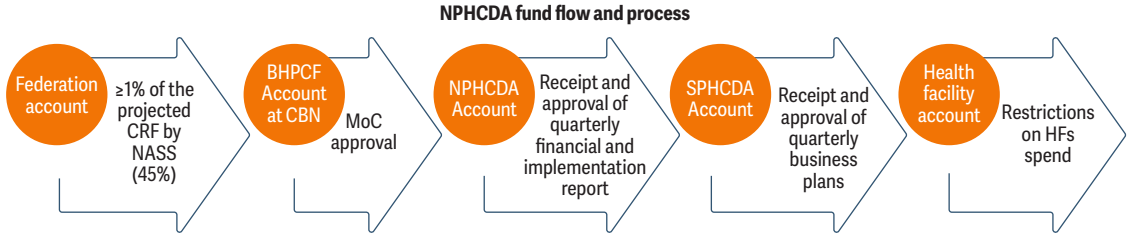
BHCPF fund flow arrangements: BPHCF, NHIA, and NEMTC plus NCDC gateways



Source: Authors

FIGURE 4-2.

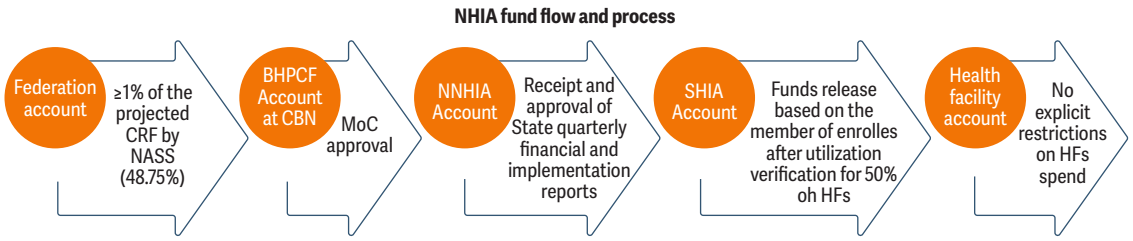
NPHCDA fund flow and process



Source: Authors

FIGURE 4-3.

NHIA fund flow and process



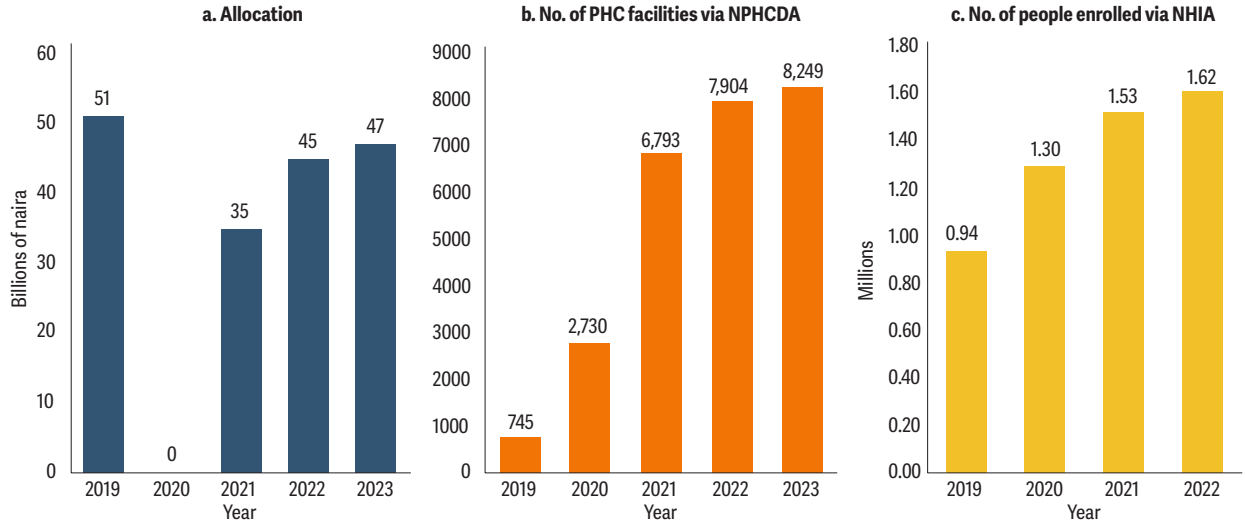
Source: Authors

The BHCPF has made significant contributions to the improvement of primary health services in Nigeria. It has funded over N130 billion from 2019 to 2023 (Figure 4-4a) to more than 8,000 PHC facilities and expanded insurance coverage to approximately 1.6 million individuals. This has been achieved with steady growth over the years in the number of facilities and individuals covered: the number of facilities authorized to receive direct facility finance (DFF) via the NPHCDA gateway has grown from 2,730 in 2019 to more than 8,000 in 2023 (Figure 4-4b). The number of people enrolled in BHCPF via the NHIA gateway has increased from 0.94 million in 2021 to a projected 1.62 million in 2023. This has been made possible due to increased allocations (Figure 4-4c).

Despite this progress, many challenges remain. First, coverage is still low. In both the NPHCDA and the NHIA gateways the coverage level remains low, with a very small proportion of the population currently covered by the fund. For the NHIA gateway, 1.6 million represents less than 2 percent of the eligible population, and even among those enrolled the utilization of services is lower than 10 percent in 14 states. Similarly, for the NPHCDA gateway, less than 30 percent of all PHC facilities in Nigeria are covered via DFF. Most importantly, there are no proper mechanisms to assess the impact on services of DFF provided to facilities.

FIGURE 4-4.

BHCPF allocation, number of PHC facilities via NPHCDA, and number of people enrolled via NHIA, 2019–23



Source: Authors own calculations.

The following three sections focus on understanding how the BHCPF in its current design ensures that funds flow to the facilities effectively and whether the funds are positioned to improve outcomes.

BPHCF as a complement to state-level efforts to expand UHC

BPHCF could be better used to support state's effort toc expand UHC, This is particularly true for the NHIA gateway. Currently the design of the NHIA is such that it does not always take advantage of state-level programs to enhance coverage. On paper the SHIS, which received the funds from NHIA, is expected to purchase a defined package of services from PHC and secondary care facilities for a fixed price. Such an "over-centralized" approach, however, presents several challenges. First, the package of services (the benefit package) is defined nationally in such a way that it is the same across all states. Second, this package usually differs from the package of services financed by state funds outside of BPHCF, Thus creating fragmentation. Finally, the price of this package financed by BHCPF is fixed and it is the same across all states. The challenge in having a uniform package of services for all states is that the states differ both in terms of disease burden and needs. Insisting on the same package of services across all states hinders their ability to respond to their needs.

Furthermore, the package of services financed by BHCPF differs from the package of services financed by other sources within the same state, meaning the citizens of one state will end up receiving a different benefit package just because their insurance premium is paid by a different financing source. This is not only unfair, eroding social and political support for the program, but it also further fragments the effort to expand UHC. It may also provide a perverse incentive in defining the benefit packages. Finally, by fixing the price and the benefit package across all states where prices are certainly different, huge efficiency gains are lost in states where prices are lower, and quality is compromised in states where prices are higher. Instead of insisting on the same package for all, a better way would have been to define a basic core set of services to be financed by BPHCF and allow states to add to this core depending on their needs. This would also allow states to harmonize benefit packages across different schemes.

Fund flow to frontline service providers

The section describes the way the funds reach the facilities, focusing on three key issues: the magnitude of the funds, their accessibility, and predictability.

States could have incentivized to allocate and spend more. In terms of the magnitude of the sources of the funds, the BHCPF could leverage large state counterpart financing. As of now, the BHCPF still remains funded largely through federal resources, while state funds remain untapped. In 2023, for example, only 9 out of 36 (and FCT) states made budgetary provisions for BHCPF. This is despite the fact that there is a 25 percent counterpart funding stipulation in the National Health Act. The opportunity to incentivize states to spend more of their own health budgets is not fully exploited.

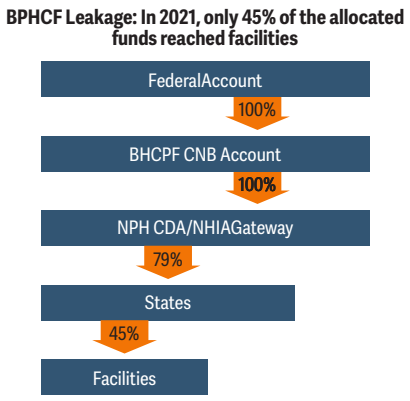
Facilities accessed less than half of the BHCPF/NPHCDA resources. Data from 2021 show that the PHC facilities accessed only about 45 percent of the BHCPF funds, while states received only 79 percent (Figure 4-5). The leakage in the funds happens at two levels: from NPHCDA to states and from each state to its health facilities. Numerous factors drive this. First, the drop in transfers from NPHCDA to states is partly by design. The total available resources are greater than the number of facilities covered multiplied by funds allocated per facility. Instead of expanding the number of facilities covered under DFF or increasing the amount for each facility beyond the mandated N300,250, NPHCDA is keeping the surplus. Second, the late submission of retirement reports to NPHCDA, due to lack of capacity at LGA and SPHCDA levels, has resulted in NPHCDA not authorizing disbursement to facilities (Figure 4-5 and 4-6).

Facilities received only 57 percent of the capitation under NHIA. Based on NHIA's current premium distribution, capitation payments made to PHCs account for only 57 percent (N570) of the N1,000 paid per enrollee per month. In other words, the lack of accountability and inefficient processes at all levels has led to significant leakage, hindering the flow of funds to facilities. This is because the total premium per enrollee of N1,000 is currently divided among different recipients and purposes:

- **Capitation (N570):** This amount (per enrollee) goes to PHC facilities to provide them with free health care services.
- **Reserve Fund (N120):** To augment the SHIAs' budgets in case of excess fee-for-service claims; 80 percent of the remainder should be used for additional coverage.
- **Fee-for-service (N113):** Reimbursements to secondary health care facilities in case of referrals from PHC facilities.
- **ICT (N98):** For SHIAs to use in the producing ID cards, integrating claims management software, and for laptops/phones for enrollment.
- **Admin (N50):** For administrative costs incurred by SHIAs (for example, management meetings, gateway forums).
- **QA/M&E (N50):** For carrying out quarterly quality assurance in 25 percent of PHC facilities, routine monitoring, and annual evaluation.

FIGURE 4-5.

BPHCF allocated funds, 2021: Only 45% reached frontline service providers



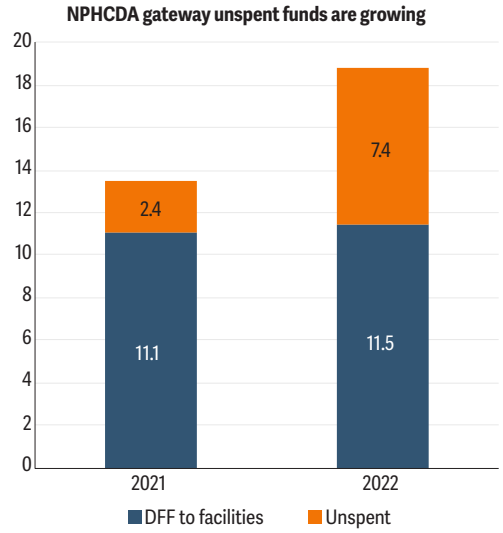
Source: Authors

Furthermore, states are unable to use all available NHIA funds. Several states failed to meet their enrollment targets, resulting in SHIAs receiving more money than they are authorized to disburse. Several of the SHIAs have excess funds in their accounts. In Q2 of 2023, for instance, Kebbi SHIA spent N51 million and had a balance of N215 million in its account, while Jigawa spent N19 million and had a balance of N409 million in its account (having only received the first 50 percent of 2023 disbursement). Figure 4-8 provides a snapshot of the funds remaining in SHIA accounts after disbursements, showing about N20 billion still unspent, suggesting inefficiencies in fund utilization. Furthermore, excess funds are rolled over, but how they are spent is not clear because there are no tracking or accountability mechanisms in place.

As far as the frontline service providers are concerned, BHCPF funding has been less predictable. Regarding predictability of BHCPF financing to the frontline service providers, the disbursement of funding from the BHCPF account to the gateways has been unpredictable. The Ministerial Oversight Committee is tasked with approving fund disbursements, but its meetings have been infrequent, leading to unpredictable fund release to gateways. Although the guidelines state that the committee's meetings should happen quarterly, this rarely happens in practice.

FIGURE 4-6.

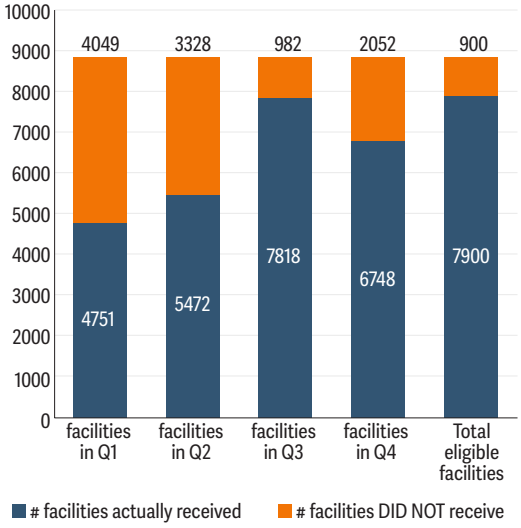
NPHCDA gateway funds, spent and unspent, 2021 and 2022 (in billion of Naira)



Source: Authprs own calculations.

FIGURE 4-7.

Number of facilities that received NPHCDA funds, by quarter, 2022

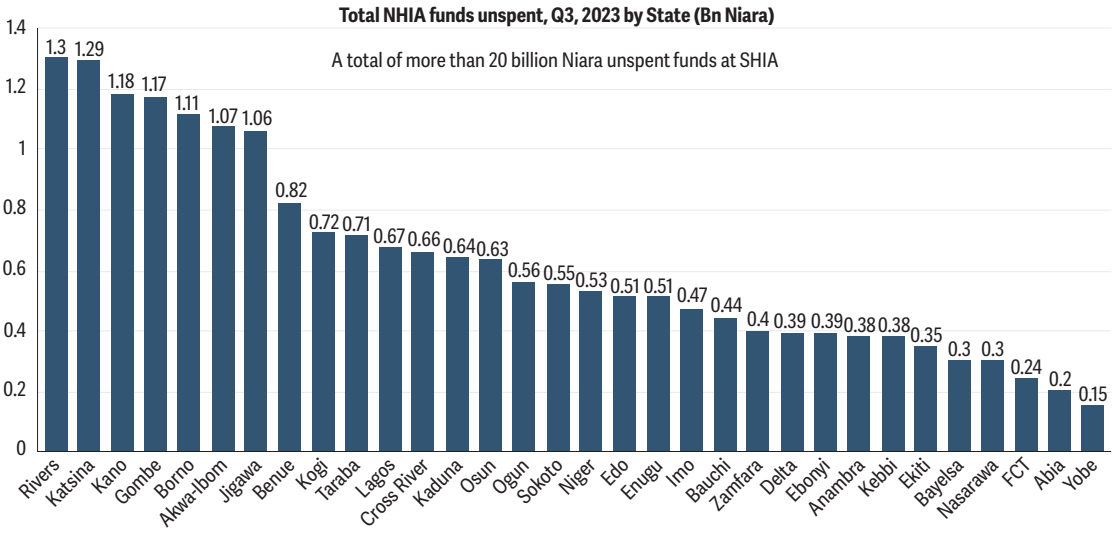


Source: Authprs own calculations.

The process of approval and documentation could be simplified to move funds to frontline providers in a timely and predictable manner. Currently, LGAs and State Primary Health Care Development Agencies (SPHCDAs) take 4 to 12 weeks to collate all facility retirement reports. On average, one LGA officer takes less than two weeks to collate reports from PHC facilities. Similarly, one to two accountants at the state level take more than four weeks to collate reports to be sent to NPHCDA. Due to these delays, several states submit their reports late. The fact that the report collation process is paper-based does not help, and dependency for collation on LGAs, which have no accountability to SPHCDAs or NPHCDA, may have exacerbated the situation. There is a high administrative burden at the state level, with reports often not being prioritized. Quotes from NPHCDA personnel indicate that some states send incomplete records, causing further delays. The impact of these administrative and systemic inefficiencies is that each quarter, several facilities do not receive funds from the NPHCDA gateway. For instance, in Q1 of 2022, 4,751 out of 7,900 eligible verified facilities (plus 900 unverified) were authorized to receive funds. In Q2, the number increased to 5,472, while the value was 7,018 in Q3 and went down to 6,748 in Q4 (Figure 4-7).

FIGURE 4-8.

Total NHIA funds unspent, Q3, by state (in N billions)



Source: NHIA Monitoring and Evaluation Report.

Note: Cross River and Akwa-Ibom have not started BHCPF implementation. As of November 9, 2023, five states—Adamawa, Kwara, Ondo, Oyo, and Plateau—had not submitted their reports to NHIA.

Accountability for results

The current system has little accountability for the use of BHCPF funds. The focus is on the process and documentation of how the funds are spent rather than whether the funds have improved service delivery. Neither the transfer of federal funds to the gateways nor the transfer from the gateways to states/facilities has any condition attached to it. There is no explicit expectation regarding the number of beneficiaries that needs to be covered with the funds. There is no system of tracking the impact of the resources provided to the facilities under the DFF. Explicitly linking the fund allocation and release to the number of beneficiaries covered provides much-needed accountability to the use of resources.

This section delves into the nature of the funds and their capacity to have an impact. The analysis is done separately for the NPHCDA and the NHIA gateways.

