Borno State Ministry of Health

Guidelines for Basic Health Sector Budget Preparation and Work Planning

February, 2025

Table of Contents

Foreword

Health is the foundation of socio-economic development, and the Government of Borno State is committed to strengthening our health system by ensuring that resources are efficiently allocated and utilized to improve healthcare delivery. These Guidelines for Borno State Basic Health Sector Budget Preparation and Work Planning serve as a comprehensive framework to guide policymakers, health administrators, and stakeholders in effective planning, budgeting, and implementation of health programs. By adhering to these guidelines – which align with national health policies and the state's strategic priorities – we aim to enhance transparency, accountability, and impact in the use of health sector funds.

The development of this guideline is a significant step towards rebuilding and improving Borno's health system, especially in the context of challenges such as conflict, disease outbreaks, and humanitarian needs. It provides clarity on processes, timelines, and roles for budget preparation and work planning, ensuring that available funds are directed to priority health interventions that save lives and promote well-being. I urge all stakeholders in the health sector to utilize this document as a practical tool for making informed decisions that will strengthen our health services and ultimately improve the quality of life for all Borno State residents.

Engr. Babagana Mustapha Mallambe
Honorable Commissioner, Borno State Ministry of Budget and Planning

Acknowledgements

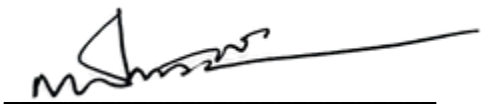
The Guidelines for Borno State Ministry of Health Budget Preparation and Work Planning is the result of collective effort, collaboration, and dedication from various stakeholders committed to strengthening healthcare delivery in Borno State.

First and foremost, we extend our sincere appreciation to His Excellency, the Governor of Borno State, for his unwavering commitment to improving healthcare and his continuous support in strengthening the Ministry of Health's programs and initiatives. We also wish to express gratitude to the Honorable Commissioner for Health, whose visionary leadership and dedication to advancing health outcomes in Borno State have been instrumental in driving this initiative forward.

Our appreciation goes to the leadership and staff of the Borno State Ministry of Health for their invaluable contributions in developing this guideline. Special thanks also go to the Ministry of Budget and Planning for their guidance in aligning these guidelines with the state's fiscal policies and budgetary processes.

We acknowledge the contributions of civil society organizations, healthcare professionals, community leaders, and development partners, whose insights and feedback have enriched this document. Your collective efforts have ensured that this guideline will serve as a valuable tool for improving health budgeting, planning, and service delivery in Borno State.

Finally, we deeply appreciate the dedication of doctors, nurses, health workers, hospital administrators, and community health leaders, who play a vital role in the implementation of health policies. It is our hope that this guideline will enhance budget efficiency, strengthen work planning, and contribute to the overall quality of healthcare in Borno State.



Dr. Shettima Maina Mohammed, Mni
Permanent Secretary,
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Preface

The effective allocation and management of resources are fundamental to achieving the goals of the health sector in Borno State. Recognizing the critical role that healthcare plays in driving socio-economic development, the Borno State Government is committed to ensuring that every citizen has access to quality and affordable healthcare services. This commitment is reflected in the development of these Guidelines for Borno State Ministry of Health Budget Preparation and Work Planning, which serve as a comprehensive framework for the planning, budgeting, and implementation of health programs across the State.

These guidelines align with the requirements of the Nigeria Human Capital Opportunities for Prosperity and Equity (HOPE) Governance project, a World Bank-supported program focused on improving governance and promoting fiscal transparency in Nigeria, with a focus on health, education, and other key sectors.

This document is designed to provide a standardized approach to budget preparation and work planning, ensuring that resources are allocated efficiently and transparently to meet the healthcare needs of Borno State. It outlines the processes, timelines, and responsibilities involved in the annual budget cycle, from policy review and strategic planning to budget execution, monitoring, and evaluation. By adhering to these guidelines, stakeholders in the health sector can ensure that financial resources are utilized effectively to improve health outcomes, strengthen infrastructure, and promote inclusive access to healthcare for all citizens.

The guidelines also emphasize the importance of collaboration among key stakeholders, including government agencies, civil society organizations, healthcare professionals, and development partners. By fostering a participatory approach to health planning, this document aims to strengthen the implementation of health policies and enhance service delivery across the state.

We extend our gratitude to all those who contributed to the development of this guideline, including the Borno State Ministry of Health, the Ministry of Budget and Planning, and various stakeholders who provided valuable insights and feedback. It is our hope that this document will serve as a valuable tool for health administrators, planners, and financial officers, enabling them to prepare realistic, needs-based budgets that prioritize critical areas such as infrastructure development, workforce training, essential medicines, and primary healthcare services.

As we move forward, we remain committed to the vision of providing equitable access to quality healthcare for all citizens in Borno State. By following the principles and procedures outlined in this guideline, we can collectively work towards building a stronger health system that empowers communities and drives sustainable development.

Prof. Baba Mallam Gana
Honorable Commissioner, Borno State Ministry of Health & Human Services

Chapter 1: Introduction

1.0 Background

Health care is a fundamental driver of social welfare and economic development. In Borno State, a region working to recover from years of conflict and disruption, effective planning and financing of the health sector are crucial for sustainable progress. The Guidelines for Borno State Basic Health Sector Budget Preparation and Work Planning have been developed to provide a standardized approach to budgeting, resource allocation, and work planning in the state's health sector. This document aligns with national health policies (such as the National Health Act of 2014) and Borno State's development objectives to ensure that budgeting processes are transparent, inclusive, and geared towards improving health outcomes.

These guidelines serve as a strategic tool to enhance accountability and efficiency in financial planning, making sure that funds are utilized where they are needed most – from revitalizing primary healthcare facilities to strengthening hospitals and public health programs. The document is designed to support health sector officials, planners, and finance officers in preparing realistic, needs-based budgets that prioritize critical areas such as primary healthcare, maternal and child health, disease control, health workforce development, and facility rehabilitation. By aligning with the state's fiscal policies and broader national frameworks, the guideline ensures that resources are allocated equitably in a way that promotes universal health coverage and resilience of the health system.

Furthermore, this guideline encourages **collaboration among key stakeholders** – including government agencies, local government authorities, development partners, civil society, and community representatives – to ensure a participatory approach in health planning. A participatory budgeting process, involving community inputs and partner coordination, is especially important in Borno's context to address humanitarian needs and the gaps in service delivery. By providing a structured roadmap for budget preparation and work planning, the guideline aims to strengthen the implementation of health policies and improve service delivery across Borno State.

Ultimately, the adoption of these guidelines will contribute to the overall improvement of the health sector in Borno State. It will help ensure that every citizen including those in conflict affected and hard-to-reach areas has access to essential healthcare services in a well-planned, well-resourced, and efficiently managed health system.

1.2 Objectives of the Guidelines

The main objectives of this guideline are to:

- Establish a structured approach for health sector budget planning, preparation, and execution at state and local levels.
- Align budgetary allocations with health priorities of Borno State and relevant national commitments (e.g. National Health Act, Primary Health Care Under One Roof policy, and health-related Sustainable Development Goals).

- Enhance transparency and accountability in the use of health funds, including federal allocations such as the Basic Healthcare Provision Fund (BHCPF) mandated by the National Health Act (NHAct) 2014.
- Facilitate monitoring, evaluation, and appraisal of health programs and projects by providing clear guidelines for tracking expenditures and health outcomes against the plans.
- Improve coordination and community engagement in the planning process, by clarifying the roles of the State Ministry of Health, State Primary Health Care Development Agency, Local Government Authorities, and community structures in budget preparation and implementation.

Chapter 2: The Health Sector in Borno State

2.1 A Brief Profile of Borno State

Borno State is located in the north-eastern region of Nigeria. It was created in 1976 (carved out of the former North-Eastern State) and has an extensive land area with international borders: to the north and east with the Republic of Niger and the Republic of Chad (around the Lake Chad area), and to the east and south-east with the Republic of Cameroon. Domestically, Borno shares boundaries with Yobe State to the west, Gombe State to the south-west, and Adamawa State to the south. The state is divided into 27 Local Government Areas (LGAs) and numerous districts/wards.

According to the 2006 national census, Borno State had a population of about 4.17 million. Despite the conflict-related disruptions, the population has continued to grow; by recent estimates, Borno's population is projected to reach approximately **6.65 million by 2025**. This growth is attributed to high birth rates and gradual resettlement of people as security conditions improve. The state's demographic is predominantly rural (about two-thirds), with a young population structure, which places increasing demand on healthcare services.

Borno has a rich history as the heartland of the Kanem-Bornu Empire, which was a major kingdom in the Sahel region for centuries. The Kanuri people are the largest ethnic group in the state, alongside others such as the Shuwa Arabs, Babur/Bura, Marghi, Fulani, Hausa, and several smaller ethnic communities. The capital city is Maiduguri, which has historically been an economic and cultural center and today hosts a large proportion of the state's population (including many displaced persons). Traditional leadership (e.g. the Shehu of Borno) and community structures remain influential in local governance and mobilization, including in health initiatives (like polio immunization drives).

In recent history, Borno State has faced severe challenges due to the Boko Haram insurgency and related conflicts (since around 2009). The violence has led to the destruction or closure of many health facilities and the displacement of a significant portion of the population. Borno State currently hosts one of the largest internally displaced persons (IDPs) populations in Nigeria – roughly 2 million IDPs as of 2024 with many families living in camps or host communities in and around Maiduguri and other garrison towns. This humanitarian crisis, coupled with periodic climate-related emergencies (such as floods or droughts), has strained the health system. Insecurity in some areas has limited access for both residents and health workers, complicating service delivery.

Despite these challenges, Borno is showing resilience. The state government, with support from the Federal Government and international partners, has initiated reconstruction efforts in liberated communities – rebuilding hospitals, primary health centres (PHCs), and other infrastructure – and has begun facilitating the safe return of IDPs to their home communities. Special interventions, such as mobile clinics and outreach services supported by humanitarian organizations, are ongoing to ensure basic healthcare (including immunization and nutrition services) reaches vulnerable populations. The context of Borno means that health sector planning must integrate disaster/crisis management and flexibility, ensuring that resources can be directed to areas of greatest need and

that mitigation measures (like contingency planning for disease outbreaks or conflict-related disruptions) are in place.

2.2 Overview of Institutional Structure for Health in Borno State

The health sector in Borno State is organized into multiple tiers and agencies, operating under the policy direction of the State Government but also aligning with federal structures:

- Borno State Ministry of Health (SMoH): The State Ministry of Health (which also encompasses Human Services in its mandate) is the lead policymaking institution for health. It is headed by the Honorable Commissioner for Health. The Ministry is responsible for overall health sector planning, setting state health policies, and supervising the implementation of health programs. It oversees secondary healthcare services (such as general hospitals) through relevant departments or boards, regulates private healthcare providers in the state, and liaises with federal health agencies (like the Federal Ministry of Health, National Primary Health Care Development Agency, and Nigeria Centre for Disease Control) and development partners. The Ministry also coordinates health sector budgeting with the Ministry of Budget and Planning and ensures that state health plans align with national strategic health plans and guidelines.
- Borno State Primary Health Care Development Agency (SPHCDA): The SPHCDA is an autonomous agency under the Ministry of Health, focused on the primary healthcare (PHC) sub-sector. Established in 2013, the SPHCDA's creation was part of the "Primary Health Care Under One Roof (PHCUOR)" policy – a national reform to integrate all primary health services under one authority to reduce fragmentation. The SPHCDA is responsible for managing and strengthening PHC services across all LGAs, including immunization programs, maternal and child health services, nutrition, and disease control at the community level. It works closely with Local Government health departments to deliver services to the remotest areas, and handles recruitment, training, and discipline of PHC staff statewide. The SPHCDA also coordinates interventions by international agencies in the PHC space, aligning them with state priorities. Importantly, the SPHCDA is the vehicle for implementing initiatives like the Basic Healthcare Provision Fund (BHCPF) at the state level – under the BHCPF, one PHC per ward is accredited to receive federal funds to provide a Basic Minimum Package of Health Services. The SPHCDA ensures these funds are used to improve PHC infrastructure, equipment, drugs, and staffing to meet minimum standards.
- Hospitals Management Board (HMB): Borno State has a Hospitals Management Board that supervises and administers secondary healthcare facilities (general hospitals, state specialist hospitals) across the state. The HMB ensures that hospitals are adequately staffed, maintained, and equipped to provide referral services, inpatient care, and specialized treatments. It operates under the policy guidance of the Ministry of Health. In the current context, the HMB also collaborates with humanitarian actors (e.g. NGOs supporting hospital surgeries or trauma care) to enhance secondary healthcare capacity.
- Borno State Contributory Health Care Management Agency (BOSCHMA): This agency was established by law in 2018 to implement the state's health insurance scheme. BOSCHMA's role is to expand financial protection for healthcare through insurance mechanisms – for example, enrolling civil servants, the informal sector, and vulnerable

groups into health insurance plans. It manages funds from premiums and the BHCPF (the NHIA/NHIS gateway share) to pay for healthcare services for enrollees, thereby reducing out-of-pocket expenditures. In budgeting terms, BOSCHMA operates as a health sector MDA focusing on health financing and demand-side support for services.

- Local Government Health Authorities: Each Local Government Area in Borno has a health department or unit often referred to as the Local Government Health Authority (LGHA). Under the PHCUOR arrangement, the LGHAs collaborate with the SPHCDA to implement primary healthcare programs. They are involved in identifying local health needs, managing PHC staff at local government level (community health workers, midwives, etc.), and maintaining primary healthcare facilities (health clinics, dispensaries). LGAs in Nigeria receive separate fiscal allocations, part of which is supposed to support primary healthcare (especially staff salaries). Therefore, coordination between state-level planning and LGA contributions is essential. In this guideline, when planning budgets, it is important to consider inputs from LGAs for PHC (such as co-funding certain programs or facility operations) and ensure there is no duplication but rather complementarity between state and LGA health expenditures.
- Community Structures and Stakeholders: At the community level, Ward Development Committees (WDCs) or similar community health committees exist in many wards. These committees, comprising community leaders, women's groups, youth, and health workers, play a role in mobilizing community support for health initiatives and voicing community needs. They prepare "Community Charters of Demand" (a list of priority needs as identified by the community) which can inform the health planning process. Including community priorities through such mechanisms helps ensure that the budget addresses grassroots health needs (for example, a community might prioritize rehabilitating a clinic or staffing a maternity post). Civil Society Organizations (CSOs) and traditional leaders also serve as important stakeholders by advocating for health issues (e.g., campaigns for routine immunization, sanitation, or gender-based violence response) and participating in planning forums.
- Coordination Mechanisms: To manage the health sector comprehensively, Borno State utilizes coordination platforms. The State Council on Health is a high-level forum (usually chaired by the Commissioner) that brings together officials from the Ministry, SPHCDA, HMB, teaching hospital representatives, donor agencies, and private sector to discuss and decide on health policies and review performance. There is also a Health Sector Working Group (particularly active in the humanitarian context) where government and partners (UN agencies, NGOs) coordinate operational plans for healthcare delivery in emergency-affected areas, aligned with the annual Humanitarian Response Plan. These coordination mechanisms ensure that budgets and workplans of various actors are harmonized as much as possible and that gaps are identified jointly.

This institutional structure underscores that multiple actors contribute to the health sector. Therefore, successful budgeting and planning require clarity on roles and collaboration. The Ministry of Health provides leadership and consolidation of plans; the SPHCDA focuses on PHC and community health needs; the HMB on hospitals; BOSCHMA on financial protection; LGAs on local support; and communities/partners on ground-level feedback and implementation support. All must work in synergy during the budgeting process.

