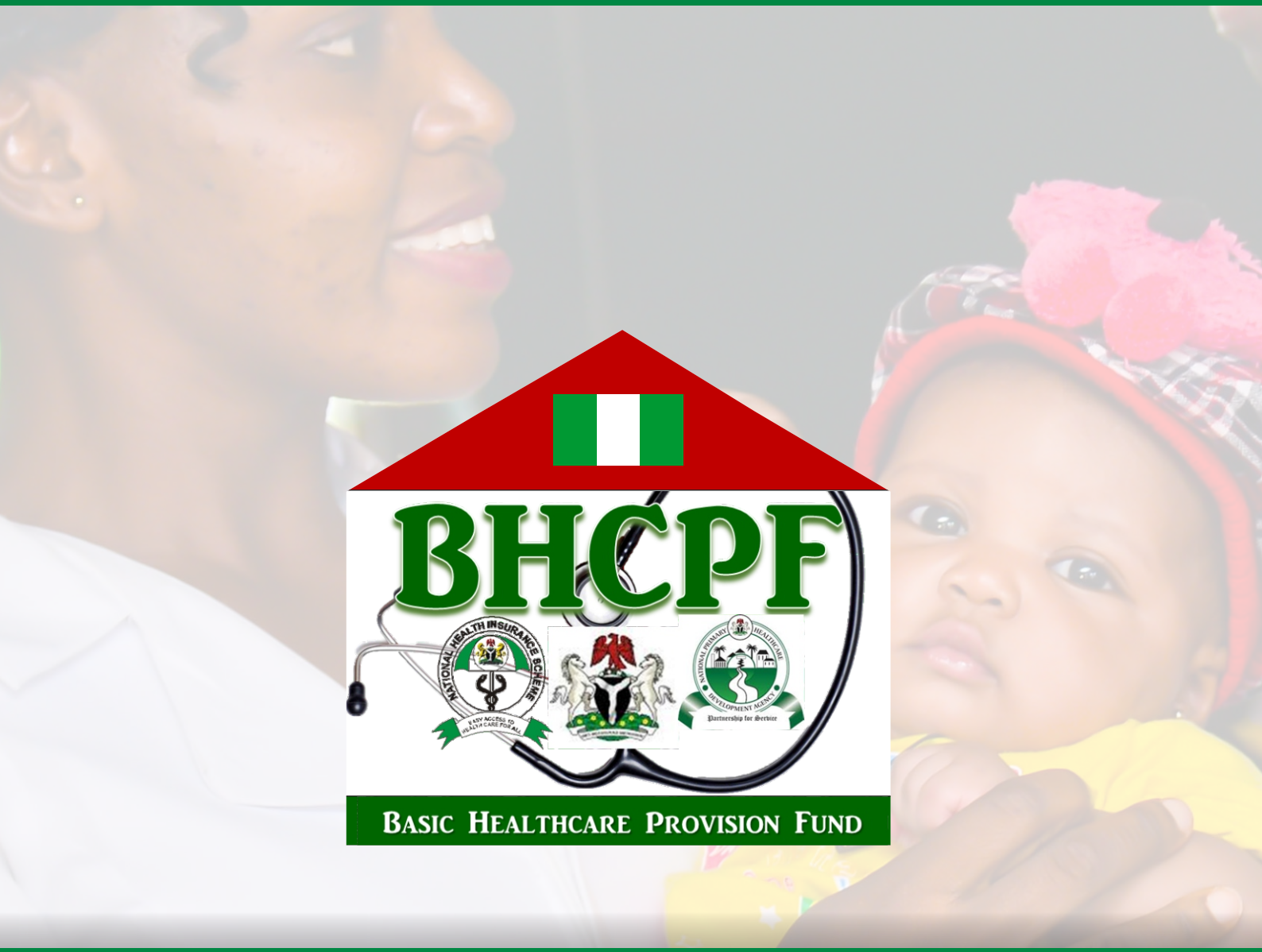

GUIDELINE FOR THE ADMINISTRATION, DISBURSEMENT AND MONITORING OF THE BASIC HEALTH CARE PROVISION FUND (BHCPF)

Developed by:
National Primary Health Care Development Agency (NPHCDA)
National Health Insurance Scheme (NHIS)
National Emergency Medical Treatment Committee (NEMTC)

FEDERAL MINISTRY OF HEALTH
FEDERAL REPUBLIC OF NIGERIA

September 2020

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FOREWORD

The **Basic Health Care Provision Fund (BHCPF)** is enshrined in the National Health Act 2014, of the Federal Republic of Nigeria. It is an irrevocable testament of the national commitment to achieving **universal health coverage**. This large-scale health sector reform effort is intended to expand the fiscal space by deploying financial resources to the frontlines, for primary health care services. The BHCPF is designed to be a sustainable model for ensuring equity and financial risk protection for vulnerable populations, by guaranteeing access to a **basic minimum package of health services**. It is funded from "not less than one percent" of the federal consolidated revenue fund, supplemented by grants from local and international donors, partners, the private sector and philanthropic organisations.

Prudent implementation of the BHCPF will improve national health indices and firmly place Nigeria on the path to achieving universal health coverage. To ensure transparency, accountability, efficiency, and value for money, this **Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (2020)**, is developed following revision of the previous Operations Manual (2018). The review was necessary to reset the implementation processes to better align with the National Health Act and address fundamental issues with the mechanism for administration of the fund, among other concerns. This revised guideline is the outcome of extensive conversations, consultations and consensus building among representatives of federal and state government, legislators, partners, civil society organisations and the private sector. Successful implementation shall require the staunch commitment of all stakeholders, including healthcare providers and citizen end-users.