Spending and outcomes in the NPHCDA gateway

In terms of the payment mechanisms, the facilities are currently paid via a direct facility financing (DFF) mechanism. The impact of the NPHCDA gateway is unclear as there is no systematic monitoring of either volume of services or quality of services. The allocation of funds to states is based on the number of wards. More specifically, states receive funding based on the number of PHC facilities/wards, and the amount awarded per PHC is the same across all states (N300,250 per quarter). There is no explicit expectation on the results that these facilities are expected to achieve for the funds they receive.

Result-focused disbursement would improve the performance of the NPHCDA gateway. The current system, where performance management is focused mainly on checking reports for completeness, can significantly be improved by making an explicit link to the services provided. In particular, the operational guideline can be explicit about what states/facilities are going to held accountable for when receiving BHCPF funds apart from continuing to do business as usual. The guidelines could include a clear set of performance indicators, both in terms of services volume and quality of services. To reduce reporting, the existing information system (HMIS/DHIS-2) could align on these indicators, which would likely improve the performance of the BHCPF. As the system matures, one could consider linking all or part of the DFF funding to performance as a way to drive results and impact.

While the guidelines for the spending categories are useful, it is important that they remain flexible. In terms of the spending categories, the BHCPF guidelines and the NHIA provide specific directions. They stipulate that 45 percent of the funds should be spent on drugs and consumables, 35 percent on equipment and maintenance, and 20 percent on HRH development. While there is no clear best practice to compare with, and while the distribution across categories depends on the needs of the system, expert opinion suggests that allowing for flexibility helps service providers respond to the changing situation. For instance, the HR component could allow for payment of bonuses/performance incentives in places where it is already difficult to attract health workers. Furthermore, the accountability mechanisms should be strengthened to avoid leakages (see above).

Involving communities in the implementation of the DFF would increase the likelihood of success. Communities, including the ward development committees, can provide input on facility business plans and most importantly be part of the monitoring system. The results-based system, when implemented, will require a robust verification and monitoring system. Experiences from countries such as Kenya, Tanzania, and the Democratic Republic of Congo show that successful results-based systems at the community level had involved communities in the verification and monitoring system.

Equity. **Compared to the education sector, where the transfers are equal to all states regardless of the number of schools, allocations for basic health care include an equity consideration**. Nevertheless, the allocation does not account for differences in the needs of facilities (such as catchment population or disease burden). However, funds could be allocated in a manner that could reduce the wide disparities in health outcomes across states. The experience from other countries, including some large federal countries, shows that this can be tackled. For example, some countries have developed different methodologies to account for equity while balancing the amount of administrative burden their system can handle. The cases of Pakistan and the Democratic Republic of Congo are worth exploring.[18]

Further refining the allocation formula would improve the equity aspects of BHCPF allocation. There is still for improvement by further As to the NHIA gateway, the allocation to states is such that 50 percent of the funds are

18 Pakistan's system, launched in 2020, categorizes facilities by type and working hours, with a base funding ranging from US$2,150 to US$2,475 per facility annually. It has a low administrative burden due to less geographical inequity, which could be advantageous for managing funds across diverse regions. The DRC approach, on the other hand, is more elaborate: The system ranks facilities based on dimensions of classification and health zone, thus considering both the quality and type of facility.

allocated to states in proportion to their populations, while the remaining 50 percent are allocated to states in proportion to the poverty level of each state (measured by the poverty index). Again, this is a more equitable arrangement than the one utilized for the education sector. However, a potential improvement would imply allocating the funds based on an adjustment for poverty and rurality, actual enrollment, and utilization. For Nigeria, a nuanced approach that considers facility size, health care demand, administrative capacity and, most importantly, that takes into account the volume of services provided may be necessary to ensure that funds are allocated to make impact and equitably.

Spending and outcomes in the NHIA gateway

Effective capitation payment systems are usually linked to performance, which is absent in the current BPHCF/ NHIA. The current provider payment system for the NHIA gateway is capitation for PHC facilities and fee-for-service for secondary health care centers. This is consistent with the global practice where capitation is widely considered an effective mechanism for primary care. However, the current system used by NHIA does not have a performance element. All facilities receive a standard amount of N1,000 per month regardless of the number of enrollees with no differentiation for equity, rurality/remoteness, or demography.[19]

The current benefit package is too broad to be affordable. The NHIA gateway covers more than 60 primary and secondary care services including RMNCH (reproductive, maternal, newborn, and child health), surgeries, laboratory services, ENT (ear, nose, and throat), and mental health. Clearly this represents an extensive set of services. A more impactful set of services could have been identified had the choice of the services been informed by the disease burden in the country. Furthermore, the benefit package could have been designed in such a way that the complementarity between the NHIA and NPHCDA gateways is strengthened to enhance the impact of the BHCPF program.

The program is not well socialized and the enrollment process can be cumbersome. The other area that could be improved is the identification and registration of beneficiaries. The current process involves socializing the program with the communities, and verification and enrollment. On average, enrollees must wait up to five weeks after registration to access services. The process consists of the following steps:

1. *Socialization of the program:* SHIA representatives meet with community and religious leaders to inform people about BH CPF.

2. *Beneficiary verification and enrollment*: On a fixed date, community interested individuals assemble at a PHC facility, are interviewed by SHIA representatives, and provide identification details. This step is informed by names in the social register and means information collected during facility interviews, leading to the selection of some individuals for enrollment.

3. Once this process is complete, the beneficiaries can access services after 4–5 weeks in the identified PHC facility for the next 12 months.

This process can significantly be improved, simplified, and it can have any arbitrariness in the beneficiary identification removed by using the existing and improved State Social Registry (which is part of the National Social Registry). All states have a State Social Registry, the aggregation of which makes up the National Social Registry. These registries are being used to identify beneficiaries for various social programs, including the ongoing cash transfer programs. Using these registries (which can be updated as necessary) to identify beneficiaries not only provides uniformity across states and across programs, but it also removes arbitrariness in the identification of beneficiaries and simplifies the process.

As in the NPHCDA gateway, there is no systemic monitoring of performance of the NHIA gateway. The only system in place is the target number of enrollees per facility and for the facilities to report on utilization. Even for this, there is no independent source of data to triangulate and no clearly defined consequence for underperformance.[20]

19 The experience of Brazil, a large federal country, provides a useful lesson for Nigeria. The Previne Brazil Program provides a base capitation of approximately US$13 per person per year. However, one critical difference with Nigeria is that the capitation is adjusted for several factors: first, demographic factors, with more weight attributed to persons under the age of 5 and above 65; second, socioeconomic factors, with more weight assigned to persons receiving social protection and pension benefits; and finally, geographical factors, with significant more weight assigned to people living in remote and rural areas.

20 More specifically, the verification of enrollment is conducted quarterly by the State Health Insurance Agencies (SHIAs) in 50 percent of facilities and by the National Health Insurance Authority (NHIA) in the other 50 percent. But there are no listed consequences for invalid enrollment.

The Universal Basic Education Intervention Fund

The Universal Basic Education Commission (UBEC) was established by the Compulsory, Free Universal Basic Education Act of 2004. The Act established the Universal Basic Education Commission, the State Universal Basic Education Boards (SUBEBs), and the Local Government Education Authorities (LGEAs).

The Universal Basic Education Intervention Fund, usually known as UBE Fund, is in practice the main source of financing for basic education for nonsalary expenditures. The resources are replenished each year as 2 percent of the Consolidated Revenue Fund of the preceding year. Thus, the UBE Fund gets twice the amount of resources compared to the BHCPF, and it guarantees a minimum amount of resources for basic education in the country. The following sections examine the UBE Fund, with particular focus on allocation, use, fund flow arrangements, access to the fund by schools, and performance management arrangements.

The UBE Fund arrangements and spending categories

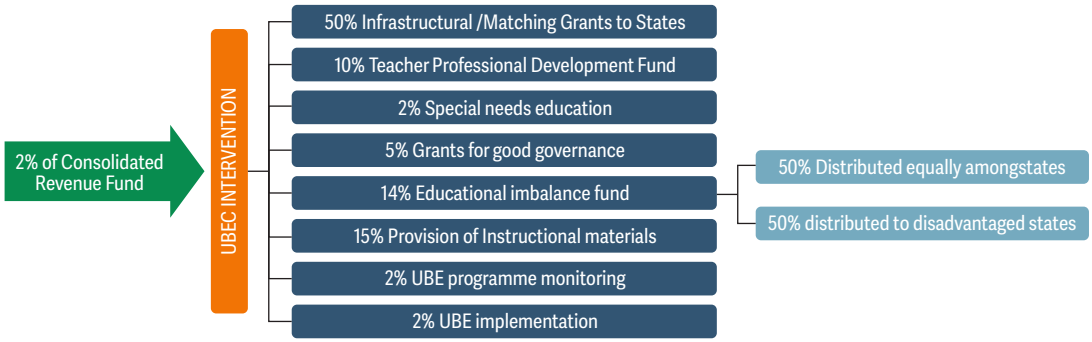
Disbursements from the UBE Fund follow a specific distribution formula that has existed since 2008. The formula determines both how the resources are distributed across states and what the main spending categories are. The formula is not defined in the UBE Act and, therefore, could be modified without legislative approval. However, preliminary discussions with stakeholders imply that a change in the formula might require approval at the level of the Federal Executive Council (FEC) or equivalent. Currently, the funds are distributed across seven spending categories outlined below.

- **Matching grants**: This category receives the largest share, accounting for 50 percent of the total UBE Fund. The funds are used for infrastructure improvements like building classrooms and toilets and providing furniture and equipment. These grants are allocated equally across all 36 states plus the Federal Capital Territory (FCT).
- **Instructional materials**: This is allocated 15 percent of the total fund, utilized for core subject textbooks and reading materials. Like the matching grants, these funds are also distributed equally across the 36 states and the FCT.
- **Educational imbalance**: To address disparities, 14 percent of the fund is earmarked for this purpose. It is used for creating model schools and providing textbooks and teacher guides. The allocation is more complex: 50 percent is equally distributed among all states and the FCT, 5 percent is specifically for girls' education, 10 percent is for almajiri (a system of Islamic education) education, and 35 percent is for community self-help projects.

- **Teacher professional development**: Receiving 10 percent of the total, this fund category is aimed at in-service training for teachers and education managers, with an equal distribution across all states and the FCT.
- **Good performance**: With 5 percent of the total funds, this is designed to reward states that implement the UBE program well. The top three performers in each zone and the national winner receive these funds.
- **Special education**: This category gets 2 percent of the fund for the provision of infrastructure, learning materials, and teacher training. The allocation is distributed so that 70 percent is shared equally among all states and the FCT, and 30 percent goes to private providers selected by UBEC.
- **UBE monitoring and UBE implementation**: Both categories are allocated 2 percent each of the total funds. UBE monitoring funds are used for overseeing the implementation of the UBE program by the state, while UBE implementation funds support the operations of UBEC itself.

FIGURE 4-9.

UBE Fund allocation formula



Source: Authors

The SUBEBs manage the funds at the state level. Once the funds are transferred to the states, they are managed by the respective SUBEBs, which were also created by the 2004 Act and with functions determined by state laws. In practice, each SUBEB is in charge of implementing basic education programs at the state level, while the respective state Ministries of Education are in charge of policy formulation.

To access the funds, states are required to contribute a matching fund. The UBE Act stipulates that for any state to qualify to receive the matching grants from the UBE Intervention Fund, such state shall contribute not less than 50 percent of the total cost of projects. Therefore, the states are required to provide an equal amount of money as counterpart funds to be able to access the matching grants funds. When that occurs, UBEC is obliged to disburse the funds to the states if it has confirmed that the state government has the counterpart funds in its designated account. In technical terms, these are conditional matching closed-ended grants since the total grant magnitude is restricted.

Flexibility of UBE funds to respond to state needs

The current distribution formula of the UBE Fund is rigid, offering scant leeway for states to tailor the resources to address their unique educational obstacles. Within the broad and varied landscape of Nigeria, the educational needs of each state are distinct. For instance, while Northern states grapple with significant shortfalls in educational infrastructure, such as a dire scarcity of schools and extremely crowded classrooms, Southern states, despite having infrastructure challenges, face them on a lesser scale. A system endowed with greater adaptability would empower states to strategically allocate funds to areas most pressing for their specific contexts. Yet, the prevailing structure is restrictive, severely limiting the capacity for such adaptive measures.

Consequently, the prevailing funding strategy is excessively dependent on supply-driven solutions aimed at expanding access to basic education. This approach might be rationalized by the high numbers of children not attending school in Nigeria, but it falls short of recognizing the disparities between states, each with its distinct challenges and priorities. The formula's rigidity means there is little room for states to invest in targeted initiatives that might enhance educational quality and outcomes for students already enrolled rather than merely increasing the number of learning spaces.

Even within other spending categories, the actual implementation arrangements limit the flexibility that each state has. This occurs even for items that are not actually rigid in the formula. For instance, the procurement of teaching and learning materials is, in many cases, done directly by UBEC, at the federal level, and consequently distributed to each state. While this might reduce the discretionary expenditures that the states would have under a low accountability system, it also creates significant delays in the distribution of materials. More importantly, this centralized procurement prevents states from tailoring their teaching and learning materials to their specific circumstances and education initiatives.

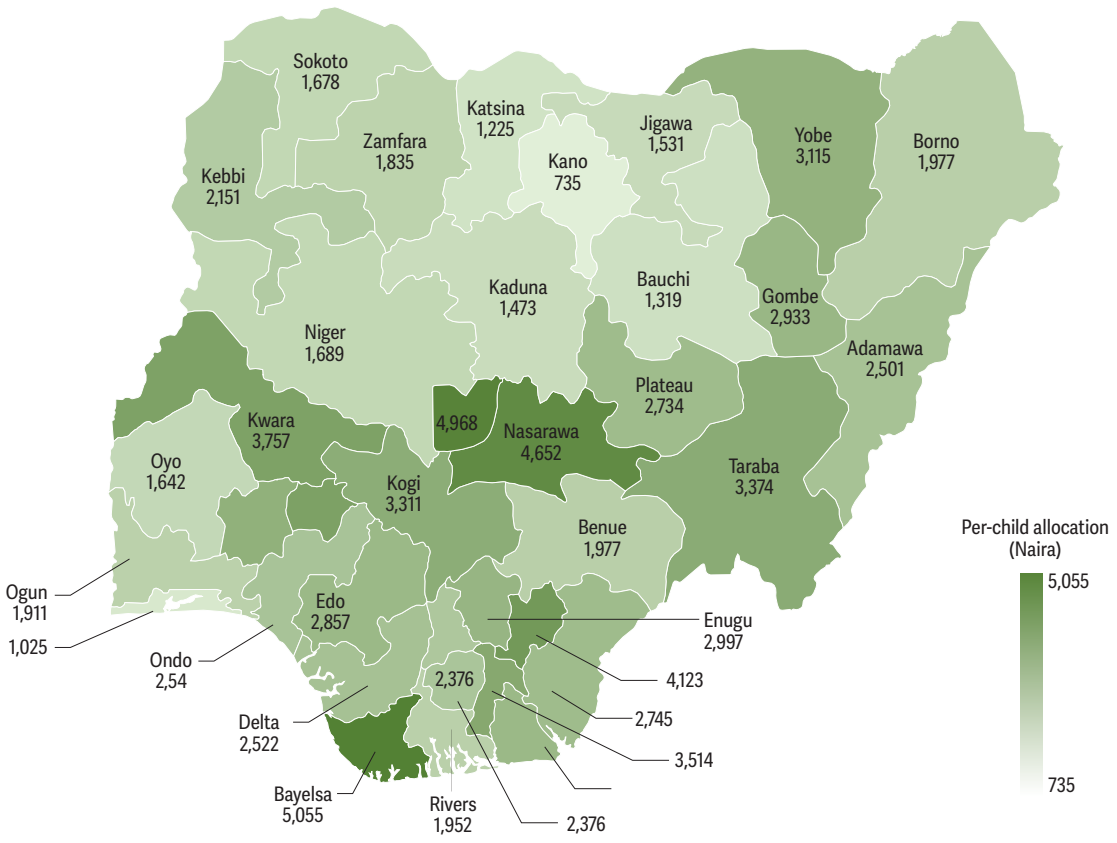
Equity in the allocation of resources across states

The current design and implementation of the UBE Fund inherently worsens the disparities. A uniform distribution of resources to all states fails to account for varying student populations, educational demands, or socioeconomic contexts. This approach starkly contrasts with the allocation mechanisms in the health sector, where resource distribution is somewhat more equitable—each state receives funding for a minimum of one facility per ward, leading to states with more wards, and presumably larger populations, receiving a proportionately greater share of resources. Furthermore, the requirement for matching funds exacerbates the challenge for smaller, less affluent states, which must match the resources of their larger, wealthier counterparts to access available funds.

This wide discrepancy illustrates a flawed system that does not equitably support the educational needs of all Nigerian children. The crux of the issue lies in the highly disproportionate allocation of resources when viewed against the backdrop of the basic education-age population across states. According to some analysis, the disparity in spending between the highest and lowest states is nearly sixfold. Focusing solely on the UBE matching grants and their required counterpart funds, the stark disparity in per capita funding allocation becomes apparent, doing little to bridge the gap in educational opportunities. For instance, there's a significant variation in funding between, on the one hand, Bayelsa (at N5,055 per child) and the Federal Capital Territory (at N4,968), and, on the other hand, Kano (at a mere N735) and Lagos (at N1,025). (See Figure 4-10.)

FIGURE 4-10.

