ENUGU STATE GOVERNMENT

Ministry of Health

Ministry of Budget and Planning

Enugu State Primary Health Care Development Agency

GUIDELINES FOR PRIMARY HEALTH CARE BUDGET PREPARATION AND CONSOLIDATED WORK PLANNING

2026 Edition

Applicable to the 2027 budget cycle and to the consolidated work plan for the 2026 financial year

Issued under the authority of the Honourable Commissioner for Health
in concurrence with the Honourable Commissioner for Budget and Planning

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Foreword

Enugu State has made the commitment to provide quality healthcare to her citizens in the spirit of Universal Health Coverage. This administration undertook to place a functional, equipped and staffed health facility within reach of every one of the 260 wards of the State, and it has invested at scale to that end. The construction and refurbishment of the ward level network is well advanced. What determines whether that investment becomes health care rather than infrastructure is whether the recurrent cost of running those facilities, staffing them, supplying them and supervising them, is planned for accurately and provided for annually. That is precisely what these Guidelines exist to secure.

This 2026 Edition supersedes the guidance issued in March 2025 and strengthens it in three respects. It corrects the descriptive record of the State's primary health care estate so that planning proceeds from verified figures rather than from inherited ones. It introduces a transparent scoring framework for the prioritization of capital projects, so that the ranking of competing proposals can be explained and defended rather than merely asserted. And it requires, for the first time, that every proposal carrying a personnel implication be costed against the established workforce position of the Agency, so that the State does not build facilities it has not budgeted to staff.

We draw the attention of every accounting officer in the health sector to one requirement in particular. No item may be proposed in an annual budget, and no item may be implemented during a financial year, unless it appears in the Consolidated Primary Health Care Work Plan prepared under these Guidelines. That rule is not administrative preference. It is the instrument by which duplication between the Ministry, the Agency, the Local Government Health Authorities and our partners is eliminated, and by which the State can state with confidence what it is spending on primary health care and to what effect.

We commend the Ministry of Budget and Planning, the Ministry of Finance and Economic Development, the Enugu State Primary Health Care Development Agency and the Local Government Health Authorities for the collaboration that produced this document. We recommend that these Guidelines be applied accordingly to improve healthcare delivery in our State.

This is in keeping with the priority that this Government places on quality Healthcare of our people.

Prof. George Ugwu.
Honourable Commissioner for Health
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Preface

These Guidelines provide a step by step framework for the preparation, consolidation, execution and review of the primary health care budget of Enugu State. They are addressed to every Ministry, Department and Agency whose mandate touches primary health care service delivery, and to the Local Government Health Authorities through which the greater part of that service is actually delivered.

Primary health care is a subsector within the wider health sector, and several institutions contribute to its objectives. That distribution of mandate is a strength when it is coordinated and a weakness when it is not. Without a single consolidated work plan, the same borehole is budgeted twice, the same training is financed by two agencies and a partner, and the State cannot state with confidence what it spends on primary health care in a given year. These Guidelines exist to close that gap.

These Guidelines shall

1. Support sector wide coordination in planning and budgeting, so that programme implementation in the primary health care subsector proceeds from a single agreed plan.
2. Promote fiscal discipline, ensuring that resources are allocated within approved ceilings and applied to activities with defined outputs.
3. Strengthen monitoring, evaluation and accountability in the delivery of primary health care services.
4. Ensure that the recurrent consequences of capital investment, above all the cost of staffing new and upgraded facilities, are recognised at the point of investment rather than discovered afterwards.

These Guidelines shall be used to

1. Guide the preparation of the annual primary health care budget proposal of every relevant Ministry, Department and Agency.
2. Guide the preparation of a comprehensive Consolidated Primary Health Care Work Plan integrating all programmes and projects related to primary health care in the State budget.
3. Ensure alignment with the Enugu State Development Plan, the Health Sector Medium Term Sector Strategy and the Annual Operational Plan, so that policy, plan and budget remain in a single line of sight.
4. Ensure that primary health care budgets are prepared within the envelope and ceilings communicated for the subsector.
5. Ensure compliance with the six segments of the Enugu State Chart of Accounts, which is aligned to the National Chart of Accounts.

6. Capture all primary health care recurrent costs, including the cost of frontline workers, salaries by cadre, allowances and recruitment expenses, specifying in each case whether the State Government or the Local Government Council bears the charge.
7. Identify and prioritise capital investment against published criteria and a transparent scoring framework.
8. Provide geographic coding for every capital project using the location segment of the Chart of Accounts, and ensure adherence to costing standards and to physical and fiscal reporting requirements.
9. Establish the timing of each activity, so that cash planning and the Annual Operational Plan can be prepared once the budget is approved.

All relevant Ministries, Departments and Agencies of the Enugu State Government are hereby required to adopt these Guidelines in preparing their annual budget proposals and Annual Operational Plans, and in preparing and submitting their work plans for consolidation.

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Executive Secretary and Chief Executive Officer
Enugu State Primary Health Care Development Agency

List of Acronyms

Acronym	Meaning
AOP	Annual Operational Plan
APR	Agency Performance Review
BCC	Budget Call Circular
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
CHEW	Community Health Extension Worker
CSO	Civil Society Organisation
DFF	Direct Facility Financing
DHIS2	District Health Information Software, version 2
EFU	Economic and Fiscal Update
ENSACA	Enugu State Agency for the Control of AIDS
ENSPHCDA	Enugu State Primary Health Care Development Agency
EXCO	State Executive Council
FSP	Fiscal Strategy Paper
HMB	Hospitals Management Board
IPSAS	International Public Sector Accounting Standards
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
LGC	Local Government Council
LGHA	Local Government Health Authority
MDA	Ministry, Department or Agency
MoBP	Ministry of Budget and Planning
MoFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategy
NCoA	National Chart of Accounts
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
SDP	Enugu State Development Plan
SHoA	Enugu State House of Assembly
SPR	Sector Performance Review
UHC	Universal Health Coverage

Acronym	Meaning
WDC	Ward Development Committee

How to use these Guidelines

These Guidelines are written to be used at specific points in the year rather than read continuously. The table below directs each category of user to the chapters that govern their work.

Table 1: Guide to use by role and by point in the budget cycle

If you are	And you are	Read
An accounting officer of a health sector MDA	Preparing an annual budget proposal	Chapters 3 and 4, and Annexures 2 to 5
A planning or budget officer	Prioritising and costing capital projects	Chapter 5 and Annexures 2, 3 and 4
A Local Government Health Authority Secretary	Preparing ward and facility level activity plans for consolidation	Chapter 3.6, Chapter 6 and Annexe 6
A procurement officer	Preparing the annual procurement plan	Chapter 6.3
A finance or accounts officer	Recording and reporting expenditure	Chapter 6.5 and Annexe 7
A monitoring and evaluation officer	Preparing performance reports and reviews	Chapter 7 and Annexe 7
Any officer	Confirming that a submission is complete before it is sent	Annexe 9
Any officer	Confirming what a term means	Annexe 10

The Guidelines are to be read together with the Budget Call Circular for the year, the Enugu State Chart of Accounts, the Public Procurement Law of Enugu State and the Enugu State Financial Regulations.

CHAPTER 1: INTRODUCTION

1.1 Background

Health is a determinant of economic performance before it is a consequence of it. A population that is repeatedly ill is a population that works less, learns less and saves less, and the arithmetic of that loss falls most heavily on households with the least capacity to absorb it. Primary health care is the level of the health system at which that loss is most cheaply prevented, and it is therefore the level at which public expenditure earns its highest return.

Enugu State has organised its health policy around that proposition. The State Development Plan places primary health care at the centre of its human capital ambition, and the Government has committed to a functional, equipped and staffed facility in every ward. Delivering that commitment requires more than capital investment. It requires a budgeting and work planning system capable of financing the recurrent consequences of that investment, year after year, within the fiscal envelope the State actually has.

These Guidelines were first issued in March 2025 to establish a standardised approach to primary health care budgeting, resource allocation and programme planning. Experience of the first full cycle of application identified three areas requiring strengthening. The descriptive figures on which planning assumptions rested were not fully aligned with the verified facility register and workforce establishment of the Agency. The criteria for prioritising capital projects, although sound, were not expressed in a form that allowed competing proposals to be scored and ranked transparently. And the recurrent cost of staffing, which is the largest single cost driver in primary health care, was not systematically linked to the established workforce position.

This 2026 Edition addresses each of those matters. It is issued jointly under the authority of the Ministry of Health and the Ministry of Budget and Planning, and it applies to the 2027 budget cycle and to the Consolidated Primary Health Care Work Plan for the 2026 financial year.