2.3 Situational Analysis of the Health Sector

Borno State's health sector is characterized by both significant needs and ongoing recovery efforts. A situational analysis provides context that will shape budgeting and planning:

- Health Services and Infrastructure: Years of insurgency have severely impacted health infrastructure. Many clinics, health posts, and even hospitals in affected LGAs were damaged or left non-functional. According to the Health Resources and Services Availability Monitoring System, (HERAMS (3) assessment 2023 which covers 927 health facilities across Borno's 27 LGAs, only about 71% (423 facilities) were fully functional while 16% were non-functional and several dozen completely destroyed. Insecurity led to the closure or abandonment of some facilities, leaving communities without nearby services. As of the assessment, 35 health facilities were completely destroyed and 194 partially damaged, indicating the scale of reconstruction needed. Where facilities are intact, they often face shortages of equipment and medicines and over 60% of health facilities lack essential drugs and sufficient skilled personnel, according to the surveys The health workforce is strained: many doctors, nurses and midwives fled the conflict areas, and those remaining are overstretched. Most front-line providers in rural Borno are lower-cadre workers like community health extension workers. Bridging these human resource gaps is a priority in the state's plans.
- Access and Utilization: Due to insecurity and displacement, 70% of households face serious barriers to accessing health services, whether from fear of traveling, long distances to the nearest functional facility, or cost barriers. In many areas, especially outside garrison towns, people rely on outreach by mobile clinics run by government or NGOs. The displacement of populations into urban centers (like Maiduguri, Biu, etc.) has also overwhelmed the facilities in those host communities, leading to overcrowding and increased wear on health resources. Conversely, resettling communities need support to re-establish health services locally. The state, with partner support, has deployed mobile health teams and is gradually re-opening or rebuilding PHCs in return areas to improve access.
- Disease Burden and Outbreaks: Borno faces a high burden of communicable diseases. The destruction of infrastructure, low immunization coverage in insecure areas, and poor water/sanitation conditions in IDP camps create ripe conditions for outbreaks. In recent years, frequent outbreaks of cholera, measles, malaria, and even newer threats like diphtheria have occurred, constituting a public health emergency. For example, in 2024 cholera outbreaks in the North-East affected thousands (with Borno accounting for a large share of the 5,850 cases region-wide, and a case fatality rate of 2.5%). Measles and polio resurge have been reported in areas with immunization gaps. Malaria remains endemic and is a leading cause of morbidity and mortality, especially among children. In addition, the region's trauma injuries (from violence) and mental health needs are significant – issues that traditional health budgets often under-address. The state's planning must therefore allocate funds for robust disease surveillance and response, vaccination campaigns, primary care services, and emergency preparedness (stockpiling essential medicines, supporting disease outbreak control teams).
- Maternal and Child Health: Maternal, newborn, and child health indicators in Borno are among the worst in the country, exacerbated by the conflict. Less than 50% of women of

reproductive age are attended by a skilled birth attendant for delivery, contributing to very high maternal mortality rates. Many pregnancies occur among displaced or rural women with limited access to emergency obstetric care. Child malnutrition is a critical problem – the North-East (including Borno) has areas in Critical nutrition phase (IPC Phase 4) with high prevalence of Severe Acute Malnutrition. Health work plans must integrate nutrition interventions (in partnership with humanitarian efforts) and strengthen reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services. The state's strategic plan emphasizes improving antenatal care, skilled delivery (including through training more midwives and deploying them to high-need areas), and expanding lifesaving interventions like immunization, vitamin supplementation, and treatment of common childhood illnesses.

- Humanitarian Response and Partner Support: Borno's health system is currently supplemented by a significant humanitarian response framework. Numerous international and local organizations (e.g. WHO, UNICEF, UNFPA, MSF, Red Cross, and others) operate in the state, running clinics in IDP camps, supporting local health facilities with drugs and salaries, and conducting mass vaccination or health education campaigns. Coordination is facilitated through the Health Sector Working Group under the humanitarian cluster system, and a Humanitarian Health Strategy aligns these efforts with government plans. These guidelines acknowledge that external funding and NGO-run projects form an important part of the health sector in Borno. Therefore, during budget preparation, the Ministry of Health and SPHCDA should coordinate with partners to integrate humanitarian project plans into the sector workplan, avoid duplication of efforts, and possibly plan for gradual government pickup of essential services as stability returns. The presence of partners also introduces parallel resources (e.g. donor grants, relief funds) – while these are not part of the state budget, understanding their scale and focus can help the state budget target gaps or complementary activities.
- Primary Health Care Revitalization: In line with national initiatives, Borno State is pursuing PHC revitalization to rebuild the foundation of its health system. Nigeria's goal is to have at least one functional (Level 2) Primary Health Centre per ward (approximately one PHC for every 10,000–20,000 population). For Borno, with over 200 wards, this means ensuring around 200+ PHCs are fully equipped to provide 24/7 services (especially for deliveries and emergencies) – even in the face of ongoing security issues. Already, with support from the federal government and partners, Borno SPHCDA has plans to rehabilitate or construct 100 PHC centers across various LGAs, upgrade some to comprehensive centers, and staff them appropriately (as announced in recent budget speeches). Revitalization efforts focus on providing infrastructure (water, solar power, communications), staffing with skilled health workers, ensuring drug supply, and engaging the community for facility security and trust. This agenda is reinforced by funds like the BHCPF (which provides direct facility financing for PHCs) and special grants (e.g. the PHC Leadership Challenge fund which Borno won for its performance. A key part of work planning will be prioritizing which facilities to revitalize first – often based on equity (serve underserved areas), readiness, and security access.
- Community Participation and Demand for Services: Due to cultural and conflict-related factors, there are varying levels of trust in the health system among the population. Community engagement is therefore critical. Borno's health sector recognizes that for programs like polio immunization, maternal health, or mental health support to succeed,

community leaders and members must be involved in planning and delivery. Ward Development Committees, as mentioned, are being activated to voice needs and monitor services. The budgeting guidelines encourage that community "Charters of Demand" be collected and considered—for instance, during the planning stage, an LGA might gather inputs from communities on needed health projects (such as a new borehole at the clinic, or outreach services to a remote village). This participatory approach not only empowers communities but also helps in prioritizing budget allocations that will be utilized and maintained locally. Additionally, transparency measures like publishing budgets and service delivery information enhance community trust and oversight.

In summary, the situational analysis highlights that Borno's health budgeting must be needs-based and context-aware. Resources are scarce relative to the vast needs; thus, prioritization is paramount (focusing on life-saving and high-impact interventions). At the same time, flexibility to respond to emergencies (disease outbreaks or population movements) should be built in. Coordination with humanitarian partners and inputs from communities will augment the state's efforts. These guidelines will incorporate these contextual considerations at each step so that the resulting health sector budget and workplan are realistic, equitable, and resilient.

2.4 Health Sector Vision, Mission, and Core Values

To provide strategic direction, it is important to articulate the overarching vision and mission for the health sector in Borno State, along with the core values that will guide all stakeholders in implementing these guidelines. These statements align with the state's health policy and the national goals for the health system (including the pursuit of Universal Health Coverage).

2.4.1 Vision

To build a healthy and resilient society in Borno State where all individuals, including the most vulnerable, have equitable access to quality healthcare services, thereby enabling them to live productive and fulfilling lives.

(This vision emphasizes universal access, quality of care, and resilience of the health system in the face of challenges.)

2.4.2 Mission

To ensure the provision of accessible, affordable, and effective healthcare at all levels (primary, secondary, and tertiary) through coordinated planning, efficient resource management, and partnership with communities and development partners. The health sector in Borno State commits to strengthening primary healthcare as the foundation, rebuilding infrastructure, developing human resources, and implementing evidence-based interventions that address the priority health needs of our people including maternal and child health, disease prevention, and emergency care – in a manner that is inclusive and sustainable.

(The mission focuses on how to achieve the vision: through strengthened systems, primary healthcare emphasis, and partnerships.)

2.4.3 Core Values

The implementation of these health budget and planning guidelines is anchored on several core values that reflect the commitments of the Borno State Government and all health sector stakeholders:

- **Equity and Inclusiveness:** Ensure that healthcare planning and budgeting prioritize the needs of all population groups, especially the underserved communities, IDPs, women, and children, so that no one is left behind due to geography, gender, or economic status.
- **Transparency and Accountability:** Conduct all budgeting and planning processes openly and with integrity. Financial information, plans, and results should be clearly documented and made accessible to stakeholders, and officials at all levels are accountable for the efficient use of funds and delivery of results.
- **Collaboration and Partnership:** Foster strong collaboration between government entities (Ministry, SPHCDA, LGAs, etc.), and with external partners such as NGOs, donors, and community organizations. A participatory approach – including community input in decision making – is valued to ensure plans are realistic and community-owned.
- **Efficiency and Results Orientation:** Utilize resources in a way that maximizes health outcomes. This means eliminating wasteful spending, avoiding duplication of efforts among agencies, and adopting innovations or best practices that allow more health impact per naira spent. Monitoring and evaluation will focus on results (e.g., improvements in service coverage and health indicators).
- **Resilience and Adaptability:** Given Borno's fragile context, the health sector must remain adaptable. Plans and budgets should incorporate risk mitigation and the ability to respond to unforeseen challenges (like outbreaks or security incidents). Building a resilient health system – one that can withstand shocks – is a key value guiding investments and program design.
- **Community Empowerment:** Recognize communities as central to health development. The health system will respect cultural values while promoting healthy behaviors. Empowered communities, through education and participation (e.g., in facility health committees), are partners in achieving health goals.

These core values guide the conduct of everyone involved in the health sector budgeting and planning process, ensuring that the approach is ethical, inclusive, and effective. By keeping these values at the forefront, Borno State aims to create a health system that not only improves statistics but truly responds to the needs of its people in a fair and sustainable manner.

Chapter 3:
The Budget System and Budgeting Processes in Borno State

3.1 Annual Budget Process

The budget is a critical instrument in government operations, serving multiple functions – economic (allocating resources to priority sectors), political (expressing policy choices), legal (authorizing expenditure), and managerial (guiding public service delivery). A well-structured budget process ensures that government expenditures are directed toward areas that best support policy objectives and public welfare.

Borno State's annual budgeting process typically follows a cycle of key stages that are similar to those in other states and at the federal level. These stages are iterative and interconnected:

1. **Policy Review and Fiscal Strategy** – Reviewing existing policies and the broader fiscal context to set the stage for planning (this includes assessing the previous year's budget performance and updating the Medium-Term Expenditure Framework).
2. **Strategic Planning** – Defining sector strategies and priorities (through tools like the State Health Sector Strategic Plan or Medium-Term Sector Strategy) that will inform the budget.
3. **Budget Preparation** – Developing the actual budget proposals for the upcoming year at the ministry/agency level, based on guidelines and ceilings provided.
4. **Budget Defense and Approval** – Reviewing and refining the budget (through bilateral discussions, State Executive Council endorsement, and legislative approval of the Appropriation Bill).
5. **Budget Execution** – Implementing the approved budget by releasing funds, procuring goods and services, and carrying out programs/projects.
6. **Accounting, Monitoring and Reporting** – Tracking expenditure, measuring performance, and auditing accounts, with feedback into the next cycle.

These guidelines primarily focus on the first four stages from policy review through budget preparation and approval as they pertain to the health sector. Stages 5 and 6 (execution, monitoring, and reporting) are also addressed to ensure that once the budget is passed, there is guidance on effective implementation and oversight. The processes described herein should be used in conjunction with Borno State's existing financial management laws, regulations, and the State Budget Manual, to ensure full compliance with state fiscal policies and uniform practices.

It is important to note that the Government of Borno State operates within the framework of the Nigeria national budget calendar and guidelines. Typically, the state budget preparation process begins in the second quarter of the preceding year and aims to have an approved budget by the start of the new fiscal year (January 1st). The Ministry of Budget and Economic Planning (MoBEP) issues a Budget Call Circular annually, which kicks off the detailed estimates preparation by each Ministry, Department, and Agency (MDA). Throughout this process, coordination between the Ministry of Health (and its agencies) and central budget authorities is crucial to ensure the health sector budget aligns with the overall state fiscal strategy and ceilings.

3.2 Key Principles for Health Sector Budgeting in Borno State

In preparing the health sector's budget, certain guiding principles must be adhered to, in order to achieve a credible and effective budget. These principles ensure that the budgeting process for health is disciplined, policy-driven, and transparent:

1. **Comprehensive Coverage:** The health budget should capture *all* planned financial operations related to the sector – including those of the Ministry of Health, SPHCDA, HMB, health training institutions, and relevant agencies. This comprehensive approach means that policy decisions with financial implications (e.g. hiring health workers, launching a new immunization campaign) are made within a unified budget framework provided by the Ministry of Budget. By considering all sources of funds (state government revenue, federal allocations like BHCPF, donor grants, etc.) and all expenditures, the budget ensures that resources are holistically allocated and that there are no "hidden" or off-budget health expenditures that could distort priorities.
2. **Affordability and Fiscal Discipline:** The health sector spending plan must be realistic and constrained by what the state can afford over the medium term. Budgets should be data-**driven**, based on credible revenue forecasts and not on wishful projections. In practice, this means aligning proposed health expenditures with the *medium-term expenditure framework (MTEF)* and the annual budget ceilings communicated by MoBEP. Proposed projects must fit within the resource envelope allocated to the health sector. Adhering to fiscal discipline also implies avoiding accumulation of debts (e.g. avoid launching projects that will incur liabilities beyond the budget). Increases in health budget allocations should ideally be backed by increases in state revenue or specific grants, to maintain fiscal balance.
3. **Alignment with Government Priorities:** Health expenditures must reflect the priority programs and policies of the Borno State Government as well as national health commitments. The State Development Plan and the State Health Sector Strategic Plan (SHSSP) or Medium Term Sector Strategy (MTSS) for health outline the strategic goals – the budget should allocate funds to activities that have clear outputs and contribute measurably to these goals. For instance, if reducing maternal mortality is a top priority in the SHSSP, the budget should prioritize funding for primary healthcare clinics with maternity services, training of midwives, and emergency obstetric care. Similarly, the budget should factor in Borno's commitments under national initiatives (like polio eradication, PHC revitalization, Basic Health Care Provision Fund requirements) and international agreements (such as Global Fund or Gavi counterpart obligations, if any). Essentially, the budget is a tool to implement policy – therefore, only those activities that advance stated policy objectives should receive funding priority.
4. **Consolidation and Coordination:** The health sector comprises multiple MDAs, but planning and budgeting must be done in a coordinated manner to avoid duplication and fragmentation. All state entities with health-related expenditures – for example, the Ministry of Health (including Department of Public Health, Department of Medical Services, etc.), the SPHCDA, the Hospitals Board, the BOSCHMA (insurance agency), the College of Nursing & Midwifery, etc. – should collaborate during the planning stage. They need to share information and work from a consolidated health sector workplan to ensure synergy. Duplications (such as two agencies budgeting for the same kind of workshop or overlapping projects in the same location) should be identified and eliminated. If any

functions overlap between agencies, clear agreements must be made on who will fund what, *before* finalizing the budget. This principle of "One Health Budget" promotes efficiency and reinforces the PHCUOR ideal by treating the sector as one entity for planning purposes, even if administratively there are different votes. It also means engaging with the Local Government level: while LGA budgets are separate, the state should encourage LGAs to invest in complementary areas (e.g., if the state funds facility construction, the LGA might fund additional staff for that facility). Coordination mechanisms such as joint budget preparation meetings or inter-departmental budget committees are useful to implement this principle.