Per child allocation by state, 2019



Source: Authors

The current effort to address this inequity can be strengthened. Interestingly, the current formula includes a specific item for the allocation of resources to more challenging settings, but its actual design is flawed. The "educational imbalance" component of the formula aims to mitigate inequalities but, ironically, allocates half of its resources equally across states. The remaining portion is reserved for targeted initiatives, such as advancing girls' education, supporting community self-help projects, and funding almajiri schools. Despite its shortcomings, the presence of this allocation within the formula could serve as a catalyst for a broader dialogue about resource equity, laying the groundwork for a more nuanced and effective approach to fund distribution.

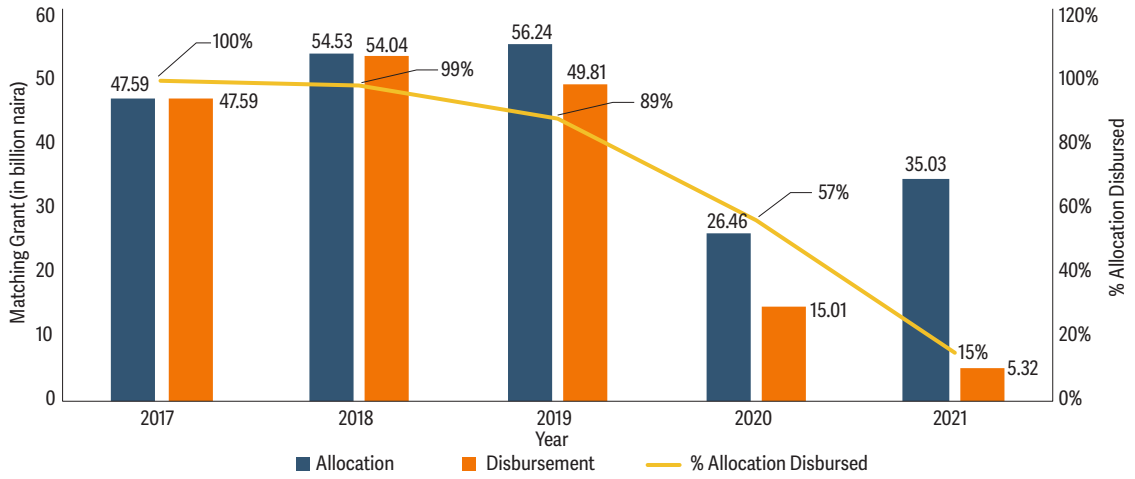
Transparent and objective criteria to allocate the resources within states, between LGAs, and across schools can address inequity within states. Interestingly, the same pattern of unequal utilization of resources that is manifested at the federal level is replicated at the state level. Despite certain heterogeneity across states, most state governments do not have clear formulas to allocate resources across LGAs once the funds are received from SUBEBs. Even within LGAs, the resources tend to be distributed unequally, in many cases following political considerations rather than criteria that prioritize needs and performance. Similarly, there are no objective criteria to allocate the resources across schools. This last point is relevant because, while changing the distribution of resources across states might be challenging from a political-economy point of view, changing the way the SUBEB resources are utilized within each state would face significantly fewer obstacles.

Disbursements and utilization

The UBE Fund, despite Nigeria's notably modest proportion of spending on education relative to other nations, remains underutilized. The existing disbursement formula has funds languishing due to states' failure to contribute their required matching grants, leading to a build-up of unused funds. There is no protocol to repurpose these unmatched funds after a certain timeframe, which restricts higher-performing states from accessing these idle resources. The graph in Figure 4-11 illustrates a worrying trend: the proportion of matching grants actually disbursed has plummeted from a full allocation of N47.59 billion in 2017 to a mere 15 percent (N5.32 billion) allocated in 2021. This downward trajectory is not straightforward and may be attributed to several factors. Predominantly, it stems from the inability—or unwillingness—of many state governments to furnish their share of funds, essential to unlock the federal matching grants. In some instances, this shortfall is due to financial constraints, but often it reflects a lower prioritization of education within state budgets. Other contributing factors include the misappropriation of UBE funds by certain states, leading to punitive measures from the overseeing Commission, and frequent delays in the submission of required action plans or the accounting for funds that have been disbursed, further complicating the fund's effective utilization.

FIGURE 4-11.

Allocations and disbursements of matching grants, 2017–21



Source: UBEC 2023.

The matching grants represent the large majority of funds that are not utilized, but not the only ones. For example, the "good performance grants," which represent 5 percent of the UBE intervention fund, tend not to be disbursed**.** The grants are intended for the top three performers in each geopolitical zone and the national winner, allowing differentiated amounts across states. Between 2005 and 2009, a total of 22 states benefited from them. However, after 2010 they were not disbursed to any state for at least seven years.

Accountability for results

UBE guidelines describe the monitoring arrangements for each component of the formula. For instance, to access the matching grants, SUBEBs are required to submit their Action Plans to UBEC. The Action Plans are prepared at the state level by a committee led by the executive chairman of SUBEB. The plans should include the implementation strategy for each activity, including the procurement method. They should also specify the target groups, outputs, expected outcomes, an achievement indicator, and clear unit costs. The UBE guidelines also stipulate that SUBEBs shall set up supervision teams comprising in-house technical staff or consultants. Besides the matching grants, other components of the allocation formula also have their own monitoring arrangements. For instance, the 14 percent associated with the educational imbalance fund includes a three-stage monitoring process: (1) verification, which is before the selection of beneficiary communities; (2) midterm monitoring, which is three months after the disbursement of the first tranche (or three weeks for micro projects); and (3) final monitoring at the end of the project. In general, monitoring responsibilities are shared by UBEC, SUBEBs, LGEAs, and SBMCs. Similarly, SUBEBs, LGEAs, schools, and UBEC are supposed to verify the delivery and distribution of instructional materials and conduct timely quality assurance on the use of the materials.

Besides these statements, however, the guidelines do not provide very clear standards for monitoring for results. In practice, monitoring tends to be relatively weak and the current allocation of resources across states does not include almost any consideration of performance. In other words, there are almost no stipulations to allow for a decreased funding allocation for underperforming states or an increased allocation for well-performing states. The only consideration for performance-based financing under the current arrangements is the "good performance" element of the formula. However, this element suffers from multiple challenges. First, it is only 5 percent of the total allocation of resources, which is not large enough to incentivize the achievement of resources, especially when the 5 percent is distributed across multiple states. Second, relatedly, the funds are supposed to be allocated to "the top three winners of each geopolitical zone and the national winner." Thus, more than half of the states benefit from these resources, reducing the amount for each of them and therefore diminishing the incentives. And third, as highlighted before, this particular component has been erratic in its actual implementation and disbursement. Thus, the UBE Fund misses an opportunity to utilize resources to incentivize specific outputs or outcomes. For instance, a portion of the resources could be allocated based on the performance during the previous year of each state, taking into consideration the change in the number or rate of out-of-school children or the actual learning outcomes.

Similarly, at the state level, none of the SUBEBs has developed a mechanism to incentivize the achievement of specific results. The allocation of funds—at either the LGA or school level—is not linked to results. There is a huge potential to incentivize performance through the way funds are allocated and disbursed. The experience of other countries, such as Brazil (outlined in Box 4-1), may be instructive for designing a similar system in Nigeria.

BOX 4-1.

A needs- and performance-based system in Brazil

Brazil is a large and diverse federation with almost the same population as Nigeria, although spread across a larger territory. In 2008, a change was made to the way funds were transferred to municipalities in the state of Ceará, linking a major general transfer to the performance in education. States are required to transfer 25 percent of their consumption tax revenues to municipalities as a general-purpose transfer. Most of these funds are distributed using a funding formula, but states have discretion over how a quarter of the total transfer is allocated. Ceará has chosen to allocate 72 percent of these discretionary funds based on how well municipalities perform in education. These transfers are a significant source of revenue for municipalities and can make up as much as one-third of all revenue for poorer municipalities. The amount of discretionary transfer is determined by an "education quality index" that aims to improve performance and increase equity between students within municipalities.

This index is calculated using a comprehensive census-based learning assessment, which includes indicators such as early grade literacy, learning measured at the end of primary school, and the proportion of children transitioning to the next grade. Municipalities are allocated transfer resources based on their scores on these indicators and on the magnitude of their educational improvements over the preceding year. Evaluations have shown that the reform has improved learning outcomes in most municipalities and increased the efficiency of spending in the state of Ceará and its municipalities.

This reform has also resulted in narrowing per capita differences in transfers between municipalities and narrowing learning gaps between poor and wealthy municipalities. Based on this success, a recent amendment to the Brazilian constitution has changed the allocation mechanism for the main education fund transfer to include a mandatory results-based component to the formula. This includes an allocation of federal top-up funds to states based on improvements in results.

Source: Adapted from Al-Samarrai and Lewis (2021).

The weak performance management of the system is coupled with weak financial management, which means greater risk. The implementation of the grants and all the other resources associated with the UBE Fund is weakly monitored and accountability is low. In addition, the mechanisms through which the resources are transferred to the state level do not have safeguards to ensure the funds are used to improve the delivery of basic education. Given the institutional and financial management capacity, the condition that on paper requiring states to use the funds appropriately in order to receive the subsequent disbursement is hard to enforce.

The current monitoring of performance is limited to checking the completion of activities. In terms of monitoring, UBEC verifies that SUBEBs have executed the plans they submitted and agreed with UBEC, for example, in terms of new school construction or teachers to be trained. This verification entails on-site visits by UBEC, and in the case of teacher training, for example, the presence of a UBEC official at the training to monitor even items such as food and accommodations provided to the trainee teachers. The monitoring is more activities- than results-oriented. In other words, the information on the numbers of teachers trained and textbooks provided is collected without monitoring or assessing how these inputs may have affected outcomes, such as enrollment and student learning. In addition, field interviews have shown that these low monitoring standards are not always met. In a nutshell, the lack of accountability and the institutional challenges demonstrate how the education system in Nigeria, in some cases, is not aligned to ensure access to quality education. The institutional incentives sometimes favor arrangements for the continuity of vested interests within the organizational structures rather than policies to increase education outcomes.

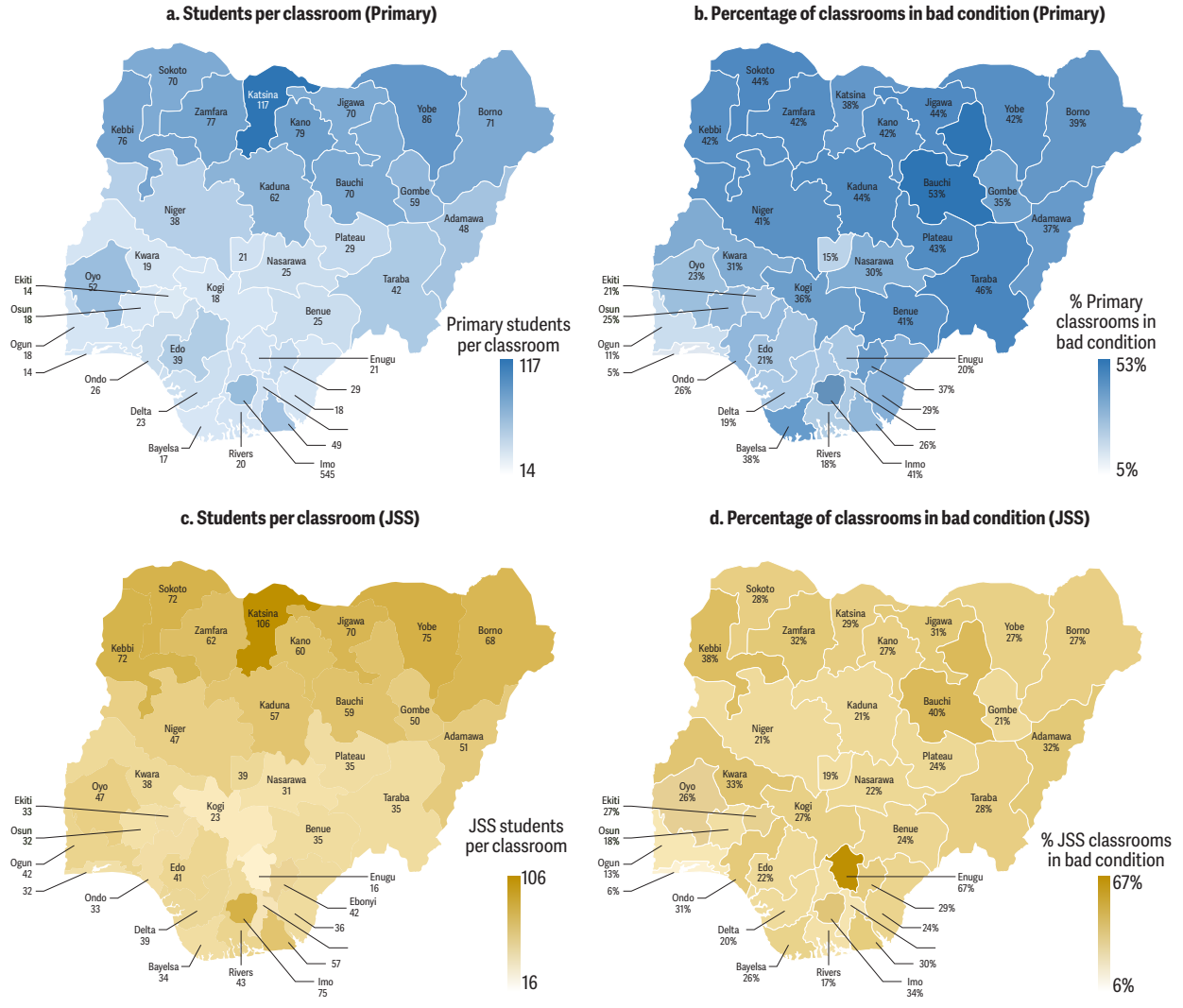
Fund flow to frontline service providers: Lack of direct school financing

Schools do not receive direct funding. Contrary to what is seen in the health sector, where at least one facility per ward receives direct financing, almost no schools in Nigeria receive any form of direct public funding. None of the UBE resources are designed to reach the schools directly to be managed locally by the schools. Schools do not have specific funding they can use for the maintenance of their buildings or any other operational costs. Thus, they rely on: (1) ad hoc grants as part of specific projects (for example, BESDA); and (2) contributions from the community, including 'old-boys' alumni associations and other local organizations. When these resources are not available, schools typically request support from the authorities, but the communication channels are not clear. The same request can be sent to the LGEA, the SUBEB, or the Ministry of Education. This creates a lack of predictability and serious challenges to managing schools appropriately, since small repairs that are not addressed promptly can become major repairs in the future. More importantly, this creates perverse incentives for the schools to charge informal fees to the students and families.

One of the consequences of no direct financing is that schools fail to ensure the availability of basic supplies and fail to do even minor repairs and the maintenance that is important for the learning environment. For instance, primary classrooms are generally overcrowded in Nigeria. Nationwide the average is 57 students per classroom (SPC), and there are large variations across states, with a low of 20 SPC in Kwara and a high of 109 SPC in Akwa-Ibom and Katsina. Even existing classrooms are in bad condition, with more than 50 percent reported by schools as needing repair and renovation. (See Figure 4-12.) The lack of maintenance also contributes to the relatively very short lifespan of the infrastructure, which does not help in a context of rapid population growth.

FIGURE 4-12.

Students per classroom and percentage of classrooms in need of renovation, by state, 2022



Source: Based on UBEC (2022).
Note: JSS= Junior Secondary Schools.

Attempts to address these challenges by providing supplements for teachers to take care of operating costs failed to solve the problem. Experience has shown that, in many cases, the funds are not used for the intended purposes, especially in the context of very low teacher salaries. Furthermore, these experiences have usually lacked the implementation of proper accountability mechanisms and have not relied on the involvement of communities, for instance through school-based management committees.

The recent experiences with school grant pilots in Nigeria are promising for scaling up. However, the experiences with school grants have left some valuable lessons for the implementation of a grant system at scale. In particular, the BESDA[21] project supported the disbursement of school grants, and more recently some states have experimented with grants financed from domestically mobilized resources. These examples provide at least three lessons. First, the implementation of such a system is possible. As in the health sector, grants in the education sector have been utilized properly for needed improvements. Second, the involvement of communities is critical to ensure the proper use of resources. Third, the implementation of school grants should be accompanied by rigorous training on, for instance, financial management to strengthen the capacity of communities to utilize the funds and account for results.

Providing schools with grants could greatly improve education results. School grants can be utilized with many different purposes, including contributing to equal access to school for all children, including the poorest, by reducing the cost barriers of schooling to parents; improving education quality in the beneficiary schools; improving school management and functioning through greater school autonomy; and increase administrative efficiency (Lugaz and De Grauwe 2016: 44–45).

The way school grants are implemented is important for their effectiveness. Evidence shows that flexible grants to schools, when utilized for business as usual, tend not to be effective (Blimpo et al. 2015; Mbiti et al. 2019; Pradham et al. 2011). However, if the implementation is accompanied by strong monitoring and evaluation efforts and solid financial management arrangements, the grants can be effective. Performance-based school grants could also offer an alternative, although they might bring more cumbersome administrative requirements. Some lessons from the literature (World Bank 2022c) could be instructive:

- **Results-based financing**: The effectiveness of school grant programs is contingent upon the intricacies of their design and implementation. The utilization of a results-based financing approach can serve to redirect attention toward specific outcomes (instead of inputs) and align incentives in a manner that is conducive to the attainment of those outcomes.

- **Grant size**: The size of the grant matters. The government must find a balance between allocations that are adequate to implement school-level interventions and allocations that are affordable and sustainable.