1.2 Purpose of the Guidelines

5. To establish a structured, sector wide approach to the planning, preparation and execution of the primary health care budget of Enugu State.
6. To align budgetary allocation with the primary health care priorities of the State and with relevant national and international commitments.
7. To promote fiscal discipline, transparency and accountability in the primary health care subsector, so that resources are allocated efficiently and applied effectively.
8. To facilitate the monitoring, evaluation and appraisal of primary health care programmes and projects.
9. To ensure that the recurrent implications of capital investment, particularly the cost of staffing, are recognised, costed and provided for at the point of investment.

1.3 Scope and application

These Guidelines apply to every Ministry, Department and Agency of the Enugu State Government whose mandate includes the delivery, financing, regulation or support of primary health care services, and to the Local Government Health Authorities of the 17 Local Government Areas. They apply to expenditure financed from the State Consolidated Revenue Fund, from Local Government Council allocations, from the Basic Health Care Provision Fund, from development partner contributions and from any other source applied to primary health care in the State.

They govern the preparation of annual budget proposals, the preparation and consolidation of work plans, the prioritisation and costing of projects, the planning of procurement, the recording of expenditure and the reporting of performance. They do not displace the Public Procurement Law of Enugu State, the Financial Regulations of the State, or the annual Budget Call Circular, each of which continues to apply according to its terms. Where an apparent conflict arises, the applicable law or the Budget Call Circular prevails and the Ministry of Health shall be notified so that the Guidelines may be amended at the next revision.

1.4 Legal, policy and fiscal basis

These Guidelines derive their authority and content from the instruments set out below.

Table 2: Instruments governing primary health care planning and budgeting in Enugu State

Instrument	Relevance to these Guidelines
National Health Act	Establishes the Basic Health Care Provision Fund and the framework for primary health care financing
Enugu State Development Plan	States the strategic objectives against which all sector priorities must be justified
Enugu State Health Sector Strategic Development Plan	Sets the medium term direction of the health sector
Medium Term Expenditure Framework and the Economic and Fiscal Update, Fiscal Strategy Paper and Budget Policy Statement	Establish the resource envelope and the sector ceilings within which all proposals must fall
Enugu State Chart of Accounts, aligned to the National Chart of Accounts	Prescribes the six segment classification for all budget lines and reports
Public Procurement Law of Enugu State	Governs procurement planning, method selection and thresholds
Enugu State Financial Regulations	Govern expenditure control, commitment, payment and recording
Annual Budget Call Circular	Communicates ceilings, formats and deadlines for the year
Primary Health Care Under One Roof framework	Establishes the consolidation of primary health care governance under a single authority
National Primary Health Care Development Agency minimum standards	Establish the service and staffing standards against which facility readiness is assessed

1.5 What is new in the 2026 Edition

Users familiar with the March 2025 edition should note the following changes.

- Corrected descriptive base. Chapter 2 now reports the verified facility register and workforce establishment of the Agency. The number of Local Government Areas, the number of wards and the number of government owned primary health care facilities have been corrected.
- A prioritisation scoring framework. Chapter 5 introduces a weighted scoring matrix with defined criteria, weights and scoring bands, so that the ranking of competing capital proposals can be reproduced and defended.
- Mandatory workforce costing. Section 5.4 requires every proposal carrying a personnel implication to be costed against the established workforce position, and prohibits the approval of a facility investment for which the staffing consequence has not been costed and assigned to a funding source.
- A responsibility matrix. Annexe 8 assigns each activity in the budget cycle to a single accountable officer, with supporting officers named.
- A submission compliance checklist. Annexe 9 allows an accounting officer to confirm that a submission is complete before it leaves the MDA, which in the first cycle was the most common cause of returned proposals.
- A glossary. Annexe 10 defines the technical terms used, so that the Guidelines can be applied consistently by officers new to the budget process.

CHAPTER 2: PRIMARY HEALTH CARE IN ENUGU STATE

2.1 State profile

Enugu State lies in the south east geopolitical zone of Nigeria. It is administratively organised into 17 Local Government Areas, subdivided into 260 wards and grouped into three senatorial zones, being Enugu North, Enugu East and Enugu West. The projected population of the State is approximately 5.5 million, growing at an estimated 2.8 per cent annually. The population is distributed between the urban corridor around Enugu, Nsukka and their environs, and a substantial rural population served predominantly through the ward level primary health care network.

Health care is delivered through three tiers. Primary health care is coordinated by the Enugu State Primary Health Care Development Agency. Secondary care is delivered through general and cottage hospitals under the Hospitals Management Board. Tertiary care is provided through three tertiary institutions in the State. A registered private sector operates alongside the public network and is regulated by the Ministry of Health.

2.2 The primary health care network

The Agency operates 566 government owned primary health care facilities across the 17 Local Government Areas and 260 wards, all recorded as functional on the State facility register. The estate spans three service levels.

Table 3: Composition of the primary health care estate

Service level	Number of facilities	Share of the estate	Service package
Level 2 primary health care facility	426	75.3 per cent	The fuller primary care package, including Basic Emergency Obstetric and Newborn Care at designated facilities
Level 1 primary health care facility	131	23.1 per cent	Basic outpatient and preventive services
Type 3 facility	9	1.6 per cent	Residual category
TOTAL	**566**	**100.0 per cent**	

Source: Enugu State Primary Health Care Facility Register, 2026.

Within the Level 2 tier, 260 facilities are designated as the focal network under the Basic Health Care Provision Fund, one in each ward of the State. These focal facilities receive Direct Facility Financing, serve as the anchor points to which community health workers are linked, and are the facilities at which Basic Emergency Obstetric and Newborn Care is expected to be available. They are accordingly the first call on primary health care investment under these Guidelines.

Planning implication

Budget proposals affecting the primary health care estate shall state, for each facility affected, its service level, whether it is a designated focal facility under the Basic Health Care Provision Fund, and its ward and Local Government Area.

Where a proposal would bring a facility to a higher service level, the proposal shall state the additional recurrent cost of operating at that level, including staffing, and shall identify the funding source for that recurrent cost.

2.3 Institutional structure and mandates

The Enugu State Ministry of Health, under the Honourable Commissioner for Health, is responsible for policy formulation, regulation and oversight of the entire health sector. The Ministry implements its strategy directly and through its agencies. Primary health care is coordinated by the Enugu State Primary Health Care Development Agency, and the State is progressing the consolidation of primary health care governance under the Primary Health Care Under One Roof framework.

Table 4: Mandates of institutions in the primary health care subsector

Institution	Mandate relevant to primary health care planning and budgeting
Enugu State Ministry of Health	Policy formulation, regulation and standards; leads the Sector Performance Review, the Medium Term Sector Strategy and the consolidation of the primary health care work plan; determines the allocation of the subsector ceiling
Enugu State Primary Health Care Development Agency	Develops and implements policy, strategy and operational plans for primary health care; maintains the facility register, the nominal roll and the establishment position; coordinates the ward level network and the Basic Health Care Provision Fund gateway
Ministry of Budget and Planning	Prepares the Medium Term Expenditure Framework; issues the Budget Call Circular, ceilings, formats and calendar; conducts bilateral discussions; consolidates the State budget
Ministry of Finance and Economic Development	Manages revenue, releases and cash planning; prescribes expenditure recording, accounting and reporting
Local Government Health Authorities	Deliver primary health care services at ward and facility level; supervise facilities; administer a share of the payroll through the Local Government Sub-Treasurers; prepare facility and ward level activity plans and returns
Enugu State Agency for Universal Health Coverage	Manages the State health insurance scheme, provider empanelment and the disbursement of social health insurance funds, including for exempt groups
Hospitals Management Board	Manages general and cottage hospitals; relevant to primary health care through the referral chain and through the provision of Comprehensive Emergency Obstetric and Newborn Care
Enugu State Agency for the Control of AIDS	Coordinates State level activity on the prevention, treatment and management of HIV and AIDS delivered through the primary health care network
Office of the Accountant General and Local Government Sub-Treasurers	Maintain the payroll against which the primary health care establishment and personnel cost are verified
Enugu State Civil Service Commission	Conducts recruitment and confirms appointments to the primary health care establishment

Institution	Mandate relevant to primary health care planning and budgeting
Ward Development Committees	Represent community priorities in facility level planning and in the identification of capital needs

Each institution named above shall designate a budget focal officer for the purposes of these Guidelines and shall notify the Ministry of Health of that designation before the issuance of the Budget Call Circular in each year.

2.4 Situational analysis of the primary health care subsector

Planning that proceeds from an inaccurate description of the present produces budgets that cannot be executed. This section states the verified position of the subsector as at 2026, and each figure in it is drawn from a State administrative record capable of independent verification.

2.4.1 Coverage and access

The State operates 566 government owned primary health care facilities for a projected population of approximately 5.5 million, giving a facility density of approximately one government owned facility for every 9,700 residents. All 260 wards carry a designated focal facility, so the structural coverage of the network is complete. The binding constraint is not the number of facilities but their capacity to deliver the service package expected of them.

