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HIV/AIDS Financing Landscape Analysis and Public Financial Management Process Flow – Kano State, Nigeria

Local Health System Sustainability Project
Task Order 1, USAID Integrated Health Systems IDIQ

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

BHCPF	Basic Health Care Provision Fund
CSO	Civil Society Organization
DHIS2	District Health Information Software 2
FSP	Fiscal Strategy Paper
GESI	Gender Equality and Social Inclusion
HAT	Office of HIV/AIDS and Tuberculosis
KSACA	Kano State Agency for the Control of AIDS
KSCHMA	Kano State Contributory Health Management Agency
KSPHCMB	Kano State Primary Health Care Management Board
LGA	Local Government Area
LHSS	Local Health System Sustainability Project
MDAs	Ministries, Departments, and Agencies
MTEF	Medium-Term Expenditure Framework
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
PLHIV	People Living with HIV/AIDS
SHIS	State Health Insurance Schemes
SHOA	State House of Assembly
SMOH	State Ministry of Health
SMT	Senior Management Team
TB	Tuberculosis
TWG	Technical Working Group
USAID	United States Agency for International Development

INTRODUCTION: OBJECTIVES, CONTEXT, AND METHODOLOGY

The USAID Local Health System Sustainability Project (LHSS) supports the Government of Nigeria in expanding sustainable pro-poor health financing options to reduce health inequalities, improve access to essential health services for the most vulnerable populations, and increase government expenditure on HIV services to support sustainability. Specifically in Lagos and Kano States, LHSS advances the priorities of the USAID HIV/AIDS and Tuberculosis (HAT) Office by strengthening HIV/AIDS financing through improved quality and quantity of government expenditure and improved coverage and implementation of financial risk protection schemes to increase sustainable access to HIV/AIDS care and treatment. To lay the foundation for effective implementation of activities with state-specific institutions that are critical to achieving the program's objectives in Kano State, LHSS conducted a landscape analysis with the following objectives:

1. Identify barriers to integrating and operationalizing HIV testing and other health services within financial protection schemes (State Health Insurance Schemes (SHIS) and Basic Healthcare Provision Fund (BHCPF)).
2. Identify priorities and opportunities for the financial integration of HIV services under financial protection schemes (SHIS and BHCPF) and for expanded population coverage and service coverage of these schemes.
3. Map the public financial management (PFM) process. Identify bottlenecks at each stage of the HIV PFM process, the underlying causes of the bottlenecks, and opportunities to address HIV PFM challenges.
4. Assess the organizational capacity of state counterpart agencies (Kano State Agency for the Control of AIDS (KSACA), Kano State Contributory Health Management Agency (KSCHMA), and Kano State AIDS/STI Control Program and other relevant stakeholders related to integration of HIV services. Outline interventions for organizational capacity development for each state counterpart agency.

LHSS conducted this assessment in close collaboration with these agencies and other appropriate stakeholders.

CONTEXT

Nigeria has the second-largest HIV epidemic in the world, with an estimated 1.9 million people living with HIV/AIDS (PLHIV) according to the 2018 Nigeria HIV/AIDS Indicator and Impact Survey—the most recent data available. Nigeria has made significant progress in increasing coverage of HIV services, with over 1 million Nigerians living with HIV currently on lifesaving antiretroviral therapy.

However, roughly 80 percent of the resources for the HIV response are from international donors. Significantly larger and more sustainable resources must be mobilized within the country through improved quality and quantity of government financing at the national and subnational levels to reach the country's ambitious goal of ending AIDS by 2030.

A recent study assessing direct user fees paid by PLHIV estimated that patients who reported incurring such a fee were paying an average of 1,235 naira (U.S. $3.40)—92 percent of Nigeria's average daily income—for services such as hospital registration, consultation, HIV testing, and antiretroviral medication refills at each clinic visit.[4]

To reduce catastrophic health spending for PLHIV, Nigeria must expand its funding and expenditures for HIV control. LHSS activities address the opportunities for this expansion. Additional funding sources could result from 1) integration of HIV services into the benefit packages of financial risk protection schemes such as the BHCPF, where the federal government pays premiums for poor and vulnerable groups (as defined by each state), who may overlap with PLHIV; and 2) the SHIS, where the state governments have policies on paying premiums for their employees and funding equity funds to pay premiums for poor and vulnerable groups. While higher budgets are unlikely given Nigeria's weak economy, existing budgets are often significantly underspent (<50% expenditure is common for HIV agencies), especially at the subnational level. Strengthened PFM processes, including in the areas of planning, budgeting and expenditure tracking, could increase expenditures by improving the efficiency and effectiveness of current budgets.

In Kano State, the LHSS Project HAT activity works with the government and other relevant stakeholders to strengthen the health system and improve domestic resource mobilization. The objectives are as follows:

- Increase the utilization of the SHIS and the BHCPF resources for HIV/AIDS through expanded service coverage of HIV services.
- Increase government funding and expenditure for HIV/AIDS through improved public financial management at the national and state levels, increased advocacy to state government by civil society, and increased demand for these services.

ASSESSMENT METHODOLOGY

LHSS used desk reviews, an organizational capacity assessment tool, and key informant interviews to generate evidence from stakeholders on the health financing landscape of HIV/AIDS in Kano State. (See Annex for data collection tools and a list of stakeholders interviewed.) Information on the state health insurance scheme operations, barriers, expansion opportunities, and priorities for HIV integration was obtained through desk review of agency documents, including strategic plans and annual operational plans, as well as stakeholder interviews of heads of units of counterpart agencies.

Budget performance reports and statistics available from the State Ministry of Budget and Planning website, and stakeholder interviews of key technical staff in charge of the health budget, were used to map the HIV PFM processes, examine bottlenecks for each stage of the PFM process, and identify opportunities to address PFM challenges affecting the HIV program.

LHSS's organizational capacity self-assessment tool was adapted and used to collect relevant data through key informant interviews and focus group discussions. To ensure that diverse views and opinions were considered, the data were collected from key technical staff involved in program management and implementation from each of the counterpart agencies. The assessment questions covered four domains, as follows:

1) Governance (agencies' organizational mandate and structure, human resource management, leadership, and management, coordination, and communication with stakeholders)
2) Service delivery (policy, strategy and planning, and implementation and technical capacity)

3) Resource mobilization (financial management and resource mobilization)
4) Health management information system (data collection, data validation and analysis, and use of data for decision making)

The assessment questions included language that described performance at each level and rated it on a numeric scale. This method enabled respondents to think not just about the current practice or capacity but also about what "better" would look like.[5] Following each assessment, a detailed summary sheet was used to present the aggregate score for each domain, the total score was expressed as a percentage, and each agency was classified based on the overall percentage score. The assessment scale was classified from 0-4 with 0 representing non-existence of systems, resources and processes, and 4 representing a well-developed and well-functioning, credible system, with adequate resources.

SITUATIONAL ANALYSIS

This section gives an overview of the health and sociodemographic profile of Kano State to provide context for interpretating and applying the findings from the landscape analysis.

DEMOGRAPHY AND ECONOMY

Kano State is the commercial and investment hub of northern Nigeria and the third largest non-oil and gas state economy in Nigeria, with a gross domestic product of approximately 11-14 trillion naira ($15–19 billion).[1] The state Medium Term Expenditure Framework (MTEF 2022-2024) is based on similar assumptions as that of the federal government. It anticipates economic growth of 2.5 percent in 2021, increasing to 4.2 percent in 2022 and a decline to 2.3 percent in 2023.

Despite the anticipated decline in economic growth in 2023, some opportunity for increased government health expenditure exists with government prioritization of health care services and optimal public financial management.

Most of the population are engaged in the informal sector, while only 10 percent are engaged in the formal sector.[2] The predominant economic activity in the state is subsistence agriculture, with 70 percent of the population directly or indirectly involved in it. The economy is driven largely by service, commerce, and manufacturing in addition to agriculture. The large informal sector presents a challenge for health insurance coverage as enrollment in health insurance schemes may be more easily achieved with the formal sector.

Poverty remains high in the state, with over 61 percent of the total population living below the poverty line. This has profound implications for health seeking behavior, as most of the population does not have adequate resources to pay for health care and avoids seeking it or may suffer catastrophic expenditures when they do.

[1] Kano State 2022-2024 MTEF/FSP.
[2] Kano State Ministry of Health: Reproductive, Maternal, Newborn, Child, and Adolescent Health plus Nutrition (RMNCAH+N) Strategy 2021–2025.

AN OVERVIEW OF THE STATE HEALTH SYSTEM

The vision of the Kano State health sector is to guarantee a healthy and productive state where all people have unhindered access to quality health care. This is to be achieved by providing "accessible, affordable, and quality health services for all residents of the state irrespective of religion and ethnic background".[3]

The State Ministry of Health (SMOH) coordinates the activities of its departments and agencies in the health sector. These agencies include, among others, the KSACA, which is responsible for the coordination and implementation of HIV/AIDS activities in the state; the Kano State Primary Health Care Management Board (KSPHCMB), which is responsible for managing primary health care; and the KSCHMA, which is responsible for implementing the SHIS.

While the KSCHMA is primarily responsible for ensuring that all residents of Kano State have access to effective, quality, and affordable health care services, it works collaboratively with the KSPHCMB and the KSACA to improve access to and delivery of integrated HIV services under the SHIS.