Responsibilities are now clearly defined; from the Ministerial and State Oversight Committees in the offices of the Honourable Minister and Honourable Commissioners of Health, to the Ward Development Committees. These parties oversee and hold the core implementing entities accountable: these being the National Primary Health Care Development Agency, the National Health Insurance Scheme, and the National

Emergency Medical Treatment Committee, together known as the “Gateways”, and the primary health care service providers. This guideline also defines the roles and functions of stakeholders who wish to support or contribute to the BHCPF and is reference material for training institutions and researchers.

The health sector will find this revised guideline to be an innovative, catalytic framework that ultimately allows access to quality health care services on demand and at no cost at the point-of-care. I enjoin everyone to support implementation of this revised BHCPF Guideline 2020, for the achievement of universal health coverage.

Dr. E. Osagie Ehanire
Honourable Minister of Health, Nigeria
September, 2020

ABBREVIATIONS

AFB	Acid-Fast Bacillus
AGPMPN	Association of General and Private Medical Practitioners of Nigeria
AIDS	Acquired Immune Deficiency Syndrome
AMSWoN	Association of Medical Social Workers of Nigeria
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
CBHIS	Community-Based Health Insurance Scheme
CBO	Community-Based Organisation
CEA	Cost Effectiveness Analysis
CHIPS	Community Health Influencers and Promoters
CMD	Chief Medical Directors
CRF	Consolidated Revenue Fund
CSO	Civil Society Organisation
DFF	Decentralised Facility Financing
DHIS	District Health Information System
DLI	Disbursement Linked Indicator
ED	Executive Director
EmOC	Emergency Obstetric Care
EMR	Electronic Medical Record
EMS	Emergency Medical Service
EMT	Emergency Medical Treatment
ES	Executive Secretary
FBO	Faith-Based Organisation
FCCPC	Federal Competition and Consumer Protection Commission
FCT	Federal Capital Territory
FFS	Fee-for-service
FGoN	Federal Government of Nigeria
FMoF	Federal Ministry of Finance

FMoH	Federal Ministry of Health
FRSC	Federal Road Safety Commission
GDP	Gross Domestic Product
GIFMIS	Government Integrated Financial Management Information System
GMD	Guild of Medical Directors
HB	Haemoglobin
HCH	Honourable Commissioner for Health
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
HMB	Hospitals Management Board
HMH	Honourable Minister of Health
HMO	Health Maintenance Organisation
HRH	Human Resources for Health
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IE	Impact Evaluation
IV	Intravenous
KPI	Key Performance Indicator
LGA	Local Government Area
LGHA	Local Government Health Authority
LQAS	Lot Quality Assurance Sampling
M & E	Monitoring and Evaluation
MDCN	Medical and Dental Council of Nigeria
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOC	Ministerial Oversight Committee
MoU	Memorandum of Understanding
NAFDAC	National Agency for Food and Drug Administration and Control
NANNM	National Association of Nigerian Nurses and Midwives
NARTO	Nigerian Association of Road Transport Owners

NASS	National Assembly
NBS	National Bureau of Statistics
NBTS	National Blood Transfusion Service
NCC	Nigerian Communications Commission
NCDC	Nigeria Centre for Disease Control
NCH	National Council on Health
NDHS	National Demographic and Health Survey
NEC	National Economic Council
NEMA	National Emergency Management Agency
NEMRC	National Emergency Medical Response Centre
NEMSAS	National Emergency Medical Service and Ambulance System
NEMTC	National Emergency Medical Treatment Committee
NGO	Non-Governmental Organisation
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NIMC	National Identity Management Commission
NMA	Nigeria Medical Association
NPF	Nigeria Police Force
NPHCDA	National Primary Health Care Development Agency
NPopC	National Population Commission
NSHDP II	2nd National Strategic Health Development Plan
NURTW	National Union of Road Transport Workers
OAGF	Office of the Accountant General of the Federation
OIC	Officer-in-Charge
OOP	Out-of-pocket
P/PROM	Preterm and Pre-Labour Rupture of Membrane
P3 or PPP	Public-Private Partnership
PCV	Packed Cell Volume
PHC	Primary Health Care, Primary Health Care Facility
PHCUOR	Primary Health Care Under One Roof

PM	Programme Manager
PPE	Personal Protective Equipment
QIT	Quality Improvement Team
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
RTI	Road Traffic Injury
SCD	Sickle Cell Disease
SDG	Sustainable Development Goal
SHC	Secondary Health Care
SHIA	State Health Insurance Agency
SHIS	State Health Insurance Scheme
SMoF	State Ministry of Finance
SMoH	State Ministry of Health
SOC	State Oversight Committee
SOP	Standard Operating Procedures
SPHCB	State Primary Health Care Board
SPHCDA	State Primary Health Care Development Agency
TMM	Top Management Meeting
TOT	Training-of-Trainers
TSA	Treasury Single Account
UHC	Universal Health Coverage
UNDARSTIP	United Nations Decade of Action on Road Safety and Traffic Injury Prevention
UTI	Urinary Tract Infection
VCT	Voluntary Counselling and Testing
WDC	Ward Development Committee
WHO	World Health Organization
WHS	Ward Health System

DEFINITIONS

Actuary: a statistician who calculates risks and probabilities for a payment plan