2.4.2 The workforce position

The Agency published its established workforce position on 31 March 2026. Against an established requirement of 8,274 posts, being fourteen posts at each of the 566 facilities together with 350 specialist posts established at Local Government level, 1,810 posts are filled. The vacancy is 6,464 posts, or 78.1 per cent of the establishment.

Table 5: Established requirement, staff in post and vacancy, 2026

Measure	Posts	Note
Established requirement	8,274	Fourteen posts at each of 566 facilities, plus 350 posts established at Local Government level
Staff in post	1,810	Eleven cadres constituting the primary health care establishment
Vacancy	6,464	78.1 per cent of the establishment
Approved establishment expansion	2,250	Recruitment approved by His Excellency the Governor
Appointees onboarded in Phase 1	450	Phase 1 completed
Cumulative appointees planned by the close of 2026	1,350	20.9 per cent of the vacancy

Source: ENSPHCDA Human Resources for Health Update Report, 31 March 2026, and the PHC Workforce Baseline Mapping Report, 2026.

Two features of that position bear directly on budgeting. First, the vacancy is concentrated in cadres where the establishment is close to unfilled: 103 nurses and midwives against an establishment of 1,132, seven medical records officers against 1,132, and 22 pharmacy technicians against 566. Budget proposals that assume the presence of these cadres at facility level are, at present, proposals that assume a condition that does not obtain. Second, filling the vacancy is a recurrent obligation. Every post filled becomes a permanent charge on the payroll, and Chapter 5 accordingly requires that charge to be identified and assigned before a proposal is approved.

2.4.3 Financing

Primary health care in Enugu State is financed from four principal sources: the State Consolidated Revenue Fund through the annual appropriation; Local Government Council allocations, which carry a substantial share of the frontline payroll; the Basic Health Care Provision Fund, including Direct Facility Financing to the 260 focal facilities; and development partner contributions. The consolidation requirement in these Guidelines applies to all four. A work plan that captures only State appropriation is not a consolidated work plan.

2.4.4 Principal constraints

- Workforce. The establishment is 21.9 per cent filled. This is the binding constraint on service delivery and the largest single recurrent cost of closing it.
- Recurrent provision for capital investment. Facilities have been constructed and upgraded faster than provision has been made for the recurrent cost of operating them. These Guidelines address this directly at section 5.4.
- Fragmented planning. Several institutions and partners fund primary health care activity. Without consolidation, duplication is not detectable at the point of budgeting.
- Data for planning. Facility and ward level reporting completeness constrains the evidence available at the point of prioritisation. The Agency is addressing this through the strengthening of routine reporting into DHIS2.
- Distribution. Staffing is unevenly distributed between Local Government Areas without close reference to need, which is a deployment matter but has budgetary consequences for the location of investment.

2.5 Vision, mission and core values

Vision	A primary health care system in which every resident of Enugu State, in every ward, can obtain quality essential health services from a facility that is open, staffed, supplied and accountable.
Mission	To plan, finance and deliver equitable primary health care through a coordinated sector, disciplined budgeting and verified evidence, so that public expenditure produces measurable improvement in the health of the people of Enugu State.

Table 6: Core values governing primary health care planning and budgeting

Value	What it requires in practice
Equity	Investment is directed first to the wards and facilities furthest from the standard, not to those easiest to reach or best represented
Evidence	Every proposal is justified by a figure drawn from a State record that can be independently verified
Transparency	Criteria, weights, scores and rankings are published, so that a decision can be explained to those it disadvantages
Accountability	Each activity has one accountable officer, one funding source and one reporting line
Efficiency	Value for money is demonstrated through costing to standard, not asserted

Value	What it requires in practice
Sustainability	No capital investment is approved without provision for its recurrent consequence
Participation	Ward Development Committees and civil society contribute to the identification of need and to the review of performance

CHAPTER 3: THE BUDGET SYSTEM AND BUDGET PROCESSES

3.1 The annual budget cycle

The annual budget is the principal instrument through which government converts policy into service. In Enugu State the budget for primary health care is prepared within the wider State budget framework, which proceeds through six iterative stages.

Table 7: The six stages of the budget cycle

Stage	What happens	Principal responsibility	Period
1. Policy review	Existing policy is examined against current priorities and against performance in the preceding year	Ministry of Health with all health sector MDAs	February to April
2. Strategic planning	Policy priorities are translated into a costed medium term strategy and an Annual Operational Plan	Ministry of Health, Health Sector Planning Committee	May to June
3. Budget preparation	Detailed proposals are prepared within ceilings and consolidated into the State estimates	All MDAs, Ministry of Budget and Planning	July to November
4. Budget execution	The approved budget is implemented through work plans, procurement and service delivery	All MDAs, Local Government Health Authorities	January to December
5. Accounting and monitoring	Expenditure and physical progress are recorded, tracked and reported	Ministry of Finance and Economic Development, MDA finance and M&E officers	Continuous
6. Reporting and external audit	Performance is reported and audited, informing the next cycle	Office of the Auditor General, Ministry of Health	Following year

These Guidelines address stages one to four in detail, through to the consolidation of the primary health care work plan, and set out the reporting requirements arising under stage five. They are to be applied together with the laws, regulations and manuals of the Enugu State Government.

3.2 Key principles for primary health care budgeting

The following eight principles govern the preparation of the primary health care budget. A proposal that offends any of them shall be returned to the originating MDA.

10. Comprehensive fiscal coverage. The budget shall capture all fiscal activity relating to primary health care, whatever its funding source. Every policy decision carrying a financial implication shall be taken within the budgetary framework issued by the Ministry of Budget and Planning.
11. Affordability and fiscal discipline. Proposals shall be evidence based, consistent with medium term fiscal realities and contained within the ceilings communicated for the subsector. Projections shall rest on credible revenue and expenditure estimates.

12. Alignment with government priorities. Expenditure shall reflect the priorities of the Enugu State Development Plan and of the Health Sector Strategic Development Plan. Resources shall be directed only to activities with defined outputs and a measurable contribution to a stated objective.
13. Consolidated planning. All MDAs and Local Government Health Authorities implementing primary health care programmes shall plan jointly. Duplication and mandate overlap shall be resolved before consolidation, not after appropriation.
14. Efficiency and value for money. Resources shall be deployed to achieve the intended result at the lowest cost consistent with quality. Costing shall be to standard and shall be demonstrable.
15. Transparency and accountability. Plans, fiscal forecasts and financial reports shall be clear, accessible and open to scrutiny by the State Executive Council, the State House of Assembly and the public.
16. Classification and publication. The approved budget shall be prepared and published in accordance with the six segments of the Enugu State Chart of Accounts, aligned to the National Chart of Accounts.
17. Sustainability of recurrent consequence. No capital proposal shall be approved unless its recurrent consequence, and in particular its staffing consequence, has been costed and assigned to a funding source.

Table 8: The six segments of the Chart of Accounts and their application to primary health care

Segment	What it records	Application in primary health care
Administrative	The MDA incurring the expenditure	Distinguishes Ministry, Agency and Local Government Health Authority expenditure
Economic	The nature of the expenditure	Distinguishes personnel, overhead and capital, which is essential to workforce costing
Functional	The government function served	Identifies expenditure classified to health
Programme	The programme to which the expenditure belongs	Identifies primary health care as a distinct programme rather than a residue of the health sector
Fund	The source of finance	Distinguishes State appropriation, Local Government allocation, Basic Health Care Provision Fund and partner contribution
Geographic location	Where the expenditure occurs	Enables geotagging of every capital project to ward and Local Government Area

Mandatory classification requirement

Every primary health care budget line shall carry a complete six segment code. A line that cannot be coded to a programme and to a geographic location shall not be admitted to the consolidated work plan.

The geographic location segment shall be coded to ward level for every capital project, so that the distribution of capital investment across the 260 wards can be reported and audited.

3.3 Budget processes, timelines and roles

The preparation of the primary health care budget is governed by the annual budget framework and calendar issued by the Ministry of Budget and Planning in collaboration with the Ministry of Health. Adherence to the calendar is what allows the Appropriation Bill to be passed by the State House of Assembly before the commencement of the financial year. The full calendar appears at Annexe 1; the principal stages are set out here.

3.3.1 Policy and fiscal planning

The cycle opens with a structured review of policy and of the preceding year's performance, anchored to the Enugu State Development Plan. Particular attention is given to the performance of the primary health care expenditure segment over a three year period. The Ministry of Budget and Planning updates the fiscal framework, which determines the annual fiscal targets and aggregate spending limits for the State and for each sector, and communicates the resulting ceilings through the Budget Call Circular.

3.3.2 Agency and Sector Performance Review

The Agency Performance Review and the Sector Performance Review are conducted annually to evaluate the outcome of public expenditure against plan. They examine budgetary allocation and release, sector and agency performance against stated targets, progress against key performance indicators, and the quality of collaboration between health sector agencies.