Currently, there are about 1,200 health care facilities in Kano State, though this figure is fluid. Among them are 40 public secondary health facilities and two tertiary hospitals. The remainder are primary health care centers and private health facilities. Of the total 1,200 health care facilities, 43 provide comprehensive (prevention, care, and treatment) HIV services.

HIV/AIDS SITUATION IN KANO STATE

Kano State has an estimated HIV prevalence of 0.6 percent, with a total estimated number of PLHIV of about 52,000[4]; this rate is lower than the national average of 1.4 percent.[5] The prevalence is higher among females (0.7 percent) than in males (0.4 percent). Currently, it is estimated that 38,125 PLHIV—73.3 percent of estimated PLHIV— are on treatment across the 43 comprehensive centers.

COORDINATION OF THE HIV RESPONSE

The coordination of the HIV/AIDS response in Kano State, led by the KSACA, is in line with the national guideline for HIV/AIDS coordination and administration. The country response is based on a tiered system of administration, with the National Agency for the Control of AIDS working at the national level, the State Agency for the Control of AIDS (SACA—in this case KSACA) working at the state level, and the Local Action Committee on AIDS (LACA) working at the local government level.

At each level, the HIV response is multisectoral to include other non-health ministries, departments, and agencies, such as the Ministry of Women Affairs, the Ministry of Youth and Sports, the Ministry of Budget and Planning, the Ministry of Justice, and the Ministry of Finance. The KSACA's main responsibility is to provide leadership and policy direction to the state response, while the Kano State AIDS/STI Control Program—a unit in the KSACA under the Directorate of Prevention, Care, and Treatment—is responsible for coordination of the health sector response.

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[3] Kano State Strategic Health Development Plan II. 2017–2021.
[4] Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) 2018.
[5] NAIIS National Fact sheet 2019

POLICY ENVIRONMENT

The state HIV response is guided by the National HIV/AIDS Strategic Plan 2021–2025 and the National HIV/AIDS Strategic Framework 2021–2023. In addition, the response is guided by the State Strategic Health Development Plan and state-specific HIV/AIDS strategic plan.

DATA MANAGEMENT

Data on HIV services and use of commodities is usually collected from health facilities (service delivery points) electronically using monthly summary forms. This data is transferred by facility and local government area (LGA) monitoring and evaluation (M&E) officers to the District Health Information System (DHIS) through a web-based link to the national-level data repository. Monthly data reviews are generally conducted first at the facility and subsequently by KSACA to ensure completeness. KSACA conducts supportive supervision using an Open Data Kit tool. The monitoring and evaluation team conducts data analysis and provides a summary of gaps, based on which further actions are taken if necessary. Identified issues requiring further action are promptly passed to the relevant authority or partner to resolve or are discussed at the various technical working groups (TWGs) if the issues involve multiple agencies or partners.

STAKEHOLDERS

Aside from the State Ministry of Health and its departments and agencies, the other key stakeholders for the HIV response in Kano State include:

- Other non-health ministries, departments, and agencies: the Ministry of Women Affairs, the Ministry of Youth and Sports, the Ministry of Budget and Planning, the Ministry of Justice, and the Ministry of Finance
- LGA departments
- Civil society organizations (CSOs), including the Kano State Level Accountability Mechanism
- Implementing partners, including the Society for Family Health and Georgetown Global Health Nigeria
- Organized private sector
- News media
- Entertainment industry
- The Network of People Living With HIV/AIDS in Nigeria (NEPWHAN) and its three affiliates—the Network of Religious Leaders Affected by HIV/AIDS, the Association of Women Living with HIV/AIDS in Nigeria, and the Association of HIV-Positive Youth in Nigeria.

LANDSCAPE ANALYSIS OBJECTIVE 1: IDENTIFICATION OF PRIORITIES AND OPPORTUNITIES FOR THE FINANCIAL INTEGRATION OF HIV SERVICES INTO STATE FINANCIAL PROTECTION SCHEMES AND FOR EXPANSION OF POPULATION AND SERVICE COVERAGE

PROGRESS TO DATE WITH HIV INTEGRATION AND EXPANSION OF COVERAGE

Nigeria has a National Health Insurance Scheme decentralization policy, which has enabled the creation of SHISs. With the decline in donor funding for the HIV response, the pooling of resources from government, households, and other sources through health insurance is a means of channeling domestic funding for the HIV response in a more efficient, potentially sustainable manner. In keeping with the decentralization policy, Nigeria also developed a national blueprint for the integration of HIV services into SHISs. The blueprint provides operational guidance for SHISs seeking to integrate HIV services at any stage of their implementation. States are expected to use this guidance in developing state-level roadmaps for implementation.

INTEGRATION OF HIV/AIDS SERVICES INTO THE KSCHMA

The KSCHMA was established by the Kano State Contributory Healthcare Management Agency Law No. 3 of 2016 to facilitate pre-payment and pooling of resources for financing health expenditures on a set of health care services through contributions, premiums, or taxes. The agency has the sole responsibility of managing the Kano State Contributory Healthcare Scheme. The vision of the agency is to provide universal health coverage for all residents of Kano State, while it functions to promote, regulate, and supervise the Kano State Contributory Healthcare Scheme and ensure its effective administration. The scheme began full operations with a take-off grant from the state government in 2017. Payroll deductions for formal public sector workers began in May 2018, with enrollees gaining access to care in June 2018.

FINANCING THE SCHEME

The scheme is financed primarily from government remittances, premium payments from the formal and informal sector, and donations from philanthropists and other donors. The law that established the SHIS states that the state government must remit at least 1 percent of the State Consolidated Revenue Fund to the KSCHMA to serve as an Equity Fund to cover vulnerable populations unable to pay premiums. This population would include the poor and socially excluded; pregnant women; children under five; people with disabilities; retirees; people with chronic medical conditions such as HIV, sickle cell anemia, and tuberculosis (TB); children in orphanages and rehabilitation homes; and internally displaced people. Although a standing order for monthly disbursements for the equity funding to the agency is in place, in practice the disbursements have been irregular. For instance, the agency has not received any disbursements for 2023.

The scheme receives federal funding through the BHCPF and additional state funding through the Kano State Health Trust Fund. Two percent of the fund's budget, about 2 million naira, is remitted monthly to the KSCHMA for covering vulnerable populations unable to pay premiums at 12,000 naira ($15.9) per person, same as the rate for the informal sector.

For formal sector deductions, the law also stipulates a fixed monthly deduction from salary for the formal sector: a minimum of 1,400 naira ($1.86) and maximum of 4,000 naira ($5.30), based on the pay grade of the worker. A process is ongoing to review the law to ensure the formal sector premium deductions reflect changes in staff salary.

Premium payments for the informal sector were set at 12,000 naira ($15.9) per annum per person, with a 10 percent discount applicable to a family of six or more. However, premium payments from the informal sector have remained very low, with less than 5.500 persons enrolled and poor penetration of health insurance.

Premiums for each of the population categories—vulnerable, formal, and informal sectors -- were actuarially determined.

ENROLLMENT (INCLUDING PLHIV)

Since the scheme started, just over 400,000 people have been enrolled, with 80 percent of enrollees from the formal public sector. The enrollment of the vulnerable populations, including PLHIV under the BHCPF, is done through a ward-based system. A ward is the basic unit of organization for primary health care delivery at the LGA level. So far, a total of 67,350 people have been enrolled under the BHCPF, while 20,500 have been enrolled under the state equity fund. The KSACA and the KSCHMA had worked collaboratively previously to enroll more than 554 PLHIV using funds from the BHCPF. Recently, KSCHMA approved the enrollment of an additional 200 vulnerable PLHIV under the BHCPF.

Although the BHCPF guidelines stipulate the use of the State Social Register for the identification of poor and vulnerable people in each state, the agency does not regard the register as a trustworthy document because of discrepancies in targeting, especially as regards the perceived socioeconomic status of certain persons registered in the State Social Register. Instead, the agency collaborates with the ward development committees to identify and enroll vulnerable members of the community.

However, the identification of vulnerable populations for enrollment into financial protection schemes without using the State Social Register is inefficient and puts these populations at a disadvantage, as they cannot access other non-health benefits such as cash transfers and empowerment opportunities that are available through the National Social Safety Net Program. This is because while KSCHMA does its targeting for health benefits (enrollment under financial risk protection schemes) through the ward development committees, the National Social Safety Net Coordinating Office (NASSCO) targets the beneficiaries for non-health benefits (cash transfers and economic empowerment interventions) using the State Social Register. Thus, those identified as poor and vulnerable PLHIV by the ward development committees may not necessarily be listed in the register. This challenge underscores the need to integrate both targeting strategies so that PLHIV can benefit from both health and non-health social benefits.

SCHEME BENEFIT PACKAGE, PROVIDER NETWORK, AND PAYMENT MECHANISMS

The current benefit package for the SHIS was adapted from the formal sector benefit package of the National Health Insurance Authority. However, with the passage into law of the new National Health Insurance Authority act, states are to align their benefit package with that of the Basic Minimum Package of Health Services (BMPHS) of the BHCPF, which has been set as the minimum standard benefit package for the country. The KSCHMA is in the process of aligning the state benefit package to the BMPHS in accordance with this new law. The HIV/AIDS services covered in the current benefit package include HIV prevention education; HIV

counseling and testing and referral at the primary level of care; baseline and follow-up laboratory investigations for chemistry and hematology; and treatment for opportunistic infections requiring admission at the secondary level of care.