- **Community involvement**: The implementation of school grant programs has the potential to promote equity and establish basic preconditions by ensuring the availability of essential resources within educational institutions. To achieve these objectives, it is necessary to involve community members in the design and execution of these interventions and to establish school-level accountability measures to ensure their effectiveness.

- **Direct transfers**: Direct transfers to schools can reduce leakages, improve the timeliness of disbursements, and strengthen efficiency.

Perhaps one of the more impactful examples in the region comes from Cameroon. A pilot program in the country that implemented a performance-based approach to school grants demonstrated improvements in student enrollment, teacher engagement, and transparency in management and budget issues. The program entailed that schools meeting specific initial preconditions, such as opening a bank account and signing a performance contract, were eligible to receive an initial grant with the aim of addressing underlying inequities by allocating additional funding to under-resourced schools. The intervention subsequently provided grants and teacher bonuses to schools for achieving targets related to student retention, teacher attendance, financial transparency, community satisfaction, and textbook use. The total grant ranged from US$500 to US$1,000, in comparison to a regular grant of US$200. Of the total grant, 70 percent was utilized to finance the implementation of the school's action plan, while the remaining 30 percent was allocated to bonuses for teachers and head teachers (World Bank 2019).

21 Better Education Service Delivery for II (BESDA) is a World Bank-financed project.

Coordination challenges

At the subnational level, coordination among the MDAs has been challenging, mirroring the problem at the federal level. In most states, there is ever present rivalry/competition between the two critical MDAs responsible for basic education. The state ministries of education (SMoE) have an overall responsibility, and the SUBEBs are responsible for the implementation of the UBE program. However, the level of coordination in terms of planning, budgeting, and execution is minimal at best. When there is such coordination, it is more driven by individuals than by institutions. Lack of strong coordination at the federal level does not help promote coordination at the state level. The implementation challenges and the low accountability for results discussed in the previous section are exacerbated by institutional constraints. The absence of a clear demarcation of roles and responsibilities among the three tiers of government as well as within state government, particularly with respect to expenditure and the management of service delivery, require close coordination. This is essential to avoid or at least minimize duplication of effort, confusion, and occasional rivalry, all of which ultimately undermine the effectiveness of service delivery.

Summary: Key messages

Streamline the process of annual release/accounting of funds to ensure predictability and transparency

- The current process of fund release from the federal level to states involves a cumbersome process and requires a Ministry of Commerce (MoC) (for BHCPF) meeting and subsequent approval.
- Although MoC meetings are scheduled to be held quarterly, these meetings are not held regularly.
- The process for release of funds to states is not transparent. The same is true for release of funds to the providers (in the case of health).
- States and facilities/schools are required to retire fund receipts of the previous cycle before they receive funds of the next cycle. This process has left some entities with prolonged delays in receiving funds, partly because of absence of capacity at that level to undertake the required reporting.

What can be done:

- Streamline the process to trigger fund releases from UBEC/BHCPF to states. To the extent possible, the process would not require meetings to be held to make a decision. Instead, it would involve an automatic release once the key criteria are met. The same streamlined process could be used for releasing funds from state to health facilities/schools.
- Perform a regular audit at the SUBEB/SPHCDA level to improve the transparency and accountability of the use of BHCPF/UBEC funds. Publish the funds released to each state and the audits so as to enhance transparency.
- Ensure TA to the state and facilities/schools include planning, budgeting, and reporting.

Lack of robust sectoral strategic coordination continues to undermine the effectiveness of flagship programs in health and education

- At the federal level, coordination among the key MDAs including NPHCDA and NHIA in the health sector is weak. Similarly, in education the level of coordination is weak.
- At the state level, the coordination between SPHCDA, SHIA, and SMoH in health and between SUBEB and SMoE is in most cases absent. In the absence of a state-level sector plan to inform the annual budget of the sector (both health and education) that reflects all sources of financing, the potential impact of BHCPF/UBEC is not realized. These programs are implemented in isolation. As a result the opportunity to align the flagship programs to the state priorities and ensuring complementarity with state-level programs is missed.

What can be done:

- Institute strategic health/education sector coordination thru a single sector plan and budget.
- Ensure timely submission of a single health/education Annual Plan and Budget which includes all sources of financing.

Resource allocations across and within states are neither equitable nor incentivize performance

- The current resource allocation mechanism responds neither to equity nor to performance differences across the states. It is prioritized equality across states.
- No consideration is made for performance/effort levels across states to reward improved performance.
- The current allocation system is also rigid in terms of spending categories. It defines for what purpose and the funds should used with little room to accommodate state differences and more importantly the needs at the service delivery point.

What can be done:

- Institute a needs and performance-based system to allocate resources.
- Use a gradual approach in moving to the new system of allocation.
- Reward a gradual move to performance- and needs-based allocations. Make sure the performance component measures the change in improvements rather than levels to ensure performance is properly incentivized.
- While maintaining an overall robust public financial management system and accountability for results, allow flexibility on the spending categories to respond to the local needs.
- Establish strong data and monitoring systems to implementing performance-based allocations. This involves having strong and reliable data systems with some form of verification to maintain the integrity of the system. At the same time, investment strengthens the existing routine data systems including the HMIS/EMIS.

CHAPTER 5.

Teachers: Too Few in Number, Poorly Recruited and Trained, and Unevenly Distributed

Introduction: The centrality of teachers

Teachers are the most important input to improving learning outcomes. The literature showing the impact of teachers and good teaching on a multiplicity of outcomes is abundant. Two students who start the academic year under the same conditions but with different teachers, one very good, the other not very good, will reach very different learning levels at the end of the year (Hanushek 2011). Students of skillful teachers learn more and attain more years of schooling; such students go on to earn higher incomes as working adults, and the girls among them are less prone to teenage pregnancy (Chetty, Friedman, and Rockoff 2014; Hanushek 2011). Skillful teachers are also valuable for imparting socioemotional skills to their students (Villaseñor 2017). Going from a low-performing teacher to a high-performing teacher increases student learning dramatically. The effect has been measured from more than 0.2 standard deviations in Ecuador to more than 0.9 standard deviations in India—the equivalent of multiple years of business-as-usual schooling (World Bank 2022c).

Despite teachers' having such importance, in Nigeria the profession is not afforded the attention it deserves. It is beset by a plethora of challenges, including a shortage of qualified educators, poor recruitment and deployment, inadequate teacher training and development, uneven distribution of educational resources, high rates of absenteeism, and substandard working conditions and wellbeing policies, including inadequate compensation.

Challenges in teacher recruitment, distribution, and deployment

The first challenge is not having an adequate number of teachers. Overall, the average pupil-to-teacher ratio (PTR) in public primary schools in Nigeria is 64:1, while 21 out of 37 states have a PTR above 40:1. The heterogeneity is prevalent, with a PTR in public primary schools as high as 160:1 in Akwa-Ibom, 117:1 in Ondo, and 109:1 in Katsina, and as low as 20:1 in Cross-River and 23:1 in Enugu. The PTR is not only highly unequal across states, but it is also unequal across LGAs within states.

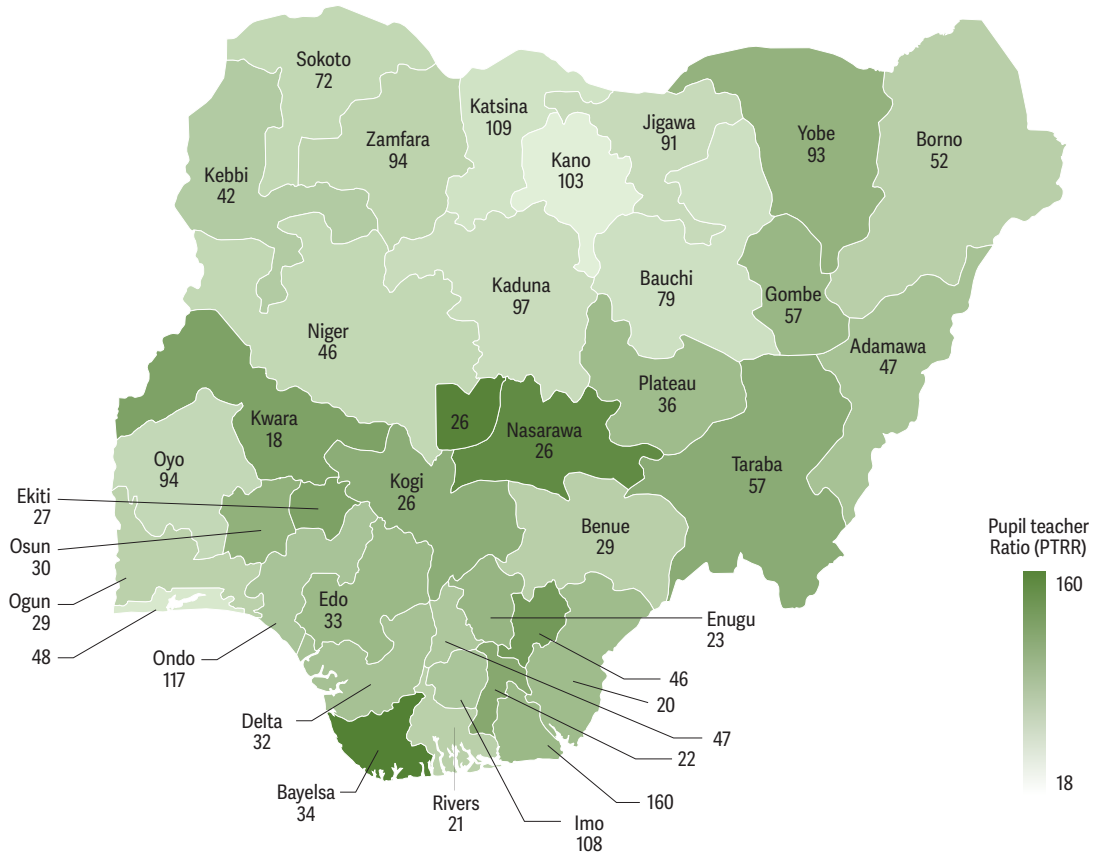
An analysis from 2019 shows that Nigerian teachers are, in general, young. The median age of teachers is 37, with the median age being lower among those teaching in private schools (32 years) than those teaching in public schools (41 years). A detailed age profile analysis of public school teachers shows that more than 13 percent of teachers are younger than age 30. Around two-thirds (64 percent) of teachers in public schools are between ages 31 and 50, while around a quarter (23 percent) are between 51 and 60. For core subjects such as English, mathematics, and science, it is estimated that one in four teachers will retire in the next 10 years (Blom 2019).

Teachers' recruitment and deployment also suffer from multiple challenges. The recruitment of teachers is currently frozen in many states. Furthermore, recruitment typically suffers from a lack of planning and inconsistencies between the recruitment plans and expansions in the number of schools. Recruiting practices sometimes show misalignment between the systems' objectives and learning because other objectives are prioritized when selecting potential teachers (and also when they are deployed), including objectives unrelated to learning. Finally, fragmentation in recruitment, posting, and teacher development exacerbate the situation. At the state level, the appointment and posting of teachers is managed by the state board and by the Local Government Education Authority (LGEA.) Teacher appointments are usually made by the SUBEB, while teacher deployment is the responsibility of the LGEA.

Deployment of teachers does not always take into account student enrollment. Figures 5-2, 5-3, and 5-4, extracted from the recently published "Education Sector Analysis," show a weak correlation between enrollment and the number of teachers deployed to schools, with the extent to which distribution is based on school size at only 27 percent. The deployment of primary school teachers is better in urban areas, with the extent to which teachers are deployed based on enrollment being 32 percent, meaning that 68 percent of allocation is based on factors other than enrollment (see Figure 5-4). In rural areas, the extent to which deployment is based on enrollment is 12 percent, meaning 88 percent of the allocation is not based on the number of children the teachers are expected to teach (World Bank, IIEP-UNESCO Dakar 2021).

FIGURE 5-1.

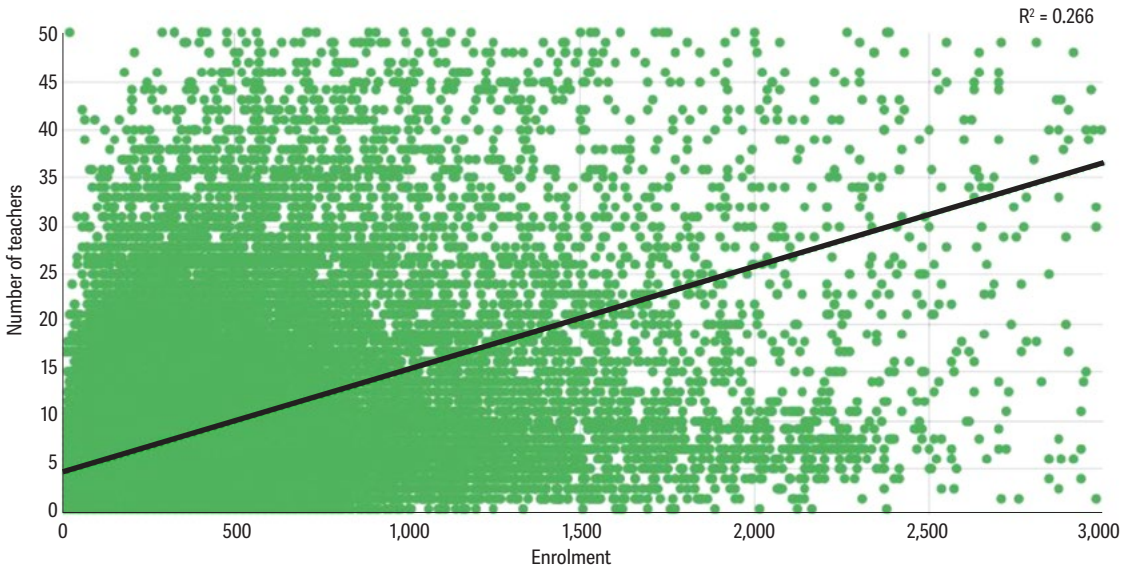
Pupil-to-teacher ratio by state, 2022



Source: UBEC 2022.

FIGURE 5-2.

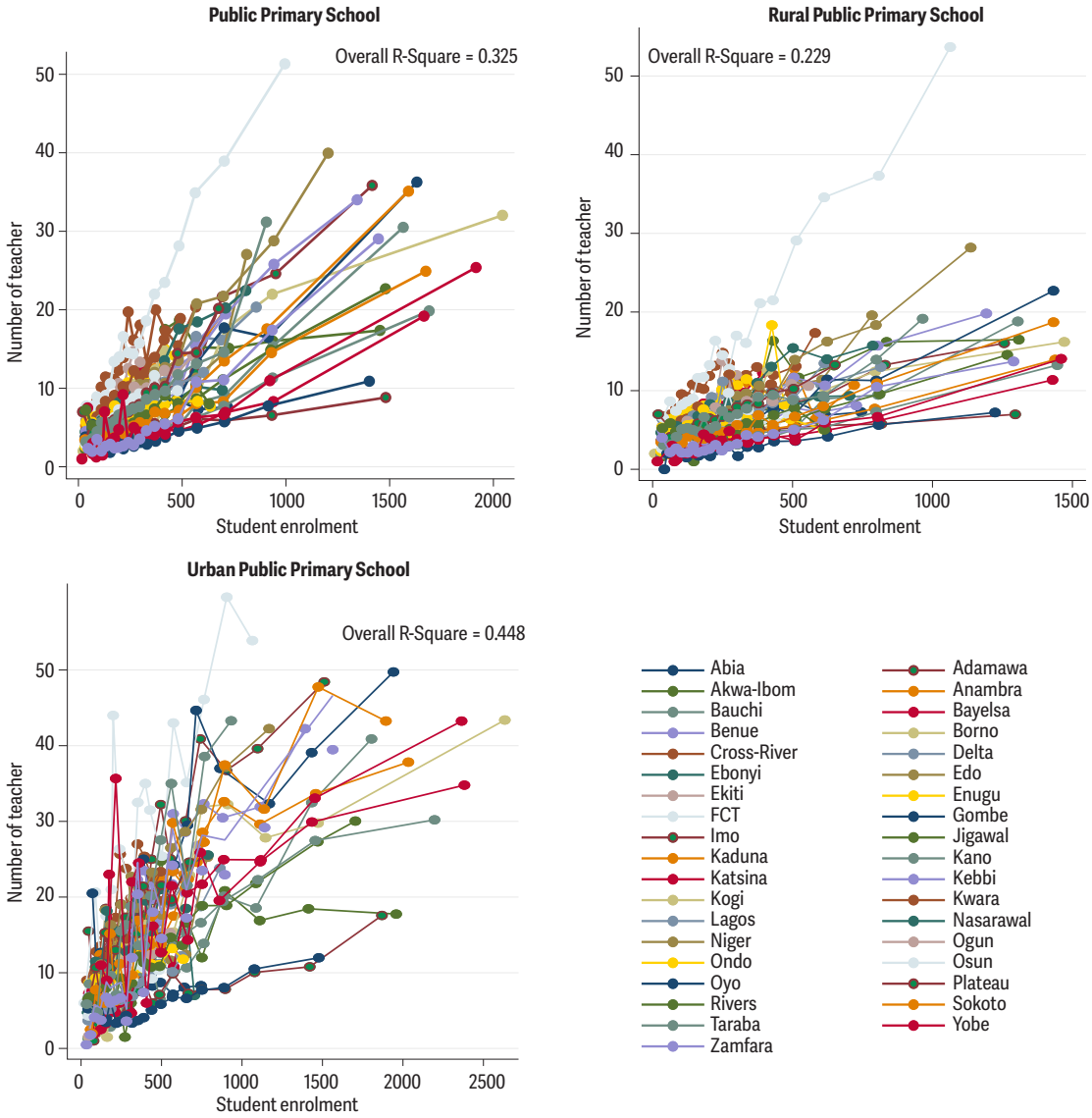
Deployment of teachers in primary schools, by enrollment, 2018



Source: World Bank, IIEP-UNESCO Dakar 2021.
Note: Each dot on the graph represents a school, with its enrollment on the x-axis, and the number of teachers on the y-axis.