Table 9: The Agency and Sector Performance Review process

Step	Activity	Responsible	Timing
1	Ministry of Budget and Planning issues the guidance note and Sector Performance Review template to the Ministry of Health	Ministry of Budget and Planning	February
2	Ministry of Health adapts and forwards the guidance and template to all health agencies and to MDAs delivering primary health care. Where no template is issued by the Ministry of Budget and Planning, the Ministry of Health shall issue one	Ministry of Health	February
3	Each agency, including the Primary Health Care Development Agency, conducts its Agency Performance Review with technical support from the Ministry of Health and the Ministry of Budget and Planning	Health sector MDAs	March
4	The health sector conducts its Sector Performance Review, incorporating the Agency Performance Reviews. Primary health care shall be presented as a standalone section and shall not be subsumed within general sector findings	Ministry of Health	March
5	Findings are revised and consolidated	Ministry of Health with the Ministry of Budget and Planning	April

Step	Activity	Responsible	Timing
6	The Sector Performance Review is validated and finalised	Ministry of Health	April
7	Findings inform the update of the Medium Term Sector Strategy and the pre budget Annual Operational Plan	Health Sector Planning Committee	April to May

Standing requirement

Primary health care shall appear as a standalone section of the Sector Performance Review in every year. The section shall report, at minimum, the primary health care allocation, releases and utilisation for the year under review; performance against the service delivery indicators of the Annual Operational Plan; the workforce establishment position; and the status of capital projects by ward.

3.4 The Medium Term Expenditure Framework

The Medium Term Expenditure Framework is a three year rolling plan that sets out expenditure priorities over the medium term and establishes the budget constraints within which sectors and MDAs prepare their plans. It is prepared by the Ministry of Budget and Planning in collaboration with the finance sector MDAs, and performs four functions.

- It provides a top down estimate of the total resources available for public expenditure in Enugu State.
- It provides a bottom up costing of the programmes and projects of MDAs and sectors.
- It reconciles the needs of MDAs and sectors with the resources available to them.
- It ensures that annual budget submission and execution align with the agreed medium term plan.

The requirements and processes for preparing the Economic and Fiscal Update, the Fiscal Strategy Paper and the Budget Policy Statement are set out in the relevant State manual. In summary, the Framework determines the funding, internal and external, that can realistically be allocated to primary health care in each year across three consecutive years.

3.5 Medium Term Sector Strategy

The Enugu State health sector shall adopt a Medium Term Sector Strategy framework by the 2027 fiscal year at the latest. The Strategy identifies the principal obstacles to the effective implementation of primary health care programmes and sets out strategic responses to them. It is prepared and updated annually by all MDAs within the health sector and is the foundational document on which every MDA work plan must rest.

Components of the Strategy process

- Alignment of primary health care goals and objectives with the overarching goals of the Enugu State Development Plan.
- Identification of the projects and programmes that contribute to those goals.

- Prioritisation, costing and phasing of initiatives over three years.
- Definition of expected outcomes in measurable terms.
- Establishment of a work plan and results framework linking outcomes to objectives and policy goals.

Operational arrangements

- The Strategy shall be prepared collectively by all health sector MDAs at an annual preparation workshop convened by the Ministry of Health on or before June each year.
- The Director of Planning, Research and Statistics of the Primary Health Care Development Agency shall serve on the Health Sector Planning Committee responsible for preparing the Strategy.
- All projects and plans proposed shall be prioritised and costed in accordance with Chapter 5.
- Costing shall remain within the ceilings approved in the Medium Term Expenditure Framework and communicated by the Ministry of Budget and Planning.
- The Ministry of Health shall determine the allocation of the ceiling assigned to the primary health care subsector, whether by distributing funds according to the cost of prioritised projects, by predetermined share, or by a combination of the two.

3.6 Consolidated primary health care work planning

The Consolidated Primary Health Care Work Plan is the single authoritative statement of what the State intends to do in primary health care in a given year, by whom, at what cost and from which funding source. The following requirements govern its preparation.

10. Derivation. All primary health care programmes, plans and activities shall be derived from the approved Medium Term Sector Strategy. Where no Strategy is yet in force, they shall be derived from the pre budget Annual Operational Plan of the health sector prepared collaboratively by all sector MDAs.
11. Templates. MDAs may use existing work planning templates provided every entry is drawn directly from the approved Strategy or Annual Operational Plan. The template at Annexe 6 shall be used where an MDA has none.
12. Submission. Each MDA shall submit its annual primary health care work plan to the Ministry of Health for consolidation into the Enugu State Consolidated Primary Health Care Work Plan.
13. Prioritisation and costing. Capital projects and activities shall be selected through the objective process at Chapter 5 and costed within the approved ceilings.
14. Comprehensive cost coverage. Costing shall reflect all costs associated with a project or activity, recurrent and capital, and shall state the funding source, whether State, Local Government, Basic Health Care Provision Fund, grant or partner.
15. Personnel related costs. Where a project or activity carries a personnel implication, costing shall include recruitment, salaries, benefits, allowances and associated overheads for frontline workers, together with the funding source. Section 5.4 governs.

16. Classification. All project and activity details shall align with the programme and other segments of the Chart of Accounts.
17. Circulation. The Ministry of Health shall circulate the approved Consolidated Work Plan to all sector MDAs and to the Local Government Health Authorities.
18. Consistency. No item may be proposed in an MDA budget, and no item may be implemented during the financial year, unless it is expressly captured in the Consolidated Primary Health Care Work Plan.

The consolidation rule

Requirement 9 is the operative provision of these Guidelines. It is the mechanism by which duplication between the Ministry, the Agency, the Local Government Health Authorities and development partners is eliminated at the point of budgeting rather than discovered at the point of audit.

An accounting officer who implements an item not carried in the Consolidated Work Plan shall account for that expenditure to the Ministry of Health and to the Ministry of Finance and Economic Development, and the item shall be reported as a variance in the quarterly performance report.

CHAPTER 4: ANNUAL BUDGET PREPARATION

4.1 Overview of the preparation process

This chapter sets out, step by step, how the annual primary health care budget is prepared. It identifies the sub activities, the responsibilities attaching to each and the documents required. The sequence is fixed and is not to be varied by an MDA acting alone.

Table 10: Summary of the annual budget preparation process

Step	Activity	Responsible	Output	Timing
1	Issuance of the Budget Call Circular with ceilings, formats and deadlines	Ministry of Budget and Planning	Budget Call Circular	July
2	Dissemination of the Circular to health sector MDAs and Local Government Health Authorities	Ministry of Health	Circulated guidance	July
3	Constitution of the MDA budget subcommittee	Accounting officer of each MDA	Constituted subcommittee	July
4	Preparation of draft proposals by departments and units	MDA departments	Draft proposals	July to August
5	Prioritisation and costing of capital proposals under Chapter 5	MDA planning and budget officers	Scored and ranked project list	August
6	Review and consolidation of proposals by the subcommittee	MDA budget subcommittee	Consolidated MDA proposal	August
7	Endorsement by the accounting officer and submission	Permanent Secretary or Chief Executive	Submitted proposal	On or before the Circular deadline
8	Review of proposals for compliance	Ministry of Budget and Planning with the Ministry of Health	Review notes	September
9	Bilateral discussions	Ministry of Budget and Planning with each MDA	Agreed adjustments	September to October
10	Consolidation into draft State estimates	Ministry of Budget and Planning	Draft estimates	October
11	Executive Council consideration and transmission to the House of Assembly	State Executive Council	Appropriation Bill	November
12	Appropriation and publication, including the Citizens Budget	House of Assembly, Ministry of Budget and Planning	Approved budget	December to January

4.2 Issuance of the Budget Call Circular

The Budget Call Circular is issued by the Ministry of Budget and Planning and communicates the resource envelope, the expenditure ceilings for each sector and MDA, the formats and templates to be used, and the deadline for submission. The Ministry of Health shall disseminate the Circular to all health sector MDAs

and to the Local Government Health Authorities within five working days of receipt, together with any sector specific guidance required for the primary health care subsector.

4.3 Preparation of budget proposals

Each MDA shall constitute a budget subcommittee chaired by the accounting officer. The subcommittee shall satisfy itself, before endorsing a proposal, that each of the following requirements has been met.