5. **Efficiency and Cost-Effectiveness:** Given limited resources, the health sector must ensure that every Naira is spent to achieve the maximum possible impact. This involves using unit cost benchmarks and cost-effectiveness analysis when planning projects (for example, choosing interventions that yield high health benefits per cost, like immunization, while also balancing immediate needs like hospital equipment). Resources should be utilized such that intended results are achieved at the lowest possible cost without compromising quality. Efficiency also calls for optimizing recurrent vs. capital expenditure – e.g., not spending excessively on administrative overheads if that money could directly finance service delivery. It includes leveraging resources: for instance, if a development partner can fund certain items (like providing free malaria bed nets), the state can redirect its funds to other gaps. Regular expenditure reviews and performance audits will help identify areas where efficiencies can be gained (like reducing waste in drug procurement by bulk purchasing through a central medical store). Value for money is the watchword – whether in constructing a clinic or running a training, the process should seek competitive procurement and avoidance of leakages.
6. **Transparency and Accountability:** The health budgeting and planning process must be open to scrutiny and input. Plans, budget proposals, and eventual fiscal reports should be clear and accessible to both decision-makers and the public. This entails documenting assumptions (like how many staff or facilities a proposal covers), using the standard budget classification (so that anyone looking can compare across sectors), and publishing relevant information. Decision-makers such as the State Executive Council (EXCO) and the State House of Assembly should be provided with all necessary fiscal information on the health sector to make informed approvals. Additionally, involving civil society and community representatives during planning (e.g., public hearings or consultations on the health budget) can improve transparency and accountability. After budget execution, preparing citizen-friendly budget performance reports (see Section 4.7 on Citizens' Budget) will further enhance public accountability. A transparent approach helps build trust, especially important in a sector where communities need reassurance that funds are used for the common good.
7. **Adherence to Budget Classification Standards:** Borno State follows the National Chart of Accounts (NCoA) which prescribes a six-segment classification (by administrative unit, Economic item, Function, Programme, Fund, and Geo-location). The health sector budget must be prepared and eventually published using these standard classifications. This ensures consistency and comparability. For example, expenditures should be tagged under the correct function (Health) and sub-functions (such as Primary Health Care, Secondary Health Care, Administration) so that one can clearly see how much is allocated to each sub-sector. Similarly, coding of expenditures as recurrent (personnel, overheads) or capital

should follow the template provided by the Budget Office. Using the correct codes and formats as directed by the Budget Office is not just a technical requirement but also aids transparency (so stakeholders can identify items easily). Health MDAs will need to fill the budget templates accordingly, and the Ministry of Health's planning unit should verify that all proposals conform to the required format before submission.

8. **Linking Budget to Work Plan Implementation:** Approval of the health budget is not the end – it must translate into actual services and projects on ground. Therefore, once the budget is approved, the health sector must prepare a comprehensive work plan for implementation of all programs and capital projects. This work plan (often an Annual Operational Plan for the health sector) details the activities quarter by quarter, responsible persons, and timelines, derived from the budget. It is a condition in these guidelines that such a work plan be prepared by the Ministry of Health/SPHCDA and approved by the appropriate authority (e.g., Health Commissioner or Health Sector Steering Committee). The rationale is that a budget without a clear implementation roadmap can lead to delays or uncoordinated actions. By planning *how* to utilize the funds effectively (e.g., scheduling procurement early for drugs, planning recruitment timing, etc.), the sector can ensure that resources are utilized in an efficient manner to produce the intended results at the best quality and least cost. Essentially, budgeting and work planning go hand in hand – the budget says "what" and "how much", the work plan says "how" and "when".

By adhering to these key principles, the Borno State health sector will produce budgets that are realistic, policy-aligned, and implementable. It will also foster trust among stakeholders (from government leadership to citizens and donors) that additional investments in health are managed well and translate into improved health outcomes.

3.3 Budget Processes, Timelines and Roles

The preparation of the health sector budget must align with the annual budget calendar of Borno State, as issued by the Ministry of Budget and Economic Planning (MoBEP). Each step of the process has designated activities, responsible actors, and deadlines. This section outlines the typical sequence and timing, as well as the roles of key actors at each stage. Adhering to these timelines is crucial to ensure that the Appropriation Bill for the state is passed by the State House of Assembly before the start of the new fiscal year and that the health sector's inputs are fully integrated.

Below is an overview of the *typical timeline* and processes (the exact dates may vary slightly year to year based on the official budget calendar):

- **Policy and Fiscal Planning Stage (around Q2 – Q3 of the year prior to budget year):** This includes the Sector Performance Review and contributions to the State's Medium-Term Expenditure Framework.
- **Budget Call Circular and Proposal Stage (Q3):** MoBEP issues the call circular with ceilings; Health MDAs prepare and submit their budget proposals by the stipulated deadline (often around August/September).
- **Bilateral Discussions and Refinement (late Q3 – early Q4):** The Budget Office reviews submissions and holds bilateral meetings with each MDA (including the Ministry of Health

and related agencies) to discuss and adjust the proposals in line with available resources and policy thrusts.

- **Executive Council Approval (Q4):** The draft state budget (with the consolidated health sector budget) is presented to the State Executive Council (Governor and Commissioners) for approval.
- **Legislative Approval (Q4):** The budget is then laid before the State House of Assembly. The House Committees (notably the Committee on Health and Committee on Appropriation) scrutinize the health allocations; hearings may be held where the Commissioner of Health or heads of agencies defend the budget. Following any amendments, the House passes the budget (Appropriation Bill).
- **Governor's Assent and Budget Publication (late Q4):** The Governor signs the budget into law. The approved budget is then published, and a citizens' version is prepared for public awareness.

Each of these broad stages involves specific roles and responsibilities:

3.3.1 Policy and Fiscal Planning

At the start of the budget cycle, broader planning and review exercises set the context for the next budget.

3.3.1.1 Agency/Sector Performance Review (SPR): Early in the year (often Q1 or by April), the health sector should conduct a review of performance from the previous fiscal year. This **Sector Performance Review** looks at both financial performance (e.g., budget utilization rates, releases versus expenditures) and program results (e.g., number of immunizations given, bed occupancy rates, health outcomes achieved). The Ministry of Health's Planning, Research and Statistics department typically leads this, in collaboration with the SPHCDA and other agencies. The findings identify successes, bottlenecks, and areas needing more resources or policy change. For example, the SPR might reveal that only 60% of allocated funds for PHC were spent due to procurement delays, or that maternal health indicators improved in areas with certain interventions. These insights are documented in an SPR report. The role of MoBEP at this stage is often to provide a template for reporting and to ensure each sector's SPR feeds into the overall budget strategy. By **April**, the health sector's SPR should be validated and submitted to MoBEP, providing evidence to justify budgetary needs in the next cycle.

Parallel to this, **fiscal strategy** is being developed at the state level. MoBEP, in consultation with the Ministry of Finance, projects the total revenues (including federal allocation, internally generated revenue, etc.) for the coming year and sets preliminary sector ceilings (often as part of a three-year Medium-Term Expenditure Framework (MTEF)). The Ministry of Health must actively engage here by submitting its Medium-Term Sector Strategy (MTSS) or inputs to the MTEF. The MTSS is a three-year plan linking the health sector goals to required resources. If a State Health Sector Strategic Plan exists (e.g., a 5-year strategy), the MTSS is essentially the costed, medium-term slice of that plan. It outlines priority programs and their funding needs for each of the next three years, given expected resource envelopes. During this stage, policy direction is clarified – for instance, the government may decide that in the next year, health and education are priority sectors to get an increased share of the budget. Or there may be a decision to launch a

new health initiative (like a free maternal healthcare program) which should be reflected in planning.

Roles of actors in this stage: The Ministry of Health (through its Permanent Secretary and Directors of Planning/Finance) coordinates the sector performance review and MTSS drafting. The SPHCDA and HMB contribute by providing data and plans for PHC and hospitals, respectively. MoBEP provides guidelines and may organize workshops for sectors to develop their MTSS. Development partners often support analytical work (for example, UNICEF or WHO may help with health data analysis during the SPR). The output is a set of strategic priorities and justifications that will guide budget proposals. By the end of this stage, the health sector should have: (a) a clear list of priority programs/projects for the next budget based on evidence, and (b) an indicative resource ceiling from the state (e.g., health sector can expect X billion Naira in total, of which Y billion for capital projects).

3.3.1.2 Medium-Term Expenditure Framework (MTEF) Alignment: Borno State's budget is prepared within a Medium-Term Expenditure Framework, which is often approved by the State Executive Council and sometimes the House of Assembly. The MTEF provides sectoral ceilings for the budget year and the two subsequent years, grounded in revenue forecasts and fiscal targets (like deficit limits). The health sector must align its plans to the MTEF. Once MoBEP releases a budget call with a ceiling for the health sector (say the health sector is allocated 10% of the total budget, or a specific figure), the Ministry of Health should distribute this ceiling internally among its departments and parastatals in a way that reflects the priorities. For example, it might preliminarily allocate 50% to SPHCDA (PHC and preventive programs), 30% to hospitals/secondary care, 10% to the health insurance subsidy, and 10% to administration and others – depending on the government's focus. This internal distribution should be discussed in a health sector budget preparatory meeting with all relevant heads (Commissioner chairs, with SPHCDA Executive Secretary, HMB Director, etc., participating). This ensures that when the time comes for each to prepare detailed budgets, they know their resource limit and focus areas.

At this policy stage, another key activity is updating investment plans or program targets. For instance, if the Federal Government is increasing the BHCPF allocation, the health sector might plan how to effectively absorb and utilize those funds (e.g., by selecting additional PHC facilities or expanding service packages). Or if there is a known donor project ending or starting, adjustments in state funding might be needed to sustain services. All these strategic adjustments happen before detailed budgeting and should be settled by the time the Budget Call Circular (next stage) is issued.

3.4 Medium-Term Health Sector Planning and Work Planning

Building on the above, the health sector uses medium-term planning tools and consolidated work planning to bridge the gap between high-level strategies and annual budgets.

3.4.1 Medium-Term Health Sector Strategic Plan / Medium-Term Sector Strategy

Borno State's **Medium-Term Health Sector Strategic Plan (or Health MTSS)** is a multi-year (usually 3-5 year) planning document that outlines the goals, objectives, and interventions for the

health sector, along with indicative costing. This plan is aligned with broader policy documents such as the Borno State 25-Year Development Framework & 10-Year Strategic Transformation Plan (if applicable to health) and the National Strategic Health Development Plan. It serves as a compass for annual budgets.

Key elements typically defined in the medium-term plan include:

- **Priority areas:** e.g., strengthening PHC systems, reducing maternal and child mortality, combating infectious diseases, rebuilding infrastructure, improving health governance.
- **Targets:** specific health indicators to achieve (e.g., immunization coverage to reach X%, or maternal mortality to reduce by Y%).
- **Initiatives and Programs:** major programs to drive improvements (e.g., a PHC Revitalization Program, a Human Resources for Health strategy to hire and train more workers, roll-out of a state health insurance scheme coverage, etc.).
- **Resource Projections:** an estimate of funding required and likely available from government and partners.

Under this guideline, the annual budget should be seen as the yearly slice of the medium-term plan. Thus, during budget preparation, reference must be made to the medium-term plan: activities included in the budget should trace back to strategies in the plan. For example, if the strategic plan has an initiative for "Revitalize 50 PHCs by 2025", then the budget for the upcoming year might include costs for revitalizing, say, 20 PHCs as part of that phased target. If a project or expenditure item cannot be linked to any strategic objective, its justification in the budget is weak and it likely should not be included.

It's the responsibility of the Ministry of Health's Planning Department (or Health Sector MTSS team) to ensure consistency between the MTSS and budget proposals. Each health MDA, when drafting proposals, should cross-check: is this item in our sector strategy? If not, why are we funding it now – is there a new need or policy change? There might be cases where new needs emerge (like an outbreak requiring new program funding); such cases should be documented and, if significant, the medium-term plan might be updated in the next revision.

In summary, the State Health Sector Strategic Plan/MTSS is the anchor, and the budget is a financing plan to operationalize that strategy. The narrative part of the budget submission from the Ministry of Health to MoBEP should highlight how the budget aligns with medium-term goals (this helps budget reviewers and lawmakers see the coherence and justification of allocations).

3.4.2 Consolidated Annual Operational Plan and Work Planning

While medium-term plans are high-level, the annual operational plan (AOP) is a detailed work plan that outlines all health sector activities for the budget year. Essentially, after determining what will be funded in the budget, the sector produces a comprehensive plan answering: *What will be done, by whom, when, and what outputs are expected?* This consolidated work plan is critical for guiding implementation once funds are available.

The process is typically as follows: Once priority programs and projects are identified (from MTSS) and ceilings known, each department or agency in the health sector prepares its draft Workplan for the year. For example:

- The Department of Public Health might plan immunization rounds, outreach activities, training sessions, etc., with timelines (perhaps broken down by quarter or month).
- The SPHCDA might plan specific interventions like "Maternal Newborn and Child Health Week" campaigns, facility renovations, drug distributions, community engagement forums, etc., each item with responsible officers and timeframes.
- The Hospitals Board might schedule hospital upgrades, hiring of specialists, monitoring visits to hospitals, etc.

These are then consolidated into one health sector workplan to ensure synergy. If different units independently plan, overlaps or gaps might occur. A consolidation workshop can be held where all units present their planned activities and these are merged, checked against the budget, and scheduled in a coordinated way. It's important that the workplan matches the budget: every activity in the workplan should have a corresponding budget line or funding source, and conversely every budgeted item should reflect an actual activity in the plan.

For Borno, given the humanitarian context, the workplan should also integrate partner-supported activities where possible. For instance, if an NGO is running a nutrition program in certain wards, the workplan can acknowledge those as ongoing and perhaps the state's role (like oversight or complementary funding for supplies). This way, the plan gives a full picture of who is doing what in the health sector throughout the year.

Tools such as templates and standardized formats for planning like project prioritization and costing sheets, and a Workplan Template can be used by MDAs to list capital projects with their implementation schedules, and key activities for recurrent programs. Adopting these templates ensures that when the health sector submits its budget and plan, it's easy to review and roll up into the state's overall planning.

The consolidated health workplan, once finalized, should be approved by the Health Sector leadership (Commissioner or a Health Steering Committee) and also shared with MoBEP. Why MoBEP? Because it demonstrates readiness to implement and can be used as a performance agreement – MoBEP can monitor whether activities in the workplan are being executed as planned during the year. Moreover, if there is a need for in-year adjustments or supplementary budgets, the workplan helps justify them with planned activities.

Finally, community participation should not stop at planning – during workplan execution, the Ministry and SPHCDA are encouraged to disseminate key elements of the plan to stakeholders. For example, letting WDCs know that "In Q2, a medical outreach is planned for your area" or informing the public that "X number of facilities will be renovated this year and these are the locations." This transparency helps manage expectations and invites public cooperation.

Chapter 4:
Annual Budget Preparation

4.1 Overview of Annual Health Budget Preparation

The annual budget preparation for the health sector in Borno State involves translating the plans and priorities into specific financial proposals for the upcoming year. This process must comply with the instructions issued by the Ministry of Budget and Economic Planning (MoBEP) and align with the timelines in the state's budget calendar (as outlined in Section 3.3). In practice, the budget preparation phase begins with the issuance of the Budget Call Circular (BCC) by MoBEP and ends with the submission of the health sector's budget proposal to MoBEP for consolidation into the State budget.

The overview of steps is as follows:

- The MoBEP issues a Budget Call Circular to all MDAs, typically mid-year (e.g., July). This circular provides guidelines on budget preparation for that year, including macro assumptions, budget policy thrusts, expenditure ceilings for each MDA or sector, and submission deadlines.
- Upon receiving the BCC, the Ministry of Health, SPHCDA, and other health agencies begin internal preparations: forming budget preparation teams, distributing internal guidelines to their departments, and gathering necessary data (such as costs, project lists, etc.).
- Health MDAs develop their budget proposals in line with the circular's requirements (both narrative and numeric forms). They use the standard budget format (often a template or software provided) to fill in their proposed expenditures by line item, categorized by economic class (personnel, overhead, capital) and by program.
- The proposals are then reviewed and consolidated at the sector level: the Ministry of Health compiles the budgets of its departments and agencies to ensure they fit the overall health sector ceiling and are internally consistent.
- A final health sector budget submission (covering the Ministry and all health-related parastatals) is sent to MoBEP by the deadline (usually late August or September). This submission includes required forms, tables, and a budget narrative or justification document.

The overview emphasizes that **timeliness and accuracy** are important: missing the deadline or submitting incorrect/incomplete information can jeopardize the sector's allocations. Therefore, the health sector must adhere strictly to BCC instructions.