Administrative Charge: amount set aside for operations

Affordability: ability to pay for health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways including access to essential medicines and technologies to diagnose and treat medical problems, sufficient capacity of well-trained, motivated health workers to provide the services to meet patient needs based on the best available evidence

Benefit: benefit or advantage of any kind derived from a scheme

Capitation: payment method in which all providers in the payment system are paid in advance, whether the enrolee uses the services or not, a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period

Catastrophic Spending: (for each individual or household) occurs when hospitalisation spending for that person or household, as a proportion of ability to pay (household consumption spending minus combined survival income for all household members) exceeds a certain threshold. The threshold value can range from 5 to 40%

Civil Society Organisations (CSOs): associations (usually Non-Governmental Organisations (NGOs)) and institutions that reflect and represent the interests and will of citizens through advocacy

Community-Based Health Insurance Scheme (CBHIS): a form of voluntary, not-for-profit insurance mechanism that often involves some form of community management.

CBHIS schemes are typically based on a collective entity defined by geographic, professional, or religious affiliations

Cost Effectiveness Analysis (CEA): economic cost of a health intervention divided by an estimate of the health effects; the interventions with the smallest ratios are considered the most cost-effective. CEA is a tool for identifying which health interventions achieve the greatest level of health impact per unit of investment, and the results can be used to evaluate ongoing health interventions or to plan for future health programmes

Electronic Medical Record (EMR): digital version of a paper record that contains an individual's full medical history with the health care provider including diagnosis, treatment and medical services rendered

Enrolee: eligible person enrolled in a health insurance scheme or health plan, or the eligible person's qualifying dependent

Faith-Based Organisation (FBO): public or private organisation consisting of individuals united based on religious or spiritual beliefs and directing their efforts toward meeting the spiritual, social, and cultural needs of the members of their community

Fee-for-service (FFS): payment model of payment per service rendered to an enrolee by a health care provider for health services not classified under capitation

Financial Catastrophe: high out-of-pocket (OOP) payment for health services in the presence of low household financial capacity and absence of prepayment mechanisms, results in financial catastrophe. This high expenditure for health care results in households or individuals reducing or becoming unable to pay for necessities like food, clothing and even education of children

Fiscal Space: availability of budgetary room that allows a government to provide resources for a desired purpose without prejudice to the sustainability of a government's

financial position. Usually, in creating fiscal space, additional resources can be made available for some form of meritorious government spending

General Government Expenditure: total amount expended by a government and reflects the total expenditure that the government needs to finance from revenues generated such as taxes, economic income and borrowed funds. Current government expenditure includes purchasing goods and services, salaries and wages, national defence, security, and health

General Government Expenditure on Health: the sum of outlays by government entities to purchase health care services and goods. It comprises the outlays on health by all levels of government, social security agencies and direct expenditure by parastatals and public firms. Aside from domestic funds, it also includes external resources passing through the government as grants or loans, channelled through the national budget

Gross Domestic Product (GDP) per Capita: gross domestic product divided by the midyear population. GDP is the sum of gross value of all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources

Health Care Provider: any government or private health care facility, hospitals, maternity centres, community pharmacies and all other service providers accredited for the provision of prescribed health services for insured persons and their dependents

Health Maintenance Organisation (HMO): a limited liability company formed by private or public establishments or individuals, to facilitate the provision of health care services to a defined group of enrolees and financed by prepaid employer-employee insurance premium payments. Care is provided by participating health care providers and all parties are bound by agreements

Local Government: public administration at local levels exercised through representative councils established by law, exercising specific powers within a defined geographical area. These powers give the local government substantial control over local affairs as well as the staff to direct the provision of services and implement projects, which complement the activities of state and federal government

Medical Documents: all prescriptions, laboratory forms, excuse duty, death certificate and other documents used in patient management

Medical Practitioner: a person with a medical or related degree registerable with the Medical and Dental Council of Nigeria (MDCN)

National Health Insurance Scheme (NHIS): social health insurance scheme in established by the National Health Insurance Scheme Act of 1999 of the Federal Republic of Nigeria Laws No. 42 VOL II 2004

National Primary Health Care Development Agency (NPHCDA): corporate body established by Degree 29,1992 with statutory responsibilities of providing policy and guidance, technical support, and resource mobilisation to state and local governments for the implementation of primary health care

Pooling: accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures

Primary-Level Health Care Facility: typically staffed by general practitioners or nurses with limited laboratory services for general, unspecialised pathological analysis; bed size ranging from 0-20 beds; often referred to as first level referral

Private Expenditure on Health: includes direct household (out-of-pocket) payment, private insurance, charitable donations, and direct service payment by private corporations

Provider Payment Mechanism: mechanisms used to transfer payment for services rendered from the purchaser or a proxy to the health care provider. The provider payment mechanism accomplishes far more than simply the transfer of funds to cover the costs of services

Public-Private Partnership (P3 or PPP): legally binding contract between government and the private sector for the provision of assets and the delivery of services that allocates responsibilities and business risks among the various partners. The goal is to combine the best capabilities of the public and private sectors for mutual benefit

Secondary-Level Health Care Facility: highly differentiated by function with 5-10 clinical specialties; bed size ranging from 20-100 beds; often referred to as Specialist Hospital

Social Health Insurance Scheme: health insurance scheme provided by government, especially to low- and middle-income populations

Specialist Care: care provided by secondary-level health care facilities that focuses on specific organs or diseases (cardiology, neurology, oncology, etc.) including special diagnostic and therapeutic services such as biopsy or dialysis