- The proposal is derived from the approved Medium Term Sector Strategy or, where none is in force, from the pre budget Annual Operational Plan, and is carried in the draft Consolidated Primary Health Care Work Plan.
- The proposal falls within the ceiling communicated for the MDA and for the subsector.
- Budget classification and coding follow the National Chart of Accounts as adopted by the State, with a complete six segment code on every line.
- Capital projects incorporate elements of community development plans and feedback from Ward Development Committees and civil society organisations.
- Ongoing projects, grant assisted projects and projects financed by development or loan finance are given priority over new starts.
- Activities fulfilling commitments of the Government under subsisting agreements are prioritised.
- Only projects within the technical and absorptive capacity of the MDA are proposed.
- New activities and projects are justified and appraised by suitably qualified officers or consultants. For new capital projects within the approval threshold of the State Executive Council, justification shall include performance indicators and the method of their measurement. Multi year projects shall carry documents setting out the full scope, financial implication and phased execution plan.
- All new projects and activities, including purchase, construction, renovation and repair, are costed using the most cost effective method and to the standards at Chapter 5.
- The recurrent cost implication of every capital project is estimated and included in the recurrent estimates, including the staffing implication under section 5.4.
- Proposals for counterpart funding of externally financed projects are incorporated.
- Actual expenditure for the preceding year and for the first six months of the current year is included.
- Every item is clearly and accurately titled with sufficient detail to be understood by a reviewer who did not draft it.

The proposal shall be reviewed and approved by the subcommittee and endorsed by the Permanent Secretary or Chief Executive before submission. Submission shall occur on or before the date specified in the Budget Call Circular and the budget calendar. Annexe 9 provides a compliance checklist which shall be completed and attached to every submission.

4.4 Technical support

Where an MDA does not possess the technical capacity to prepare proposals to the required standard and format, the budget subcommittee shall obtain support from the Ministry of Health or the Ministry of Budget and Planning. The established process and approved format shall be followed in every case. Departure from them compromises the integrity of the process and the quality of the resulting budget, and is a ground for return of the proposal.

4.5 Submission and review of proposals

On receipt, the Ministry of Budget and Planning reviews each submission for substantial compliance with the Budget Call Circular, verifying that ceilings have been observed and that the correct forms have been used. The review proceeds under five heads.

Revenue proposals

Revenue lines submitted by revenue generating MDAs are examined to confirm that no source has been omitted, and that actual figures for the preceding year, the current year and projections for the budget year are stated for every line. Actual performance for the preceding year and for the first six or nine months of the current year is examined to establish trend and to test the realism of projection.

Personnel cost proposals

Personnel submissions shall state the actual number and grade of staff in post. The review considers increases arising from promotion, advancement or conversion, and from the recruitment of additional staff against approved vacancies. Allowances, bonuses and total emoluments are examined. For the primary health care subsector, personnel proposals shall be reconciled against the established workforce position published by the Agency, and section 5.4 governs.

Overhead cost proposals

Overhead proposals are reviewed for appropriateness, with particular attention to overheads arising from completed capital projects, such as the maintenance of new buildings coming into use during the budget year. Where a line deviates significantly from the current year, and particularly where actual cost in the preceding or current year was materially lower, the MDA shall explain the increase. New events such as conferences or training shall be explained and justified.

Capital expenditure proposals

Capital activities and projects shall be consistent with policy and shall appear in the Medium Term Sector Strategy or the pre budget Annual Operational Plan. Capital projects shall not overlap between MDAs. Where duplication is identified it shall be rationalised in bilateral discussion or, failing agreement, referred to the State Executive Council. All new activities shall be supported by justification and appraisal documents, with costing prepared by suitably qualified officers or consultants. The Ministry of Budget and Planning shall review the reasonableness of costing having regard to the past performance of the MDA and to its technical and absorptive capacity.

Coding and classification

Officers of the Ministry of Budget and Planning shall verify that each line carries the correct International Public Sector Accounting Standards and National Chart of Accounts codes, and that the geographic location segment is coded to ward level for every capital project.

4.6 Bilateral discussions

Following review, the Ministry of Budget and Planning holds structured discussions with each MDA on both capital and recurrent submissions. At the bilateral discussion the Ministry shall:

- Review the proposals with the MDA for consistency with the Budget Call Circular.
- Confirm that the MDA has complied with input spending boundaries.
- Review personnel and overhead inputs for compliance with the recurrent expenditure policy of the Government, with particular attention to the personnel profile.
- Confirm that capital activities align with policy priorities and development plans and are captured in the Medium Term Sector Strategy and in the draft Consolidated Primary Health Care Work Plan.
- Verify that any new capital activity within the Executive Council threshold is supported by formal justification and by evidence of the approval of His Excellency the Governor.
- Assess the fairness of costing to establish value for money.
- Review performance indicators and the methods of measuring output and outcome for consistency with the monitoring and evaluation policy of the State.
- Where necessary, allocate additional resources from the planning reserve to fund important activities not accommodated within the MDA ceiling.

4.7 Consolidation and approval

Following bilateral discussion, agreed amendments are made and the revised proposals are consolidated into the draft budget estimates of the Enugu State Government. The consolidation proceeds through review, validation and approval before implementation, in the following sequence.

18. The Ministry of Budget and Planning consolidates MDA submissions into draft estimates and prepares the accompanying budget documents.
19. The draft estimates are presented to the State Executive Council for consideration and approval.
20. The Appropriation Bill is transmitted to the Enugu State House of Assembly by His Excellency the Governor.
21. The House of Assembly considers the Bill, conducts budget defence with MDAs and passes the Appropriation Law.
22. The Appropriation Law is assented to and the approved budget is published in accordance with the six segments of the Chart of Accounts.
23. The Ministry of Health finalises the Consolidated Primary Health Care Work Plan in line with the approved appropriation and circulates it to all sector MDAs and Local Government Health Authorities before the end of January.

4.8 The Citizens Budget

The Ministry of Budget and Planning shall prepare and publish an abridged version of the approved budget in accessible language. For the primary health care subsector, the Citizens Budget shall state, at minimum, the total primary health care allocation, its share of the health sector and of the State budget, the distribution of capital investment by Local Government Area, and the principal service delivery targets for the year. The Ministry of Health shall provide that content to the Ministry of Budget and Planning within fifteen working days of the assent to the Appropriation Law.

CHAPTER 5: PROJECT PRIORITISATION AND COSTING

Ceilings are always lower than proposals. Prioritisation is therefore not an occasional exercise but the central discipline of budgeting, and the credibility of a budget rests on whether the ranking it embodies can be explained to those it disadvantages. This chapter establishes how competing primary health care proposals are to be scored, ranked and costed.

5.1 General requirements

24. Every capital proposal shall be scored using the framework at section 5.2. A proposal that has not been scored shall not be admitted to the Consolidated Primary Health Care Work Plan.
25. Scores, weights and the resulting ranking shall be recorded on the template at Annexe 2 and shall be submitted with the budget proposal. They are subject to review at bilateral discussion.
26. Ongoing projects, projects supported by grant or loan finance, and projects fulfilling a subsisting commitment of the Government shall be ranked ahead of new starts of equal score.
27. No proposal shall be admitted unless it falls within the technical and absorptive capacity of the implementing MDA, evidenced by its delivery performance in the two preceding years.
28. Every capital proposal shall carry a complete recurrent cost consequence, including staffing, calculated under section 5.4.
29. Every capital proposal shall be geotagged to ward and Local Government Area using the location segment of the Chart of Accounts.

5.2 The prioritisation scoring framework

Each capital proposal shall be scored against seven criteria. Each criterion carries a weight, and each is scored on a scale of one to five against the bands set out at Table 12. The weighted score is the sum of the products of weight and score, giving a maximum of 100.

Table 11: Prioritisation criteria and weights

Criterion	What it measures	Weight
1. Equity of access	The extent to which the proposal serves a ward or population currently furthest from the service standard	20
2. Strategic alignment	The strength of the link to a stated objective of the Enugu State Development Plan, the Health Sector Strategic Development Plan or the Medium Term Sector Strategy	20
3. Health impact	The expected contribution to priority health outcomes, particularly maternal, newborn and child health, immunisation and communicable disease control	15
4. Readiness and deliverability	Whether design, site, title, approvals and implementation capacity are in place such that the project can be delivered within the financial year or an agreed phase	15
5. Sustainability of recurrent cost	Whether the recurrent consequence, and above all the staffing consequence, has been costed and assigned to a funding source	15

Criterion	What it measures	Weight
6. Cost effectiveness	The unit cost of the expected output relative to comparable projects and to published costing standards	10
7. Community priority	The extent to which the proposal reflects a need identified through the Ward Development Committee or community development plan	5
TOTAL		**100**

Table 12: Scoring bands

Score	Meaning	Illustration using criterion 1, equity of access
5	Fully satisfies the criterion on documented evidence	The ward has no functional facility, or the focal facility holds no staff
4	Substantially satisfies the criterion	The ward is in the lowest quartile of the State on the relevant measure
3	Partially satisfies the criterion	The ward is below the State average but not in the lowest quartile
2	Weakly satisfies the criterion	The ward is at or slightly above the State average
1	Does not satisfy the criterion	The ward is already at or above the service standard

A proposal scoring 1 on criterion 5, sustainability of recurrent cost, shall not be admitted regardless of its total score. See section 5.4.