4.2 Issuance of Annual Budget Call Circular

The **Budget Call Circular (BCC)** is a formal document from the MoBEP that kick-starts the detailed budget preparation. It is usually addressed to heads of all Ministries, Departments, and Agencies. When Borno State's BCC is issued for a given fiscal year, the Ministry of Health and its agencies must study it carefully. Key contents of the BCC include:

- **Budget Policy Statement:** This outlines the state government's policy priorities for the year. For example, it might state that "In the 2026 fiscal year, the government will focus on human capital development, with increases in allocations to health and education sectors" or it might emphasize fiscal tightening where necessary. This section sets the tone and should be reflected in how the health sector prioritizes its budget.
- **Macroeconomic Assumptions and Ceilings:** The BCC provides assumptions like expected oil price (for federal revenue), projected state revenues, inflation rate (useful for adjusting costs), etc. It then gives the expenditure ceiling for each MDA or sector. For instance, it may say "Ministry of Health (including parastatals) total budget envelope is NGN X million, of which NGN Y million is for capital projects". These ceilings are binding – the health sector's proposals must not exceed them unless explicitly allowed (like statutory expenditures, which usually do not apply to health aside from perhaps donor funds outside the state budget). The circular may also break down ceilings into recurrent and capital.
- **Guidelines and Instructions:** The BCC will detail how to prepare the budget submission. This includes which forms to fill (for personnel, overhead, and capital), the format of the narrative, any new classification codes, requirement for gender-responsive budgeting or SDG tagging if any, and the **deadline** for submission. It may also instruct MDAs to include certain analyses – for example, "each MDA should include a table of their ongoing projects and the amount needed for completion" or "provide a brief on how your MDA addressed the previous year's audit queries" etc. For the health sector, any such instruction must be followed. If the BCC requires integrating the Medium-Term Sector Strategy, the health ministry should reference its MTSS in the proposal.
- **Additional Requirements:** Some years the BCC might highlight specific fund sources. For example, if the state expects grants or wants to incorporate off-budget donor projects, it might ask MDAs to list those. For health, if there are known partner-funded activities that require government co-funding, the BCC might request that these are clearly itemized.

Upon receiving the BCC, the **Commissioner of Health** or Permanent Secretary should promptly disseminate the relevant portions to all units (this corresponds to Step 4.3.1 (b) below about distributing guidelines). Often an internal circular or briefing meeting is held within the Ministry of Health and including SPHCDA, HMB, etc., to explain the BCC content and internal allocations.

One critical aspect is that if the health sector finds the initial ceiling too restrictive to meet core needs, it can internally prepare a case for additional funding, but it still must submit within the ceiling first. Negotiations for any adjustment happen at bilateral discussions stage (Section 4.5), not by simply breaking the rule at submission.

In summary, the Budget Call Circular is the "rulebook" for budget preparation in that year. The health sector must align its process to those rules, ensuring compliance to avoid its budget being returned or arbitrarily cut for non-compliance.

4.3 Guidelines for Preparation of Health Budget Proposals

With the BCC in hand, the health sector proceeds to actually prepare its budget proposals. The following guidelines must be observed to ensure a high-quality and compliant proposal:

- **Formation of a Budget Team/Sub-Committee:** Each health MDA (the Ministry, SPHCDA, HMB, etc.) should establish a small budget committee chaired by the chief executive or a designate (e.g., Permanent Secretary or Director of Finance). This team coordinates all budgeting activities and communications. In the Ministry of Health's case, the committee would include representatives from all major departments (Public Health, Hospital Services, Nursing, Admin, etc.) and perhaps the parastatals, to ensure sector-wide coherence.
- **Internal Distribution of Guidelines:** As soon as the health sector leadership gets the BCC, they disseminate the guidelines to all relevant divisions and units, along with internal instructions. For example, a memo to the Director of Medical Services might say "Prepare your unit's budget inputs for secondary hospitals in line with attached ceiling and policy priorities; submit to the Health Ministry's budget committee by X date.". The SPHCDA headquarters will similarly instruct its program managers (immunization, nutrition, etc.) and also reach out to LGA health departments to gather inputs on PHC needs. This ensures inclusivity in gathering budget needs.
- **Preparation of Draft Budget Proposals:** Each sub-unit compiles its needs and costs them. This should be guided by the *consolidated workplan and MTSS* as mentioned earlier. They fill out the official budget forms, which typically require detailing each expenditure line with code, description, and amount for the budget year (and possibly projections for 2 subsequent years for capital projects). Key points:
    - *Personnel costs:* Typically prepared in a separate template, listing all existing positions, salaries by grade level, new positions requested (if any approved), and related allowances. The health sector must ensure any request for new hiring is consistent with approvals from the government (e.g., if government placed a embargo on new recruitment or requires specific clearance, that must be factored). Personnel budgets must consider promotions or increments due, and any health-specific incentives (like rural posting allowances, if applicable).
    - *Overhead costs:* Estimate running costs realistically. This includes utilities for hospitals, fuel for ambulances/generators, maintenance of facilities, training, supervision travel, etc. Overheads should consider **actual spending trends** – the guideline is to look at last year's actual overhead spending and the current year's allocation used so far, adjusting for any new needs or inflation. If a significant increase is needed in an overhead line (say more fuel needed for expanded outreach activities), it should be justified clearly in the narrative.
    - *Capital projects:* These are the big development items – building or renovating health facilities, procuring medical equipment, investing in health ICT systems, etc. Each proposed capital project should have a clear title and location. Only projects that the health sector genuinely has capacity and funds to execute within (or across) the year should be proposed. The guideline is to **prioritize ongoing projects** (ones started in previous years) to ensure completion over starting too many new ones. New projects should be introduced only if they are high-priority and align strongly with development goals, and preferably if they can be completed within the year's budget (or have a clear multi-year financing plan).
    - *Geographical and equity consideration:* The proposal should ensure equitable distribution of resources. For example, capital projects should be spread to reach conflict-affected and underserved LGAs, not just the capital. If some areas are not

reachable due to insecurity, consider mobile solutions or partner collaboration and still allocate something for those populations (perhaps via the SPHCDA's mobile clinics budget). The **geo-location segment** of the budget will capture where projects are to be executed.

- **Compliance with Formats and Template:** All figures must be entered according to the chart of accounts codes provided by MoBEP. The health budget should use the correct **functional codes** (e.g., primary health care vs secondary), program codes (if the state uses program budgeting, e.g., a program code for "Malaria Control Program"), and economic codes. This was stressed in section 3.2 principle 7 – to use the six-segment code format. The Budget committee should double-check that codes are accurate because errors can lead to misclassification or even rejection of entries by the automated budget system.
- **Integration of Donor Funds:** If the MoBEP requires, any donor or partner funds that flow through government accounts should be reflected. For instance, if UNICEF provides drugs through a government account, that might be captured in a "Aid/Grants" fund category in the budget. Clarity on this should be sought during preparation.
- **Adherence to Sector Ceiling:** Perhaps the most challenging part – ensuring the total proposed (sum of all personnel, overhead, capital for health sector) does not exceed the given ceiling. Often initial drafts from units will sum to more than the limit. The Budget Subcommittee must then **review and trim or prioritize**. This may involve tough decisions, such as postponing lower-priority projects to a later year, reducing quantities (e.g., instead of 10 new ambulances, maybe 5 this year), or finding efficiency savings (maybe cutting down on travel costs by combining supervision visits). This stage should be guided again by criteria from Section 5.1 (project prioritization). It might use a scoring or ranking as recommended in the Annex template – for example, rank capital projects by their contribution to strategic goals and fund the top ones until the budget envelope is exhausted.
- **Narrative Justification:** Alongside the numbers, the Ministry of Health should prepare a **budget narrative** or "Budget Memorandum". This document explains the major allocations and any significant changes from previous years. It should highlight, for instance: "Personnel cost increased by 5% due to planned recruitment of 50 nurses for rural PHCs to improve maternal health outcomes"; or "A new capital project – construction of a trauma center in Biu – is proposed to strengthen emergency care in southern Borno, in line with the health strategic plan objective 4." The narrative should also mention how the budget aligns with the National Health Act/BHCPF (e.g., state's counterpart commitments), and other directives. Essentially it is the story behind the numbers, which helps MoBEP, EXCO, and legislators understand and support the proposal.

4.3.1 Summary of Key Steps in the Health Budget Preparation Process

To recap the process in a stepwise fashion, each MDA in the health sector should follow these key steps during budget preparation:

a) Establish a Budget Subcommittee: Form a committee chaired by the Permanent Secretary (for the Ministry) or Chief Executive (for an agency) to steer the preparation. This subcommittee includes finance officers, planning officers, and heads of key programs. It will coordinate gathering of inputs and ensure internal deadlines are met.

b) Distribute Call Circular Guidelines: As soon as the BCC is received, distribute its guidelines to all departments, units, and parastatals under the health sector, along with the internal ceiling for each unit. Request each to prepare and submit their budget proposals (activities and funding needs) in line with these guidelines by an internal deadline (well before the MoBEP deadline).

c) Prepare Draft Budget Proposals (Department/Unit Level): Each sub-unit prepares its detailed proposal using the official format. This includes listing all activities/projects, costing them, and ensuring they align with the workplan and policy priorities. They fill required templates for personnel, overhead, and capital. For example, the Pharmacy department might propose a budget for drug procurement and distribution (overhead) and request cold-chain equipment (capital). Each of these should be justified by planned outputs (e.g., number of facilities to receive drug kits, etc.).

d) Review & Consolidate Proposals (Sector Level): The Budget Subcommittee of the Ministry of Health convenes to review all submissions from departments and agencies. They will:

- Check compliance with the BCC and internal instructions.
- Prioritize and possibly trim down proposals to fit the ceiling.
- Consolidate overlapping requests. For instance, if two departments requested vehicles separately, consider whether one shared request is more efficient.
- Ensure no critical area is overlooked (cross-check against core functions and last year's budget to see everything necessary is covered).
- Integrate proposals into one consolidated template (merging all line items from various units).
- Fill any summary forms required (e.g., summary by economic classification, summary by program, etc., which MoBEP may require).

During this step, it is useful to involve the **Ministry of Budget's desk officer for health**, if one exists, informally to advise on technical issues. Also, consultation with stakeholders can be valuable: for example, sharing the draft priorities with the Health Sector Working Group or a quick validation meeting with key health partners or CSOs can give feedback on whether the budget addresses the major needs.

e) Internal Approval: Once the subcommittee has a final draft, it should be reviewed by the top management of the health sector – i.e., the Commissioner of Health and possibly the board of SPHCDA/HMB. Their sign-off is needed on the submission. They will ensure it aligns with political directives and approve the justifications given.

f) Submission to MoBEP: The consolidated health sector budget proposal, signed by the Commissioner and including all required forms and narratives, is then formally submitted to the Ministry of Budget and Economic Planning on or before the deadline stated in the BCC. Delays should be avoided, but if extra time is needed for quality, communication with MoBEP is important – however, timely submission reflects well on the sector and avoids rushed decisions by others on the sector's behalf.

By following these steps, the health sector ensures a thorough and well-organized budget proposal. This structured approach also makes the next phase – **technical support and budget review** – smoother, because a well-prepared submission is easier to defend and likely to receive favorable consideration.

4.4 Technical Support for Budget Preparation

Preparing a budget can be technically complex, especially with evolving templates (e.g., if the state introduces a new budgeting software or new accounting standards). If the health sector MDAs **lack sufficient technical capacity** to prepare the budget proposal correctly, they should not hesitate to seek assistance.

Options for technical support include:

- **Internal Government Support:** The health budget subcommittee can reach out to the Budget Department of MoBEP or the Department of Planning, Research and Statistics in the Ministry of Health for help. Often, budget officers at MoBEP are assigned to each sector and can clarify how to use the charts of accounts, how to fill forms, or how to interpret ceilings. The Ministry of Health can formally request that MoBEP provide a **technical officer or template training** to its staff if needed. In many cases, MoBEP holds workshops right after issuing the BCC to walk MDAs through preparation; health representatives should attend and ask questions.
- **Use of Finance and Planning Experts:** Within the Ministry and agencies, the Directors of Finance and Accounts (DFA) and Directors of Planning are key resources. They usually have experience from previous budget cycles. The guideline emphasizes that if some departments lack skilled staff for budget formulation, the subcommittee should reallocate the task to more experienced officers or form small teams combining experienced and inexperienced staff to build capacity through practice.
- **Engaging Consultants or Partner Support:** If allowed by the state's practices and time permits, the health sector could engage a consultant (for instance, a public finance management expert or a health economist provided by a development partner) to support the costing and formatting of the budget. For example, partners under the World Bank or UNICEF often provide technical advisors to health ministries for planning and budgeting. However, caution is that final responsibility lies with the government staff; consultants can assist but the numbers and narrative must be owned and understood by the ministry officials, especially since they will need to defend it.

The guideline warns that failure to follow the prescribed budget process and format will undermine the quality of the budget and could lead to its rejection or revision by authorities. Common pitfalls if technical support isn't sought might include: arithmetic errors that cause totals not to match ceilings, misclassification of an expense (e.g., putting a drug purchase under overhead when it should be capital or vice versa), or incomplete justification for a significant new project. These issues can erode confidence during budget defense.

Therefore, it is far better to proactively get assistance and **"get it right the first time."** Using the available technical resources ensures the health budget proposal is compliant, complete, and convincing. This reduces back-and-forth corrections later on.

For instance, if the SPHCDA is unsure how to budget for the BHCPF funds, they should coordinate with NPHCDA or MoBEP for guidance so that the funds are captured correctly (perhaps under a specific funding code and matching expenditure lines like operations costs for PHCs). Getting such details right strengthens the case that the health sector is well-organized.

In summary, technical support is an allowable and encouraged part of the process. The goal is to ensure a polished budget proposal. The outcome of this will be evident in the next phase (review/bilateral discussions) – a well-prepared submission likely faces fewer queries and faster approval.

4.5 Review of the Budget Proposal and Bilateral Discussion

After the health sector submits its budget proposal to the Ministry of Budget and Economic Planning, a thorough **review process** is conducted by the Budget Office (Budget Department in MoBEP). This stage is critical: it's where the health budget is scrutinized for compliance, realism, and alignment with policy before being incorporated into the state's draft budget.

Budget Office Review: The Budget Directorate at MoBEP will examine the health sector proposals to ensure they substantially comply with the BCC requirements:

- They will check if the total is within the ceiling and if the distribution between personnel, overhead, and capital matches any guidelines given (like maybe a directive that at least X% of sector budget go to capital).
- They will verify that all forms and templates are correctly completed – for example, that every line item has a code, that the arithmetic is correct, and that justifications are provided where needed.
- Consistency with the **MTEF projections** will be ensured. If the health budget assumed some revenue or grant that isn't in the state's revenue framework, MoBEP will flag that (e.g., if health budget expects a donor fund that MoBEP wasn't told about, they will inquire).
- They will also check spending boundaries: for instance, the government might have set a limit on certain expenditures (like no new vehicle purchases unless old ones are boarded off, or a cap on training expenses). The proposal will be reviewed for any such policy breaches.

After this desk review, MoBEP organizes bilateral discussions/negotiations with each MDA. For the health sector, this means a meeting between the Budget Office (and possibly Planning Department of MoBEP) and the health sector team (Commissioner or Permanent Secretary, finance director, planning director, and relevant agency heads).