Strategic Purchasing: planning and purchasing of preventive, curative and rehabilitative clinical services to meet the health needs of a population

Tertiary-Level Health Care Facility: highly specialised staff and technical equipment, (cardiology, intensive care unit (ICU) and specialised imaging units); clinical services are

highly differentiated by function; may have teaching activities; bed size ranging from 100-800 beds; often referred to as Teaching or Tertiary Hospital

Total Expenditure on Health: sum of public and private health expenditure that covers provision of all health services, family planning services, nutrition activities and emergency aid designated for health

Universal Health Coverage (UHC): process that ensures all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services

User Fees: charges levied on any aspect of health services at the point of delivery

Vulnerable: persons at higher risk for poor health because of barriers to resources, and limitations due to illness or disability. In the BHCPF, the following categories of people are classified as vulnerable: (a) pregnant women, (b) children under 5 years, (c) the elderly over 85 years, (d) person with disability, (e) the poor, and others falling within the group

EXECUTIVE SUMMARY

The enactment of the National Health Act (NHAct) 2014 and establishment of the Basic Health Care Provision Fund (BHCPF) in Section 11, represents a watershed moment in the journey toward providing equitable access to health care and universal health coverage (UHC). Implementation will be informed by this guideline which details the governance, administrative, funding and monitoring mechanisms for the BHCPF.

In accordance with the National Health Act, the BHCPF is derived from (a) an annual grant from the Federal Government of Nigeria (FGoN) of not less than one percent (1%) of the Consolidated Revenue Fund (CRF); (b) grants by international donor partners; (c) funds from any other source, inclusive of the private sector. Implementation is aimed at increasing the fiscal space for health, strengthening the national health system particularly at primary health care (PHC) level, and ensuring access to health care for all, particularly the poor, thus contributing to overall national productivity.

The BHCPF will be managed by a robust governance framework led by the Honourable Minister of Health (HMH) at the federal level and Honourable Commissioners for Health (HCHs) at the state level. The governance framework and operational protocols outlined herein eliminate additional layers of bureaucracy and strengthen implementation by leveraging the mandates and structural advantages of the main implementers i.e. the National Health Insurance Scheme (NHIS), the National Primary Health Care Development Agency (NPHCDA), and the National Emergency Medical Treatment Committee (NEMTC), thereby ensuring operational synergy. This efficiency is achieved with the support of the National Assembly (NASS) Committees on Health, the Ministerial Oversight Committee (MOC), the State Oversight Committees (SOCs) and the Gateways Forum, the Local Government Health Authority (LGHA) Advisory Committee, the Ward Development Committee (WDC) and Primary Health Care Centre (PHC) Management Committees; comprises implementers and beneficiaries across the tiers of government and health care delivery structure.

The overall objective of the BHCPF is to ensure the provision of a Basic Minimum Package of Health Services (BMPHS), strengthen the Primary Health Care (PHC) system and provide emergency medical treatment. This is to be achieved by:

- Disbursing 50% of the BHCPF through the National Health Insurance Scheme (NHIS) via a pathway to be called the "NHIS Gateway", for the provision of a BMPHS in eligible primary and secondary health care facilities;
- Disbursing 45% of the BHCPF through the National Primary Health Care Development Agency (NPHCDA) via a pathway to be called the "NPHCDA Gateway", for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (20%), the provision and maintenance of facilities, laboratory, equipment and transport for eligible primary health care facilities (15%) and the development of Human Resources for Primary Health Care (10%); and
- Utilising 5% of the BHCPF through the National Emergency Medical Treatment Committee (NEMTC) via a pathway to be called the "EMT Gateway", for the provision of emergency medical treatment

This Guideline details the governance structure and operations of each of the gateways, and fiduciary measures and sanctions.

The sections on the NHIS Gateway outline the process for individuals and health care providers to enrol as beneficiaries of the BHCPF, which shall enable access to care included in the BMPHS, in designated PHC and secondary health facilities. The gateway shall purchase the BMPHS from the State Health Insurance Agencies and State Health Insurance Schemes (SHIA, SHIS), at an agreed premium. Payment for services rendered at the PHC level shall be by capitation, while services at the secondary level shall be paid by fee-for-service.

The sections on the NPHCDA Gateway outline roles and responsibilities for the NPHCDA, the State Primary Health Care Development Agencies (SPHCDAs) and State Primary Health Care Boards (SPHCBs), the LGHAs, WDCs and PHC facilities. The gateway actions shall provide skill, capacity, and technical support; fund the availability of essential medicines and health commodities; ensure availability of vaccines and human resources; maintain PHC facilities and sustain outreach services; all culminating in improvement in the quality of PHC services.

Funding through the NPHCDA Gateway is based on annual improvement and quarterly business plans of the PHC facilities, and annual proposals by the SPHCDAs and SPHCBs. Investment by the SPHCDAs and SPHCBs shall be initially guided by the outcome of baseline assessments and prevailing health priorities in each state. Subsequent investments shall be determined by

outcomes of quality improvement assessments, monitoring and supervision, and other surveys and financial audits. On a quarterly basis, PHC facilities will receive decentralised Facility Financing from the NPHCDA through their SPHCDA or SPHCB, while SPHCDAs and SPHCBs shall receive and manage quarterly grants for human resources. SPHCDAs and SPHCBs shall be required to retire a statement of expenditure before receipt of funding for subsequent quarters.