Worked illustration

A proposal to upgrade a Level 1 facility in a ward whose focal facility currently holds no attributable staff, which is expressly provided for in the Medium Term Sector Strategy, which has completed design and site title, and for which the staffing consequence of eight additional posts has been costed and assigned to the Local Government Council payroll, would score as follows.

Table 13: Worked example of the scoring framework

Criterion	Weight	Score	Weighted score	Basis
Equity of access	20	5	20.0	Focal facility in the ward holds no attributable staff
Strategic alignment	20	5	20.0	Expressly provided for in the Medium Term Sector Strategy
Health impact	15	4	12.0	Upgrade enables antenatal and delivery services in the ward
Readiness and deliverability	15	5	15.0	Design complete, site title held, contractor prequalified
Sustainability of recurrent cost	15	5	15.0	Eight posts costed and assigned to the Local Government Council payroll
Cost effectiveness	10	3	6.0	Unit cost slightly above the State benchmark
Community priority	5	4	4.0	Identified in the ward development plan

Criterion	Weight	Score	Weighted score	Basis
TOTAL	**100**		**92.0**	**Ranked in the first quartile of proposals**

The weighted score is computed as the score divided by five, multiplied by the weight. Proposals shall be ranked by weighted score within each funding source, and the ranked list shall be submitted with the budget proposal. Where two proposals score equally, the tie shall be resolved in favour of the proposal serving the ward with the lower staffing ratio, as recorded in the workforce baseline of the Agency.

5.3 Costing standards

Costing shall be prepared by suitably qualified officers or consultants and shall be demonstrable. The following standards apply.

- Costing shall use current market prices evidenced by at least three quotations, by a published schedule of rates, or by the cost of a comparable project completed within the preceding eighteen months.
- Costing shall be disaggregated to the level at which it can be verified. A single lump sum for a facility upgrade is not a costing.
- Costing shall state the assumptions applied, including inflation, exchange rate where relevant, and the treatment of taxes and statutory deductions.
- Multi year projects shall be costed in full and phased, with the annual tranche stated for each year of the project and the full financial implication disclosed at the point of first approval.
- Costing shall include the cost of supervision, of commissioning and of any equipment necessary for the asset to enter service. An asset that cannot be used on completion has not been fully costed.
- Costing shall separately state the recurrent consequence of the investment for each of the three years following completion.

5.4 Costing the primary health care workforce

Personnel cost is the largest single recurrent cost in primary health care and the one most frequently omitted at the point of capital approval. The consequence is a facility that is built, equipped, commissioned and then operated below the service standard because no provision was made for the staff to run it. This section exists to prevent that outcome, and its requirements are mandatory.

> **The staffing rule**
>
> No capital proposal that creates, upgrades or expands a primary health care facility shall be approved unless the proposal states the number of posts, by cadre, required to operate the facility at its intended service level; costs those posts at the applicable grade level; and assigns the resulting recurrent cost to a named funding source, being the State Consolidated Revenue Fund, the Local Government Council, or another identified source.
>
> A proposal that does not satisfy this rule shall be returned to the originating MDA, whatever its score against the other criteria at Table 11.

The established staffing norm of the Agency shall be used as the basis for calculating the posts required. That norm is fourteen posts at each primary health care facility, together with specialist posts established at Local Government level. The composition is set out below.

Table 14: Established staffing norm per primary health care facility

Post	Number per facility	Establishment basis
Nurse or Midwife	2	Per facility
Community Health Extension Worker	4	Per facility

Post	Number per facility	Establishment basis
Junior Community Health Extension Worker	2	Per facility
Medical Records Officer	2	Per facility
Medical Laboratory Technician	1	Per facility
Pharmacy Technician	1	Per facility
Cleaner	1	Per facility
Security	1	Per facility
Sub total per facility	14	
Medical Officer	170 in total	Established at Local Government level, ten per Local Government Area
Pharmacist	90 in total	Established at Local Government level
Medical Laboratory Scientist	90 in total	Established at Local Government level

Source: ENSPHCDA Human Resources for Health Update Report, 31 March 2026. Applied to the 566 facility network this gives an established requirement of 8,274 posts.

MDAs shall obtain from the Agency, before preparing a proposal with a personnel implication, the current staffing position of the facility concerned. Where the facility already holds posts, only the incremental posts required shall be costed. Where the facility holds none, the full complement shall be costed.

Table 15: Format for stating the personnel implication of a capital proposal

Cadre	Posts currently in place	Posts required at intended service level	Incremental posts	Annual cost per post	Total annual cost	Funding source
TOTAL						

This format shall be completed for every capital proposal with a personnel implication and submitted as part of the costing at Annexe 3. Annual cost per post shall be taken from the salary schedule applicable to the grade level, confirmed by the Office of the Accountant General.

Recruitment costs shall be stated separately from salary costs and shall include advertising, examination, screening, interview, certificate verification, onboarding and pre deployment training. Where a proposal depends on posts being filled through an approved recruitment phase, the proposal shall state the phase and its expected completion date, and the profile of the expenditure shall reflect the point in the year at which the posts are expected to be filled rather than assuming a full year charge.

CHAPTER 6: BUDGET IMPLEMENTATION AND WORK PLAN EXECUTION

An approved budget is an authority to spend, not an instruction to spend evenly. This chapter sets out how the approved primary health care budget is converted into an executable work plan, procured, implemented and recorded.

6.1 Pre-implementation activities

6.1.1 Budget and expenditure profiling

Within thirty days of the assent to the Appropriation Law, each MDA shall profile its approved primary health care budget across the twelve months of the year. The profile shall state, for each line, the amount expected to be committed and the amount expected to be paid in each month or quarter. Profiling serves three purposes: it enables the Ministry of Finance and Economic Development to plan cash releases; it exposes lines whose delivery is concentrated in the final quarter, which is the commonest cause of underspending; and it establishes the baseline against which quarterly performance is measured.

- Profiles shall be realistic. A profile that assumes an even twelve month spread of a project requiring procurement is not a profile.
- Profiles shall reflect the procurement lead time applicable to the method selected under section 6.3.
- Profiles shall reflect, for personnel lines, the expected month in which appointees enter the payroll.
- Revisions to a profile shall be notified to the Ministry of Finance and Economic Development and to the Ministry of Health before the start of the quarter to which they relate.

6.1.2 Capital work planning

Each capital project in the approved budget shall carry a work plan prepared on the template at Annexe 6 and stating, at minimum, the following.

30. The project title, the Chart of Accounts code including the ward level location segment, and the approved appropriation.
31. The scope of work, expressed in deliverables rather than in activities.
32. The implementation schedule, showing the sequence and duration of each stage from procurement through to commissioning.
33. The procurement method selected and the anticipated date of each procurement milestone.
34. The officer accountable for delivery and the officer accountable for supervision.
35. The performance indicators against which progress will be measured, and the method and frequency of their measurement.
36. The recurrent cost consequence on commissioning, including the staffing complement required under section 5.4 and the date from which that cost will arise.
37. The risks to delivery and the mitigation proposed for each.

6.1.3 Procurement planning

Procurement shall be conducted in accordance with the Public Procurement Law of Enugu State and the regulations made under it. These Guidelines add the following requirements specific to primary health care.

- Each MDA shall prepare an annual procurement plan for its primary health care budget within forty five days of the assent to the Appropriation Law, and shall submit it to the Ministry of Health for inclusion in the consolidated procurement schedule of the subsector.
- The consolidated procurement schedule shall be examined by the Ministry of Health for duplication across MDAs. Where two MDAs propose to procure the same item for the same facility, the procurement shall be consolidated.
- Procurement of medicines, vaccines, medical consumables and laboratory reagents shall be coordinated through the State Logistics Management Coordinating Unit, so that quantification reflects consumption data and existing stock rather than historical allocation.
- Procurement of equipment shall be accompanied by provision for installation, commissioning, user training, warranty and the first year of maintenance. Equipment procured without that provision is a liability rather than an asset.
- Procurement lead times shall be stated in the plan and shall be reflected in the expenditure profile prepared under section 6.1.1.
- Contracts shall not be awarded for works at a facility whose staffing consequence has not been provided for in accordance with section 5.4.

Table 16: Indicative procurement planning milestones

Milestone	Responsible	Indicative timing
Approval of the annual procurement plan	Accounting officer of the MDA	Within 45 days of assent
Submission to the Ministry of Health for consolidation	MDA procurement officer	Within 50 days of assent
Consolidated subsector procurement schedule issued	Ministry of Health	Within 65 days of assent
Advertisement and solicitation	MDA procurement officer	In accordance with the plan
Evaluation and award recommendation	MDA tenders committee	In accordance with the plan
Approval and award	Accounting officer or the relevant approving authority	In accordance with thresholds
Contract management and delivery certification	Project supervising officer	Through to completion

6.2 Implementation

Implementation shall follow the approved work plan. The following controls apply throughout the year.