During the **bilateral meeting**, the following typically happens:

- **Presentation:** The health team may be asked to present an overview of their budget, highlighting key allocations and any new initiatives.
- **Review for Consistency and Policy Alignment:** MoBEP will raise any issues found. They might say, for example, "Your personnel cost seems high; have you accounted for the statewide salary increase policy correctly?" or "We noticed you budgeted NGN 200m for a new State Laboratory Center – how does this align with the state's development plan and is there an appraisal for it?"
- **Verification of details:** The budget office ensures that projects align with policy priorities and plans (they will refer to the health sector strategic plan or government priorities). If health proposes a project outside known policy, they will question it. Also, any new large capital project above a threshold likely needs a justification and appraisal document; MoBEP will check if that is available. For instance, a new hospital construction might require a feasibility study – the team should be ready to present that or at least a concept note.
- **Classification Check:** They will confirm the proposal uses proper budget classification codes (IPSAS compliant, NCoA coding). If any item was miscoded, the health team may be asked to recode it on the spot or in a resubmission.
- **CSO and Community Input:** There may be a discussion on stakeholder input – MoBEP could ask, "Did you consult communities or consider any Community Charters of Demand?" Especially if there's a government directive on participatory budgeting, MoBEP will want assurance that some level of consultation happened. The health team can mention the community engagement done and point out any changes made due to that (which would satisfy the check on integration of CSO feedback).
- **Priority and Continuity:** MoBEP will ensure the health budget gives high priority to ongoing projects (so money isn't spread too thin on many new projects) and to any externally funded projects requiring counterpart funding. For example, if there's a World Bank health project, the state might need to co-fund some part; MoBEP will ensure that's included. They also emphasize fulfilling commitments under any agreements – e.g., if the state signed Abuja Declaration to allocate 15% to health or any specific MoU with partners.
- **Costing Reasonableness:** The costs of major programs and projects will be examined for value for money. MoBEP analysts might compare unit costs with benchmarks. If something looks overpriced (say a generator for a clinic costing significantly more than market rate), they'll call it out. Health must justify that costing, or MoBEP might reduce it.
- **Performance Indicators:** MoBEP will look at how the health sector plans to measure results. The presence of clear performance indicators and an M&E framework (possibly referencing the state's M&E policy) is important. They may ask, "How will we know this spending improved health outcomes?" The health team should discuss their monitoring plans – e.g., quarterly reviews, health management information system data, etc.
- **Adjustments and Negotiation:** Based on the discussion, some adjustments to the budget may be agreed. For example, MoBEP could say "Your total capital ask overshoots the envelope; we recommend dropping Project X (NGN 50m) or scaling it down. Or consider using the planning reserve for the new project next year instead." The health team might negotiate for some increases if they make a strong case that an important program was underfunded. Ultimately, MoBEP tries to ensure the overall state budget is balanced, so it might trim requests. If a planning reserve exists (an unallocated sum for strategic

priorities), the health team can argue for a piece of it if they have a very important unfunded need (for instance, "Cholera outbreak response funds" might not fit in the ceiling but can be given from a reserve due to its urgency).

The outcome of the bilateral meeting is usually an agreed set of figures for the health sector, possibly different from the original submission in some lines. The Budget Office documents these changes.

From the guideline points:

- Ensure any **supplementary information** requested by MoBEP is provided quickly (like that appraisal report or additional breakdown).
- Recognize that the MoBEP team is checking that health's budget is in line with state-wide policies (like the share of recurrent vs capital, personnel policy, etc.) and technical soundness.

Importantly, this stage also helps prepare for the next level of defense: the State Executive Council and the legislature. A well-justified budget at bilateral stage will likely be approved by EXCO with minimal issue. MoBEP often advocates for the sector's budget in those forums, so if Health convinces MoBEP thoroughly, MoBEP in turn can defend it in the bigger picture.

By the end of 4.5, the health sector's draft budget is refined and ready to be **consolidated into the** state budget (except any last tweaks by EXCO or House).

4.6 Completion and Consolidation of Annual Health Budget

After bilateral discussions and any agreed modifications, the health sector budget moves into the final stages of consolidation within the overall state budget. The **completion and consolidation phase** ensures that the health budget is formally included in the **Borno** State Government's draft budget estimates for the fiscal year.

Key steps in this phase include:

- **Incorporation into Draft State Budget:** The MoBEP integrates the health sector figures (as finalized in bilateral) into the master budget document, alongside all other sectors. This creates a unified Appropriation Bill. At this point, the health sector figures are considered *nearly final* but still could be subject to high-level adjustments if the government needs to trim or reallocate resources before submission to the legislature. For example, if total proposed expenditure exceeds revenue too much, MoBEP/EXCO might cut all sector budgets by a certain percentage or delay some projects. The health sector should remain in contact with MoBEP during this short window in case clarifications are needed.
- **Budget Stakeholder Consultations:** Before finalizing the draft budget for EXCO, many states hold consultations with various stakeholders (sometimes called **town hall meetings or budget hearings**). These may involve civil society, traditional leaders, and sector experts. The health sector may be asked to present its key budget items in such fora. This step enhances transparency and can flag any public concerns or suggestions which, if

significant, might lead to minor adjustments. For instance, stakeholders might strongly support more funding for rural clinics, influencing EXCO to allocate an extra amount if possible. According to the guideline, "Budget Stakeholders Consultations and Engagement" is one of the key steps in finalizing the budget. The health sector should be prepared to communicate its budget in simple terms to the public (focusing on the benefits, like number of facilities to be fixed or new services to be provided).

- **Executive Council (EXCO) Presentation:** The Commissioner of Budget (or Planning) typically presents the entire budget to the State Executive Council. The Commissioner of Health should be present and ready to answer any health-specific questions from the Governor or other EXCO members. Given that health is often a priority, the Governor might pay special attention to health allocations. If EXCO members propose changes (for instance, adding a project they personally consider important or adjusting something for political reasons), MoBEP will communicate those and require an update to the figures. The health sector must then accommodate that directive (e.g., if asked to include a new General Hospital in a particular LGA, possibly by reallocating something else or noting it for supplementary budget if beyond capacity). Ideally, such late changes are minimal, since the structured process prior should have covered priority needs.
- **Legislative Submission:** Once EXCO approves the draft budget (including health sector), it becomes the Appropriation Bill laid before the **State House of Assembly**. At this stage, the health sector's budget is a part of that Bill, broken down by economic classification and maybe by program in the documentation given to legislators. The **House Committee on Health** and the **Appropriations Committee** will specifically review it. The Commissioner of Health and team will typically be invited to defend the budget before the Health Committee. This legislative defense is similar to the bilateral but more political: lawmakers might ask questions like "We need a PHC in our constituency, is it in the budget?" or "Why did maternal health allocation decrease?" The health sector should use evidence and the strategic plan to answer, and if needed, politely note where resources couldn't cover everything but highlight future plans or needs for supplementary funding. The House may make adjustments – such as reallocating some funds within the health budget (they might cut an overhead they deem excessive to add to a capital project, or vice versa). Any such changes by the legislature will be communicated in their report.
- **Approval and Governor's Assent:** After legislative review, the House of Assembly passes the budget (possibly with amendments) and the final approved budget is sent to the Governor for assent. Upon the Governor's signature, it becomes law – the **Appropriation Law** – and the health sector can legally spend as per the allocations from the start of the fiscal year.

The guideline emphasizes that **implementation can only begin after the Appropriation Law is in place**. Even if the budget was ready earlier, no expenditures from the new budget (especially capital) should occur until passage and assent. This is a legal requirement for accountability.

In summary, completion and consolidation involve multiple layers of validation and approval (EXCO, House, Governor). For the health sector, maintaining clarity, justifications, and responsiveness through these steps is vital. Once the budget is approved, any further changes would generally require a supplementary budget or virement approvals, so the sector should ensure at this final stage that the budget as passed is workable. If the legislature made cuts that hinder an

important program, the Ministry of Health may need to plan accordingly or seek alternative funding sources.

With the budget approved, attention shifts to making the budget accessible and executing it – which leads to the next brief section on publication and the citizens' budget.

4.7 Preparation and Publication of Abridged Approved Budget (Citizens' Budget)

Transparency does not stop at budget approval; it is crucial to communicate the final budget to the public in an understandable format. After the budget is passed and signed, the Budget Office will produce a **Citizens' Budget**, which is a simplified, user-friendly summary of the approved budget. The health sector should contribute to and utilize this process.

For the health sector, the Citizens' Budget typically will show: the total health sector allocation, possibly breakdowns like how much for primary vs secondary health, or key initiatives (if the state chooses to highlight them). The idea is to present it in plain language (local languages like Hausa as well, if needed) and include charts or infographics.

The guideline notes that the Citizens' Budget will be produced in both English and Hausa with simple illustrations. For example, it might include a pie chart showing sectoral allocations – health's share might be depicted to show government's commitment. It could list some **health projects by name** (especially major ones like hospital constructions or number of PHCs to be rehabilitated) as part of key deliverables.

The health sector can assist the Budget Office by providing any clarifications or data for the citizens' budget. For instance, stating "what will NGN 10 billion health budget achieve? – e.g., train 100 nurses, build 3 new PHCs, provide drugs for X patients, etc." Such input can make the citizen's budget more meaningful.

From an accountability perspective, once the public knows the health sector has, say, NGN X allocated, they are empowered to expect results and question if they don't see them. Community groups might hold local authorities to account ("our clinic was supposed to get solar power from this budget, did it happen?"). This is healthy for governance and is encouraged by the guideline's transparency principle.

For planners and implementers, the Citizens' Budget is also useful to quickly brief staff and stakeholders on the highlights of the approved budget without wading through the entire law.

Finally, publishing the health budget details on government websites or notice boards (especially details like which facilities get capital projects) can enable local monitoring. The guideline's mention of special sections for the vulnerable or priority areas in the citizens' budget ensures inclusivity. For example, a section might highlight allocations for maternal health or for IDP health services, showing the government's response to specific needs.

In conclusion, at the end of the budget preparation and approval cycle, the **Citizens' Budget** is the capping step that ensures all this planning is communicated and understood broadly. The health

sector should actively support this and then move into the implementation phase armed with an approved plan and public awareness. The next chapters will focus on how to implement the budget (work planning, execution, and monitoring) and ensure that the goals set during preparation are achieved in practice.

(End of Chapter 4. The document now transitions to guiding principles for project prioritization and costing, which complement the budgeting process by ensuring resources are allocated to the most important needs and that those needs are realistically costed.)

Chapter 5:
Guidelines for Project Prioritization and Costing

Effective utilization of the health budget requires not just compliance with process, but also wise choices about *what* to fund and accurate estimation of *how much* funding is needed. This chapter provides guidelines on prioritizing health projects and programs and on costing them realistically. This ensures that scarce resources are directed to the highest-impact interventions and that budget figures are based on sound calculations.

5.0 General Guidelines

Before delving into specific tools, some general principles apply to both prioritization and costing of health sector activities:

- **Link to Strategic Goals:** As a rule, projects or expenditures should only be included if they clearly contribute to the strategic health goals of Borno State (as identified in policy documents like the State Health Strategic Plan or development plan). If an item cannot be linked to a goal or outcome (e.g., a proposal to buy very expensive office furniture that doesn't improve health services), it should be questioned or dropped. Prioritization favors those projects with maximum contribution to health outcomes and system strengthening.
- **One Budget Year Focus (with Multi-Year Perspective):** Priority should be given to activities that can yield results within the budget year or are necessary steps within a larger multi-year project. Costing should distinguish between what is needed *this year* versus subsequent years. Projects ideally should be designed to be achievable with the resources in one year, or if multi-year, broken into phases with yearly deliverables.
- **Sustainability and Recurrent Cost Implications:** Prioritization should consider not just the immediate capital cost but the future recurrent costs. For example, building a new hospital is huge capital, but it also creates recurrent obligations (staff salaries, utilities). If the budget can't sustain those in future years, then perhaps focus on upgrading existing facilities might be a better priority. Similarly, costing should include maintenance – if you buy equipment, cost in training and maintenance contracts so it doesn't break down unused.
- **Equity and Vulnerability:** Give priority to projects that address the needs of the most vulnerable populations or underserved areas. In Borno's context, that could mean projects in conflict-affected LGAs, services for IDPs, or interventions targeting high-mortality conditions (like maternal health in rural areas). This principle ensures the budget promotes equity. When scoring projects, one criterion can be how much the project benefits high-need groups.
- **Community Demand and Ownership:** If communities have actively demanded certain projects (through Charters of Demand or feedback), these should have weight in prioritization. A project known to have strong community support (like a request for a staff quarter at a rural clinic to retain a midwife) might be prioritized because community support increases the chances of success and sustainability.
- **Cost-Benefit and Evidence of Effectiveness:** Use available data or evidence to judge which interventions give a good "bang for the buck." For example, investment in immunization or primary healthcare might prevent more disease per Naira than an

equivalent investment solely in curative services. Not to underplay curative, but if data shows certain interventions are highly cost-effective (e.g., malaria nets, immunization, basic emergency obstetric care), those should rank high.

- **Avoiding Duplication:** As noted before, ensure no two agencies are proposing to do the same thing in parallel. Rationalize projects across the health sector. E.g., if SPHCDA is prioritizing PHC construction in an LGA, the Ministry shouldn't separately propose a similar PHC in same LGA without coordination. Consolidate such efforts to one project that multiple agencies support rather than splitting funds.

With these general guidelines in mind, the next sections outline a more structured approach to prioritization and costing.

5.1 Guideline for Project Prioritization in the Health Sector

When faced with many possible projects and limited funds, a systematic prioritization approach is needed. The following considerations (drawn from best practices and adapted to health) should guide how the health sector ranks its projects. Each proposed project or program can be *scored* or qualitatively assessed against these criteria, and those with the highest scores should be prioritized for funding:

- **Contribution to State Development and Health Sector Objectives:** Projects that make the most significant contribution to Borno State's development goals and health sector strategic objectives should be top priority. For example, if a state goal is to reduce maternal mortality, then projects like upgrading maternity wards or training skilled birth attendants will score highly. The alignment could be checked by seeing how directly a project's outcomes link to key performance indicators (KPIs) of the health sector. A scoring scale could be 3 for directly and significantly contributing, down to 0 for no clear contribution.
- **Within Budget Envelope and Feasibility within One Year:** Give preference to projects whose costs fit within the allocated envelope for health and which can be largely completed within the budget year. An achievable project (e.g., renovating 5 PHCs for NGN 100m which you have) ranks higher than an over-ambitious one (building a new hospital for NGN 2 billion when only NGN 500m is available, which would remain uncompleted and tie up funds for years). The idea is to avoid thinly spreading resources. One could score: 3 for project fully fundable within this year's budget; 2 if needs multi-year but this year's portion is feasible; 1 if barely fundable; 0 if clearly beyond means.
- **Development vs. Administrative Expenditure: Developmental (service delivery) projects** should be prioritized over purely administrative capital projects. In health, developmental means things like new clinics, ambulances, medical equipment – tangible improvements in service capacity. Administrative might be an office building or vehicles for admin staff beyond what's needed for service. This doesn't mean admin tools are never funded, but in scoring, service delivery projects get higher points as they directly benefit health outcomes. For instance, constructing a staff quarters or doctor's residence in a rural area (which could be seen as "administrative capital") might still be justified if it directly improves service availability by retaining staff – so one weighs the context.
- **Ongoing Projects vs. New Projects:** Generally, **ongoing projects** (those that started in a previous year and are yet to be completed) should be given preference for continued

funding over starting new projects. This prevents a multitude of half-finished projects. Only launch new projects if they clearly offer significantly more benefit than continuing an old one or if the old ones are nearly done. In scoring, an ongoing project might get a 3, a new project 1, unless the new project is of exceptional strategic importance (then maybe it can score equal or higher but only if it addresses a critical gap that ongoing ones do not).

- **Clarity of Project Definition (Specificity and Geo-location):** Prioritize projects that have a **clear description and specified location**. Vague projects (e.g., "Capacity building program" with no detail) should rank low. In contrast, "Train 100 community health extension workers on Integrated Management of Childhood Illness, in 3 batches in Maiduguri" is clear. Also, each capital project should list the LGA or community – if a project doesn't specify where, it's hard to assess need and monitor later. Only projects with specific geo-location should move forward. This also feeds into equity: you can then check that different areas are covered.
- **Impact on Essential Health Services and Emergency Needs:** Additional criterion for health: projects that address life-threatening conditions or emergencies (e.g., establishing a cholera treatment center in a hotspot, or equipping a blood bank to reduce maternal hemorrhage deaths) could be given extra weight. In Borno, projects improving security of health service delivery (like perimeter fencing of clinics in vulnerable areas) might also rank high because without them services can't function.
- **Funding Source and Partnerships:** Projects that come with external funding support or partnership commitments can be attractive priorities because they stretch state funds further. For example, if a partner is ready to contribute 70% of cost for a trauma center if the state puts 30%, that state contribution project might be high priority as it leverages more resources. However, ensure partner commitment is firm.