Closing the gap between need and access to health care in emergencies, is the Emergency Medical Treatment (EMT) Gateway, managed by the National Emergency Medical Treatment Committee (NEMTC), appointed by the National Council on Health (NCH). Sections for the EMT Gateway outline the administrative structures and processes for the establishment of a National Emergency Medical Service and Ambulance System (NEMSAS). The ambulance system shall operate with extensive private sector participation and utilise an emergency call centre system to be co-located with the national emergency call-centre, both at the federal and state levels.

This Guideline ensures transparency and accountability through the application of a robust monitoring and evaluation (M & E), and accountability framework; key performance indicators (KPIs) at federal and state levels; and the governance structure of the BHCPF. Development partners and CSOs shall also support the implementation and monitoring of the fund as outlined in the sections on monitoring and evaluation.

Judicious implementation of this Guideline shall enable Nigeria effectively fast-track the implementation of the BHCPF and yield impactful health benefits for all.

Dr. Faisal Shuaib	**Prof. M. N. Sambo**	**Dr. Felix Ogedegbe**
Executive Director/CEO	Executive Secretary/CEO	Chairman,
NPHCDA	NHIS	NEMTC

1.0 INTRODUCTION

The National Health Act (NHAct) 2014 is a milestone in the national momentum to strengthen the health system, achieve universal health coverage (UHC), and improve health indices with the consequential improvement in economic productivity.

National commitment to UHC was symbolised by the passage of the National Health Act (NHAct) of 2014, which in Section 11, mandates the establishment of a Basic Health Care Provision Fund (BHCPF) to support the effective delivery of primary and secondary health care services through the provision of a Basic Minimum Package of Healthcare Services (BMPHS) and Emergency Medical Treatment (EMT).

The NHAct 2014 was enacted to ensure improved health outcomes, by providing a legal framework for the provision of health care services and establish an organisational and management structure for the health system in Nigeria. To achieve these important objectives, the NHAct specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS). The BMPHS is a set of preventive, protective, promotive, curative, and rehabilitative health services to be developed and reviewed from time to time by the Honourable Minister of Health (HMH), in consultation with the National Council on Health (NCH).

The Basic Health Care Provision Fund (BHCPF) or “The Fund”, was established under Section 11 of the National Health Act, as the principal funding vehicle for the BMPHS, and serves to increase the fiscal space and overall financing in the health sector. It is expected that the attendant service upscale from application of this funding, shall enable Nigeria to achieve UHC. Funding the BHCPF shall be derived, as stipulated in the NHAct, from (a) an annual grant from the Federal Government of Nigeria (FGoN) of not less than one percent (1%) of the Consolidated Revenue Fund (CRF); (b) grants by international donor partners; (c) funds from any other sources, inclusive of the private sector.

The purpose of the BHCPF is threefold:

1. Ensuring the provision of a Basic Minimum Package of Health Services (BMPHS) by applying 50% of the funds towards purchase of the BMPHS, to be managed by the National Health Insurance Scheme (NHIS);

2. Strengthening the Primary Health Care (PHC) system, with 45% of BHCPF to be disbursed by the National Primary Health Care Development Agency (NPHCDA) for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (20% of BHCPF); the provision and maintenance of facilities, laboratories, equipment, and transport for eligible primary health care facilities (15% of BHCPF) and the development of Human Resources for Primary Health Care (10% of BHCPF); and

3. Providing Emergency Medical Treatment, with 5% of the BHCPF to be administered by the National Emergency Medical Treatment Committee (NEMTC) as appointed by the National Council on Health (NCH).

It is noted that primary health care (PHC) is the foundation for the provision of health care and this fundamental role is recognised by the NHAct, in sections designed to strengthen PHC. The health care agenda of the administration of President Muhammadu Buhari is centred around the establishment of at least 1 (one) fully functional primary health care centre in every political ward, with the ultimate objective of ensuring UHC; the BHCPF is key to accomplishing this agenda.

In order to adequately fund health care services under the current challenging economic climate in Nigeria, the federal government considered radical options and made important choices including: a review of the current system of annual allocations to public health care facilities; a reorientation in disease burden priorities, ensuring efficiency savings to reduce costs; and increased private sector participation, especially in the delivery of care. All these factors were taken into consideration in defining the BMPHS.

Childbirth difficulties and health challenges of children under-five remain significant causes of the national disease burden and untimely death. These are brought into sharp focus by the extremely high Maternal Mortality Ratio (MMR) and under-five mortality rates in Nigeria; estimated at 512 per 100,000 births[1] and 132 per 1,000 live births, respectively. Given the huge impact of maternal and under-five morbidity and mortality on disease burden, targeted cost-effective interventions and services have been prioritised in the BMPHS.

The treatment of medical emergencies is a significant challenge to health care delivery; there is no coordinated national emergency medical response system or ambulance service. This is against a backdrop of rising trends of non-communicable disease (NCD) and injuries in adults; Nigeria has the highest road traffic injury death rate (52.4 per 100,000) of any country globally[2]. Road Traffic Injuries (RTIs) are now the fifth leading cause of death in Nigeria, up from eleventh in 1990[3]. The rate of death from medical emergencies thus remains extremely high and the development of an Emergency Medical Service (EMS) is therefore a priority under the BHCPF, for effective access to emergency medical care. Additional justification for prioritising RTIs is the Sustainable Development Goal (SDG) 3.64: "*Halve the burden due to global road traffic crashes by halving the number of fatalities and serious injuries by 2030 compared to 2010".*

1.1 Aim of the Basic Health Care Provision Fund

The overall aim is to significantly move Nigeria towards achieving Universal Health Coverage (UHC) utilising the 2nd National Strategic Health Development Plan (NSHDP II) (2018-2022) in the medium term; and in line with the health-related sustainable