- No item shall be implemented that is not carried in the Consolidated Primary Health Care Work Plan.

- Variation to scope shall be approved in advance by the accounting officer and, where the variation exceeds the threshold prescribed by the Financial Regulations, by the relevant approving authority. Variations shall be reported in the quarterly performance report.
- Physical progress shall be certified by the supervising officer before payment, and certification shall be supported by evidence capable of independent inspection, including photographs bearing the location and date.
- Facilities shall not be commissioned until the staffing complement provided for under section 5.4 has been deployed or a dated deployment schedule has been agreed with the Agency.
- Local Government Health Authority Secretaries shall report monthly to the Agency on the physical status of projects within their Local Government Areas.

6.3 Expenditure recording and accounting

Expenditure shall be recorded in accordance with the Financial Regulations of Enugu State, the International Public Sector Accounting Standards as adopted by the State, and the six segment Chart of Accounts.

- Every payment shall be classified to the same six segment code under which the appropriation was made. Reclassification after the event shall be approved by the Ministry of Finance and Economic Development and reported.
- Commitments shall be recorded at the point of commitment and not at the point of payment, so that the uncommitted balance of an appropriation is known at any point in the year.
- Expenditure financed from the Basic Health Care Provision Fund, from Local Government Council allocations and from development partner contributions shall be recorded under the fund segment applicable to it, so that the consolidated position of primary health care expenditure can be reported irrespective of source.
- Facility level expenditure under Direct Facility Financing shall be recorded and reported by the receiving facility in the form prescribed by the Agency, and shall be consolidated into the subsector position.
- Retirement of advances and the reconciliation of imprest shall be completed within the period prescribed by the Financial Regulations. Outstanding retirements shall be reported in the quarterly performance report.

CHAPTER 7: PERFORMANCE REVIEW, MONITORING AND EVALUATION

7.1 Expenditure review and appraisal

The purpose of expenditure review is to establish whether the money appropriated to primary health care was released, whether it was spent, whether it was spent on what it was appropriated for, and whether the expected result followed. All four questions are to be answered, and the fourth is not to be inferred from the first three.

Table 17: The performance monitoring and review framework

Level	What is measured	Source	Frequency
Input	Appropriation, release, commitment and payment by six segment code	Accounting records and the State financial management system	Monthly
Activity	Physical progress against the work plan schedule	Supervising officer certification and Local Government Health Authority returns	Monthly
Output	Facilities completed, staff deployed, commodities delivered, personnel trained	MDA and Agency records, deployment register	Quarterly
Outcome	Service utilisation and coverage, including antenatal attendance, skilled birth attendance, immunisation coverage and facility readiness	DHIS2 and routine health information	Quarterly
Impact	Health status indicators of the State population	Population surveys and the Health Sector Strategic Development Plan results framework	Annual and periodic

7.2 Monitoring and evaluation

Monitoring shall be continuous and evaluation periodic. The following arrangements apply to the primary health care subsector.

- The Agency shall maintain a project register recording every capital project in the Consolidated Work Plan, its ward level location, its appropriation, its cumulative expenditure and its physical status.
- Joint monitoring visits shall be conducted quarterly by the Ministry of Health, the Ministry of Budget and Planning, the Agency and, where invited, civil society representatives. Visits shall be to a sample that includes at least one facility in each senatorial zone and shall prioritise facilities in wards recorded as least staffed.
- Data quality assessment of routine reporting shall be conducted quarterly, since performance reporting that rests on unassured data is not assurance.
- An annual evaluation of the primary health care programme shall be conducted as part of the Sector Performance Review and shall be presented as a standalone section in accordance with Chapter 3.

7.3 Reporting requirements

Table 18: Reporting calendar for the primary health care subsector

Report	Prepared by	Submitted to	Due
Monthly budget performance report	MDA finance and planning officers	Ministry of Health and Ministry of Finance and Economic Development	Within 10 days of month end
Quarterly physical and financial performance report	MDA accounting officer	Ministry of Health, Ministry of Budget and Planning	Within 15 days of quarter end
Quarterly primary health care subsector consolidated report	Ministry of Health	State Executive Council	Within 30 days of quarter end
Half year budget performance review	Ministry of Budget and Planning with the Ministry of Health	State Executive Council and the House of Assembly	By 31 July
Agency Performance Review	Each health sector agency	Ministry of Health	March
Sector Performance Review	Ministry of Health	Ministry of Budget and Planning and the State Executive Council	April
Annual primary health care performance report	Ministry of Health with the Agency	State Executive Council, published	By 31 March following the year

The template at Annexe 7 shall be used for monthly and quarterly reporting. Reports shall state both financial and physical performance. A report stating expenditure without stating what that expenditure produced does not satisfy this requirement.

7.4 Committees and stakeholders

Body	Role in performance reporting and review
State Executive Council	Receives quarterly and annual subsector reports; approves the Medium Term Expenditure Framework and the draft estimates
Enugu State House of Assembly	Appropriates, conducts budget defence and oversight, and receives the half year performance review
Health Sector Planning Committee	Prepares and updates the Medium Term Sector Strategy and reviews the Consolidated Work Plan
Primary Health Care Subsector Technical Working Group	Reviews monthly and quarterly performance, resolves duplication and escalates delivery risk
MDA budget subcommittees	Prepare, review and endorse budget proposals and performance reports
Local Government Health Authorities	Report facility and ward level physical progress and service delivery data
Ward Development Committees	Contribute community level verification of project completion and facility functionality
Development partners	Report contributions for consolidation and participate in joint monitoring
Civil society organisations	Participate in joint monitoring and in the review of the Citizens Budget
Office of the Auditor General	Conducts the external audit of primary health care expenditure

CHAPTER 8: CONCLUSION

These Guidelines establish a single, disciplined route from policy to service in the primary health care subsector of Enugu State. Their requirements are not procedural preferences. Each addresses a specific failure that the State has observed and intends not to repeat.

The consolidation rule addresses duplication, which cannot be detected after appropriation and is expensive to unwind. The scoring framework addresses the ranking of competing proposals, which becomes contestable the moment it cannot be explained. The staffing rule addresses the most consequential omission in health capital budgeting, which is the facility built without provision for the people who must run it. The classification and geotagging requirements address the inability, common across States, to say where public money was actually spent.

The evidence base on which this edition rests is stronger than that available in 2025. The State now holds a verified facility register of 566 government owned facilities across 17 Local Government Areas and 260 wards, a designated focal network of 260 facilities, and a published workforce establishment position stating a requirement of 8,274 posts, 1,810 in post and a vacancy of 6,464. Planning assumptions drawn from those figures can be defended. Planning assumptions drawn from anything else should not be used.

Application of these Guidelines will not by itself close the workforce vacancy, complete the ward network or improve a health outcome. What it will do is ensure that every naira appropriated to primary health care in Enugu State is directed by a stated priority, costed to a standard, coded to a location, executed against a plan and reported against a result. That is the necessary condition for everything else the State intends.

The Ministry of Health shall review these Guidelines annually in the light of experience of their application, and shall issue a revised edition where necessary before the issuance of the Budget Call Circular.

ANNEXURES

Annexe 1: Budget calendar

The calendar below governs the preparation of the primary health care budget. Where the Ministry of Budget and Planning issues a calendar for the year, that calendar prevails and this annexe is read as indicative.

Table A1: Annual budget calendar for the primary health care subsector

Month	Activity	Responsible	Output
January	Circulation of the approved Consolidated Primary Health Care Work Plan; budget and expenditure profiling; commencement of implementation	Ministry of Health; all MDAs	Circulated work plan; approved expenditure profiles
February	Issuance of the Sector Performance Review guidance note and template; dissemination to health agencies and Local Government Health Authorities	Ministry of Budget and Planning; Ministry of Health	Guidance note and template in circulation
February	Preparation and approval of annual procurement plans	All MDAs	Approved procurement plans
March	Agency Performance Reviews conducted; Sector Performance Review compiled with primary health care as a standalone section	Health sector MDAs; Ministry of Health	Agency and Sector Performance Reviews
April	Revision, consolidation, validation and finalisation of the Sector Performance Review; publication of the annual primary health care performance report	Ministry of Health with the Ministry of Budget and Planning	Final Sector Performance Review
May	Preparation of the Medium Term Expenditure Framework and the Economic and Fiscal Update, Fiscal Strategy Paper and Budget Policy Statement	Ministry of Budget and Planning	Draft Medium Term Expenditure Framework
May to June	Medium Term Sector Strategy preparation workshop; prioritisation and costing of proposals; preparation of the pre budget Annual Operational Plan	Ministry of Health; Health Sector Planning Committee	Draft Medium Term Sector Strategy and Annual Operational Plan
June	Approval of the Medium Term Expenditure Framework by the State Executive Council; determination of sector ceilings	State Executive Council; Ministry of Budget and Planning	Approved Framework and ceilings
July	Issuance of the Budget Call Circular; dissemination to health sector MDAs; constitution of MDA budget subcommittees	Ministry of Budget and Planning; Ministry of Health; MDAs	Budget Call Circular in circulation
July to August	Preparation of budget proposals; prioritisation scoring; costing including the personnel implication	All MDAs	Scored, ranked and costed proposals
August	Half year budget performance review submitted	Ministry of Budget and Planning with the Ministry of Health	Half year review