One approach the guideline suggests is to use a **Project Prioritization Template** in a spreadsheet as shown in Annex 2a of the guideline. The steps would be:

1. List all potential projects (ongoing and proposed new) with codes and names.
2. Create columns for criteria like contribution to goals, status (ongoing/new), completion timeline, type (development vs admin), etc.
3. Assign scores (e.g., 0-3 as per guideline example) for each criterion for each project.
4. The template calculates a total score and ranks the projects.
5. Sort projects by score (highest first) and that ranking informs which projects to include fully, which to include if funds allow, and which to drop if short on funds.

By following this systematic approach, the health sector can justify that it used an objective method to choose projects. If questioned why Project X was not funded, the team can show it scored low compared to others on agreed criteria, which is a rational explanation.

Finally, once projects are prioritized, they should be cross-checked against the **capital budget ceiling**. If the list of priority projects exceeds the capital budget ceiling, then only the top ones that fit in the ceiling will be taken. If the priority list is under the ceiling (rare, but if so), that means there's room to add either more projects or increase scope of existing ones.

(Note: The guideline's annex suggests documenting the steps of prioritization and using the summary in submission, which can enhance transparency and reduce political interference because it shows a clear methodology behind choices.)

5.2 Project Costing in the Health Sector

Accurate costing is as important as choosing the right projects. This section covers how to cost health sector activities realistically so that budget allocations are neither too low (causing project failure) nor inflated (wasting resources or causing funds to sit idle).

Health sector expenditures can be broadly grouped into **Personnel**, **Overheads**, and **Capital**. Each has specific considerations:

5.2.1 Personnel and Overhead Expenditure Costing

Personnel Costs: Personnel expenses include salaries, wages, and allowances of health workers and administrative staff. To cost personnel correctly:

- Use **actual staff numbers and grade levels** currently in service as the baseline. The HR department should provide an updated nominal roll (list of all employees, their grade level/step, and annual salary). Make sure to account for any retirements that will happen in the year (those posts might be vacant part of the year) and any recruitments the government has approved.
- Include increases due to **promotions or grade advancements**. If staff are due for promotion or annual increment, factor that in. E.g., if 20 nurses will move from grade level 7 to 8 mid-year, their second-half salary will be higher.
- If the government has **minimum wage adjustments or general salary increases** planned, incorporate those as guided by official circulars.
- **New hires:** If additional staff are planned (say government approved hiring 50 nurses for PHCs), include their salaries but likely for part of the year (depending on when recruitment will be completed). Only cost additional staff if there is explicit approval (in many cases, MoBEP or civil service commission sets limits on new hiring).
- **Allowances and benefits:** These can be significant in health (e.g., hazard allowance, call duty allowance for doctors, rural posting allowance, etc.). Ensure all such statutory allowances are included. Also factor any contributions like pension, NHF, NHIS if the budgeting covers those.
- Use the previous year's actual personnel spending as a guide but adjust for the above changes. If last year some salaries weren't paid due to delays but will be paid fully this year, include full year costs.
- If any **staff conversion or regularization** (e.g., many contract staff being moved to permanent) is expected, include that cost difference.

Essentially, personnel cost should be calculated using a **detailed salary model** to minimize error. Overestimation ties down funds unnecessarily, underestimation causes shortfalls (which often leads to unpaid salaries or the need for supplementary budgets).

Overhead Costs: Overheads are the operational expenses for running health services (other than salaries). For realistic costing:

- Look at the **actual expenditure of last year and the current year's half-year** for each overhead item. This gives a baseline of what is currently being spent. For example, if last year NGN 10m was spent on fuel for generators and vehicles in health facilities, and more clinics have opened since, you might need slightly more.
- Adjust for **inflation and expansion of services**. If diesel costs have risen 20%, and usage will be similar, the fuel budget should increase ~20%. If new programs are starting (e.g., a new ambulance service), overhead for fueling and maintaining ambulances must be added.
- **Maintenance for new capital:** When capital projects are completed (e.g., new PHC centers built), overhead must include maintaining and operating them. The guideline specifically says to ensure maintenance is budgeted for new facilities put to use (e.g., if 5 new clinics open, overhead should cover their utilities, cleaning, consumables, etc.). This avoids a common pitfall: building infrastructure but not running it well due to no operational funds.
- Identify any significant upcoming events or changes. For instance, if there's going to be a major immunization campaign funded partly by state, overhead should include that campaign's logistics (unless fully donor funded). Or if a health summit or training series is planned.
- **Justify increases:** If the overhead proposal is significantly higher than last year's, be ready to justify. For example, "We are increasing drug distribution budget by 50% because we plan to extend supplies to 50 additional PHC clinics reopened in liberated areas." Without justification, big overhead hikes might be flagged by budget reviewers as potential inefficiency. The guideline suggests any major new events (conferences, etc.) must be explained.
- Conversely, check for any overhead that can be reduced (efficiency savings). For instance, if certain training can be integrated or if travel costs can be reduced by better coordination, reflect that.
- Overheads often include: office operations, utilities (electricity, water) for hospitals, fuel, vehicle maintenance, training/workshops, monitoring and evaluation costs, stationeries, communications, etc. Ensure none of these is omitted or severely underfunded, otherwise implementation suffers. It's better to realistically fund fewer activities than to spread thin and then can't implement for lack of operational funds.

To sum, overhead costing should be **evidence-based** (past spending pattern and future needs) and **comprehensive** (cover new commitments). The goal is to avoid the scenario where mid-year the Ministry runs out of overhead funds and things grind to halt or they have to seek emergency funds.

For both personnel and overhead, an important practice is to create a **Budget Profile** (which will be discussed in Chapter 6) that spreads out these costs over months/quarters, as many costs are time-bound (e.g., some training might happen in Q2, etc.). While that's more for execution, it can also inform the costing (knowing how long things run).

5.2.2 Capital Project Costing

Capital expenditures involve physical and tangible projects or large one-time procurements. Costing them requires careful breakdown of components:

As a guiding principle, the list of capital projects to be costed should be **consistent with the prioritized list from Section 5.1**. Don't add new capital items at costing stage that weren't in prioritization; likewise, don't drop any prioritized item without reason. Also, ensure **no duplication of projects among MDAs** – e.g., if SPHCDA is costing a PHC in LGA A, the Ministry shouldn't independently cost a PHC in the same LGA; coordinate or merge them. If any such overlap is found, it should be resolved (either by merging budgets or assigning it to one agency) before final costing, or escalate to EXCO if it's a policy clash.

General guidelines for capital costing:

- **List all components of the project:** Break the project into parts. For a facility construction, components might be site clearing, foundation, structure, roofing, finishing, plumbing, electrical, furnishing, external works (water, power, fencing), etc. For an equipment purchase, components could be the equipment cost, installation cost, training of users, initial spare parts kit, etc. Ensure all required parts to make the project functional are included. This prevents under-costing where a building is built but has no equipment or a borehole drilled but no generator for pumping, etc.
- **Determine quantities needed for each component and price them at current market rates**. This may require technical input: e.g., an engineer for buildings to compute bill of quantities (BoQ), or a procurement unit to get price quotes for equipment. Use up-to-date prices, considering recent inflation or exchange rate changes for imported items. If needed, reference ongoing similar projects or ask suppliers for pro-forma invoices.
- **Consider ongoing project context:** If it's an existing project, check how much was allocated last year and what remains. For example, if a hospital build got NGN 200m last year and is half done, with maybe NGN 150m worth of work remaining, cost that with any inflation adjustment. Don't blindly start a new cost from scratch ignoring what was spent; incorporate previous expenditure and remaining cost to complete.
- **Multi-year projects:** If a project will span multiple years (e.g., a big hospital may take 2-3 years), determine the portions and costs required in outer years as well. However, budget year should only include the current year's portion – but in planning, note the future obligations. Documenting multi-year cost helps avoid starting something that can't be finished (or to inform government of commitments).
- **Summation:** Sum up the cost of all components to arrive at the total project cost. This total is what will be budgeted (or the portion for the year if multi-year).
- **Use of Costing Templates:** Similar to prioritization, the guideline references a **Project Costing Template** (Annex 2b) which can help organize this info. In that template:
    1. The prioritized projects from earlier (with their ranking) would appear already listed.
    2. For each project, list its components/activities in a column.
    3. In adjacent columns, put the quantity needed for each component for the budget year (and perhaps for the next two years if multi-year).

4. Next, input the unit cost for each component (in Naira).
5. The spreadsheet will calculate the cost per component (unit cost * quantity) and sum up for the project.
6. If an amount was allocated in last year's budget, there might be a column to input that (so one can see if more needed or if any balance).
7. The template likely auto-calculates totals and even comparisons with budget ceilings.

- **Cross-check against envelope:** After costing all projects, sum the capital costs of all prioritized projects. If it exceeds the capital budget available, you may need to drop the lowest priority or reduce scope. If it's under, that's fine or maybe an opportunity to add a smaller project if something critical was left out.
- **Documentation:** For major projects, it's good practice to have a short **Project Profile or appraisal document** (as MoBEP asks for those above certain threshold) including the cost breakdown, timeline, objectives, etc. This not only helps defend the budget but also guides implementation.
- **Value for Money:** Ensure that costing is reasonable; use standard costs where available (like if state has a standard design and cost for a Type II PHC clinic, use that). Outlier costs will draw scrutiny, so be prepared to justify (maybe a remote location has higher transport costs, etc., so it costs 10% more – note that reason).
- **Physical and Price Contingencies:** Often budgets include some contingency for unforeseen costs or price increases, especially if execution is later in the year. If permitted, include a small contingency in project cost (like 5-10%) to cushion inflation or minor scope changes. But sometimes MoBEP might not allow explicit contingency line; in that case, best is to price components slightly conservatively to avoid shortfalls.

Using these costing practices, the health sector can be confident that the budgeted figures will actually cover the projects intended. Poor costing leads to stalled projects (if underfunded) or wastage (if overfunded and funds remain idle or get reallocated in haste). So invest time in getting it right.

To illustrate: if planning a new *Primary Health Centre* building:

- List components: design (maybe existing standard, so minimal cost), site prep, building materials (cement, blocks, etc.), labor, roofing, painting, plumbing (borehole for water), solar power installation, basic medical furniture, etc. Quantity and unit cost for each. Sum = e.g., NGN 50 million.
- Suppose last year design and foundation was done with NGN 10m. Now NGN 40m remains needed. If budget envelope allows NGN 40m this year, great, can finish. If not, plan phase: do NGN 25m worth this year (maybe up to roofing), and note that NGN 15m will be needed next year to complete finishing and equipping. That way, planners and policymakers know a future commitment is there.

After costing, we move to the **Summary Report Sheet** which aggregates the total capital cost and compares it to the ceiling:

- It calculates the difference between total cost of chosen projects and the available envelope.

- If balance is zero, you fit perfectly.
- If positive balance (you haven't used all funds), you could add another small project or allocate that money to existing ones (maybe expand a project's scope).
- If a deficit (negative balance), you must cut something to get to zero. The guideline says you'd need to reduce projects equivalent to the deficit to fit the envelope.
- Ultimately, ensure the projects selected exactly use up (or just under) the capital budget available. You don't want to leave money unallocated because that might get taken by someone else or just reduce health's share. Conversely, you can't plan beyond your means.

Also, the final chosen projects (that make the cut) and their costs become the **capital budget proposal**. It's good to atprioritized and costed list in the submission to show a clear line of reasoning for each project included.

By following these guidelines, the health sector will have a robust, prioritized list of projects with realistic budgets. This maximizes the likelihood of projects being completed and delivering the expected health benefits to the population of Borno State.

(End of Chapter 5. The next chapter will address how to translate the approved budget into actual implementation: profiling releases, planning procurements, and executing projects effectively.)

Chapter 6:
Budget Implementation and Work Plan Execution

Once the budget is approved, the focus shifts to implementation**,** ensuring that the plans and allocations result in actual health services delivered and projects completed. This chapter covers the preparatory steps needed for smooth implementation, the execution of projects and programs, and the financial management during execution (recording and accounting). Following these guidelines will help avoid delays and bottlenecks in utilizing the budget.

6.1 Pre-Implementation Activities

Before jumping into spending, certain pre-implementation activities are essential at the start of the fiscal year (or even immediately upon budget approval). These set the stage for orderly execution.

6.1.1 Budget Profiling

Budget profiling means breaking down the annual budget into expected expenditures over the 12 months (or quarters) of the year. This is a planning tool to match the timing of funds release with the work plan schedule.

Steps for budget profiling in health:

- **Divide each budget line by month/quarter:** For instance, if NGN 12 million is budgeted for immunization outreach, you might profile NGN 3m per quarter (if equal), or maybe more in certain quarters if campaigns are seasonal (e.g., polio campaigns often in specific months). Personnel costs are typically profiled monthly (since salaries are paid monthly) in equal parts, with perhaps an extra in the month of bonus if applicable.
- **Profile capital project expenditures according to project schedules:** If a hospital construction will take 8 months from March to October, profile the capital releases accordingly – e.g., mobilization payment in March, progressive payments, with completion payment by October. This helps the Treasury know when to release funds.
- **Consider procurement lead times:** If equipment purchase is in budget, profile expenditures later in the year if procurement will take a few months. Conversely, if drugs need to be bought before rainy season (to pre-position for malaria season), profile that expenditure in first quarter.
- **Cash flow smoothing:** Work with the State Treasury or Accountant-General's office – they often prefer that large expenditures are spread out so the state can manage cash flow. If all sectors try to spend mostly in Q4, that's a problem; better to start activities earlier. So health should plan some major activities in first half of the year too (plus it's good for service delivery not to bunch everything late).
- **Set quarterly targets and indicators:** Along with financial profiling, set physical targets for each quarter (e.g., "Q1: renovate 2 PHCs, Q2: additional 3 PHCs..."). This ties budgeting to performance timeline.

The output is a **Budget Performance Plan** by quarter. This will be used in monitoring – to check if we're on track each quarter.

Budget profiling is sometimes a requirement by MoBEP or Ministry of Finance – they may ask MDAs to submit their cash flow plans early in the year. The health sector should comply because timely releases of funds often depend on a submitted plan.

6.1.2 Work Planning for Capital Projects and Key Programs

While we did an annual work plan in the planning stage, at the start of implementation it's often necessary to develop more detailed implementation plans for each major project or program (particularly capital projects). This ensures readiness.

For **Capital Projects**:

- **Verify project scopes on ground:** Particularly for construction or renovation, it's good to re-validate the scope at the start of the year, especially if conditions might have changed (e.g., additional repairs needed due to ongoing deterioration or new damage). Conduct site visits in January to confirm needs.
- **Develop Project Implementation Plans (PIPs):** For each project, create a timeline with milestones. E.g., "Renovation of Clinic X: Jan - prepare BoQ and bid docs; Feb - procurement; Mar - contractor mobilization; Apr-May - construction; June - completion; July - commission facility." This plan should align with budget profile (e.g., funds in Q1 for procurement advance, Q2 for construction, etc.).
- **Assign project managers:** Designate responsible officers or teams for each capital project. Perhaps the Ministry's civil engineer for building projects, the ICT unit head for any IT project, etc. They will oversee day-to-day and report progress.
- **Procurement planning:** (This is touched in 6.1.3, but related) – part of pre-implementation is preparing all procurement documents early (bill of quantities, technical specifications, terms of reference for services, etc.) so that tenders can be launched as soon as possible.

For **Key Recurrent Programs** (like a statewide immunization campaign, distribution of bed nets, training programs):

- **Activity scheduling:** Break the program into sub-activities and schedule them. For example, the immunization program might have microplanning workshops in January, training of vaccinators in February, actual campaign rounds in March and October, and monitoring in April and November.
- **Responsibility matrix:** Clarify which unit or partner does what. Perhaps an NGO is co-implementing certain outreach – put that in the plan to coordinate.
- **Logistics arrangements:** Plan how to get materials (vaccines, nets, etc.) to the field. If vehicles or fuel are needed, arrange with the logistics department or partners early.