Five hundred and thirteen health facilities are empaneled (381 primary health care centers, 40 secondary facilities, two tertiary facilities, and 90 private facilities). The KSCHMA receives claims from facilities for reimbursement for HIV testing services. However, the number of empaneled health facilities offering HIV testing services under the SHIS is unknown. Broadly, the scheme pays its providers through capitation for primary care services and fee-for-service for secondary care services using KSCHMA's prescribed payment tariffs, which providers contractually agree to. While the capitation fee for the state scheme is 400 naira per enrollee per month, it is 570 naira for the BHCPF per enrollee per month. Following a series of complaints from providers who view the capitation from the state scheme as grossly inadequate, and because enrollees see the poor service quality as being due to the low capitation fee, the agency is currently considering aligning its benefit package with that of the BMPHS, to increase the number of services provided.

PREVAILING GAPS AND BARRIERS TO HIV INTEGRATION AND EXPANSION OF COVERAGE

The integration of HIV services into SHIS requires enabling policy, strong leadership, sufficient and skilled human resources, access to commodities, strong community engagement, and financial resources.

Based on the landscape analysis, the following factors were identified as the barriers to the integration of HIV services into the SHIS:

Policy gap. While the country has developed the national blueprint for the integration of HIV services into SHISs, from which states are expected to develop their state-level roadmaps, Kano State has yet to develop its state-specific roadmap for HIV integration. In the absence of this, the resources, activities, targets, and timelines to move beyond the current stage of implementation remain unknown.

Unfavorable leadership disposition. Although KSCHMA admits that there have been discussions with the Global Fund and the World Health Organization for the inclusion of more TB and HIV services into the benefit package, the leadership of the agency generally believes that this will have a large and detrimental cost implication for the scheme at its current stage. An actuarial analysis is needed to determine the financial feasibility of HIV integration beyond the minimum package and to provide the basis for evidence-based advocacy.

Inadequate financial resources. The irregularity in the disbursement of the equity fund from the state government reduces the flow of funds available to the agency to carry out its mandate and hinders progress in the enrollment of vulnerable populations. The KSCHMA is also failing to maximize its revenue from other sources, which could potentially affect the financial viability of the SHIS. The agency has faced significant challenges in penetrating the informal sector and has not been able to sustain its demand-generation activities such as engagements with market associations and the organized private sector because it does not have a unit or staff dedicated to business development and marketing. Moreover, the flat deductions from the salaries of formal public sector employees mean that the agency cannot take advantage of increases in salaries from those who earn more to contribute more to the pool of funds.

Suboptimal service coverage and quality. While the KSCHMA has 513 empaneled facilities, the number of facilities that provide HIV testing, especially at the primary care level, is unknown.

In addition, the agency has no clearly defined process for determining the competence of health workers who carry out HIV testing, or for tracking the quality of HIV service delivery. There is a need to strengthen the collaboration between the KSCHMA, the KSACA, and the KSPHCMB on capacity strengthening and monitoring of the quality of empaneled facilities' HIV service delivery.

Inefficient, parallel targeting of vulnerable groups. The current mechanism for the identification of vulnerable PLHIV through the ward development committees is inefficient, often leading to the "crowding out" of the group, as they are not recognized as a distinct category but share the category of "chronic medical conditions" with other vulnerable people. It would require strengthening the communication and relationship between the ward development committees and the PLHIV community through NEPWHAN to promote the opportunities for improved and sustained participation of PLHIV in financial protection schemes.

Low service utilization. Use of services under the financial protection schemes can be influenced by enrollees' awareness of scheme benefits, quality of service provision, attitude of health care providers, facility waiting time, service availability, and travel time.

Although a few of the enrolled PLHIV described their user experience as "wonderful" because it included access to the health care service needed without out-of-pocket expenses, most of them relayed the difficulties they encountered in accessing care. This included inability to locate their name on the enrollee list in their facility of choice, long waiting time at the facilities, long travel time to facility, poor attitude of facility staff, lack of awareness of scheme benefits, and non-resolution of complaints even when these were reported through the KSCHMA complaints redress channels. These negative experiences may have affected service use by enrolled PLHIV and the decision of other PLHIV not to enroll even though they can afford to pay the premium. In addition, the agency did not track utilization data for the previously enrolled PLHIV, thus making it difficult to quantify the HIV services that had been rendered using domestic funds from the SHIS.

Data management. Although the agency has desk officers assigned to each empaneled facility who are responsible for the collection and transmission of data on service utilization, it does not track utilization data for PLHIV but claims this can be done if there is a demand. This means that the progress, if any, in HIV integration under KSCHMA is not being measured. This would make it difficult for the agency to course-correct or conduct its HIV integration activities in a sustainable manner. In addition, the agency says the data quality from the desk officers is poor; the agency has identified some capacity strengthening needs for this cadre of staff.

LANDSCAPE ANALYSIS OBJECTIVE 2: PRIORITIES AND OPPORTUNITIES FOR HIV INTEGRATION AND EXPANSION OF COVERAGE

Based on the identified barriers and gaps, the following priorities and opportunities are recommended for effective integration of HIV services into the SHIS in Kano State:

PRIORITIES

1. LHSS to support KSCHMA, KSACA, implementing partners and other relevant stakeholders to develop a state-specific roadmap for the integration of HIV/AIDS into the SHIS.
2. LHSS to collaborate and support the efforts of World Health Organization and Global Fund through the provision of data elements and technical guidance for the conduct of an

actuarial analysis to determine the incremental cost (if any) of integrating more HIV services into KSCHMA's benefit package.

3. LHSS in collaboration with other stakeholders to support KSCHMA in developing an informal sector strategy with a robust marketing plan and structure to boost informal sector enrollment.
4. In collaboration with KSACA, NEPWHAN, and KSCHMA, LHSS will support improved awareness and education of PLHIV on the benefits of enrollment in financial protection schemes.
5. LHSS will determine the number of already empaneled facilities providing HIV testing services, verify their capacity, and support KSCHMA in progressively increasing the number of health facilities offering HIV testing under the SHIS.
6. LHSS will support improved collaboration between the KSCHMA, the KSACA, and the KSPHCMB on capacity strengthening and monitoring of the quality of HIV service delivery by empaneled facilities.

OPPORTUNITIES

1. LHSS will leverage the ongoing discussion between KSCHMA, the World Health Organization, and the Global Fund for the inclusion of additional TB and HIV services in the state benefit package.
2. LHSS will support advocacy to high-level stakeholders in the executive and legislative arms of government, such as the executive governor, the House Committees on Health and Appropriation, the Ministry of Economic Planning and Budget, and the Ministry of Finance, for the statutory releases of the state equity fund.
3. LHSS will support advocacy for the ongoing review of the KSCHMA law and its revision to enable formal sector deductions to reflect variations and changes in staff salaries, including increases in salaries that should result in proportionate increases in premiums.
4. LHSS will strengthen the collaboration between the KSCHMA and State Operations Coordinating Unit to harmonize the strategies used in identifying vulnerable groups so that they can access other social protection programs apart from social health protection. This has the potential to enable them to exit vulnerability and become premium-paying members who contribute to the financial viability of the scheme.

LANDSCAPE ANALYSIS OBJECTIVE 3: KANO STATE PUBLIC FINANCIAL MANAGEMENT FOR HIV/AIDS

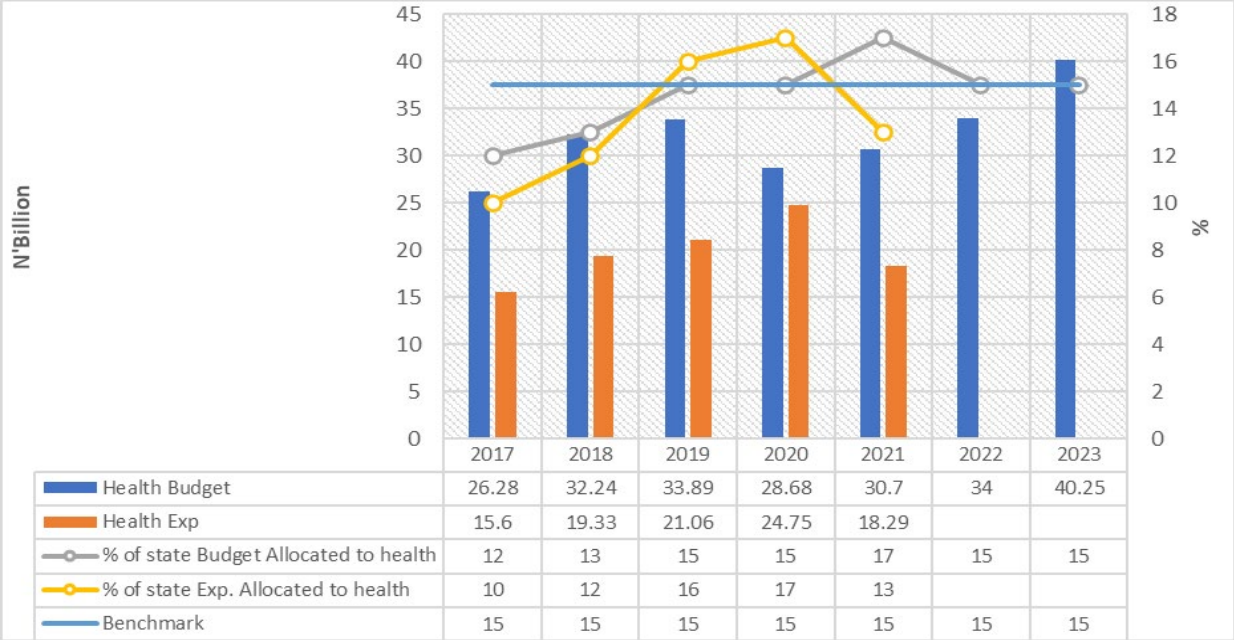
A good PFM system promotes fiscal discipline, optimizes allocation of public resources, and ensures efficient use of resources in the implementation of strategic priorities. This section presents the findings from the assessment of the PFM process, including the bottlenecks and the recommendations for an improved PFM system for HIV/AIDS.