[1] Nigeria Demographic and Health Survey 2018. National Population Commission Abuja, Nigeria 2014

[2] Bhalla, K, Harrison, J, Shahraz, S, Abraham, JP, Bartels, D, Yeh, PH, Naghavi, M, Lozano, R, Vos, T, Phillips, D, Chou, D, Bollinger, I, Gonzalez-Medina, D, Wurtz, B, and Murray, CJL, 2013, Burden of Road Injuries in Sub-Saharan Africa, Department of Global Health and Population, Harvard School of Public Health, Boston, MA, africa.globalburdenofinjuries.org

[3] Bloom, D, Cafiero, ET, Jane-Llopis, E, Abrahams-Gessel, S, Bloom, L, Fathima, S et al., 2011. The Global Economic Burden of Non-Communicable Diseases. Geneva: World Economic Forum

development goals (SDGs) in the long-term. The BHCPF therefore, in an initial phase over the next 3 years, is targeting the NSHDP II goals of reducing maternal mortality from 576 to 400 per 100,000 live births representing a 31% reduction; reducing neonatal mortality from 39 to 26 per 1,000 live births representing a 33% reduction; and reducing under-5 mortality from 120 to 85 per 1,000 live births representing a 29% reduction (NSHDP, 2018). The BHCPF will also ensure that medical emergencies are attended without delay to minimise mortality and morbidity.

1.2 Objectives of the Basic Health Care Provision Fund

The specific objectives of implementing the Basic Health Care Provision Fund (BHCPF) are:

1. To achieve at least 1 (one) fully functional public or private primary health care (PHC) facility in each political ward; at least 30% of all wards over the next 3 years, 70% within 5 years, and 100% within 7 years.

2. To achieve at least 3 (three) fully functional public or private secondary health care facilities, benefitting from the BHCPF in each state; at least 50% of all states over the next 3 years, and 100% within 5 years.

3. To establish effective emergency medical response services in 36 states and the Federal Capital Territory (FCT) in 5 years, including a national ambulance service.

4. To reduce out-of-pocket expenditure by 30% in 5 years and increase financial risk protection through health insurance.

5. To increase life expectancy to at least 60 years over the next 10 years.

1.3 Establishment of Implementation Gateways

In line with the NHAct 2014, which stipulates that at least 1% of the CRF of the Federal Government shall be deducted as a statutory first line charge; which shall be disbursed to and through the NHIS, NPHCDA and NEMTC in predetermined percentages; the NHAct sets out important drivers and streams for the disbursement and utilisation of the BHCPF. These streams have been identified as the 3 (three) **"Payment and Implementation Gateways".** The percentage and nomenclature for each gateway is outlined below.

1. Fifty percent (50%) of the Fund shall be disbursed through the National Health Insurance Scheme (**NHIS Gateway**) and deployed towards purchasing (and thus ensuring availability) of the Basic Minimum Package (BMPHS) in eligible primary or secondary health care facilities nationwide.

2. Forty-five percent (45%) of the Fund shall be disbursed through the National Primary Health Care Development Agency (**NPHCDA Gateway**) and deployed to strengthening Primary Health Care (PHC) facilities; through the provision of essential drugs, vaccines and consumables, provision and maintenance of health facilities, equipment and transport; and development of human resources.

3. Five percent (5%) of the Fund shall be administered by the National Emergency Medical Treatment Committee (**EMT Gateway**) and deployed towards emergency medical treatment.

1.4 Guiding Principles for Implementation of the Basic Health Care Provision Fund

The implementation of the BHCPF will comply with the following overarching principles under the NHAct 2014: These principles have informed the content of this Guideline.

1. Population Coverage:

The BHCPF shall focus on provision of a BMPHS in line with the NHAct 2014.

2. Service Provision:

Provision of health care services within the BHCPF shall be by Primary and Secondary Health Care facilities duly registered by the State Ministries of Health (SMoHs) or the FCT Health Secretariat and granted a Certificate of Standards. As a prerequisite for registration as a provider, the NPHCDA will certify Primary Health Care Facilities (according to the Standards for Primary Health Care in Nigeria) in alignment with sections 12 and 13 of the NHAct 2014; and by the NHIS based on the NHIS Operational Guideline. Accredited and registered public and private primary and secondary health care facilities and emergency service providers may serve as BHCPF delivery points.

3. Scope of Services:

This is based on the Basic Minimum Package of Healthcare Services (BMPHS) as defined by the Honourable Minister of Health in line with the NHAct 2014.

4. Governance Structure:

In line with the NHAct 2014, the 3 payment gateways shall be responsible for management of the funds, under the supervision of the Honourable Minister of Health and Honourable Commissioners for Health at federal and state levels, respectively.

5. Flow of Funds:

Funds will be transferred from the Consolidated Revenue Fund account by the Federal Ministry of Finance (FMoF) to the 3 gateways (NHIS, NPHCDA, and NEMTC). The NHIS and NPHCDA gateways will in turn allocate the funds to the corresponding state gateways (SHIA and SHIS, SPHCDA and SPHCB). For the NPHCDA gateway, the state organs shall then disburse directly to health facilities. For the NHIS gateway, the SHIA or SHIS shall pay health facilities according to the number of persons enrolled and services rendered for referred cases, while the NEMTC will reimburse emergency service providers directly, for the delivery of services itemised in the BMPHS. Donor funds shall be disbursed in accordance with section 2.4 of this guideline.