Essentially, 6.1.2 is about turning the high-level workplan into actionable project and program plans, likely instructing MDAs to plan capital project execution properly. Therefore, the health sector needs to:

- Prepare an **MDA Workplan Template (Capital Project)** that might include columns: project name, location, Q1 tasks, Q2 tasks, etc., responsible officer, etc. Fill that out and possibly submit to MoBEP or keep for internal tracking.

By doing this, the health sector can avoid the common scenario of budgets sitting idle for half the year. It ensures by the time Q1 releases come activities are ready to go.

6.1.3 Procurement Planning

Procurement is often a time-consuming process due to rules (tendering, evaluation, approvals). Planning it well in advance prevents undue delays and lapsed funds.

Key procurement planning steps:

- **Create a Procurement Plan** listing all goods, works, and services to procure, their estimated costs (from your costing exercise), and the expected procurement method (open tender, restricted tender, request for quotes, etc., based on value and regulations). Also include timeline for each procurement.
- **Prioritize early procurement for critical items:** If something must happen in dry season (e.g., construction in a flood-prone area), start that procurement in Q1. If drug procurements need to align with disease peaks, time them accordingly. The plan should have start dates and end dates for each tender process.
- **Standard Bidding Documents:** Prepare bidding documents or RFPs early. For repeatable procurements like drugs or equipment, ideally have standardized specs ready. The same for construction – have technical designs/BoQs ready so you can advertise tenders within the first few weeks of the budget year.
- **Procurement Committee Scheduling:** Ensure the Ministerial Tender Board or Procurement Department schedules the bid advertisements, bid opening, evaluation meetings ahead of time. If boards or external approvals (like State Tenders Board or Due Process office) are needed for high-value contracts, engage them early with your plan so they allocate slots for health procurements.
- **Framework contracts:** For common supplies (like diesel for generators, routine drugs), consider using framework contracts or ordering agreements to avoid re-tendering every time. If allowed, one tender can secure supply for the year with staggered deliveries.
- **Transparent and fair process:** The plan should adhere to the Public Procurement Law. This reduces risk of contract awards being delayed by queries or cancellations. Ensure advertisement periods, evaluation criteria, etc., are all as per law.
- **Community contracts:** In some cases, for small works (like minor PHC repairs), involving community-based contracting can speed up and build ownership. If using such approaches, plan how to do so within procurement rules (maybe as direct labor or community driven projects).

- **Procurement for Donor-funded items:** If some procurements are funded by donors or via federal (like vaccines by NPHCDA), coordinate so you don't double-procure or conflict with their schedule.

A well-thought procurement plan is often required by budgeting oversight, as it ties expenditures to timeline. If done, by Q2 many of your contracts should be underway, rather than only starting then.

All pre-implementation tasks 6.1.1 to 6.1.3 essentially ensure that by the time funds are released, the health sector knows exactly what to do with them, with minimal last-minute confusion. This prevents situations like money being sent back at year-end due to inability to spend (which in a resource-starved context is tragic).

6.2 Project and Service Delivery Implementation

This section covers the actual execution of projects and delivery of services as per the plans:

- **Release of Funds:** Typically, the Ministry of Finance/Treasury releases funds quarterly or monthly. The health sector must promptly utilize releases for intended purposes. Good communication with the accountant general ensures releases match the profile as much as possible. If there's shortfall in releases (common in revenue-limited contexts), then re-prioritize within what's available – focus on essential activities first.
- **Executing Capital Projects:** Once contractors are engaged through procurement:
    - Monitor their work closely. The assigned project managers/engineers should conduct site visits and verify work quality and progress against milestones. Use standard project management tools (reports, site meetings).
    - Address issues promptly: e.g., if security situation hampers a contractor from working in a location, find solutions (maybe involve local security or adjust schedule).
    - Ensure payment certificates are processed quickly for completed milestones, to keep contractor cash flow and motivation. But also ensure they meet contract terms before payment (accountability).
    - Community involvement: For health facility projects, involve local community leaders in oversight where possible (they can help monitor and report problems, improving transparency).
    - Keep records of all variations or changes in scope and get necessary approvals for them – this helps later in audit or if additional funds needed.
- **Implementing Programs/Services:** For recurrent activities like training, outreaches, drug distributions:
    - Follow the detailed work plan schedule. Conduct the activities as planned.
    - Ensure logistic support: vehicles available, per diems paid on time to personnel going to field, supplies pre-positioned, etc.
    - Supervision: Senior officers should supervise critical interventions (for quality assurance). E.g., during an immunization campaign, have state monitors visiting LGAs.

    - Coordination: If multiple stakeholders (e.g., NGOs, partner agencies) are involved, hold coordination meetings during implementation phases to avoid overlap and to share progress.
    - Community engagement: Use local radio or community meetings to inform people of upcoming health activities (like "free surgery week" or vaccination days) so uptake is good.
- **Flexibility:** Despite plans, field realities might require adjustments. E.g., an outbreak could occur needing diverting resources temporarily. Or a contractor might face delay due to insecurity. The health sector should adapt, possibly rescheduling less urgent tasks. However, any major reallocation of budget might need approval (if moving funds between lines beyond allowed limits, you'd seek virement approval from MoBEP or even legislative if significant).
- **Reporting during implementation:** Institute a routine (monthly/quarterly) progress report within the ministry:
    - Financial report: how much of release spent, how much work done.
    - Physical progress: e.g., "PHC X renovation is 60% complete", "Y number of patients reached in outreach, vs target".
    - Highlight issues needing resolution by higher-ups (like "need extra security escort for team in LGA Z" or "contractor for project W is underperforming, may need contract review").
    - These reports feed into management meetings and allow timely intervention.
- **Use of Funds for Intended Purposes:** A cardinal rule in execution – spend funds on the items they were budgeted for. Avoid diversion. If savings occur in one project, officially seek approval to use them for another within the sector if allowed (virement). Unplanned spending outside budget lines is not permitted without authorization, as it breaks both the budget law and can lead to audit queries.
- **Record Keeping:** Document everything – contracts, work certificates, training attendance, equipment delivery notes. This ensures accountability and helps in later evaluation.

By diligently implementing, the health sector aims to deliver by year-end the outputs agreed in the budget. For example:

- X number of facilities built or renovated and functional.
- Y health workers trained and deployed.
- Z number of immunizations given, etc.

6.3 Expenditure Recording and Accounting

Proper financial management is crucial throughout implementation:

- **Books of Accounts:** The Ministry and each agency must maintain up-to-date books (vote books, cash books, ledger of commitments, etc.). Every expenditure should be recorded against the budget line it was charged to. This allows tracking of balances – to know, for instance, how much of the drugs procurement budget is already committed in a contract and how much remains.

- **Use of Accounting Standards:** Borno State follows the national accounting standards (likely IPSAS – International Public Sector Accounting Standards). All health MDAs should comply. That means classifying expenditures in accounts as per the NCoA, using accrual or cash basis as required, and preparing any financial reports accordingly.
- **Periodic Financial Reporting:** The Ministry of Health's finance director should prepare monthly or quarterly financial statements to compare budget vs actual expenditure (this ties into monitoring and helps detect underspending or overspending early). These are shared with management and perhaps MoBEP. In some states, MDAs must submit quarterly budget performance reports (the Annex 6 template suggests a format for that).
- **Budget Performance Reviews:** Internally, hold quarterly performance review meetings (this connects to Chapter 7 on performance review) where both program and financial progress is reviewed side by side.
- **Internal Control:** Ensure all spending is properly authorized and documented. The Permanent Secretary or Chief Executive as accounting officer must enforce internal controls: all payments should go through verification, internal audit unit should pre-audit if required by state policy, and procurement processes followed to avoid irregular expenditures.
- **Managing Variances:** If certain line items are running out faster than anticipated while others have surplus, that's a variance. The Ministry should seek virement if allowable: for example, if fuel cost was under-budgeted but travel cost was over-budgeted and can cover, request MoBEP to approve transferring funds between those overhead lines. The state likely has a threshold (like Commissioners or Governor can approve certain level virements, beyond that House approval needed).
- **Cash Management:** Particularly for health, large cash usage might happen in programs (e.g., paying field workers per diems). Aim to use secure payment methods (bank transfers or mobile money) where possible to reduce cash handling risks. If cash advances are taken for activities, account for them promptly with retirement of advances.
- **Asset and Inventory Records:** Keep records of any assets procured (vehicles, equipment) – log them in inventory, tag them, and assign custodians. For drugs and consumables, maintain stock registers so it's clear how supplies moved (to avoid pilferage).
- **Audit Trail:** Maintain an audit file for each project: budget allocation, procurement docs, contracts, payment vouchers, progress reports. This makes external audit or monitoring visits easier to satisfy, and protects the MDA in case of queries. External auditors (State Auditor-General or partners) will likely audit the health expenditures post-year; good records ensure compliance and reduce risk of audit sanctions.
- **Compliance with Financial Regulations:** Adhere to all state financial regulations, e.g., on advances, on end-of-year commitments (no contract should be awarded very late in year that can't be executed, or else roll-over properly), and ensure all unspent balances are handled as per law (some states allow carryover of on-going project funds, others require revalidation; follow whatever rule).
- **Financial Discipline:** Avoid unauthorized spending – e.g., spending more on a project than budgeted hoping to get a supplementary later is risky. Instead, if more needed, formally seek additional funds or scale the project. Also, ensure expenditures deliver value – accounting not just for money spent, but linking to output (this connects to M&E, e.g., how many patients got treated per amount spent on a program).

By rigorously recording and managing expenditures, the health sector can account for every Naira and demonstrate that funds were used for intended purposes effectively. This not only satisfies oversight bodies but also builds trust with the public and partners, encouraging continued or increased investment in the health sector.

In summary, Chapters 6.1 to 6.3 provide a blueprint for turning budget plans into on-the-ground results through careful pre-implementation preparation, active execution of works and services, and strict financial stewardship. Next, the focus will move to how to review performance and feed that back into planning, ensuring a cycle of continuous improvement.

Chapter 7:
Budget Performance Review, Monitoring and Evaluation

Even as implementation is ongoing, it is important to monitor progress and, at the end of the cycle, evaluate what was achieved with the budget. This chapter outlines how the health sector should conduct performance reviews of its expenditures and services, and how monitoring and evaluation (M&E) systems are used to ensure accountability and learning.

7.1 Conducting Health Expenditure Review and Appraisal

A **Health Expenditure Review** (HER) is a systematic assessment of how the budgeted funds were utilized and what results were obtained. Typically done annually (or mid-year for quick checks), it answers questions like: Did we spend as planned? If not, why? Did spending lead to expected outputs/outcomes?

Steps for conducting such a review:

- **Gather Financial Data:** Pull together the actual expenditure data for the period under review (e.g., the full year). This includes releases vs expenditures for each program and project. For instance, if PHC department had NGN 500m budget and spent NGN 450m, note that and the breakdown.
- **Gather Performance Data:** For each major activity or project, collect data on outputs and, if available, outcomes. E.g., number of facilities built, number of patients served, immunization coverage rates, etc. Use the indicators set during planning as the reference points.
- **Compare Budget vs. Actual:** Identify variances – both financial (like underspent or overspent lines) and physical (targets met or not). For example, maybe only 8 of 10 planned facility renovations were completed (80% achievement) and 90% of the funds were spent – analyze why the shortfall (perhaps two projects delayed due to security).
- **Analyze Efficiency and Effectiveness:** If there were significant deviations, examine causes. Common issues might be procurement delays, contractor issues, capacity gaps, or late release of funds. Also, identify if some programs achieved more with less or vice versa – that informs resource allocation going forward.
- **Appraisal of Outcomes:** Look at higher-level effects where possible. For instance, did maternal mortality ratio in facilities decrease after deploying more midwives? Did immunization rates improve in areas where cold chain was fixed? While one year might be short for big outcome changes, any positive trend helps justify budget allocations.
- **Document Lessons:** The review should highlight what worked well (to replicate or scale) and what didn't (to fix or drop). For example, if an innovative community health volunteer program achieved high coverage cheaply, that's a success to continue. If a certain contractor consistently underperforms, maybe don't engage them again.

This review could be part of the **Sector Performance Review (SPR)** referenced earlier (Chapter 3 for planning). This could be done at year-end to feed the planning of the next budget cycle. The output is typically a **Health Budget Performance Report** and a presentation for stakeholders.

7.1.1 Performance Monitoring and Review Framework

To systematically do the above, the health sector should have a **Performance Monitoring and Review Framework** in place:

- **Key Performance Indicators (KPIs):** Define KPIs for the health sector that link to budget items. These include output indicators (e.g., number of outpatient visits, number of surgeries performed, percentage of immunization coverage) and outcome indicators (maternal mortality rate, under-5 mortality, etc.). Each KPI should have a baseline and targets. Many might align with national indicators or the state's strategic plan.
- **Data Sources and Tools:** Use the Health Management Information System (HMIS) for service data, financial management system for expenditure data, surveys for population health outcomes (like DHS or SMART surveys if available), and facility assessments. Ensure that data collection is ongoing and timely. For instance, monthly HMIS reports from facilities can track service outputs.
- **Monitoring Responsibilities:** Assign who collects and reports each indicator. E.g., SPHCDA M&E unit compiles PHC service data, the Ministry's M&E unit compiles hospital data and workforce data, the finance unit provides financial performance data.
- **Regular Monitoring Meetings:** On a quarterly basis, hold internal review meetings (maybe the Health Sector M&E Committee) to check progress. They would look at e.g., Q1: only 15% of capital budget spent – maybe due to procurement processes – then decide actions to speed up. Or find that some district has low uptake of services – send a supportive supervision team.
- **Annual Performance Review Event:** Once a year (mid-year or year-end), do a comprehensive review with wider stakeholders (similar to Joint Annual Review done in some places). Invite representatives from LGAs, health worker reps, partner agencies, and perhaps legislators. Present the budget and program performance, discuss challenges and solicit solutions. This inclusive approach fosters accountability and shared ownership of improvements.
- **Use of Findings:** The framework should ensure findings are reported to decision-makers: the Commissioner, EXCO, and the legislature's Health Committee. Also share relevant info with the community (maybe via a state health bulletin or town hall) to maintain transparency and trust. For example, if immunization improved by 10% because of a new strategy, publicize that as a success of public spending. If targets weren't met, communicate the plan to address it next year.

By institutionalizing this framework, performance monitoring becomes routine rather than ad-hoc.

7.2 Monitoring and Evaluation of Health Programs and Budget

Monitoring and Evaluation (M&E) are related but distinct:

- **Monitoring** is continuous tracking of activities and outputs.
- **Evaluation** is deeper assessment of outcomes/impact and efficiency, usually periodic or at project end.

For the health budget:

7.2.1 M&E Processes

- **Routine Monitoring:** As described above, monthly and quarterly monitoring of inputs (money spent), activities (what was done), and outputs (immediate results). This is largely internal management function.
- **Supportive Supervision:** A form of monitoring where teams visit healthcare facilities or project sites to observe implementation quality. E.g., the State Ministry might have a supervision checklist for PHCs to assess service quality and resource use. Findings from supervision feed into adjustments (like need for retraining staff or sending more supplies).
- **Data Quality Assurance:** Ensure the data used for monitoring is reliable. Conduct periodic data verification (like sample checking facility reports against registers) to build confidence in reported numbers.
- **Mid-Year Review:** Many states do a mid-year budget implementation review. Health should actively participate, analyzing first half performance and recommending any course corrections for second half (like reallocation if needed).
- **End-year Evaluation:** At the end of the year, or when a specific project ends, conduct evaluations. For example, evaluate a pilot program (like a mobile clinic initiative) to see if it achieved intended health outcomes and at what cost, to decide on expansion or modification. Or evaluate the impact of an infrastructure project on service utilization.

The evaluation aspect ties to **effectiveness** (did we achieve goals?) and **efficiency** (did we use resources optimally?). Perhaps commission independent evaluation for major programs (partners might fund these). The National Health Act or policies might also require certain reviews (for instance, BHCPF requires some performance evaluation to continue funding).