STATE GOVERNMENT FUNDING FOR HEALTH AND HIV

The proportion of the Kano State budget allocated to health increased steadily from 10 percent of the total state budget in 2017 to 17 percent in 2021 and then dropped to 15 percent in 2022 and 2023 (Figure 1). Since 2019, the state budget allocation to health has been in alignment with the Abuja declaration, which set a target benchmark for African countries to allocate 15

percent of the annual budget to health. At the same time, health spending as a proportion of total state government expenditure consistently increased between 2017 and 2020, from 10 percent to 17 percent, almost mirroring the budget allocation proportions; it then dropped in 2021 to 13 percent at a time when state revenue declined due to the decreased budget allocation from the federal level.

Figure 1. State Budget Allocations and Expenditure



	2017	2018	2019	2020	2021	2022	2023
Health Budget	26.28	32.24	33.89	28.68	30.7	34	40.25
Health Exp	15.6	19.33	21.06	24.75	18.29		
% of state Budget Allocated to health	12	13	15	15	17	15	15
% of state Exp. Allocated to health	10	12	16	17	13		
Benchmark	15	15	15	15	15	15	15

Source: Kano Annual Approved Budgets 2017–2023; Kano Accountant General's Report 2017–2020; Kano State Medium-Term Expenditure Framework (MTEF)/Fiscal Strategy Paper (FSP) 2022–2024; Kano State 2021 Q4 Budget Performance Report.

To increase the fiscal allocation for health through the mobilization of more domestic resources, the state government established the Kano State Health Trust Fund in 2017 as an earmarked fund for health. The fund is to complement the budgetary provision for health in the state. As stipulated in the law, the funding sources for the fund include 5 percent of state internally generated revenue (average of 40-50 million naira per month); 1 percent of the 44 LGAs' statutory allocation; and other sources such as from partners (cash and in-kind), donations, grants, endowment funds, and support from corporate and private philanthropists. Currently, the only funding source that is operational is the state's internally generated revenue. However, plans are underway to ensure that funds are mobilized from the other approved sources, especially the 1 percent from the statutory allocation of the 44 LGAs. The Kano State Health Trust Fund also provides funds to the KSACA for HIV/AIDS interventions, such as empowerment programs and provision of test kits for the comprehensive centers.

Accumulated funds from various sources are designed to be shared as follows:

- 50 percent for public primary, secondary, and tertiary health facilities to support infrastructure development, procurement of drugs and medical consumables, and capacity strengthening of human resources for health
- 25 percent for public training institutions
- 10 percent for malaria and nutrition

- 5 percent for maternal and child health services (up to six weeks after delivery)
- 10 percent for other services:
  - 2 percent for the Kano State Health Trust Fund's operational expenses/supervision
  - 2 percent for the enrollment of vulnerable groups through the KSCHMA
  - 6 percent for chronic medical conditions such as HIV/AIDS, TB, and sickle cell disease

Because the law is not specific as to how the money should be allocated among "chronic medical conditions," the allocation is currently by request. However, the law is being reviewed to address this gap.

The state HIV/AIDS response is funded mainly by development partners, and to a lesser degree by the state government and the private sector (including corporate organizations and households). To determine the actual level of funding from each of these sources, a state AIDS spending assessment is necessary, but this assessment has never been conducted in Kano State.

KANO STATE HIV/AIDS BUDGETING PROCESS

Understanding the budget processes, the institutions involved, and the bottlenecks at each stage of the process will provide information to support evidence-based advocacy for improved allocation for HIV/AIDS interventions in Kano State. The HIV budget process includes planning, allocation, budget execution, and monitoring.

PLANNING AND ALLOCATION PROCESS

The state budget planning and allocation process is set out in Figure 2. The detailed description of the tasks, activities, and timelines can be found in Technical Appendix 1.

Figure 3 shows the trend of budgetary allocation (2017 to 2023) to the KSACA. The average budgetary allocation between 2017 and 2019 was 347 million naira, as the allocation increased from 332 million naira to 353 million naira (excluding personnel cost). However, it decreased in 2020 to 265 million naira, with further decreases in 2021 and 2022 to 215 million naira and 207 million naira, respectively. It increased in 2023 by 88 million naira (from 207 million naira to 295 million naira), representing a 43 percent increase in the 2023 budget. A further analysis showed that between 2017 and 2019, an average of 1.14 percent of the total health budget was allocated to the KSACA.

The assessment identified several bottlenecks in the budget planning and allocation process that affect the budget for HIV/AIDS spending, as set out in Table 1.

Figure 2. Budget Allocation Process Flow

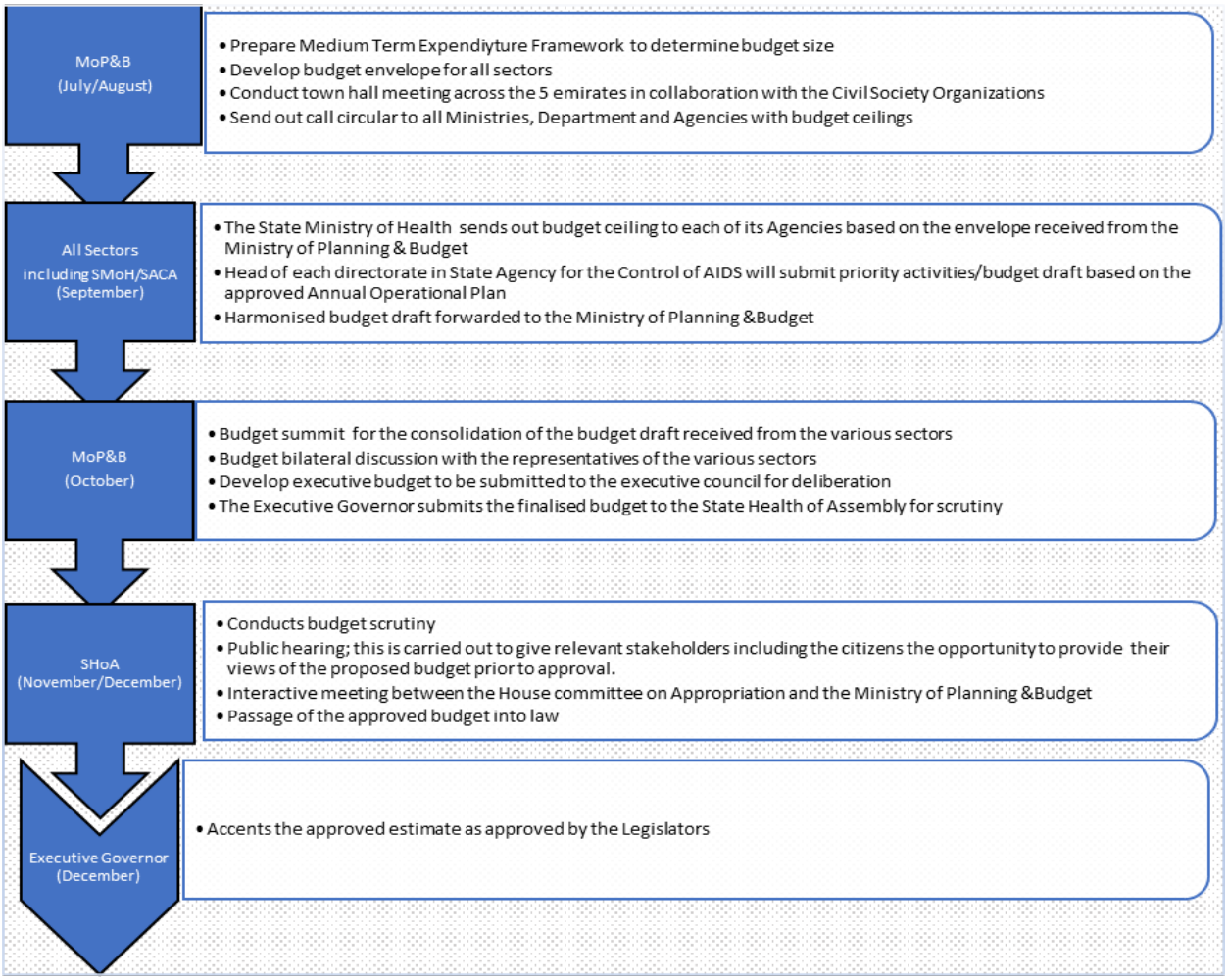
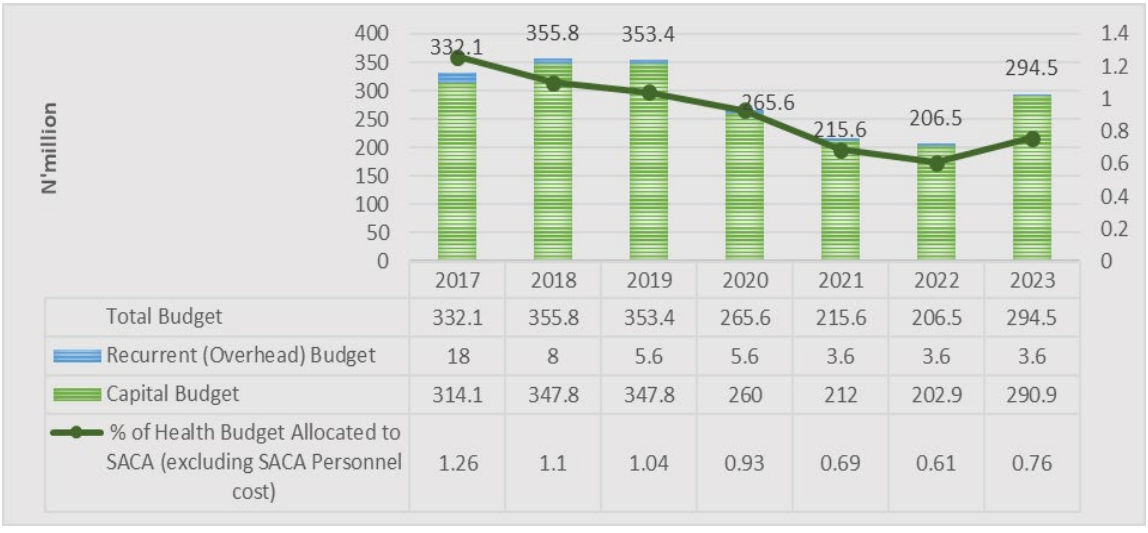