6. On-boarding:

On-boarding to each gateway by state level organs can be achieved by fulfilling the eligibility criteria for each gateway as documented in this guideline, and the designation of 25% of the total cost of projects as counterpart funding as stipulated in the NHAct

2014. State governments may wish to set aside 25% of the cost of the project from their annual budgetary provision as first line charge.

7. Enrolment (NHIS Gateway only):

Enrolment activities may be carried out by NHIS as well as state level health insurance agencies and schemes.

8. Monitoring and Evaluation:

There shall be routine monitoring and periodic evaluation of activities related to the Fund by the respective gateways and their state counterparts. Implementation reports (programmatic and financial) are to include successes, challenges, and limitations for all planned activities in the initial proposals. The Honourable Minister may, at discretion, periodically constitute a team to monitor the implementation of the Fund.

1.5 Purpose of the Guideline

This Guideline has been written with thorough reference to the National Health Act 2014 and following extensive consultation with stakeholders in the health sector. They define the requirements for administration, disbursement, monitoring and financial management of the Fund. All stakeholders including (but not limited to) participating health care providers, health care facilities, federal government parastatals and partner organisations, will work to adopt, implement and comply with the stipulations set out in this guideline, in collaboration with the gateways (the National Health Insurance Scheme (NHIS), the National Primary Care Development Agency (NPHCDA), the National Emergency Medical Treatment Committee (NEMTC)); state and local governments; and their participating agencies including the State Primary Health Care Boards and Agencies (SPHCDAs, SPHCBs) and State Health Insurance Agencies and Schemes (SHIAs, SHISs).

The overarching strategic objective of this guideline is to ensure that utilisation of the Fund catalyses improved health outcomes. This will be achieved by targeting specific areas of concern such as maternal, newborn and child health and non-communicable diseases. In developing this guideline, great emphasis was placed on the ease and speed of implementation, safeguarding equity in health service delivery across Nigeria, as well

as entrenching a robust accountability and probity framework to guarantee prudent financial management of the BHCPF.

Specifically, the primary purpose of this guideline is to:

1. Set out the criteria for administration, disbursement, monitoring and financial management of the Basic Health Care Provision Fund as provided under Section 11 of the National Health Act.

2. Specify the eligibility requirements, terms of participation and attendant responsibilities for parties to access the Fund.

3. Set out the requirements to be met by beneficiary health facilities.

4. Enumerate the course of action for all other matters which shall ensure that the Basic Health Care Provision Fund achieves its intended objectives, as stated in the National Health Act.

In addition, it is expected that each of the implementing gateways may, out of exigencies of programme implementation, publish and disseminate detailed protocols for use by actors within the various gateways. However, such protocol and standards of practice shall not, in any form, be contradictory to this guideline or the NHAct 2014.

1.6 Basic Minimum Package of Health Services

The Fund specifically stipulates the provision of a Basic Minimum Package of Health Services (BMPHS) which is to be provided by eligible primary and secondary health facilities, enrolled under the NHIS Gateway. The additional fiscal space created by the BHCPF will, however, be insufficient to finance a comprehensive health care package for all Nigerians but, if utilised efficiently, can serve as a catalyst for creative disruption of existing trends in poor health outcomes. The BMPHS is a defined and actuarially costed baseline entitlement, this guideline outlines the components that will be provided under the BHCPF.

1.7 Review of Guidelines

This guideline shall be subject to review after 3 years in the first instance, and every 5 years subsequently.