Month	Activity	Responsible	Output
August	Review and endorsement of proposals by budget subcommittees; submission with the compliance checklist	MDA accounting officers	Submitted proposals
September	Review of proposals for compliance; commencement of bilateral discussions	Ministry of Budget and Planning with the Ministry of Health	Review notes
September to October	Bilateral discussions concluded; adjustments agreed	Ministry of Budget and Planning; MDAs	Agreed proposals
October	Consolidation into draft State estimates; assembly of the draft Consolidated Primary Health Care Work Plan	Ministry of Budget and Planning; Ministry of Health	Draft estimates and draft work plan
November	State Executive Council consideration; transmission of the Appropriation Bill to the House of Assembly	State Executive Council; His Excellency the Governor	Appropriation Bill
November to December	Budget defence; passage of the Appropriation Law; assent	House of Assembly; His Excellency the Governor	Appropriation Law
December to January	Publication of the approved budget and of the Citizens Budget; finalisation and circulation of the Consolidated Work Plan	Ministry of Budget and Planning; Ministry of Health	Published budget; Citizens Budget; final work plan

Annexe 2: Project prioritisation template

To be completed for every capital proposal and submitted with the budget proposal.

Field	Entry
Project title	
Implementing MDA	
Facility, ward and Local Government Area	
Chart of Accounts code, including location segment	
Facility service level and focal network status	
Criterion 1, equity of access: score and evidence	
Criterion 2, strategic alignment: score and evidence	
Criterion 3, health impact: score and evidence	
Criterion 4, readiness and deliverability: score and evidence	
Criterion 5, sustainability of recurrent cost: score and evidence	
Criterion 6, cost effectiveness: score and evidence	
Criterion 7, community priority: score and evidence	
Total weighted score out of 100	
Rank within the MDA submission	
Scored by, name and designation	
Date	

Annexe 3: Project costing template

Cost element	Unit	Quantity	Unit cost	Total cost	Basis of the estimate
Works					
Goods and equipment					
Installation and commissioning					
Consultancy and supervision					
User training					
Contingency					
TOTAL CAPITAL COST					
Recurrent consequence, year 1					
Recurrent consequence, year 2					
Recurrent consequence, year 3					
Of which personnel cost, per Table 15					

The personnel line shall be supported by the completed format at Table 15 stating posts, cadre, grade level, annual cost and funding source.

Annexe 4: Prioritised and costed project summary sheet

Rank	Project title	Ward and LGA	Weighted score	Capital cost	Recurrent consequence, year 1	Funding source	Phase
TOTAL							

Annexe 5: Capital expenditure projection template

Project title	Chart of Accounts code	Total project cost	Expenditure to date	Year 1 projection	Year 2 projection	Year 3 projection	Balance to complete
TOTAL							

Annexe 6: MDA work plan template

Activity or deliverable	Chart of Accounts code	Ward and LGA	Accountable officer	Start date	Completion date	Cost	Funding source	Performance indicator

Annexe 7: Budget performance report template

Budget line and code	Approved appropriation	Profiled to date	Released	Committed	Paid	Variance	Physical progress	Explanation of variance
TOTAL								

Physical progress shall be stated as a percentage of the deliverable, supported by certification of the supervising officer. A financial report submitted without physical progress does not satisfy Chapter 7.

Annexe 8: Responsibility matrix

Each activity in the budget cycle has one accountable officer. Supporting officers contribute but are not accountable for delivery.

Activity	Accountable	Supporting
Issuance of the Budget Call Circular	Permanent Secretary, Ministry of Budget and Planning	Director of Budget
Dissemination to the health sector	Permanent Secretary, Ministry of Health	Director, Planning, Research and Statistics
Sector Performance Review	Director, Planning, Research and Statistics, Ministry of Health	Agency Directors of Planning; Local Government Health Authority Secretaries
Medium Term Sector Strategy	Permanent Secretary, Ministry of Health	Health Sector Planning Committee
Prioritisation and scoring of proposals	Accounting officer of the proposing MDA	Planning and budget officers; Ward Development Committees
Costing, including the personnel implication	Director of Planning of the proposing MDA	Director of Administration and Human Resources; Office of the Accountant General
Endorsement and submission of proposals	Permanent Secretary or Chief Executive of the MDA	Budget subcommittee
Consolidation of the work plan	Permanent Secretary, Ministry of Health	Director, Planning, Research and Statistics; all sector MDAs
Procurement planning and execution	Accounting officer of the MDA	Procurement officer; tenders committee; State Logistics Management Coordinating Unit
Expenditure recording and accounting	Director of Finance and Accounts of the MDA	Ministry of Finance and Economic Development
Physical progress certification	Project supervising officer	Local Government Health Authority Secretary
Monthly and quarterly performance reporting	Accounting officer of the MDA	Monitoring and evaluation officer; finance officer

Activity	Accountable	Supporting
Consolidated subsector performance reporting	Permanent Secretary, Ministry of Health	Executive Secretary, ENSPHCDA
Workforce establishment position and staffing advice	Executive Secretary, ENSPHCDA	Director of Administration and Human Resources; Human Resources for Health Focal Person

Annexe 9: Submission compliance checklist

To be completed by the accounting officer and attached to every budget proposal. A submission received without a completed checklist shall be returned.

No.	Requirement	Yes or No	Reference
1	The proposal is derived from the Medium Term Sector Strategy or the pre budget Annual Operational Plan		Chapter 3.6
2	The proposal is carried in the draft Consolidated Primary Health Care Work Plan		Chapter 3.6
3	The proposal falls within the communicated ceiling		Chapter 3.2
4	Every line carries a complete six segment Chart of Accounts code		Chapter 3.2
5	Every capital project is geotagged to ward and Local Government Area		Chapter 3.2
6	Every capital proposal has been scored on the framework at Table 11 and the scoring sheet is attached		Chapter 5.2
7	Proposals are ranked by weighted score and the ranked list is attached		Chapter 5.2
8	Costing is disaggregated, evidenced and states its assumptions		Chapter 5.3
9	The recurrent consequence is stated for each of the three years following completion		Chapter 5.3
10	The personnel implication is stated on the format at Table 15 with a named funding source		Chapter 5.4
11	Actual expenditure for the preceding year and the first six months of the current year is included		Chapter 4.3
12	Ongoing, grant assisted and loan financed projects are prioritised over new starts		Chapter 4.3
13	The proposal is within the technical and absorptive capacity of the MDA		Chapter 4.3
14	The proposal has been reviewed by the budget subcommittee and endorsed by the accounting officer		Chapter 4.3

Name and designation of the accounting officer	
Signature	
Date	

Annexe 10: Glossary

Term	Meaning as used in these Guidelines
Absorptive capacity	The demonstrated ability of an MDA to implement and account for expenditure within the financial year, judged by its delivery performance in the two preceding years
Budget Call Circular	The annual instrument by which the Ministry of Budget and Planning communicates ceilings, formats, templates and deadlines to MDAs
Ceiling	The maximum expenditure a sector or MDA may propose, derived from the Medium Term Expenditure Framework
Consolidated Primary Health Care Work Plan	The single authoritative statement of all primary health care activity planned in the State for a financial year, irrespective of funding source
Direct Facility Financing	The channel through which Basic Health Care Provision Fund resources are transmitted to a facility for use at facility level
Established requirement	The number of posts prescribed for the primary health care network by the staffing norm adopted by the Agency
Expenditure profile	The distribution of an approved appropriation across the months or quarters of the year, stating expected commitment and payment
Focal facility	A Level 2 facility designated under the Basic Health Care Provision Fund as the anchor facility of a ward; there are 260, one in each ward
Geotagging	The coding of a capital project to a specific ward and Local Government Area using the location segment of the Chart of Accounts
Medium Term Expenditure Framework	The three year rolling plan establishing the resource envelope and sector ceilings
Medium Term Sector Strategy	The three year costed strategy of the health sector from which all MDA work plans derive
Recurrent consequence	The continuing annual cost arising from a capital investment once it enters service, including staffing, utilities, maintenance and consumables
Vacancy	The difference between the established requirement and the number of posts filled
Weighted score	The score of a proposal under the prioritisation framework, being the sum across seven criteria of the score divided by five multiplied by the weight

End of Guidelines.