Figure 3. KSACA Budget Trend (2017–2023)



	2017	2018	2019	2020	2021	2022	2023
Total Budget	332.1	355.8	353.4	265.6	215.6	206.5	294.5
Recurrent (Overhead) Budget	18	8	5.6	5.6	3.6	3.6	3.6
Capital Budget	314.1	347.8	347.8	260	212	202.9	290.9
% of Health Budget Allocated to SACA (excluding SACA Personnel cost)	1.26	1.1	1.04	0.93	0.69	0.61	0.76

Source: Kano Annual Approved Budgets 2017–2023.

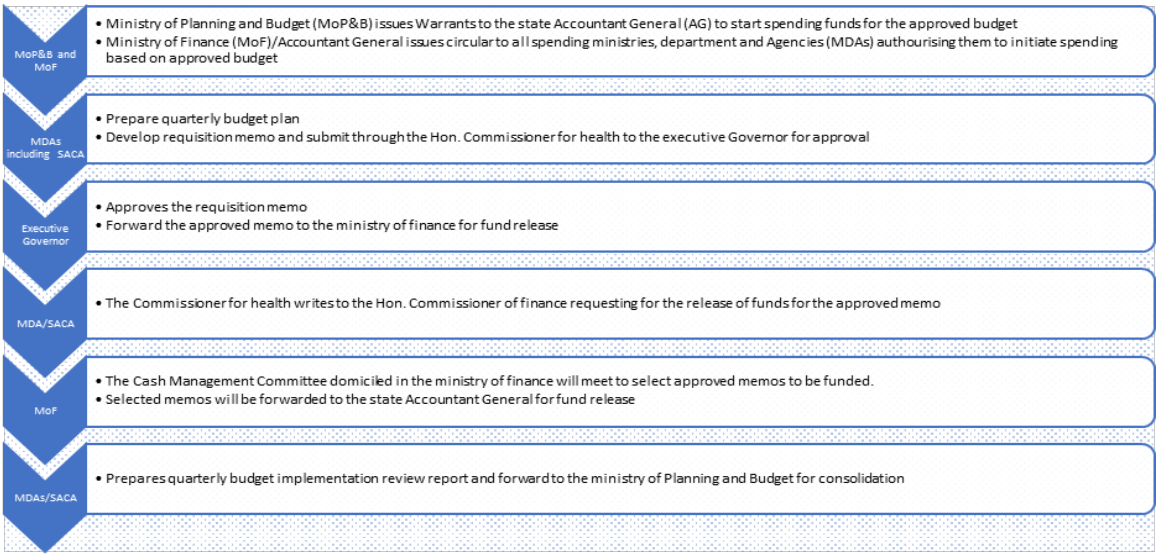
Table 1. Bottlenecks in the Budget Planning and Allocation Process

Bottlenecks	Recommendations
Misalignment between State government's budget priorities and KSACA's budget priorities.	KSACA to work closely with the Ministry of Planning and Budget to strengthen the capacity of their staff in understanding the state government's budget priorities and how to prepare KSACA's budget in line with that.
Low prioritization of HIV/AIDS services/KSACA budget.	KSACA to work with the Health Financing-TWG to develop evidence-based advocacy briefs for engaging relevant stakeholders such as the governor, the commissioner for health and the State House of Assembly members on the need to prioritize health and HIV/AIDS in the State.
The Ministry of Planning and Budget erroneously believes that HIV attracts sufficient donor funding. The ministry requires the KSACA to submit donor funding and grant reports for the determination of counterpart funding. However, the KSACA does not submit these reports, thus reinforcing this erroneous belief.	KSACA to consider conducting a state AIDS spending assessment in collaboration with its implementing partners to delineate the contributions for HIV financing from the various sources as well as identify the funding gaps. In addition, KSACA should prepare and submit detailed donor funding and grant reports as required to the Ministry of Planning and Budget and other relevant stakeholders.
Some domestic funding sources are not used optimally.	The KSACA should develop a multi-sectoral state-specific resource mobilization and sustainability strategy (, which would identify, prioritize, and optimize domestic funding sources. For instance, an increased percentage allocation from the Kano State Health Trust Fund to the KSACA would mean more funds for HIV.
Weak participation of HIV-focused CSOs such as NEPWHAN in the budget planning process. This is due to their poor understanding of how to align their budget demands with state budget priorities during the budget planning process.	LHSS could strengthen the capacity of NEPWHAN and other HIV-focused CSOs to improve their understanding of the state's budget priorities and how to properly align their demands and elevate their request through advocacy to high level stakeholders such as the office of the wife of the governor, SHOA, and others.

BUDGET RELEASE/EXECUTION PROCESS

The state budget release and execution process is set out in Figure 4. The detailed description of the tasks, activities, and timelines can be found in Annex A.

Figure 4. Budget Execution Process Flow



A review of the KSACA's budget and financial reports shows that although the agency receives memo approvals, the approved memos barely translate to fund release, despite consistent follow-up with the Ministry of Finance. Table 2 shows the low and declining level of releases as a proportion of allocations from 2017 to 2021.

Table 2. HIV/AIDS Budget Performance

Year	Appropriation	Release	Performance Percent
2017	332,069,400	5,000,000	1.5
2018	355,800,000	5,500,000	1.5
2019	353,400,000	5,442,000	1.5
2020	265,600,000	999,000	0.4
2021	215,625,000	500,000	0.2

Figure 5 shows actual expenditure for the KSACA between 2017 and 2021. The actual expenditure deviates significantly from the trends under budgetary allocation, as the budget performance has been suboptimal. Figure 5 shows that since 2017 there have been no releases for capital expenditure, with an almost constant amount released for overhead expenditure. The overhead expenditure increased marginally from 5 million naira in 2017 to 5.5 million naira and 5.4 million naira in 2018 and 2019, respectively. A drastic reduction was recorded in 2020, when the overhead expenditure was only 0.99 million naira.

Figure 5. KSACA Expenditure Trend (2017–2021)

Source: Kano Accountant General's Report 2017–2020; Kano State MTEF/FSP 2022–2024; Kano State 2021 Q4 Budget Performance Report.

Table 3. Bottlenecks in the Budget Execution Process

Bottlenecks	Recommendations
Lassitude in raising effective fund requisition memos from KSACA's annual budget.	LHSS to work with KSACA directors and program officers to strengthen their capacity on raising effective and timely fund requisition memos, as only funds that have been requested stand the chance of being approved.
Lack of active follow-up of submitted memos at the Ministry of Finance.	KSACA to designate staff and the state House of Assembly to follow up on approved fund requisition memos at the governor's office, the Ministry for Planning and Budget, and the Ministry of Finance to ensure timely releases. Consistent and persistent follow-up is required for approvals to translate into cash releases for activity implementation.

BUDGET MONITORING

The monitoring department of the Ministry of Planning and Budget is responsible for monitoring budget execution to ensure that the budget is being executed as planned. It is done in collaboration with the planning and monitoring unit of the KSACA using the results-based monitoring and evaluation framework and key performance indicators developed by the Ministry of Planning and Budget. A comprehensive activity monitoring report on results-based key performance indicators and outcome, output, and impact level is usually developed by the Ministry of Planning and Budget and presented to stakeholders at the mid-year and full year budget review meetings.

Although the agency is supposed to conduct quarterly budget performance and expenditure reviews with the review report submitted to the Ministry of Planning and Budget, the review reports are not developed due to weakness in basic PFM skills among KSACA staff. In addition, the review meetings are not regularly convened by the multi-sectoral Health Financing TWG, as they are not budgeted for by the health financing unit of the SMOH. As a result, the meeting is only convened when donors or implementing partners provide financial support.