- **Community Feedback Mechanisms:** Integrate community feedback as part of M&E. Through community health committees or scorecards, gather how users perceive health services improvements. This qualitative info can highlight issues not evident in data (like patient satisfaction, or reasons they might not use a new facility). If, say, a clinic was built but usage remains low, community feedback might reveal maybe a lack of staff or cultural issues, guiding further action.
- **Reporting to National Systems:** Some programs might need reporting to Federal Government (e.g., if Basic Health Care Provision Fund was used, they require performance reports). Ensure compliance to keep credibility and funding flows.

Remember, the ultimate aim of M&E is to improve decisions. It should inform the **next planning and budgeting cycle** (closing the loop: budget -> implement -> monitor -> review -> feed into next budget).

7.3 Key Committees and Stakeholders Involved in Performance Reporting and Review

A robust review process involves multiple eyes. Key committees/stakeholders include:

- **State Health Steering Committee:** If existing, this might consist of top Ministry officials, heads of agencies, possibly Ministry of Budget or Finance reps, and partner reps. They oversee and endorse major plans and review outcomes. Under something like a **State Council on Health** meeting (which might happen annually), performance is reviewed and new resolutions made.
- **Ministry of Budget and Economic Planning (MoBEP):** They will look at budget performance across sectors. The health sector should actively engage with MoBEP's Budget Monitoring Department or similar, which often tracks and reports budget performance to EXCO and donors (like for the World Bank if performance-based financing exists). If health underperforms financially (low budget utilization), MoBEP might reduce future allocations; if it demonstrates capacity to absorb funds well, it can argue for more. So show MoBEP your credible performance data.
- **State House of Assembly (Legislators):** The House Committee on Health and/or Appropriations may conduct oversight visits or request performance reports. They approved the budget, so they'll want to see results. Keeping them informed fosters goodwill and support for future budgets. For instance, organizing a field tour for legislators to see completed projects can be powerful.
- **Health Partners Coordination Forum:** In Borno, given humanitarian context, a cluster or health partners forum exists. Sharing budget execution results with them helps align their support. They can also offer inputs on gaps they observe. Some development partners also require performance data for their contributions (like if UNICEF gave vaccines, they track coverage).
- **Community and Civil Society:** Groups like Health Advocacy networks, patient associations, etc., should be considered. Some states have Civil Society observers in budget reviews. For example, a CSO might be invited in the annual sector review to give independent feedback on what they see at community level. Also, Ward Development Committees' feedback can come through the SPHCDA's community engagement wing to the review table.
- **Facility Managers:** Hospital Medical Directors and PHC coordinators are critical stakeholders. They actually manage services and their insight on resource utilization is valuable. In performance review, including some facility managers (maybe in a panel or working group) can highlight operational challenges. They might say, e.g., "we had equipment funds but procurement delays at central level hindered us" or "drugs budget was fine but distribution was an issue," etc.
- **Accountability Platforms:** If any, like a Health Sector Transparency Committee or Budget Transparency working group, involve them. In the spirit of open government, having citizen representatives see and discuss health budget performance builds public trust.

The guideline should list "Key Committees & Stakeholders for Annual Performance Reporting & Review"

To operationalize:

- **Set a schedule** for reviews: e.g., Q2: internal mid-year review meeting; Q4: annual health summit including all stakeholders to review the year.
- **Prepare materials** in accessible format: performance scorecards, financial summaries, etc., for these committees.
- **Follow-up on recommendations:** If the Health Committee of Assembly recommends action (like allocate more to rural ambulances next year, or investigate a poorly executed project), ensure those are taken seriously.

By involving all these players, the health sector creates a culture of accountability. It also spreads the responsibility – improvement of health outcomes is a collective effort, not just the Ministry in silo. When stakeholders are part of reviewing performance, they are more likely to contribute to solutions and support the sector (for instance, communities might commit to help maintain facilities if they feel included, or partners might align their funds to cover a gap identified).

In conclusion, regular performance review and robust M&E, with wide stakeholder engagement, ensures that the budgeting and planning process remains dynamic and responsive. It closes the loop of the budget cycle by feeding lessons and results back into the next cycle's planning (as we saw in Chapter 3 about using SPR for next budget). Over time, this will lead to improved health outcomes and more efficient use of resources, as the system learns and adapts.

Chapter 8:
Conclusion

The **Borno State Guidelines for Basic Health Sector Budget Preparation and Work Planning** presented in this document provide a comprehensive roadmap for planning, financing, executing, and reviewing health sector activities in the state. By following these guidelines, Borno State aims to achieve a more transparent, accountable, and results-driven health budgeting process that is sensitive to the state's unique challenges and opportunities.

In summary, the guideline emphasizes the following key takeaways:

- **Strategic Alignment:** Health budgets and work plans must be closely aligned with Borno's health priorities, including strengthening primary health care, addressing conflict-related health needs, and achieving national policy targets (such as those in the National Health Act and PHC revitalization agenda). This ensures that every Naira spent is pushing the state closer to its vision of accessible and quality healthcare for all.
- **Inclusive Planning:** The preparation process involves all relevant actors – from the State Ministry of Health and SPHCDA to LGAs, development partners, and community representatives. Such inclusive planning and the incorporation of community needs (e.g., through Community Charters of Demand) make the resulting plans more robust and more likely to succeed, as they have broad buy-in.
- **Evidence-Based Decision Making:** The use of data and reviews (situational analysis, performance reviews, and M&E frameworks) is central to the guidelines. Borno will continuously learn from past implementation, using evidence to prioritize projects and allocate resources to interventions that yield the greatest health impact.
- **Efficient Resource Use:** Given limited resources and significant health needs, the guidelines put forward measures for cost-effectiveness – from rigorous project prioritization criteria to realistic costing methods and early procurement planning. These help to avoid delays, cost overruns, and wastage, thereby delivering more with what is available.
- **Accountability and Transparency:** Each step of the process, from budget formulation to execution and performance reporting, has mechanisms for accountability. Adhering to standard financial management practices, engaging oversight bodies, and publishing citizen-friendly budgets and reports will strengthen public trust. Communities and stakeholders can see how funds are allocated and used, and what results are achieved, which in turn encourages their continued support and participation.
- **Resilience and Adaptability:** The guideline is tailored to Borno's context – acknowledging issues like facility destruction, IDP population pressures, and partner-led services. It encourages integrating humanitarian efforts with government planning and building flexibility into plans (for example, readiness to reallocate funds during an outbreak or adjust implementation in insecure areas). This makes the health system more resilient to shocks and able to maintain essential services under various conditions.

Moving forward, it is expected that all health sector entities in Borno State will **institutionalize these processes**. The Ministry of Health, in collaboration with the Ministry of Budget and

Economic Planning, should orient and train relevant staff at state and LGA levels on these guidelines. Tools like the annexed templates for project prioritization, costing, workplans, and performance reports should be made available and utilized in the upcoming budget cycle.

Where specific data or inputs are required (such as updated health indicators, exact financial figures, or names of responsible officers), responsible persons will fill those sections as the living documents are developed. Users of this guideline are encouraged to adapt the details as needed while keeping the overall structure and principles intact.

By diligently applying the guidance contained in this document, Borno State can improve the coherence and effectiveness of health sector planning and budgeting. Over time, this will translate into tangible improvements: more functional health facilities, a more motivated and well-distributed health workforce, better stock of medicines and vaccines, and ultimately, healthier communities even in the face of adversity. The **ultimate goal** is to ensure that public funds in the health sector are managed in a way that maximizes health outcomes, saves lives, and builds a stronger, more equitable health system for all people of Borno State.

The journey of strengthening the health system through better planning and budgeting is continuous. As we implement these guidelines, we will remain committed to learning and refining our approaches. Together – government, health workers, partners, and communities. We can achieve a more efficient and responsive health sector, laying the foundation for a healthier Borno State.

Annexures

Annex 1: Consolidated Budget Activities, responsibilities, outputs, and timelines (BudgetCalendar)

S/N	Budget Activity	Month												Start Dates	End Date	Responsibility	Output
		J	F	M	A	M	J	J	A	S	O	N	D				
Budget Planning and Preparation																	
1	Agency/Sector performance/ review (previous year's Budget Performance Report)															Planning Directorate	Agency/Sector Performance/ Review Report
2	Collection of spending, revenue, and expenditure performance data - budgeted and actual, macroeconomic indicators, etc., for preparation of EFU-FSP-BPS															Ministry of Finance, Planning and Budget Directorates	Updated EFU-FSP-BPS dataset
3	Issue Budget Calendar															Budget Directorate	Budget Calendar
4	Preparation of EFU-FSP-BPS															Ministry of Finance, Planning and Budget Directorates	Draft EFU-FSP-BPS document
5	Submit EFU-FSP-BPS draft to ExCo															Ministry of Finance, Planning and Budget Directorates	Memo, Executive Summary of EFU-FSP-BPS
6	Governor's approval of EFU-FSP-BPS document															HE Governor	Updated EFU-FSP-BPS document
7	Submission of EFU-FSP-BPS document to, and approval by Gombe State House of Assembly (GSHA)															GSHA	Updated EFU-FSP-BPS document
8	Medium term (three year) sector ceilings circulated (indicative ceilings may be issued earlier)															Planning and Budget Directorates	Memo (accompanied by EFU-FSP-BPS document)
9	Develop/ Update Medium Term Sector Strategies (MTSS)/Budget Plans															MDAs/ Sector Teams	MTSSs/MTBP
10	Issue Budget Call Circular (BCC)															Budget Directorate	Call circular document

11	Preparation and submission by MDAs of first draft budget (incorporating updated MTSS budgets)														MDAs/ Sector Teams/ Budget Directorate	Budget submissions
12	Collation of MDAs' first budget draft														Budget Directorate	First draft budget
13	MDAs' budget defence/ negotiations														MDAs/ Budget Directorate	Minutes
14	Revision of draft submission of budget estimates														Budget Directorate	Updated budget submissions
15	Consolidation of MDAs' budget estimates														Budget Directorate	Second draft budget
Budget Approval																
16	Submission of draft budget estimates to ExCo														Budget Directorate	Memo
17	Further revision, correction, and resubmission to ExCo/Governor														Budget Directorate	Third draft budget
18	ExCo presentation of the budget proposal to GSHA														HE Governor	Presentation
19	GSHA review and passage/presentation for Governor's Assent														GSHA	Fourth draft budget
20	Budget sign-off by the Governor														HE Governor	Appropriation Bill
21	Public presentation of the approved annual budget by the Governor														HE Governor	Budget speech, published budget
22	Publication of the budget, including Citizens' Budget, online														Budget Directorate	Citizens' Budget, full budget online
'Floating' Activities																
A	Internal budget retreats, for example, for budget planning and budget presentations														Various	Agenda, presentation, minutes
B	External budget retreats, for example, stakeholder/ CSO engagement in sector reviews, EFU-FSP-BPS preparations, MDA budget preparation														Various	Agenda, presentation, minutes

Annexe 2a: Snapshot of Project Prioritization Template

S/N	Project Code (The Code of the Project in the current year's budget. If the Project is new, add 6 zeros)	Project Name (As in the current year's budget or if it is a new project, as you want it to appear in the next year's budget)	Project's Contribution to State Development Plan Goals					Project Status (Ongoing = 3; New = 1)	Likelihood of completion not later than 2028 (2026 = 3; 2027 = 2; 2028 = 1; Beyond 2028 = 0)	Nature of Project (Developmental = 3; Administrative = 1)	Total Score	Project Ranking	Physical Location: Local Government/ Multiple LGAs/ Statewide (Add comment if more than one LGA)	Project Status (Ongoing/ New)	Timelines	
			An inclusive economy that creates income and employment opportunities	A sustainable infrastructure that improves living standards and catalyses economic growth and development	An educated, productive skilled, enterprising, healthy and secure citizen	A clean, green, healthy, and sustainable environment	Setting out the principles that underpin support for good governance								Project Commencement Year	Expected Year of Completion
1	000000	Construction of 2 primary health care center in Biu, Borno State	2	2	3	3	2	3	3	3	21	1	Multiple LGAs	Ongoing	2026	2026
2	000000	Project 2	2	2	2	1	1	1	2	1	12	3	Multiple LGAs	New	2026	2029
3	000000	Project 3	3	3	3	1	1	1	0	3	15	2	Multiple LGAs	New	2028	2030
4											0	4				

Annexe 2b: Snapshot of Project Costing Template

S/N	Project Code	Project Name	Project Components	Unit or Quantity			Cost per Unit (=N=)			Amount Approved for the Project in 2025 Budget (N)	Budget Requirement in MTSS Years (N)			Total Budget Requirement for the MTSS Period (N)
				2026	2027	2028	2026	2027	2028		2026	2027	2028	
										20,000,000	222,350,000	1,600,000	1,600,000	225,550,000
1	000000	Construction of 2 primary health care center in Biu, Borno State								20,000,000	222,350,000	1,600,000	1,600,000	225,550,000
			2 Acre of Land	2	0	0	5,000,000				10,000,000	0	0	
			Sand	20	0	0	50,000				1,000,000	0	0	
			Stone	25	0	0	70,000				1,750,000	0	0	
			Iron	200	0	0	23,000				4,600,000	0	0	
			Cement	300	0	0	10,000				3,000,000	0	0	
			Roofing and Finishing	2	0	0	100,000,000				200,000,000	0	0	
			Labour/Personnel cost	25	20	20	80,000	80,000	80,000		2,000,000	1,600,000	1,600,000	
2	000000	Project 2									0	0	0	0
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
3	000000	Project 3									0	0	0	0
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	
											0	0	0	

Annexe 3: Snapshot of Prioritized and Costed Project Summary Sheet

S/N	Project Code	Project Name	Project Score	Project Ranking	Physical Location	Project Status (Ongoing/ New)	Timelines		Amount Approved for the Project in 2025 Budget (N)	Budget Requirement for Plan (N)		
					LGA(s)		Project Commencement Year	Expected Year of Completion		2026	2027	2028
1	000000	Construction of 2 primary health care center in Biu, Borno State	21	1	Multiple LG	Ongoing	2026	2026	20,000,000	222,350,000	1,600,000	1,600,000
2	000000	Project 2	12	3	Multiple LG	New	2026	2029	0	0	0	0
3	000000	Project 3	15	2	Multiple LG	New	2028	2030	0	0	0	0
4	0	0	0	4	0		0	0	0	0	0	0
5	0	0	0	4	0		0	0	0	0	0	0

Annex 4: Capital Expenditure Projection Template

Economic Code	Expenditure Entity	Budget	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Annex 5: MDA Workplan Template (Capital Project)

	Spending Entity (MDA):							
Economic Code	Activity/Project/Programme	Budget/Costs	Start Date	Completion Date	Cost Broken down to Months	Outputs	Responsible Person(s)	Remarks

Annex 6: Monthly/Quarterly Budget Performance Report Template

Economic Code	Particulars	Annual Budget	Month/Quarter Actual	Actual to Date	Liability Committed	Total Exp & Liability	Balance Available
	Personnel						
21010100	Salaries and Wages			-		-	0
21020100	Allowances			-		-	0
21020200	Social Contribution			-	-	-	0
	Total	0	-	-	-	-	0
22010100	Social Benefits					-	0
	Overhead						
22020100	Travels and Transport			-		-	0
22020200	Utilities			-		-	0
22020300	Materials and Supplies			-		-	0
22020400	Maintenance Services			-		-	0
22020500	Training			-		-	0
22020600	Other Services			-		-	0
22020700	Consulting and Professional Services			-		-	0
22020800	Fuel and Lubricants			-		-	0
22020900	Financial Charges			-		-	0
22021000	Miscellaneous Expenses			-		-	0

22030100	Staff Loans and Advances			-		-	0
22040100	Local Grants and Contributions			-		-	0
22040200	Foreign Grants and Contributions			-		-	0
22050100	Subsidies to Government Owned Parastatals						
22060100	Public Debt Charges						
	Total	0	-	-	-	-	0
	Capital						
23010100	Fixed Assets General						
23020100	Construction & Provision						
23030100	Rehabilitation/ Repairs						
23040100	Preservation of the Environment						
23050100	Acquisition of Non-Tangible Assets						
	Total						
	Grand Total						