FIGURE 5-3.

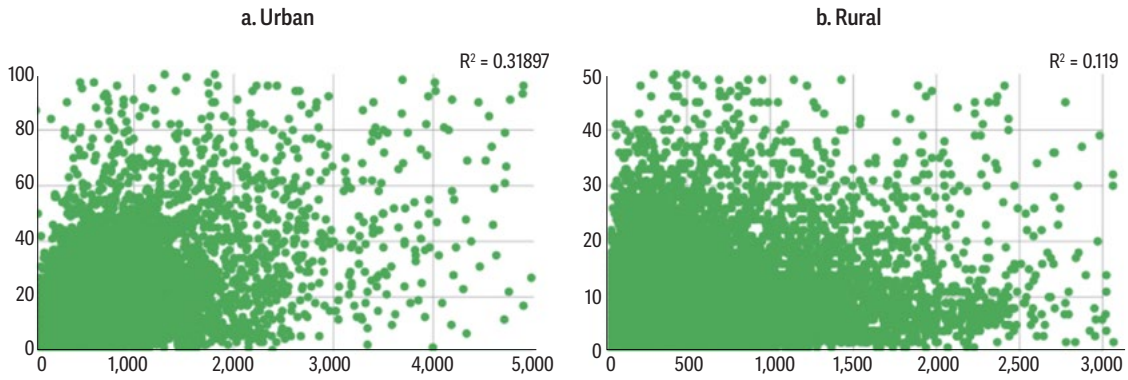
Deployment of teachers in primary schools, by enrollment, by state, 2022



Source: UBEC 2022.

FIGURE 5-4.

Deployment of teachers in primary schools, by enrollment, urban versus rural, 2018



Source: World Bank, IIEP-UNESCO Dakar 2021.

The data shows that the reality is heterogeneous across states. Figure 5.3 shows the distribution of states based on the overall average PTR in the state and the inequality in PTR across schools within the state. Inequality in PTR is measured as the difference between the 90th percentile PTR and the 10th percentile PTR. A state with more efficient deployment of teachers across schools will have more equitable distribution of teachers across states, so schools within the state will have similar PTR and thus a smaller difference between the 90th and 10th percentile PTR values. On the other hand, states with less efficient deployment of teachers will have a large variation in PTR across states and thus a larger difference between the 90th and 10th percentile PTR values. States can be grouped across four categories:

- **Category A**: States with relatively good PTR (below the recommended PTR of 40:1) and reasonable efficiency as measured by lower inequality in the deployment of teachers (difference between 90th and 10th percentile PTR). This group includes states like Anambra, Cross River, Enugu, Ekiti, FCT Abuja, and Kwara. Such states can be used as benchmarks to demonstrate what they have done to efficiently utilize the teaching resource.

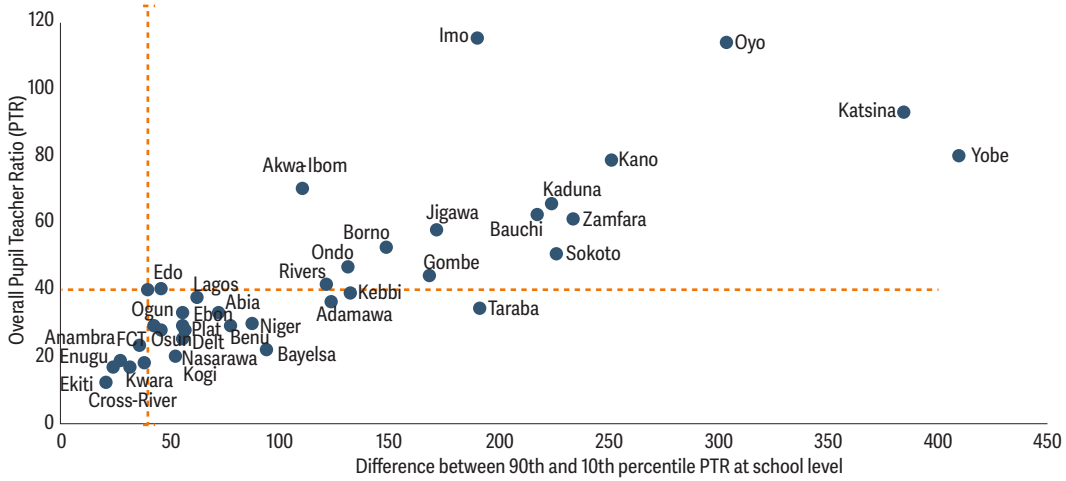
- **Category B**: These are states with a low number of teachers, and hence a high PTR, but whose deployment is reasonably equitable. These states would have PTRs above 40 and the difference between the 90th and 10th percentile PTR below 40. It is likely that the extent to which the deployment of teachers follows enrollment would be relatively high for states in this category. However, none of the states fall in this category based on this definition.

- **Category C**: States with relatively good PTR (recommended PTR of 40 or below), but with low efficiency in the deployment of teachers. The majority of states fall under this category. This group includes states like Abia, Adamawa, Bayelsa, Benue, Delta, Ebonyi, Edo, Kebbi, Kogi, Lagos, Nasarawa, Niger, Plateau, Ogun, and Taraba. They should review their teacher deployment to ensure a more equitable distribution as a first step to improving the utilization of teaching resources.

- **Category D**: These are states with low resources, in other words a low number of teachers and hence a high PTR, and whose deployment is not efficient. Deployment of teachers is highly inefficient, as indicated by a highly inequitable distribution of PTR across schools (difference between 90th and 10th percentile PTR is over 40). The degree of randomness in teacher deployment is high for these states, which include Akwa-Ibom, Bauchi, Borno, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Ondo, Oyo, Rivers, Sokoto, and Yobe. States such as Katsina, Oyo, Imo, Yobe, and Kano have a very high PTR, suggesting an extreme shortage of teachers and extremely crowded classrooms.

FIGURE 5-5.

Distribution of states by overall PTR and efficiency in teacher allocation



Source: World Bank based on UBEC 2022.

Ineffective deployment of teachers to areas where they are needed has been identified as a significant contributing factor to the current educational situation. This failure is often linked to political considerations at the LGEA level, as outlined in the 2013 Education Sector Support Program in Nigeria (ESSPIN) report. The relationship between political representation and education governance is particularly evident in the LGEA context, where the executive secretary is appointed by the SUBEB from candidates recommended by the local government council chair, who is typically affiliated with the local ruling party, regardless of their educational expertise. The executive secretary, who is responsible for the appointment of head teachers and the transfer of teachers, is often reluctant to transfer teachers, as they may not wish to work in "ordinary" schools and female teachers may prefer to work in urban areas that are closer to their families.

Cost considerations also play a role in the distribution of teachers within LGEAs. The higher costs of qualified teachers can influence the distribution of teachers within LGEAs, resulting in less qualified head teachers being appointed to save on cost. This undermines head teachers' authority, respect, and trust, as their appointment is perceived to have not been based on their ability, qualifications, and experience. The situation is particularly challenging in rural areas and hard-to-reach places, where the PTR tends to be much higher. New teachers have little incentive to be deployed to these areas.

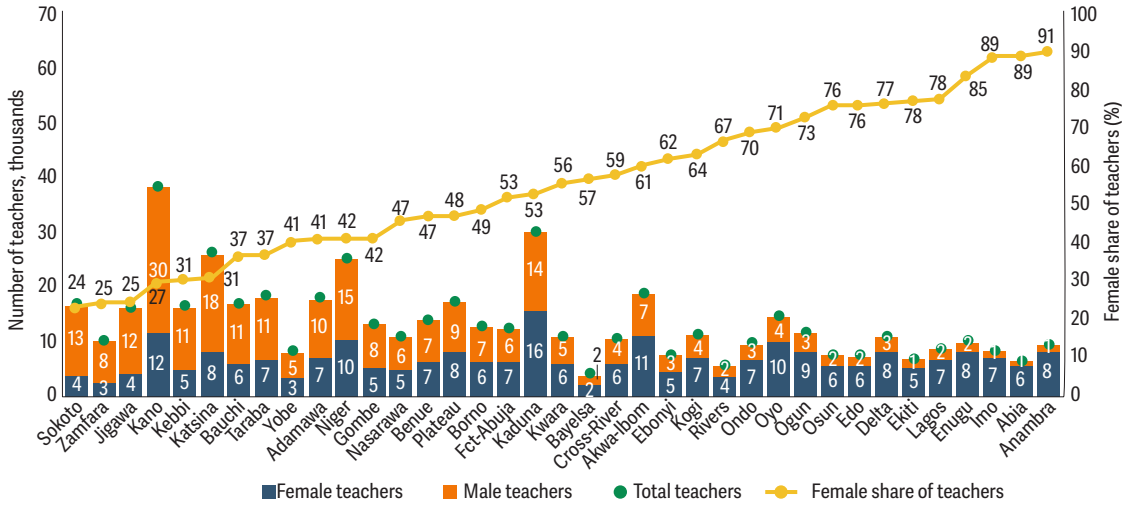
Absence of proper planning well aligned with resources has been a key challenge in the recruitment and deployment of teachers at the basic education level. The financing of salaries for basic education teachers, in most states, is withheld at the state level at the JCCA from local government area (LGA) allocations. This is meant to ensure timely payment of salaries. However, it has also contributed to inadequate line of sight by the LGAs on the budget and on number of teachers deployed/required. As a result, this method of withholding at times leads to underfunding in areas where there is a high demand for education services and a shortage of teachers. This method also undermines the planning and execution processes of the education subsector. Furthermore, it discourages LGAs from promoting education services in their local council areas, as greater participation in schools would lead to an increase in the number of teachers needed and therefore an increase in the amount withheld for staff salary at source. Therefore, it can be argued that this method of withholding resources allocated to the education sector may have negative effects on the sector, particularly in terms of planning, as it does not take into account the potential input requirements needed to address current sector issues (World Bank 2015a).

The recruitment and retention of female teachers has been identified as an effective strategy for improving educational outcomes for girls. Research has demonstrated that girls exhibit improved performance on standardized tests when taught by female teachers. For example, a study conducted in the Republic of Korea using random assignment of students to classrooms found that female students performed substantially better on standardized tests when assigned to female teachers (Lim and Meer 2015). Similarly, in Francophone Africa, female teachers have been shown to be effective in boosting girls' performance in reading and mathematics, without negatively impacting the performance of boys (Lee, Rhee, and Rudolf 2018). Furthermore, female teachers serve as positive role models for young girls, and evidence suggests that their presence may increase girls' likelihood of staying in school, heighten their aspirations, and decrease their likelihood of experiencing violence (Evans and Nestour 2019). It is important to note that, in order to achieve these positive outcomes, it is crucial to create an inclusive and supportive environment that encourages female teachers to stay in the profession (World Bank 2022c).

Some states are already doing well in recruiting and retaining female teachers. One particularly positive aspect to highlight is the relative balance between female and male teachers at the primary school level (not so much for junior secondary school). Approximately 50 percent of public primary school teachers are female, and 21 out of 37 states have more female than male teachers in public primary schools. In some states, such as Enugu, Imo, Abia, and Anambra, over 85 percent teachers are female. However, in other states, particularly in the North East and North West, male teachers out-number female teachers. In states such as Kano, Jigawa, Zamfara, and Sokoto, female teachers comprise less than 30 percent of the teaching force in public primary schools. (See Figure 5-6.)

FIGURE 5-6.

Number of male and female teachers in public primary schools and female share of teachers, by state, 2022



Source: UBEC 2022.

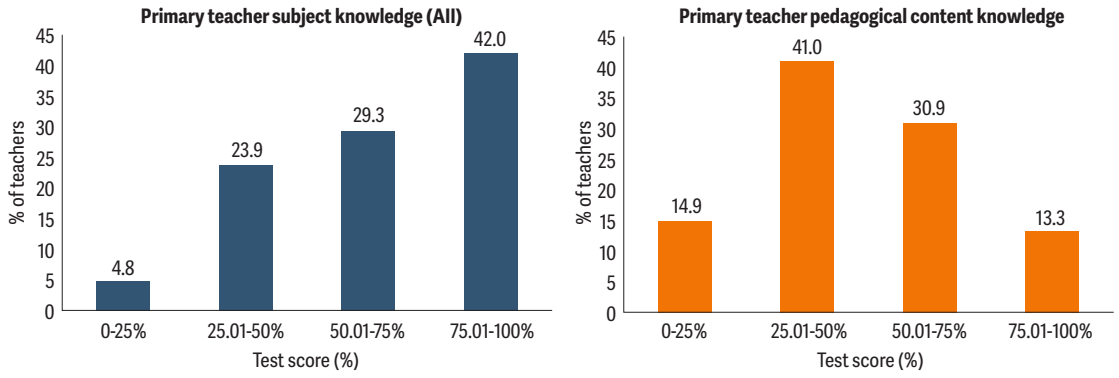
Low quality of teachers

Many teachers do not have sufficient professional qualifications. The "Education Sector Analysis" shows that at least 20 percent of teachers in public basic education schools are not qualified to teach, and this number is nearly double in private schools. In primary schools, the proportion of untrained teachers ranges from 5 percent in Osun to 59 percent in Sokoto in the case of public schools, and from 25 percent in the FCT to 72 percent in Kebbi in the case of private schools (World Bank, IIEP-UNESCO Dakar 2021). These findings emerged from the Monitoring Learning Achievement (MLA) study, conducted by the Federal Ministry of Education in 2019, which included assessment in mathematics, science, and English for grade 4 and 8 students as well as for primary and junior secondary teachers in a nationally representative sample of schools. Teachers were also assessed in general pedagogical knowledge. The methodology employed was broadly consistent with a Service Delivery Indicators (SDI) study conducted in four states in Nigeria in 2013 and profiled the professional knowledge, skills and competencies of Nigerian teachers.

The subject content knowledge and the general pedagogical knowledge of Nigeria's teachers is poor. According to the 2019 Monitoring Learning Achievement (MLA) study (Federal Ministry of Education 2019), only 42 percent of teachers could correctly answer over 75 percent of the test items in primary mathematics, science, and English; 29.3 percent could correctly answer more than half but fewer than 75 percent of the assessment items, while 23.9 percent of teachers could answer more than one-fourth but fewer than half of the assessment items (Figure 5-7). Among all teachers, 4.8 percent have very poor content knowledge of primary mathematics, science, and English and could only answer correctly less than a quarter of the items on a test paper designed for primary 4 learners. Teachers' performance on general pedagogical knowledge is even poorer. Only 13.3 percent of teachers could correctly answer more than 75 percent of general pedagogical knowledge assessment items; 30.9 percent of teachers could correctly answer between half and three-fourths of the items in the general pedagogical assessment test; 41 percent could answer between a quarter and half of the assessment items; and 14.9 percent could answer less than a quarter of the assessment items.

FIGURE 5-7.

Teachers' content knowledge in core content and in pedagogical knowledge, distribution of teacher test scores by score quartile (%)



Source: Federal Ministry of Education 2019.

Compared to other African countries, few Nigerian teachers met the minimum competency benchmark. The SDI survey in 2013 (World Bank 2015b) found that only 4 percent of teachers in Nigeria met the minimum competency benchmark.[22] (See Table 5-1.) The contrast with other countries is enormous. For instance, 40 percent of teachers reached the competency benchmark in Kenya. Teacher capacity varies significantly among states in Nigeria, with teachers in the South performing better than those in the North.

22 Defined as teachers scoring 80 percent in the SDI teacher assessment module.

TABLE 5-1.

Teacher content knowledge

	All	Public	Private	%Difference (%)	Urban public	Rural public	%Difference (%)
Minimum knowledge (% teachers)	3.7	2.4	7.7	-69.4***	2.8	2.3	21.2
Average score							
English, mathematics, *pedagogy (out of 100)*	32.9	30.5	40.4	-24.5***	37.8	29.1	30.1***
English and mathematics *(out of 100)*	43.6	41.0	51.2	-19.9***	49.2	39.5	24.7***
Difference in thresholds							
Overall score 100%	0.1	0.0	0.4	-91.2	0.2	0.0	n/a
Overall score: 90%	0.6	0.3	1.3	-74.5*	0.6	0.3	124.2
Overall score 80%	3.7	2.4	7.7	-69.4***	2.8	2.3	131.3**
Overall score: 70%	10.5	8.1	17.8	-54.7***	15.5	6.7	131.3**
Observations	1345	777	568		166	611	

Source: World Bank 2015b.

Note: The results are based on observations from 2,434 teachers in 760 schools (2,001 teachers either teach English or both English and mathematics, and 2,010 teachers teach either mathematics or both English and mathematics.)

Level of significance: *** p < 0.01; ** p < 0.05; * p < 0.1. n/a = not available.

Results of the SDI survey revealed a significant deficit in teachers' content knowledge. Specifically, fewer than 4 percent of teachers scored higher than 80 percent on an English language test. Notably, there was a marked difference between public and private school teachers, with 69 percent of private school teachers scoring higher than their counterparts in the public sector. However, it is important to note that levels of content knowledge were low in both sectors.