To promote good governance and fiscal transparency, members of the State House of Assembly (SHOA) provide legislative oversight for the activities of the ministries, departments, and agencies, including the KSACA, as part of the budget monitoring process. However, it appears that the involvement of the legislators has been limited to the budget preparation phase, with minimal involvement in other activities in the budget cycle within the fiscal year.

Although the CSOs are involved in budget advocacy, analysis, and tracking for the health budget, there are no specific efforts directed at HIV budget advocacy. The CSOs interviewed pointed out the need for capacity strengthening for strong, civil society-led budget advocacy and monitoring.

Table 4. Bottlenecks in the Budget Monitoring Process

Bottlenecks	Recommendations
Lack of quarterly budget performance reports by KSACA.	LHSS will support KSACA to produce quarterly budget performance reports, which will be presented at the Health Financing TWG for peer review. LHSS will also support the Health Financing TWG to add a line item for the convening of the TWG meetings to their budget
Lack of active involvement of the SHOA regarding monitoring and evaluation of the KSACA budget implementation.	Partners to conduct a sensitization meeting with the relevant members of the SHOA to identify the cause of their non-involvement in budget monitoring activities for the KSACA. NEPWHAN, CSOs, and implementing partners to advocate to legislators on the need for improved budget execution for HIV response while emphasizing the link between legislative oversight and improved government expenditure as well as HIV epidemic control and socioeconomic development.
Inadequate capacity of HIV-focused CSOs to conduct budget tracking and monitoring.	Capacity strengthening for HIV-focused CSOs on budget tracking and monitoring.

LANDSCAPE ANALYSIS OBJECTIVE 4: ORGANIZATIONAL CAPACITY ASSESSMENT

Integration of HIV services into the SHIS potentially introduces new actors into the governance structure for HIV and key health roles and responsibilities. This section of the landscape analysis presents the report of the organizational capacity assessment conducted to determine the institutional capacities of KSACA, KSPHCMB, and KSCHMA as they relate to HIV integration. The findings from the assessment guided the development of an action plan that will enhance performance and impact. Therefore, this report also presents suggested interventions for organizational capacity development for each of the three state agencies.

METHODOLOGY

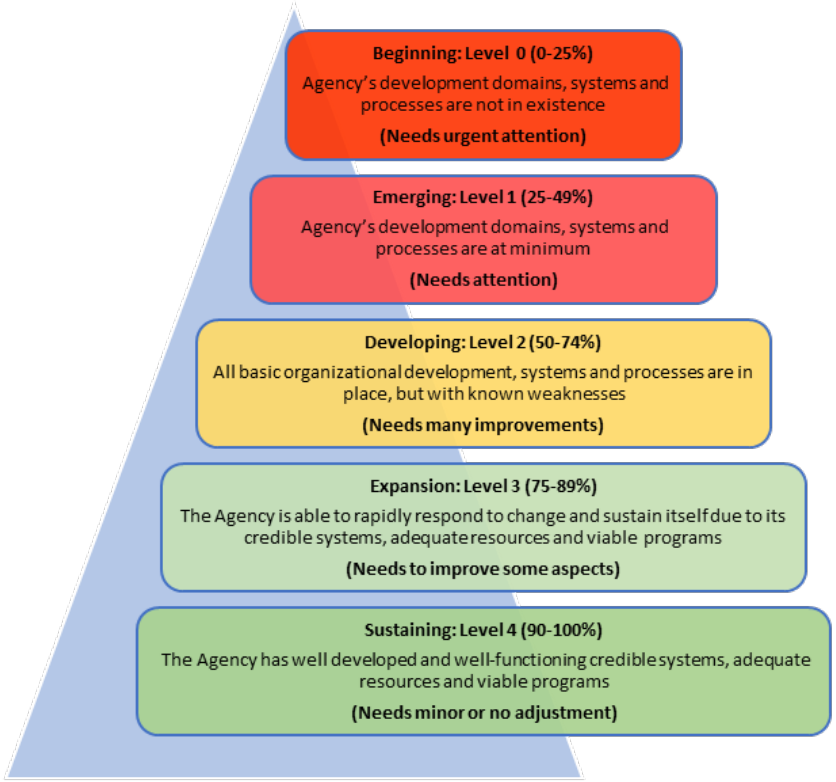
LHSS's self-assessment organizational capacity tool was adapted and used to collect relevant data through key informant interviews and focus group discussions. To ensure that varying views and opinions were considered, the data were collected from key technical staff involved in program management and implementation from each of the counterpart agencies.

The assessment questions included language that described performance at each level and rated it on a numeric scale. This method enabled respondents to think not just about the current practice or capacity but also about what "better" would look like.[5] Following each assessment, respondents received the results from their responses: a detailed summary sheet presenting the aggregate score for each domain; the total score expressed as a percentage; and an agency classification based on the overall percentage score.

The questions were divided into five areas as described below:

1. **Governance:** This area examined the structures and processes by which the agencies are directed, controlled, and held to account in order to operate effectively to achieve their missions. The agencies' mandate, structure, leadership, and accountability and coordination mechanisms were discussed.
2. **Human Resources:** This area assessed how the agencies organize staff and measure performance, and their recruitment policies regarding gender equality and social inclusion (GESI).
3. **Service Delivery:** This area related to policy, strategy and planning, implementation, and technical capacity.
4. **Resource Mobilization:** This area covered issues relating to financial management and resource mobilization
5. **Health Management Information System:** This area covered data collection, data validation and analysis, and use of data for decision making.

Figure 6. Organizational Capacity Scoring Chart



Adapted from Capable Partners Program Botswana: FHI360 Organizational Capacity Assessment. *https://hewlett.org/wp-content/uploads/2017/11/A-Guide-to-Using-OCA-Tools.pdf*

FINDINGS

KANO STATE AGENCY FOR THE CONTROL OF AIDS

Table 5. KSACA: Summary of Findings from the Organizational Capacity Assessment

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
1	**Organizational mandate**	**75**	There is a written vision and mission statement that is relevant to the provision of HIV/AIDS services. It is widely known among staff at various levels.	The vision and mission statement is not always displayed in a strategic location for reference.
2	**Organizational structure/ governance**	**70**	The agency has a well-defined organogram, which is fully implemented. Roles and responsibilities of various units and staff are defined and adequately communicated. There is a formal staff performance evaluation system, which is sometimes followed (Annual Performance Evaluation Report). By design, this should be done annually, but the assessment is only carried out every three years, as part of the staff promotion process.	The organogram is not currently displayed in strategic location. Roles and responsibilities are not documented. There is no policy specifically for GESI. No standard operating procedures and technical guidelines have been developed in the state; staff occasionally refer to national implementation guidelines.

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
3	**Capacity**	**58.33**	The agency staffing level is almost adequate, especially with the current level of funding; there may be a need for additional staff if the funding level improves considerably. The agency has ample technical capacity to plan, implement, and monitor and track its activities, which has been acknowledged in different for a The agency's planning unit designed a tracker to monitor program implementation.	The tracker is not used for program implementation monitoring as it is not updated regularly.
4	**Policy, strategy, and planning**	**68.75**	The state has an active strategic plan (2021–2025), which was developed in collaboration with the National Agency for the Control of AIDS. The strategic plan aligns with the national plan, though with small deviations to respond to state context. The strategic plan is used to develop the Annual Operational Plan, which guides activity implementation. The agency plans to conduct a mid-term review and will require technical assistance for the process.	Agency staff have insufficient technical skills to conduct mid-term review.
5	**Leadership and management**	**73**	The leadership has been effective and supportive despite the paucity of funds. Collaboration, learning, and adaptation processes have been developed and are operational; monthly update meetings are held for both senior management teams (SMTs) and mid-level staff. This platform provides the opportunity for peer learning and capacity building.	There is no established plan for SMT capacity development, although the SMT usually attends an annual retreat and selected structured trainings in the course of the year.
6	**Accountability and oversight**	**25**	There is no documented accountability mechanism. By design, the SMOH is expected to monitor and supervise the agency but has been weak in performing this function. The oversight role of SHOA to the agency has been weak.	No documented accountability mechanism. Weak oversight support from the SHOA.
7	**Communication with stakeholders**	**68**	The agency has a multi-sectorial TWG, with well-defined terms of reference for the coordination of the HIV/AIDS program. TWG meetings are not held regularly.	The agency has no budgetary provision for the activities of TWG. TWG meetings are often held at the instance of implementing partners who provide logistical support.
8	**Donor coordination**	**62.50**	Mechanisms for engaging and coordinating donors' support have been established and are operational. The first donor coordination meeting for the agency was held recently with support from a USAID-implementing partner, GGHN	Skills to engage, coordinate, and communicate with stakeholders are weak.

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
9	**Financial management**	**56.74**	Quarterly budget review meetings are not usually held.	Cash flow projection is not usually developed due to poor budgetary release with uncertainty around inflow.
10	**Resource mobilization**	**16.67**	The agency does not have a resource mobilization strategy. Currently, the agency is working with an implementing partner to commence the development of the strategy.	Lack of technical and financial capacity to develop the resource mobilization strategy.
11	**Data management**	**60.33**	There is a functional health management information system with some capacity to collect data, conduct routine health management information system data review, analyze the cleaned data, and influence decision-making with findings. There is also some capacity to develop protocols for health research and surveys.	Except for the director, the planning unit staff lack the capacity to develop summary reports and advocacy briefs using insights from data analysis.
	Overall Score	**57.67%**	The agency has in place basic organizational development systems and processes, but with known weaknesses.	The agency has an effective and supportive leadership but lacks the technical capacity to institute the system improvements required.

KANO STATE CONTRIBUTORY HEALTH SCHEME

Table 6. KSCHMA: Summary of Findings from the Organizational Capacity Assessment

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
1	**Organizational mandate**	**100**	There is a clear written vision and mission, widely known and relevant to the mandate of promoting, regulating, supervising, and ensuring the effective administration of the contributory health care scheme in the State.	
2	**Organizational structure/ governance**	**100**	Organizational structure is defined and fully implemented	
3	**Capacity**	**79.17**	The staffing level is sufficient; most technical staff have a moderate capacity to plan, implement, and monitor their activities. Staff are provided with requisite standard operating procedures and technical guidelines, which are consistently adhered to by all.	The agency has no dedicated business development and marketing unit for engaging the informal/private sector
4	**Strategy and planning**	**100**	The activity of the Agency is guided by an approved strategic and operational plan. The strategic plan is aligned with the current national strategy without any significant deviation.	

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
5	**Leadership and management**	**85**	Leadership is very effective at setting direction and motivating staff. Roles and responsibilities of individuals and sub-units are defined and implemented. All staff are formally evaluated annually against approved KPIs.	Collaboration, learning and adaptation processes have been developed but are not operational.
	Gender equality and social inclusion	**50**	In terms of service delivery, a policy and regulations exist that affirm the rights of women and other socially excluded groups. The policy has been communicated and is well-understood and consistently adhered to by all staff.	GESI practices and functions are not defined for staff recruitment.
6	**Accountability and oversight**	**100**	Accountability structures are documented and understood to ensure accountability.	
7	**Communication with stakeholders**	**68**	The capacity to engage, coordinate, and communicate with stakeholders is modest.	The agency does not have a communication strategy.
8	**Donor coordination**	**62.5**	Mechanisms for engaging and coordinating donor support are currently not in place but the process to establish them has begun.	Weak mechanisms for engaging and coordinating donors' support
9	**Financial management**	**87.5**	Appropriate financial policies and procedures are in place with systematic means of monitoring adherence.	
10	**Resource mobilization**	**41.67**	The Agency's approved budget is not usually adequate to execute planned activities. There exists modest skill to conduct advocacy to policy makers. The Agency is in the process of developing a resource mobilization strategy.	Weak technical capacity to develop and implement a resource mobilization strategy.
11	**Data management**	**58.33**	There is a functional online, real-time dashboard but it does not capture all indicators. Data collected are routinely analyzed and summary reports are developed detailing insights from the analysis. Agency management has been able to influence key decisions/policies in the state using evidence generated by the M&E team.	Online, real-time dashboard does not capture all necessary indicators and it is not reviewed regularly for possible upgrades.
	Overall Score	**84.74%**	The Agency can rapidly respond to change and sustain itself due to its credible systems and adequate resources.	The Agency has weakly defined processes for GESI, resource mobilization, and data management and needs to improve these aspects

KSPHCMB

Table 7. KSPHCMB Summary of Findings from the Organizational Capacity Assessment

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
1	**Organizational mandate**	**100**	There is a clearly written vision and mission statement that is relevant to the mandate of promoting, regulating, supervising, and ensuring the effective administration of the primary health care scheme. It is widely known among staff at various levels, and they refer to it regularly. It is displayed in a conspicuous location around the board.	
2	**Organizational structure/ governance**	**70**	Organizational structure is defined and fully implemented. The current one was developed in 2012 and the agency is planning to review it in view of the expanded scope of the agency. Roles and responsibilities of staff and sub-units are defined and implemented as designed; they have been communicated adequately to all concerned. The job duties are linked with those created at the national level and modified to suit the state context. Although there is no known GESI policy, it was emphasized that primary health care is a comprehensive program where no one is left behind due to age, gender, social status, ability, or disability.	Lack of technical and financial capacity to develop its organizational guideline. There is no known law or policy for GESI.
3	**Capacity**	**54.17**	Technical capacity at the board level is considered sufficient, though not optimal, to plan, manage, and monitor its own activities. However, there is low technical capacity at the facility level. Staff are provided with appropriate standard operating procedures and technical guides for reference purposes; however, the staff hardly adhere to the guidelines, in part because some of the standard operating procedures are outdated and yet to be reviewed. Activity tracking system exists but is weak and is not used regularly.	Weak capacity at the facility level. There is low adherence to standard operating procedures and technical guidelines, and the guidelines are not usually reviewed. Activity trackers are not used as required.
4	**Policy, strategy, and planning**	**81.25**	The board is currently developing the eight-year primary health care strategic plan for the first time. (The KSPHCMB has always used the State Strategic Health Development Plan.) The new primary health care strategic plan is at the costing stage and will be finalized and validated soon. The strategic plan is aligned with the national strategy. The specific elements it responds to are clearly stated. The Annual Operational Plan is usually developed and used to guide activities. All known national policies have been adapted to the state level where applicable.	The state has not been able to operationalize task shifting and task sharing because of the capacity gap.

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
5	**Leadership and management**	75	Leadership is highly effective at setting direction and motivating staff. There is no established plan for SMT capacity development. However, the senior and middle-level staff are trained in brown bag sessions, during which trainers are invited to discuss selected relevant topics to broaden the knowledge of staff.	The SMT has no structured capacity development plan.
6	**Accountability and oversight**	25	A structure to provide oversight exists but is not well documented, well understood, or followed. Direct supervision is consistent and effective as a means of holding staff accountable. The CSOs and the ward development committee members are actively involved, especially for the implementation of BHCPF. Other programs, however, do not have an active accountability and oversight system.	Accountability mechanism and structure to provide oversight are not documented.
7	**Communication with stakeholders**	100	The agency has established multi-sectorial coordination platforms such as TWGs with well-defined terms of reference to effectively coordinate HIV/AIDS programs. Members of the TWGs meet regularly and engage in problem solving on HIV/AIDS issues and follow up on agreed action points. Three TWGs exist: monitoring and evaluation, health financing, and primary health care. The primary health care TWG oversees all the agency's activities as well as those of other TWGs. The executive secretary chairs the primary health care TWG.	
8	**Donor coordination**	25	The SMOH and the agency coordinate the activities of donors and partners working in primary health care. The agency keeps partner profiles, including details of team lead, contact, and thematic area. The donor coordination meetings are held irregularly due to inadequate funds. Partners often miss the meetings because of competing priorities and may not report their activities to the agency.	Inadequate financial resources for effective donor coordination. Failure of partners to report activities to the agency.

S/N	DOMAIN	SCORE (%)	FINDINGS	GAP
9	**Fiscal management**	**35**	The facilities usually prepare a quarterly business plan, and projections are made based on revenue and expenditure trends. The appropriate financial policies have been communicated to staff. The staff were trained and are generally adhering to them, but there is weak enforcement. The state did not receive direct facility financing disbursements for two quarters in 2022 due to failure of facilities to retire funds as required by the guidelines. Budgetary allocation and releases are poor, leading to non-execution of planned activities. Most facilities rely heavily on donor support with very minimal contribution from the government. The BHCPF facilities receive additional support from the state equity fund and the two BHCPF gateways.	The facility has a weak capacity for facility fund management. The account clerks attached to the facilities need refresher training and mentoring to provide better support to facility fund managers.
10	**Data management**	**33**	Data collection is paper based. Data is validated at the facility level using registers and summary sheets to ensure accuracy and completeness. A facility data review meeting with all units is conducted at the end of the month. Thereafter, the paper records are taken to the LGA for entry into the DHIS. The final data quality assessment and validation is done using the DHIS tool. However, the monitoring and evaluation officers often fail to do this validation. The agency conducts data validation quarterly instead of monthly. Data analysis is usually done both at the facility level and at the agency. However, facility reports are not written to highlight the findings from the data. The agency uses the findings for decision making, capacity strengthening, and strategy development through management meetings and other coordination platforms.	Lack of refresher training following the upgrade of the DHIS. Report and briefs development.
	Overall Score	**58%**	The agency has basic organizational development, systems and processes but with known weaknesses.	The agency has weak technical and financial management capacity at the facility level, and poor use of data for decision making and data presentation. The agency would need to initiate improvements in many areas.

CONCLUSION AND RECOMMENDATIONS

Kano State has made progress in implementing its state-supported health insurance scheme, with visible efforts to enroll the PLHIV into the social health protection scheme. A review of the SHIS benefit package found that some HIV services are covered in the state health insurance benefit package, including HIV prevention education; HIV counseling and testing and referral at the primary level of care; baseline and follow-up laboratory investigations for chemistry and hematology; and treatment for opportunistic infections requiring admission at the secondary level of care.