There are significant variations among states. Data by state also revealed a high level of variability, with teachers in Anambra and Ekiti performing better than those in Bauchi and Niger. Furthermore, the average score on the mathematics section of the assessment was only 36.8 percent. In this regard, private school teachers outperformed public school teachers, both overall (by more than 10 percentage points) and on all individual questions. Additionally, among public school teachers, those in urban schools tended to perform better than those in rural schools, with differences ranging from two to almost 20 percentage points. Similar to the findings for the English test, teachers in Anambra and Ekiti outperformed teachers in Bauchi and Niger, with significant variations across states.

Moreover, the results of the assessment indicated that most teachers also possess relatively poor pedagogical skills. On an assessment of teachers' pedagogical skills, the overall score was 15.3 percent, meaning that on average, teachers only managed about one in six of the pedagogical tasks included in the assessment. In addition to low content knowledge, teachers tend to exhibit weak pedagogical skills. In Bauchi and Niger, fewer than one in ten teachers were able to assess children's abilities, and only 3 percent of teachers could assess students' learning progress. In Anambra and Ekiti, the share of teachers with these core pedagogical competencies was three times higher.

The National Policy on Education[23] stipulates that a teacher at the basic education level requires a minimum teaching qualification of a National Certificate of Education (NCE). While a majority of teachers have NCE and Bachelor of Education qualifications, based on these qualifications requirements 14 percent or one in six teachers in public schools do not have any teaching qualifications (Blom et al. 2020).

The low quality of teachers is due to many factors, among which are the low status of the profession and weak preservice and in-service professional development. The teaching profession in Nigeria is often seen as a low-status occupation, despite the crucial role that teachers play in shaping the future of the country. For preservice training, the main issue is the lack of practical experience and the disconnection between the program and the reality on the

23 http://www.education.gov.ng/index.php/78-featured/106-nigerian-education-digest.

ground. Although there exists an accountability structure to foster teacher quality improvement, the practice has been to transfer teachers who have been subject to any sort of disciplinary action to remote or rural schools, which likely has an adverse effect on the recipient schools (World Bank 2015b).

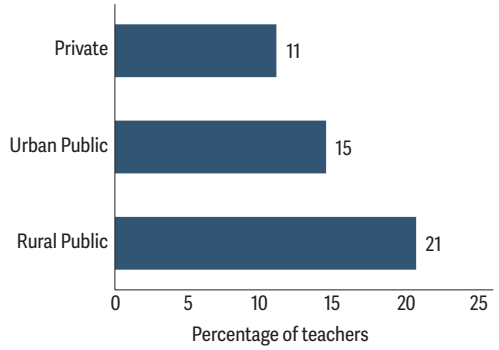
For in-service training, the main problem is the lack of a systematic program for teachers. An estimated 40 percent of teachers never had any training in the last five years (Blom et al. 2020). In fact, older male teachers with more experience are most likely to have attended training workshops. Private school teachers are provided with more opportunities for professional development.

Teacher absenteeism

Teacher absenteeism is widespread. The MLA 2019 survey collected information on teachers' absenteeism from school on the day of the survey. The survey found significant teacher absenteeism. About 21 percent of teachers in rural public schools were absent from the school on the day of the survey, as were 15 percent of teachers in urban public schools and 11 percent of teachers in private schools. The SDI survey of 2013 showed a high degree of teacher absenteeism and a great variability in teacher absenteeism, ranging from 49 percent of teachers in class teaching in Bauchi to 85 percent in Anambra. An issue of concern is that teacher absenteeism is perceived as being normal and acceptable by a significant proportion of teachers. The MLA 2019 survey found that almost 3 in 4 teachers believe it is acceptable for teachers to be absent from classroom if they are doing something for the community; 73 percent of the surveyed teachers agreed or strongly agreed with the statement, "It is acceptable for teacher to be absent if … doing something for the community." One in 3 teachers believe that it is acceptable to be absent if they give students sufficient work to complete, and 28 percent teachers believe it is acceptable for teachers to be absent if the curriculum is completed for the year.

FIGURE 5-8.

Teacher classroom absenteeism

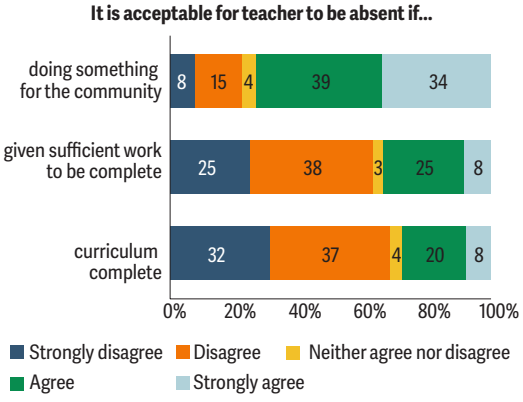


Source: NLA, 2019.

There is a lack of urgency to address teacher absenteeism. Despite 14 percent of teachers being absent from school (21 percent for rural public schools), school principals do not necessarily think that teacher absenteeism is a serious issue in their school. (See Figure 5-10.) Only 5 percent of the school head teachers think that the extent of problem

FIGURE 5-9.

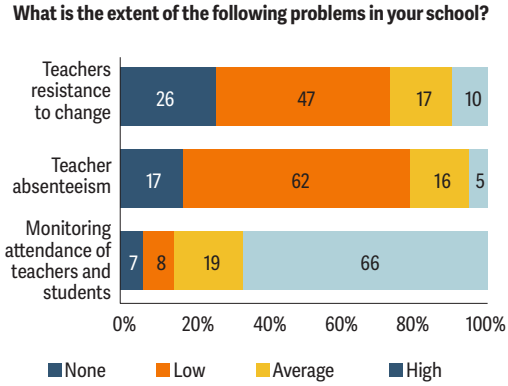
Teachers' attitudes toward classroom absenteeism



Source: NLA, 2019.

FIGURE 5-10.

School principals' and head teachers' perceptions of teacher absenteeism and related issues



Source: NLA, 2019.

of teacher absenteeism is high in their school. Another 16 percent of head teachers think that teacher absenteeism is an average or moderate problem in their school. However, 66 percent of head teachers seem to think that the extent of the problem related to monitoring attendance of teachers and students in their school is high. Other than a few surveys collecting information on teacher absenteeism, regular and systematic recording and collection of data on teacher absenteeism is lacking. Maybe one of the most concerning issues is the lack of reliable data to understand the dynamic of teacher absenteeism. Despite the existence of isolated initiatives, most states do not collect systematic data to understand how frequently teachers are in school, in class, and actually teaching.

Teacher well-being

In Nigeria, teachers' pay is inadequate and falls below the minimum wage for many individuals in the profession. While some teachers receive an allowance, this is not a universal benefit. Moreover, teachers are not paid on time, with some LGAs owing several months of salaries. This is often perceived by teachers as lack of concern or neglect of their work (Blom et al. 2020). The funding for teachers' pay is channeled through a system of federal-state general-purpose transfer, beginning with the federal government, and subsequently passing through the state government and local government. However, in many states teachers do not receive their wages in a timely manner, with local governments owing several months of salary to teachers.

Despite the prevalence of salary payment arrears, most teachers do not leave their positions, possibly due to the scarcity of alternative wage employment opportunities. The consequences of low and delayed pay are multifaceted, with low teacher morale, absenteeism, and strikes among the most notable outcomes. In fact, one of the most common reasons cited for the frequent teacher strikes is the low pay that teachers receive. In many cases, the scarcity of resources to pay for salaries has detrimental effects on the quality of teachers, and it also forces states to recruit teachers in nonconventional ways. For instance, it is common for states to train personnel to teach in rural areas even though they might not have a teaching degree. Similarly, it is common to harness graduates that participate in the Nigeria Youth Service Corps (NYSC) to act as teachers.

Summary: Key messages and potential reform areas

Teachers are critical for the education system. Addressing the challenges of teachers training, recruitment, deployment, retentions, motivation, and performance assessment would require more in-depth assessment of the situation and piloting different interventions before a large-scale intervention is proposed. Based on the review in the current report, few areas of reform are suggested but each need to be piloted and its impact assessed before they are scaled up.

Incentivizing teacher deployment and redeployment: To address imbalances in teacher distribution, particularly in regions with high pupil-to-teacher ratios, it is crucial to develop a system that encourages the strategic placement of teachers. This could involve both the recruitment of new educators and the redeployment of current staff to underserved areas, such as rural primary and junior secondary schools. The success of such a system hinges on transparent deployment policies that offer tangible benefits, such as financial bonuses or clear pathways for career advancement, to incentivize teachers to work in high-need locations. In some cases, the incentives could be behavioral rather than monetary, based on valuable experiences from the region.

- **Establishing a teaching performance assessment framework**: To foster continuous professional growth among educators, the development of a comprehensive system for evaluating teaching performance is essential. This system should include regular classroom observations and assessments of teacher competencies, with the dual aims of recognizing exemplary teaching and identifying specific areas for development. Such an evaluation framework would not only provide valuable insights into teaching practices but also serve as a basis for personalized professional development plans. In more advanced states, the framework could focus on establishing clear performance-based mechanisms to determine teacher's career progression and, potentially, payments.

- **Implementing biometric attendance systems for teachers**: Drawing inspiration from successful case studies within some states, other sectors like health, and examples from abroad, the adoption of biometric technology for monitoring teacher attendance offers a promising solution. This approach requires the installation of biometric devices across schools to ensure accurate and reliable attendance tracking, thereby promoting accountability and reducing absenteeism.

These measures should be accompanied by specific policies designed to support teachers. This includes providing resources—for instance, through structured pedagogy programs—and putting a focus on teachers' wellbeing, salaries, and career advancement.

These proposed reforms, aligned with the World Bank's principles, represent a holistic approach to strengthening the teaching profession. By addressing key areas such as recruitment, deployment, attendance monitoring, and performance evaluation, these initiatives aim to create an environment that supports teacher excellence, ultimately leading to improved educational outcomes.

CHAPTER 6.

Strengthening Data Systems for Human Capital

Introduction

The importance of having strong information systems for education and health is critical to monitor progress. In addition to the population-based surveys and facility surveys, having robust administrative data is key. Administrative data would provide timelier and at times more granular information. A dependable health and education management information system cultivates a culture of data-driven decision-making and can assist in ensuring a more precise alignment between resources and priority goals. Data systems that furnish disaggregated data, classified by schools/health facilities, health workers/teachers, patients/students, and so forth can provide direction for targeted actions and broader reforms aimed at enhancing efficiency and fairness in service delivery. Recent technological advancements provide an opportunity to strengthen the information system with geospatial data, which can further facilitate informed decision-making across a variety of domains.

The information systems in education and health are at different stages of development. The health information management system has been in place for a long time, though the quality of the information has been questioned. A similar development in the education sector is practically nonexistent. The system depends instead on the annual school census to collect and collate information which otherwise could have been collated regularly, similar to the health sector.

Challenges of the information systems in the health of Nigeria

The Health Management Information System (HMIS) has undergone several changes since its establishment in the 1960s to get to its current state, where it is now managed using the District Health Information System (DHIS). The HMIS provides a large source of information from frontline providers, and it has the potential to serve as the first source of information to monitor service coverage, identify those who are underserved, and inform decisions. However, the quality of the information it contains is usually questioned, which is partly a function of the use of the information for decisions, creating a self-reinforcing factor that results in poor quality data.[24] The challenges the HMIS has been facing include the following.

Data quality and digitizing HMIS

Data recording and compilation at the facility level is still paper based and done manually. Efforts to move to an electronic system have yet to cover health facilities. From the LGA level upwards, significant progress has been made to move away from paper-based records toward an electronic system. In terms of using electronic system, the remaining task is making data recording and reporting possible at the facility level.

Improving the quality of HMIS data requires more than transitioning from paper to an electronic system. Transition from paper to electronic is expected to improve the quality of HMIS data. However, this is not enough to facilitate the use of data for decision making. Digitizing the system in a way that ensures interoperability of the various components will make access easier. A robust test of the system is its use for decision making. At the same time, use of the data generated through the system means that close attention will be paid to the quality of the data. In addition, robust external validation of the HMIS data would help improve its quality. Such a system can be instituted through a regular data quality assurance (DQA) procedure to verify system-generated data with sample-based household visits. Finally, although the first order of business is to get all data recorded and compiled electronically, the aim is to move to a digital system where the facility-level data and other sources in the health information system can be integrated and easily accessible.

24 For a review of the literature see Asangansi (2012), Makinde et al. (2012), and Kumar et al. (2017).

Data use for decision making and harmonization of surveys

Changes in the incentives around use of data for decision making are key to changing the prevailing behavior and culture. Data use and quality are interrelated and reinforce each other. One of the reasons potential users of HMIS data identify the data quality as poor is that people are not using the data—because the quality is poor. At the same time, when the data is not used the quality of the data generated does not get enough attention. Hence the quality of the data generated by the HMIS will increase the demand for more quality data (at least it will draw attention to data quality), which in turn will feed back into improvements in the quality of HMIS data.

The various sources of data generated by the health system need close harmonization. In addition to HMIS, population-based household surveys are important sources of data used in the health sector and need harmonization. These surveys can be used to triangulate for quality control of the HMIS. There are a multitude of population-based surveys, including the Demographics and Health Survey (DHS), the National Living Standards Survey (NLSS), the Multiple Indicators Clusters Survey (MICS), and the SMART survey, to mention few. Each of these surveys has its own sampling frame, methodology, and estimation precision, which makes comparison across surveys difficult. What is more, these surveys are financed and at times conducted by different agencies and partners, with no or little coordination in terms of both the data collected and timing of the survey. Such lack of coordination has resulted in a multitude of estimates for some of the key indicators, such as mortality rates, making it difficult to reach a consensus.

Challenges of the education information systems in Nigeria

The education management information system is in its early stages. In August 2021, the federal Ministry of Education (MoE) issued a new National Policy on the Education Management Information System (EMIS), which was accompanied by implementation guidelines. The policy identifies the MoE as the main entity in charge of education data and assigns it the responsibility of leading data collection efforts. It also establishes the creation of multiple bodies, including a National Committee on EMIS, a Federal EMIS Committee, state-specific EMIS Committees, EMIS Committees at the local level, and EMIS teams in each school. It stipulates that there shall be a database situated within the Statistics and National EMIS (NEMIS) offices of MoE that shall be the apex data warehouse for the totality of educational data that flow from the schools and other sources through designated nodes to it.

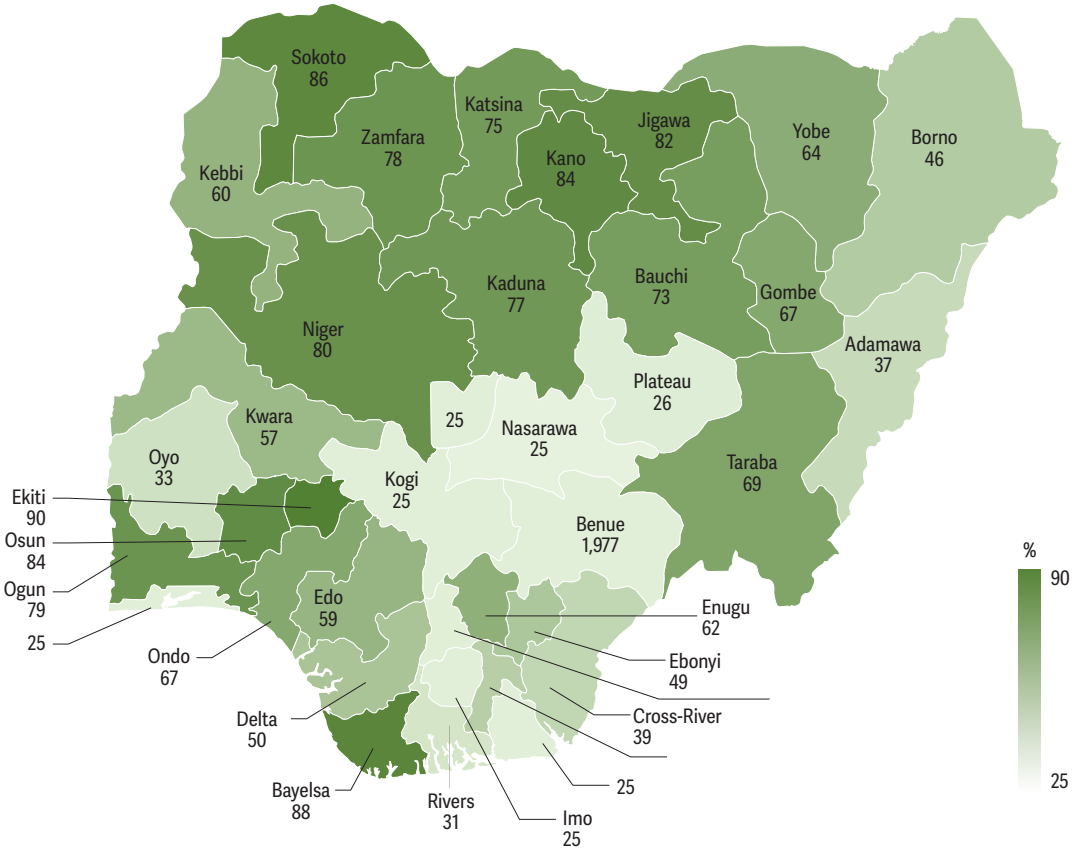
Lessons from the health sector are key for guiding the EMIS to carefully and deliberately identify the sets of information to be collected. The policy as it is does not identify a key series of indicators that need to be collected, their frequency, or their sources. It is also particularly vague regarding the funding of the NEMIS, stating that "FME, SMoEs, SUBEBs, UBEC, SECo, AEO and LGEAs shall fund EMIS activities at the federal, state, and local government levels respectively. Development Partners (DPs) shall continue to support EMIS activities Private partners and NGOs shall also assist in funding EMIS development" (FoE 2021).