Identified barriers to integrating and operationalizing HIV services in the state include the lack of a state-specific HIV integration roadmap, the perceived high cost of fully integrated HIV services, inadequate financial resources, suboptimal service coverage and quality, and low service utilization. Based on these barriers, some of the priority interventions to be considered for implementation include the following:

- Development of a state-specific HIV/AIDS integration roadmap
- Conduct of actuarial analysis to determine the incremental cost of integrating HIV/AIDS services into the state benefit package
- Development of informal sector demand strategy to boost informal sector enrollment
- High-level advocacy for the statutory release of the state equity fund
- Increased involvement and representation of PLHIV in KSCHMA's enrollment activities
- Improved collaboration between the KSCHMA, KSACA, and the KPHCMB for improved quality of service

The HIV response in Kano State is financed primarily by international donors. Although the state government should provide funding to the state HIV agency KSACA, a review of the state expenditure on HIV found that the agency has had inadequate budgetary allocation and an extremely low budget execution rate. Some of the PFM bottlenecks for budgetary allocation include low prioritization of HIV/AIDS in the health sector budget, lack of a resource mobilization plan for HIV/AIDS, and misalignment between the state government's budget priorities and SACA's budget priorities. For budget execution, bottlenecks include lassitude in raising effective fund requisition memos from KSACA's annual budget and lack of active follow-up of submitted memos at the Ministry of Finance. For budget monitoring, bottlenecks include lack of quarterly budget performance reports by KSACA, lack of active involvement of the State House of Assembly regarding monitoring of budget implementation, and inadequate capacity of HIV-focused CSOs to conduct budget tracking and monitoring.

To mitigate the identified PFM bottlenecks, the recommended actions to improve government funding for HIV/AIDS programs include the following:

- Strengthening the PFM skills of KSACA staff across the budget cycle
- Supporting the Health Financing TWG and HIV-focused CSOs to develop evidence-based PFM advocacy briefs and conduct high level PFM advocacy to relevant stakeholders
- Supporting KSACA to develop a multi-sectoral, state-specific resource mobilization and sustainability strategy to identify, prioritize, and optimize domestic funding sources

- Supporting KSACA to produce quarterly budget performance reports
- Strengthening the capacity of HIV focused CSOs on budget monitoring

The organizational capacity assessment conducted for the three agencies shows they have effective leadership and a good policy environment. However, gaps in capacity persist, especially with respect to stakeholder coordination, gender equality and social inclusion, resource mobilization, activity tracking, and data management.

Specifically, KSACA was found to lack the capacity to develop a resource mobilization strategy and the technical capacity to institute the other system improvements required. KSCHMA was found to have weakly defined processes for enrollment expansion, especially for the informal sector, while KSPHCMB had weak technical and financial management capacity, especially at the facility level.

The following capacity development plan is recommended for consideration to bridge the identified capacity and operational gaps.

Table 8. Recommended Interventions for Capacity Development

S/N	DOMAIN	Recommended Intervention	Responsible Agency
1	**Capacity**	Train facility staff on task shifting and task sharing.	KSPHCMB
		Provide refresher training for the LGA monitoring and evaluation staff on effective use of the DHIS.	
		Review of the report of the capacity assessment supported by technical assistance connect to identify training needs for possible support.	
2	**Policy, strategy, and planning**	Engage and sensitize stakeholders on GESI (e.g., SHOA, commissioner, directors, CSO, ward development committees, Ministry of Planning and Budget, Ministry of Finance).	SMOH/KSPHCMB/KSACA
		Provide technical assistance for the adoption of national standard operating procedures and technical guidelines.	KSACA
		Provide technical assistance to conduct mid-term review of the agency's strategic plan.	
		Provide technical assistance for the development and production of organizational guidelines.	KSPHCMB
3	**Accountability and oversight**	Provide support to develop and institutionalize accountability framework.	SMOH/KSPHCMB/KSACA
		Provide capacity building of relevant members of the SHOA on health financing and oversight role. Also help the state develop its legislative agenda on health and HIV/AIDS.	
4	**Communication with stakeholders, and donor coordination**	Provide technical assistance and logistics support for TWG meetings.	KSACA
		Train TWG members and relevant officials of the KSACA on donor coordination, budget tracking, presentation of data, and use of data for evidence-based decision making and advocacy.	
5	**Fiscal management**	Train relevant facilities staff on financial management process with three months mentoring period (based on the National Primary Health Care Development Agency facility and financial management plan).	KSPHCMB
6	**Resource mobilization**	Collaborate with Solina to develop and institutionalize the resource mobilization strategy.	KSACA

S/N	DOMAIN	Recommended Intervention	Responsible Agency
7	**PLHIV enrollment and service utilization tracking**	Promote continuous engagement of the leadership of the state ward development committees and the NEPWHAN to ensure enrollment of PLHIV. Engage one focal person per LGA to track enrollment and utilization. This should be done in close collaboration with the NEPWHAN.	KSACA
8	**Informal sector engagement and enrollment**	Support the development and operationalization of informal sector engagement strategy. Support study tour of KSCHMA officials to Lagos to observe the working strategy in place in the state.	KSCHMA

ANNEX A: KANO STATE BUDGET PROCESSES

1. Kano State Budget Planning and Allocation Process

- **July:** Following the mid-year budget review, the Ministry of Planning and Budget prepares the state budget using the Medium-Term Expenditure Framework (MTEF) and the Fiscal Strategy Paper to determine the resources available. Then the budget envelope or ceiling for each sector is set as influenced by the state's expenditure priorities and the sector's absorptive capacity (proportion of expenditure relative to budget) from its previous year's performance. The Ministry of Planning and Budget collaborates with relevant civil society organizations to conduct the town hall meetings in each of the five emirates (traditional administrative divisions composed of local government areas) of the state to gather citizens' input and elicit citizens' priorities for the state budget. The Ministry of Planning and Budget aggregates the demands, analyzes the data, and produces a report, the "citizens' budget," which is disseminated to line ministries to take into consideration when developing their draft budget. This process is in line with best practice to increase transparency, accountability, and citizens' involvement in the budget process.
- **August:** The Ministry of Planning and Budget sends out the budget call circular, which is a request for submission of the revenue and expenditure estimates for the next financial year from ministries, departments, and agencies (MDAs), consistent with priorities set out in the MTEF. The call circular for each sector contains the sector's budget envelope or ceiling. Each sector's budget envelope is determined by factors such as the state revenue projection, the state government's priority for the proposed year, and the sector's previous year budget performance. MDAs draft and submit their budget proposals based on their priorities and the budget ceiling from their budget departments. The MDAs have between 30 and 35 days upon receipt of the call circular to submit their budget draft. The SMOH shares its budget envelope among all its MDAs, including the KSACA; the size of the KSACA's budget is determined largely by the health sector's budget envelope. Nonetheless, MDAs can exceed their budget ceiling if they provide a strong justification. On receipt of its budget envelope from the SMOH, each unit of the KSACA submits its budget draft based on the approved activities contained in the agency's Annual Operational Plan. The Annual Operational Plan outlines relevant activities and resource requirements with timelines necessary to achieve the agency's strategic objectives. The budget draft is collated by the planning unit of the KSACA and submitted to the SMOH for onward submission and approval by the Ministry of Planning and Budget.
- **October:** The budget proposals received from the various MDAs are consolidated and finalized in a budget summit. The MDAs are then invited to defend their submissions; the budget estimates can be either increased or reduced during the defense session. Following the budget defense sessions, the Ministry of Planning and Budget develops the executive budget and forwards it to the state executive council for deliberations after taking into consideration issues and resolutions from the defense. Then the executive governor presents a draft budget to the state legislators at the State House of Assembly (SHOA).
- **November/December:** The SHOA legislators scrutinize the budget and conduct public hearings and interactive meetings on the appropriations bill with all stakeholders, including citizens, the House Committee on Appropriation, and the Ministry of Planning and Budget. The SHOA has the power to add or remove any project or activity from the draft budget, thereby increasing or decreasing the total budget estimate. The SHOA is expected to pass the budget into law by the second week of December at the latest.

- **December:** The governor assents to the approved budget estimate and signs the bill into law by December 31.

As stated in the Kano State Public Financial Management Law (2020), when it becomes necessary in any financial year to change (increase or reduce) an already approved budget, proposals for a supplementary budget will be presented to the SHOA seeking approval for the required adjustment.

2. Kano State Budget Release and Execution process

Budget execution starts with the issuance of warrants (authority to spend) to the state accountant general, which will be certified by the Ministry of Justice and approved by the executive governor. This instrument authorizes the accountant general to start spending public funds within the stipulation of the approved legislative budget of the year.[6] Upon receipt of a general warrant to incur expenditure, the accountant general will issue a circular to all spending MDAs authorizing them to initiate spending based on the approved budget.

The fund release process is initiated by the development of a quarterly plan based on priority activities of the agency. Based on the plan, the responsible officer will develop and submit fund requisition memos to the honorable commissioner for health, the executive governor, or any other relevant approving authority depending on the approval threshold for the office. Table 9 shows the approval threshold for each approving authority.

Table 9. Approval Threshold for Requisition Memos

S/N	Threshold	Approving Authority
1	< 5 million naira	Honorable commissioner
2	5 million–50 million naira	Executive governor
3	> 50 million naira	Executive Council

Approved requisition memos are forwarded to the Ministry of Finance for fund release, with the commissioner for health writing to the commissioner of finance to request the release of funds. Because of competing government priorities amid limited funds and other exigencies, the cash management committee of the Ministry of Finance meets to reprioritize the approved requisition memos to be funded. Often, this reprioritization favors infrastructure management and revenue generating agencies, to the detriment of health agencies, which are perceived as spending entities only. In fact, this reprioritization at the level of the cash management committee is adjudged to be responsible for most of the delays in fund releases, or non-cash backing of approved memos.

Memos selected by the cash management committee are forwarded to the state treasury /accountant general's office for cash backing.

[6] Kano State Government: 2022 Debt Sustainability Analysis & Debt Management Strategy (DSA-DMS) Report.