Nigeria currently has several instruments and initiatives that collect education data, which are urgently in need of coherence.[25] The first one is the Annual School Census (ASC), the main way through which NEMIS has been implemented. The ASC is a data collection exercise led by the federal MoE, even though the actual data collection is done at the state level. This has led to some inconsistencies and difficulties regarding data comparability, and to a situation where not every state finalizes the data collection every year, creating multiple data gaps. In general, due to the weakness of NEMIS, the statistical data produced by states are often inconsistent and often unreliable. Critical indicators, including inputs, outputs, and outcomes are not collected under the current model. For instance, data on teachers' absenteeism is not available.

25 An EMIS can be defined as "a system for the collection, integration, processing, maintenance and dissemination of data and information to support decision-making, policy-analysis and formulation, planning, monitoring and management at all levels of an education system. It is a system of people, technology, models, methods, processes, procedures, rules and regulations that function together to provide education leaders, decision-makers and managers at all levels with a comprehensive, integrated set of relevant, reliable, unambiguous and timely data and information to support them in completion of their responsibilities" (UNESCO, 2008: 101).

FIGURE 6-1.

Percentage of schools with complete ASC/NPA data between 2016/17 and 2019/20

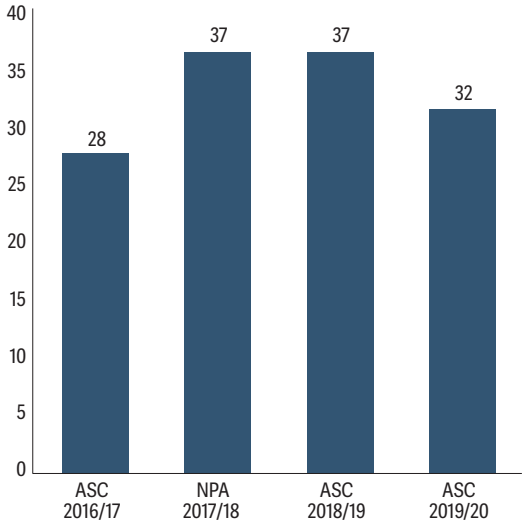


Source: Based on UBEC (2019) and NBS 2022.

There is a large gap in the information collected using the current system. A recent verification exercise conducted by the National Bureau of Statistics (NBS) for the BESDA program showed that between 2016/17 and 2019/20, complete data records are available only for 50 percent of all schools. This highlights the extent of incompleteness and unreliability of the ASC data. Significant lags in data collection add to the poor quality of data. It is not uncommon for states to conduct the ASC with a two-year delay. For example, some states collected 2019/20 data only in 2022. Figure 6-2 shows that at least five states did not have ASC 2019/20 data collected by 2022. Recently, there has been some modest progress to implement digital data collection tools. In 2022, the federal MoE conducted a pilot in five states (Kano, Bauchi, Katsina, Zamfara, and Sokoto) to test a digital application to collect data for the annual school census.

FIGURE 6-2.

Number of states included in recent data collection exercises, 2016/17 to 2019/20



Source: NBS 2022.

In the absence of comprehensive EMIS, the National Personnel Audit conducted by UBEC provides useful information. As part of its statutory responsibilities, UBEC is tasked with carrying out a data collection exercise on education in Nigeria every three years—the National Personnel Audit (NPA). The NPA collects data on students, teachers, schools (including their resources), and infrastructure. Despite the requirement to conduct this exercise every three years, the NPA has only been completed four times (in 2006, 2010, 2018, and 2022). Nevertheless, the data collection instrument and the practices have improved significantly. For instance, in 2006 and 2010 the NPA did not include private schools, but the private sector was added in 2018 (UBEC 2019). Similarly, the 2006

exercise, only two years after the UBE Act, did not include JSSs, whereas today JSSs are routinely part of the audit. Even with its limitations, the NPA is probably the best source of information for the education system in Nigeria.

It is important to align state-level EMIS with the national vision. Besides the efforts coordinated at the federal level, several states have implemented or are implementing their own EMIS. For instance, Edo state is currently working, with the support of a World Bank Program for Results, on the development of a system that will include data on students, teachers, principals, schools, and LGAs. It will also include real-time data on teaching practices, attendance of students and teachers, and learning assessments.

In addition to routine administrative data, population-based surveys are key sources of information. One of the most notable sources is the Nigeria Education Data Survey (NEDS), which was last conducted in 2020. The 2020 survey was the fourth of its kind and was designed to provide information on education for children ages 4–16, focusing on factors influencing household decisions about children's schooling. The previous rounds of the survey were conducted in 2004, 2010, and 2015. The 2020 NEDS yielded critical information pertaining to the demand for schooling, including data on the age of children at first school attendance, dropout rates, and the perceptions of parents/guardians regarding the benefits and drawbacks of schooling and the quality of schools. Other important household surveys with data on education include the Demographics and Health Survey (DHS), the National Living Standards Survey (NLSS), and the Multiple Indicators Clusters Survey (MICS). Given that the last population and housing census in Nigeria was conducted in 2006, it is a challenge to obtain reliable population estimates, and often one must rely on population projections from various sources such as the National Population Commission and the UN Population Division.

Clearly, having such broad sources of information presents the challenge of coordination and harmonization. Adding to the problems faced by each of these initiatives, the system as a whole suffers from at least five problems: (1) lack of coordination across the multiple initiatives; (2) lack of real-time data; (3) lack of funding to roll out an EMIS appropriately and sustainably; (4) weak utilization of the data that is actually collected; and (5) lack of human capacity.

- ***First, the lack of coordination is probably the main problem.*** The federal MoE and UBEC pursue their efforts without coordinating and, usually, following conflicting views. As mentioned above, this occurs not only when assessing the NPA and the ASC, but also with respect to large-scale learning assessments, which makes the comparability across years very challenging. Vertical coordination has also proven difficult, with the political constraints of some states being an important factor hindering the implementation of the recommendations based on the data collection efforts of federal organizations. At the state level, conflicting responsibilities between SUBEB, the state Ministries of Education, and the Teaching Service Commission (TESCOM) contribute to the challenges. In some cases, parallel information systems are developed under each organization, duplicating efforts and creating confusion at the school level.

- ***Second, real-time data is barely collected.*** This includes students' attendance and enrollment, teachers' attendance, learning data, and teachers' performance, including through classroom observation tools.

- ***Third, there is a persistent lack of funding to roll out an education management information system appropriately and sustainably.*** This creates uncertainties about the many data collection exercises and reduces the incentives of stakeholders to collaborate with the process, given the lack of continuity of efforts. Budget challenges include a lack of specific budget lines for physical infrastructure, personnel and professional development, maintenance of an EMIS system, and reporting costs.

- ***Fourth, even the data that is collected tends not to be utilized.*** Potential users of the existing systems are not always aware of their existence and, when they are aware, they do not always have the opportunity to develop the skills to interpret, manipulate, and utilize the data. At the strategic level, data tends not to be used for governance purposes and decision-making. At the school level, data is not an input for improving teaching practices and the learning environment, with the exception of some embryonic initiatives in some states. The data are also not used for accountability purposes, since most of the information is not easily accessible, although the ASC and the NPA produce public reports, which is an important step. More importantly, data is not utilized to measure the performance and needs of the states, LGAs, and schools, and therefore resources are not assigned based on these criteria.

- ***Finally, the human capacity to manage a comprehensive system is also limited.*** The core tasks of EMIS are not always identified and the organizational units are not always staffed with qualified people. When they are, their opportunities for professional development tend to be limited.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Limited and sporadic learning data

One of the main constraints to improve learning outcomes in Nigeria is the limited availability of learning data. Besides sporadic efforts, there are no standardized and institutionalized systems to track learning achievements during the basic education cycle. The landscape features three types of learning assessment: classroom assessments, high-stakes examinations, and large-scale assessments. Classroom assessments are useful for providing real-time information to teachers and students to support teaching and learning in individual classrooms. They help to guide day-to-day instruction and tailor teaching to the needs of individual students (Clarke and Luna-Bazaldua 2021). They tend to be formative in nature or, in other words, assessments for learning. In Nigeria, classroom assessments are not systematic, typically because they are not emphasized as a common practice during pre-service and in-service training.[26] Large-scale assessments are for providing information on overall performance levels and trends in the education system as an aid to policy decision-making. They provide system-level insights and data on achievement trends that help guide systemwide reforms (Clarke and Luna-Bazaldua 2021). Nigeria has had experiences with some large-scale learning assessments, but the fragmentation and lack of coordination of the multiple efforts reflects some of the systemic problems the country faces.

Data on learning outcomes has been collected for quite some time, albeit on an ad hoc basis. In 1996, the federal MoE conducted the first nationwide evaluation of primary school education. This was done in collaboration with UNESCO and UNICEF, under the Monitoring Learning Assessment (MLA) project (MoE 2019). The assessment targeted Primary 4 students and covered three key subject areas: literacy, numeracy, and life skills. The results of the assessment revealed a significant learning crisis in the country, as only one in five students demonstrated the level of competency expected for their grade level according to the national curriculum. Furthermore, the data revealed that this learning crisis was not limited to any specific group of students, as low achievement rates were found across all demographic categories, including gender, school type, and location (Obiakor 2023). In 2001, 2003, and 2017, the federal MoE conducted a national assessment, known as the National Assessment on Learning Achievement in Basic Education (NALABE). Similar to the MLA, the NALABE was a school-based assessment initially administered to

26 High-stakes examinations are for making decisions about the formal progression of students through the education system, for example, student certification, graduation, or selection decisions. They are used to provide a standardized way to make decisions about the allocation of scarce educational opportunities among students (Clarke and Luna-Bazaldua 2021). The main examination for basic education is the Basic Education Certificate Examination (BECE), which is conducted for candidates in their final year of JSS and serves as the main examination to qualify students for admission into senior secondary and vocational schools in Nigeria. It is administered by each state Ministry of Education, with the supervision of the National Examinations Council (NECO). It is conducted annually in May or June. It is not as institutionalized as other high-stakes examinations in the country, such as the Senior Secondary Certificate Examination.

Primary 4 students in the subjects of English and mathematics. The NALABE was again administered in 2022 where all states were included, and the results will be representative at the LGA level. In the middle of that process, FME conducted a National Learning Assessment (NLA) in 2019, which included grades 4 and 8 and covered language and math.

Nigeria has also conducted international learning assessments. The country implemented an Early Grade Reading Assessment in 2014, with the support of USAID and RTI International. However, the assessment was not nationally representative since it included only four states: Jigawa, Kaduna, Kano, and Katsina. The NLA conducted in 2019 was a much more comprehensive national learning assessment for grades 4 and 8 in mathematics, science, and English, and incorporated some assessment items from international assessments such as Trends in International Mathematics and Science Study (TIMSS) and Progress in International Reading Literacy Study. Currently, the federal MoE is in discussions to conduct PASEC in Nigeria.

Other sources of learning data come from household surveys. Between 2004 and 2020, the National Population Commission, with the support of international development partners and the FME, conducted the four nationally representative household surveys known as NEDS. The last two rounds of NEDS, conducted in 2015 and 2020, included assessment items on basic literacy and numeracy. The most recent round of MICS, conducted in 2021, also has a learning module that assesses foundational learning skills for children ages 7 to 14.

The picture described in the paragraphs above shows the lack of coordination between the multiple agencies. For instance, the assessments organized by UBEC and the federal MoE are typically not aligned, in the sense that their results are not comparable, given that they target different grades, have different samples, and have different assessment instruments. This has led to a serious duplication of resources. Besides the technical aspects of learning assessments, the institutional challenges have been at the center of the problem. Nowadays, it is not entirely clear who is responsible for organizing learning assessments, with what frequency, and at what levels.

Given this situation, some states have decided to go ahead and create their own learning assessment systems. For instance, Edo state is designing, with the support of the World Bank and the Accelerator Program, a learning assessment system. The first round of the assessment conducted in 2023 included grades 3, 6, and 9 in the areas of English and math. The Edo state government is investing in the institutionalization of the system to ensure its continuity beyond political cycles.

Finally, the lack of systematic and frequent learning data has led some organizations to conduct "citizen-led" assessments, following the Annual Status of Education Report (ASER) methodology. In 2017/2018, Let's Engage, Assess & Report Nigeria (LEARNigeria) was conducted, assessing children between the ages of 5 and 15 on foundational literacy and numeracy skills based on the Nigerian curriculum. Unlike the NEDS, LEARNigeria surveyed students from only six states, which represent the country's geopolitical spread: Akwa Ibom, Ebonyi, Lagos, Kano, Plateau, and Taraba. Additionally, LEARNigeria went beyond the basic assessment conducted by NEDS. The results of the assessment reveal low levels of learning across all states, even in national languages.

Summary: Key messages and potential areas of reform

The following four areas of reform are recommended.

Strengthen the routine collection of data.

- ***Primary health:*** Mandate the transition away from the paper-based system. Address the last-mile gap in making HMIS data collection and compilation electronic by providing health facilities with the necessary infrastructure and training to transition out of the paper-based system.

- ***Basic education:*** Institute self-reporting by schools on a monthly or term basis using digital platforms, and institute clear timelines for reporting data at the school, LGA, and state levels. Learning from the health sector HMIS, education can also develop a system whereby schools regularly submit information which can be compiled at the LGA, state and federal levels. This will (1) increase the availability of information at regular intervals, and (2) reduce the need for an annual school census to collect information.

Improve on data quality.

- Introduce an external data validation system. It is critical that the data generated through the HMIS and EMIS be robust and reliable. Improvements in data quality would come from both within the system and from a push from users. From within the system, carry out periodic sample-based validation surveys to determine accuracy of self-reported data, with the aim of reducing the discrepancy between the reported and validated data. Data validation will be even more important if formulas for the allocation of school grants are based on enrollment or transition numbers reported by the schools.

Increase the transparency of data.

- Mandate annual publication of service coverage, school access, and attendance of students, teachers, and health workers data.

Enhance coordination.

- ***Primary health:*** Create a national coordinating system within the department of planning of the federal MoH to coordinate the timing, methodology, and substance of the various household surveys.

- ***Basic education:*** Create a mechanism where the federal MoE and UBEC coordinate their efforts on the NPA and the ASC, preferably combining them into one, and in conducting large-scale learning assessments. This coordination is required both among the federal MDA and between the federal and subnational bodies.

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RECOMMENDATIONS:

Matrix of Policy Actions to Address Financing and Governance Constraints in Primary Health care and Basic Education

Background

Why present a long list of recommendations and what is the likelihood of their implementation? The presentation of recommendations in the form of a list of policy actions/reforms is deliberate. From the onset of the study, the objective was to identify sets of either policy or service delivery level actions that can be incentivized. The preparation of the report was unorthodox in that at every stage of the work, the team has been engaging with the stakeholders at the federal and state level. The aim was to better understand from the stakeholder's perspective whether these findings make sense, and to test the feasibility of their implementation. These engagements were done in an iterative way and have helped to enrich the report. Because of these engagements, the operations that are being designed to implement these recommendations are in a better position in terms of client buy-in. Three operations that are interrelated are being designed to implement these recommendations. These operations are sequenced to ensure that the enabling environment is secured. The first operation is focused mainly on addressing the cross-sector issues identified in the matrix below that are common to the health and education sectors. These recommendations aim to reduce leakage and enhance both the volume and quality of spending in these sectors and prepare the ground for the subsequent operations. The subsequent two operations, one in health and another in education, are focused on the sector-specific issues identified in the matrix below.

Matrix of Policy Actions to Address Financing and Governance Constraints in Primary Health Care and Basic Education

Legend:

Difficulty/potential Impact/Cost: ● Most difficult/Least impact/Highest cost;
Difficulty/potential Impact/Cost: ● Least difficult/Highest impact/Least cost.

The rest of the color fall between the two extremes of red and green.

Policy Area /Action	Indicator	Rationale	Responsibility
Cross- Sectoral			
1: Increasing fiscal transparency and accountability in budget and expenditure			
1.1: Streamlined processes to trigger fund releases from UBEC and BHCPF (from federal to state and to facilities).	The BHCPF guideline is revised to reflect streamlined process of fund release to the Gateways without requiring MoC meeting. UBEC guideline is prepared with a streamlined process of fund releases to the states.	The current fund release involves a cumbersome process and requires MoC (for BHCPF) meeting and subsequent approval. Although they are supposed to be held every quarter, MoC meetings are not always held regularly. A streamlined process would improve predictability of finds and transparency of the system.	FMoH, NHIA, NPHCDA
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.2: Improved transparency, predictability, and timeliness of UBEC and BHCPF transfers to states.	i) MoF releases and publishes the amount of appropriated UBEC and BHCPF funds within the first month of the quarter. ii. a) UBEC release funds to states and published within 2 weeks of receipt from MoF. b) MoH releases funds to the Gateways and publishes within 2 weeks of receipt from MoF. c. NPHCDA and NHIS Gateways release funds to the states and publishes within 2 weeks of receipt. iii) States transfer to health facility/school funds and publish the amount and the list of facilities.	The current fund release involves a cumbersome process and requires MoC (for BHCPF) meeting and subsequent approval. Although they are supposed to be held every quarter, MoC meetings are not always held regularly. A streamlined process would improve predictability of finds and transparency of the system	FMoH, NHIA, NPHCDA
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.3: Timely and adequate accounting by PHCs and primary schools.	PHCs and school retire within 2 weeks of end of quarter and receive quarterly transfers within 4 weeks of the quarter	Health facilities and schools do not retire funds on time leading to delays in release of subsequent rounds funds. Currently such information is not publicly available	SPHCDA/SUBEB

Policy Area /Action	Indicator	Rationale	Responsibility
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.4: Publication of UBEC/SUBEB and BHCPF audited financial statements within 5 months of the end of the FY.	Publication of the audit reports on their respective websites.		UBEC/SUBEB, NPHCDA/ SPHCDA, NHIA/ SHIA, NCDC
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.5: Publish audited report on the use of local government funds for health workers and teachers' payroll.	Publication on the states/LGA website.		SUBEB, SPHCDA
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2: Enhanced planning and budgeting for strategic sector coordination and implementation			
2.1: Timely submission of single state coordinated annual plan and budget for implementation of universal health care; and similarly for universal basic education consolidating all funding sources with performance and results targets.	State-level health and education sector annual plan and budget prepared, submitted and approved reflecting a consolidated, fully costed plan covering all sources of funding for [basic] education and [primary] health (UBEC, state, LGA, and DP funded resources) and following enhanced guidelines.	At the state level the various MDAs in the health sector do not have a single sector plan that guides their action. At best, each MDA will have its own plan which informs their annual budget. A comprehensive state sector plan and associated annual budget for health as well as education will help coordination within the sector.	SUBEB/SMoE, SPHCDA/SHIA/ SMoH
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2.2: Increased state budget credibility, measured by deviation from approved budget to actual releases for functional category of primary health and basic education.	The difference between approved and actual released budgets in health and education does not exceed 10 percent.		SMoF
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
3: Improved system for recruitment and performance management of civil servants (esp. teachers and health workers			
3.1: States prepare and approve multi-year basic education teacher & primary health care workers recruitment and deployment plan including scheme for incentivizing remote deployment	Approved plan for teachers/health workers recruitment and deployment plan including scheme for incentivizing remote deployment.		
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		

Policy Area /Action	Indicator	Rationale	Responsibility
Basic Education			
1: Improving the efficiency and equity of UBE resources.			
1.1: Establishment of a need-based and performance-based system for allocating UBE resources across states.	Change in the UBEC intervention fund allocation based on state's needs and performance.	Such a system will improve equity and results by prioritizing states with more needs (based on school-aged population) and better performers (reduction of OOS, and improved literacy/numeracy). This requires reliable data systems to measure the indicators that determine the need and performance.	UBEC
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.2: Establishment of a need-based and performance-based system for allocating resources at the state level.	States to develop a system to assign resources across LGAs based on the number of in-school and OOSC and on the performance of each LGA.	Same as above	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.3: Increasing the flexibility of the UBE formula across state.	Establishment of a mechanism through which states can determine the percentage they assign to each item of the UBE formula according to their own needs.	Currently, all the states follow the same formula regardless of their needs. For instance, some states need more construction whereas others need to invest more in teachers. This reform would allow that needed flexibility.	UBEC
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
1.4: Monitoring funds and resources flow at the state level.	Establishment of a digital technology-based mechanism to collect and report on how/when/how much resources (construction, textbooks, etc.) are delivered from UBEC to SUBEBs and from SUBEBs/states to schools.	Currently, there is room for improvement in monitoring system to check how resources flow from the top to bottom all the way to schools. This reform would strengthen timeliness and predictability of fund/resource flow in the system and can be done through the use of digital technologies. KoBo toolbox or a similar system could be used.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2: Improving data and information systems for basic education			
2.1: Improving information at the school level.	Development of a system for schools to submit information periodically and compilation of information at the state and federal levels.	Currently, there is a lack of information at the school level, on teachers and student attendance and the information available is not captured consistently and does not follow the same guidelines across schools. A reform could establish the need for each school to receive a table with a pre-determined format using KoBo toolbox or similar software (to be developed at the federal level) and complete the information at the end of each term.	UBEC, SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2.2: Improving the accuracy of school-reported data.	Carry out periodic sample-based validation surveys to determine accuracy of self-reported data and incentivize the states that show reduced discrepancy in reported and validated data.	If school-reported data (on student enrollments and attendance, teachers, etc.) are to be used for funding formula, this may induce perverse incentives for schools/LGAs/states to inflate the data. Thus, as schools load data into the EMIS system, there needs to be a mechanism to verify the accuracy of data. This periodic survey will be done with the objective of checking the validity of information at the school level.	UBEC , SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		

Policy Area /Action	Indicator	Rationale	Responsibility
2.3: Increasing the transparency of data on access, teachers and student attendance and finance.	Annual publication of official statistics by state on OOSC, Teacher, and Student Attendance, and Finance at the LGA level.	Currently, the estimates for OOS children are based on household surveys, since they are considered more reliable. However, once data are captured at the school level in a reliable manner, OOS data can be calculated annually. This will require the development of a common methodology at the federal level, to ensure the data is comparable across states. Similarly, teacher and student attendance data are not regularly collected and published.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2.4: Establishment of a periodic classroom learning assessment.	Establishment and implementation of a regular classroom assessment system based on good practices in the country/region.	Good classroom assessment systems can help collect information about the students' learning to make adequate instructional decisions to meet the students' needs, thus helping teachers improve their practices to help students.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
2.5: Establishment of early warning systems to prevent dropouts at the state level	An operational early warning systems to prevent dropouts at the state level.	Development of a system that collects data on students and schools and identifies, through an algorithm students at risk of dropping out. A simple system could alter students with low attendance rates, while a more sophisticated system could use machine learning to predict dropouts based on multiple variables, including attendance, performance, and social risk factors.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
3: Empowering schools through school grants and decision-making power for non-grants resources			
3.1: Establishment of a system to operationalize school grant.	i) Production of overall standards on Grant Management System (GMS) to be implemented by the states. ii) Grant Manual with robust school funding formula (equity and performance based). LGEA/ SUBEB to have adequate resources (manpower, equipment, and technology systems) to operationalize GMS. Building a system to verify funds eligibility and utilization.	GMS would provide credibility to the system that funds are in fact going to eligible beneficiaries (schools, teachers, or students) and are used for intended purposes.	UBEC, SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
3.2: Establishment of school grants as the main school financing instrument.	Establishment of a system through which UBE and state resources are distributed across schools in the form of grants (e.g. block grants based on number of in-school children and performance grants based on achieving basic accountability targets). E.g. each state may assign certain portion of infrastructure and matching funds as grants to schools.	Currently, very few schools receive direct grants for regular operation cost or maintenance expenses. Most schools depend on ad hoc contributions from the community. Assigning resources to schools will significantly improve their management. This will require a) a change in the way resources are allocated to schools, which requires agreement from multiple actors; b) Accountability at school/community level (SBMCs)—clarity in roles in the execution of grants and monitoring, public reporting; c) Good grant management system, including a grant management information/data system and financial management officers in schools. Resources going directly to schools tend to be better managed by schools/SBMCs provided there is a sufficiently strong accountability and transparency mechanism in place	UBEC, SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		

Policy Area /Action	Indicator	Rationale	Responsibility
3.3: Increasing decision-making authority of schools to plan their needs and expenditures.	Establishment of a system through which states allocate non-construction budget per school.	This is a planning mechanism for SUBEB and the schools. The resources will not go directly to the schools but they would know how much resources they can expect for different items (such as renovation, learning materials, etc.). The schools will have the decision-making authority to request these resources, based on which the SUBEB can execute. The decision making at the school level will be made by SBMCs. This is separate from the school grants, whose resources will go directly to the schools.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
4: Improving recruitment, deployment, and performance of teachers in basic education			
4.1: Improved recruitment and deployment of teachers for basic education.	i) Development and implementation of clear multi-year recruitment plans and a meritocratic system to recruit teacher. ii) Development and implementation of incentive system for teacher deployment/re-deployment in areas/schools with high pupil-teacher ratios.	i) Currently, the recruitment of teachers is not based on a clear analysis of needs and, in many states, does not follow a meritocratic process. This system will help strengthen the system for the recruitment of new teachers, including through clear standards for the teacher profession. ii) Currently, the deployment of teachers is not based on a clear analysis of teacher-to-pupil ratios, needs, and gaps between different areas. This action will foster deployment of newly recruited teachers or re-deployment of existing teachers to rural primary and JSS schools with shortage of teachers. The main requirement is to have a transparent system of deployment based on monetary incentives and/or career progression incentives.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
4.2: Improved teacher attendance in basic education.	Development and implementation of system for biometric register for teacher attendance.	Currently, teacher absenteeism rate is deemed to be high. The use of biometric systems has worked well in some states, as well as in other sectors (health), and other countries. It requires deployment of technological devices.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
4.3: Improved teaching assessment system.	Development and implementation of teaching performance assessment system/systems to identify teachers that need more support and tailor that support.	System to assess and measure teaching performance through classroom observation instruments and teacher competencies to identify areas for teacher development.	SUBEB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
Primary Care			
1: Establishment of an output-based system for allocating resources			
1.1: BHCPF budget is linked to number of beneficiaries.	The budget reflects output-based nature of BHCPF specifying the number of beneficiaries from the SSR **[[define]]** list the funds will cover and number of facilities that will be funded each year.	Currently, the budget allocation makes no reference to the number of people benefiting from the program. Having such a system will ensure a direct link between the budget allocated and released and the number of people benefiting from it. It will strengthen the mutual accountability between the Federal institutions. This will also serve as a basis for the governments at all levels to commit to an incremental percentage of Nigerians to be covered year on year under the health insurance.	FMoF, FMoH, NPHCDA, NHIA
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		

Policy Area /Action	Indicator	Rationale	Responsibility
1.2: Release of funds to states is linked to number of beneficiaries in the state	MoU between FMoH/NPHCDA/NHIA and states reflecting the allocation and release of the Funds and associated expected number of beneficiaries from the SSR and health facilities to be covered.	Currently, the states are not explicitly required to cover a certain number of beneficiaries for the funds transferred nor how the beneficiaries are identified. Having the MoU will strengthen the mutual accountability between the federal and state levels for funds transferred and the beneficiaries covered.	NPHCDA, NHIA, SPHCDB, SHIA
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●
1.3: Release of special intervention fund (SIF) is linked to the number of beneficiaries.	i) The FG releases the SIF annually specifying the number of beneficiaries from the SSR to be covered by the SIF. ii) Release of EF by states as contained in their state health insurance law specifies the number of beneficiaries from the SSR to be covered.	i) Currently, the SIF is yet to be released. As the funds are released, they are linked it to the number of beneficiaries. ii) Currently, there is no uniformity on the budgeting and release of equity funds across states. States provide equity funds based on incremental coverage of beneficiaries in the state.	i) FMoF, FMoH, NPHCDA, NHIA ii) SUBEB, SHIA
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●
2: Improving accountability and transparency of resources transferred through the Basic Health Care Provision Fund			
2.1: Strengthened Accountability Systems for the Management of BHCPF Resources	i) FG to produce and publish annual performance report on beneficiaries covered, services rendered and funds transferred by and to each state on their website within 6 months of end of FY. ii) States to publish quarterly performance report on people covered & services rendered and funds transferred.	i) Currently, information on the performance of each of the states and funds transferred to each is not publicly available. Such a system will ensure improved accountability to the public on the amount and use of resources at the state level. ii) Currently, information on the performance of each of the states is not publicly available.	i) FMoH, NPHCDA, NHIA ii) SPHCDB, SHIA
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●
2.3: Timely and predictability of financing.	i)Funds to be released at federal level from FMoH to NHIA and NPHCDA within 2 weeks of receipt by FMoH. ii) Funds released from SHIA and SPHCDB to facilities within 2 weeks of receipt by the state.	i) Currently, there is no predictability of funds receipt to the MDAs from FMoH. ii) Currently, no predictability of funds to health facilities.	i) FMoH, NPHCDA, NHIA ii) SPHCDB, SHIA
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●
3: Expanding BHCPF coverage in all states of the federation			
3.1: Expansion of BHCPF coverage	i) The NPHCDA gateway resources to be prioritized for direct transfer to facilities by moving all BHCPF funds to the facilities ii) State appropriate/mobilize its own resources to expand BHCPF (i.e. the insurance coverage and the coverage of PHCs beyond what is covered under the NPHCDA gateway).	Currently, the coverage of NPHCDA gateway is limited to one PHC per ward. Any residual resource are set aside perhaps for other interventions. Currently, only few states use own resources to expand the coverage of insurance. Similarly, only few states have used own resources to expand the implementation of DFF beyond what is covered under the NPHCDA gateway resources	i)NPHCDA ii)States
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●
3.2: Harmonization of benefit packages	i) Basic benefit package needs to be defined broadly to allow states to include services that relevant to their context. ii) All citizens in the state will have access to the same package of services irrespective of the sources of financing for their insurance coverage.	Currently, the benefit package is defined to include all kinds of services that are not necessarily relevant for all states. Currently, individuals within a particular state enjoy different benefit packages depending on the sources of financing for their insurance. Those covered by BHCPF funds have a different benefit package to those covered by the state own	NHIA SHIA
	Difficulty ●●●●●	Potential Impact ●●●●●	Cost ●●●●●

Policy Area /Action	Indicator	Rationale	Responsibility
4. Strengthening capacity for decentralized management of services			
4.1: Improved health facility autonomy (capacity).	i) States are supported to submit their business plan and get timely approval. (*Percentage of states that have 50 percent or of facilities submit business plan and signed off by NPHCDA within the first month of the quarter).* ii) Facilities are supported to submit their business plan and get timely approval. *(Percentage of facilities that submit business plan and signed off by WDC chair and facility management team* *ii) within the first two weeks of the quarter & approved by SPHCDA).*	i) Currently no specific TA is provided to facilities to prepare work plan. ii) Currently no specific TA is provided to facilities to prepare work plan.	i) NPHCDA ii) SPHCDB
	Difficulty ●●○○○ Potential Impact ○○○○○ Cost ●○○○○		
4.2: Improved health facility autonomy (implementation).	i) Number of states that have at least 50 percent of facilities spend at least 70 percent of the funds according to the approved business plan. ii) Percentage of facilities that spent at least 80 percent the funds according to the business plan and reported within two weeks of the end of the quarter.	i) To incentivize NPHCDA to provide the support necessary to enable facilities to use the resources according to the approved plan. ii) To incentivize the states provide the support to facilities meet the requirements to obtain and spend funds.	i) NPHCDA ii) SPHCDB
	Difficulty ●●●●○ Potential Impact ●○○○○ Cost ●○○○○		
5: Improving infrastructure for basic health services			
5.1: Improved health facility infrastructure for quality of Care	i) Publish on FMoH/NPHCDA website report of quality assessment/ facility service readiness survey report ii) Publish on SMoH website list and quality score/rating of public and private facilities accredited to participate in the NPHCDA and NHIS gateways.	i) Currently no information is made available to the public. Providing these information will enhance transparency and accountability. ii) Currently no information is made available to the public. Providing these information helps monitor progress.	i)FMoH and NPHCDA ii)SMoH ,SPHCDB and SHIA
	Difficulty ●○○○○ Potential Impact ○○○○○ Cost ●○○○○		
6: Improving human resources for basic health services			
6.1: Adequacy, distribution and performance of health workers (policy).	i) Develop a national policy on health workers recruitment, retention, and performance management. ii) States adopt/domesticate the policy on health workers recruitment, retention, and performance management. This would include the policy on automatic replacement of retired/lost health workers and task shifting policy.		i) FMoH, and NPHCDA ii) SMoH and SPHCDB
	Difficulty ●○○○○ Potential Impact ○○○○○ Cost ●○○○○		
6.2: Adequacy, distribution, and performance of health workers (implementation).	i) State develops a costed HRH workplan including incentive for health worker deployed to hard-to-reach areas and priority locations as part of the implementation of the health workers policy.		i) SMoH, SPHCDB
	Difficulty ●●○○○ Potential Impact ○○○○○ Cost ●○○○○		
6.3: Health workers registry.	i) A national registry of health workers is developed and maintained with annual update. ii) Each state develops a registry of health workers and maintain with annual update.	i) Currently, up to date information on the number and distribution of health workers is not readily available either at the state or national level. ii) Currently, up to date information on the number and distribution of health workers is not readily available either at the state or national level.	i) FMoH and NPHCDA ii) SMoH and SPHCDB
	Difficulty ●●●●○ Potential Impact ○○○○○ Cost ●○○○○		

Policy Area /Action	Indicator	Rationale	Responsibility
6.4: Health workers absenteeism.	Implement a biometric register for health workers attendance.	Currently, only few states have piloted in few health facilities. This can be scaled up to improve health worker availability at the health facility level.	SPHCDB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
7. Strengthening data systems and use of data for decision making			
7.1: Strengthened National HMIS (electronic data and reporting).	i) Ensure the national electronic HMIS system is functional and used at the state level. ii) Data recording at the facility level be electronic.	i) Currently the DHIS2 is not updated regularly to ensure the facilities are up to date. ii) Currently, data at the facility level is collected and reported on a paper-based system. *This would require regular supervision support, especially to facilities in underserved areas.*	i) FMoH and NPHCDA ii) SMoH and SPHCDB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		
7.2: Improve the quality of HMIS.	Institutionalize sample-based validation check to determine accuracy of self-reported HMIS data and incentivize the states that show reduced discrepancy in reported and validated data.	Data quality check is currently weak. As a result, the accuracy of HMIS data is not widely accepted and hence affecting the use of HMIS data for decision making.	FMoH, NPHCDA, SMoH, SPHCDB
	Difficulty ●●●●● Potential Impact ●●●●● Cost ●●●●●		

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