2.0 GENERAL ADMINISTRATION OF THE BASIC HEALTH CARE PROVISION FUND (BHCPF)

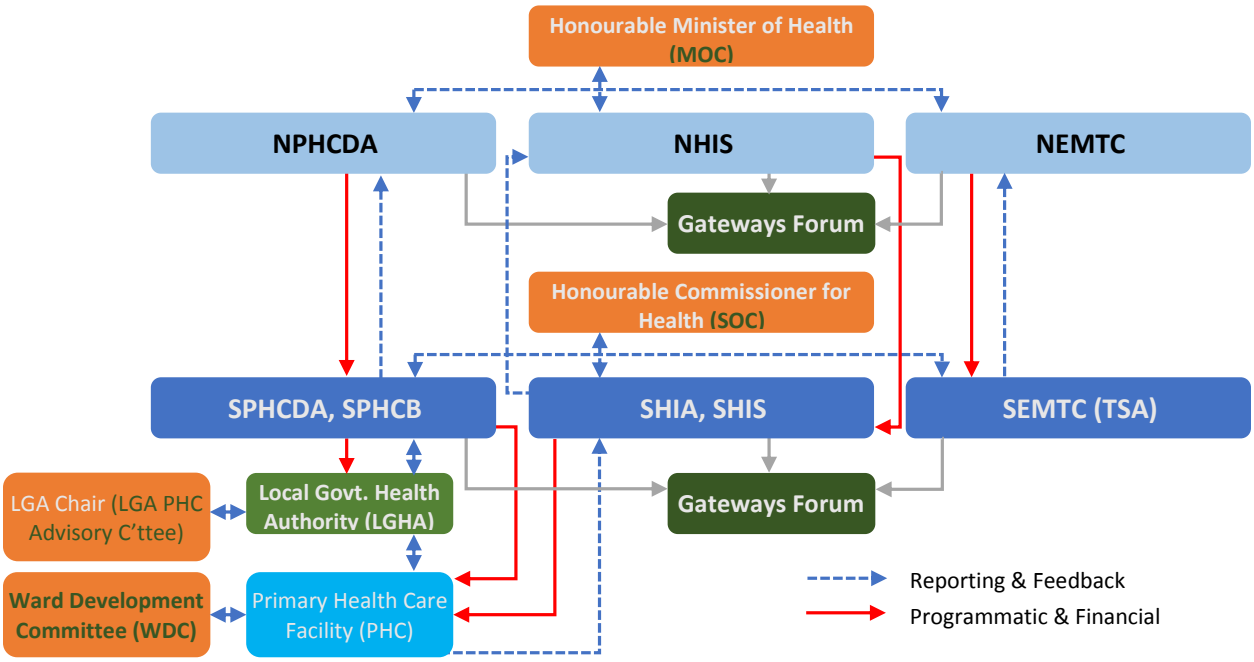

Figure 1: Governance Structure of the Basic Health Care Provision Fund

2.1 Federal Government Level

The Honourable Minister of Health shall have oversight over the implementation of the Basic Health Care Provision Fund (BHCPF) and approve annual plans and budgets for the 3 gateways.

2.1.1 Ministerial Oversight Committee (MOC) for the Basic Health Care Provision Fund (BHCPF)

The Ministerial Oversight Committee (MOC) is to be chaired by the Honourable Minister of Health and shall serve as a platform to routinely brief stakeholders on the implementation of the BHCPF by the 3 gateways. The briefings shall provide updates on programme implementation and financial reporting.

2.1.1.1 Membership of the Ministerial Oversight Committee

The Ministerial Oversight Committee shall be comprised as follows:

1. **Chair**, Minister for Health
2. **Alternate Chair**, Minister of State for Health
3. **Vice Chair**, Permanent Secretary Federal Ministry of Health (FMoH), and in the absence of the Minister of Health and the Minister of State for Health, shall Chair the Oversight Committee
4. **Secretary**, a Director of the FMoH in the Honourable Minister of Health's Office and a non-voting member

Members:

5. Representative, Minister of Finance
6. Executive Secretary, National Health Insurance Scheme (NHIS)
7. Executive Director, National Primary Health Care Development Agency (NPHCDA)
8. Chair, National Emergency Medical Treatment Committee (NEMTC)
9. Director, Department of Family Health FMoH
10. Director, Department of Public Health FMoH
11. Director, Department of Health Planning, Research and Statistics FMoH
12. Director, Department of Hospital Services FMoH
13. Chair, Committee of State Commissioners of Health
14. Representative or Chair, State Primary Health Care Development Agency (SPHCDA) or State Primary Health Care Board (SPHCB) Executive Secretaries
15. Representative or Chair, State Health Insurance Agency (SHIA) Executive Secretaries
16. 1 (one) Representative each of Development Partners and Private Sector Organisations contributing to the fund
17. Representative, World Health Organization (WHO)
18. Representative, Civil Society Organisations (CSOs) focused on health (selected by CSOs)
19. Representative, Federal Competition and Consumer Protection Commission (FCCPC)

2.1.1.2 Terms of Reference for the Ministerial Oversight Committee

1. Function as a national oversight group promoting robust collaboration among implementing agencies (NPHCDA, NHIS and NEMTC) in the evolution and implementation of the BHCPF.

2. Coordinate the operations of the stakeholders to ensure alignment with the objectives of the NHAct for the BHCPF.

3. Review annual work plans and budgets of federal and state implementing entities, as presented by implementing agencies, for endorsement.

4. Review updates on flow of funds, performance management and verification of results, as presented by the implementing agencies for guidance and feedback.

5. Evaluate periodic programme reports presented by the implementing agencies.

6. Ensure compliance of all participating agencies and entities with this guideline.

7. Review performance of the implementing entities based on a clear set of agreed upon Key Performance Indicators (KPIs) across the BHCPF.

8. Ensure that funds are disbursed, managed, and accounted for in a transparent manner and in accordance with this guideline.

9. Advocate for and ensure the provision of the required resources for planning and delivery of the BHCPF.

10. Facilitate implementation of financial audits by external auditors.

11. In exceptional circumstances, at the discretion of the Honourable Minister of Health or Chair of the MOC, the MOC may direct the engagement of an independent entity to review implementation on a case-by-case basis.

12. Prepare progress reports for the National Council on Health (NCH), the National Economic Council (NEC), the National Assembly (NASS), and other stakeholders as may be required from time to time.

13. Resolve any disputes, discrepancies or issues arising from implementation of the BHCPF.

2.1.1.3 Ministerial Oversight Committee Meetings

The MOC shall meet quarterly, or at the instance of the Honourable Minister of Health or Chair of the MOC.

2.1.2 Basic Health Care Provision Fund (BHCPF) Gateways Forum

There shall be a Gateways Forum at federal and state levels for interaction of the 3 (three) implementing gateways, the NPHCDA, NHIS and NEMTC. The forum shall be co-chaired by the Chief Executives of the 3 gateways.

Fundamental objectives of the Gateways Forum shall be to:

- Ensure synergy, alignment and enable effective collaboration while implementing the BHCPF
- Address common challenges to the implementation of the BHCPF
- Leverage existing institutional resources for the implementation of the gateways

2.1.2.1 Meeting of the BHCPF Gateways Forum

The forum shall meet at least quarterly; attended by a minimum of 3 representatives from each gateway.

2.2 State Government Level

The Honourable Commissioner shall provide leadership and supervision of the Basic Health Care Provision Fund (BHCPF) implementation in the state; and approve annual work plans and reports. The Honourable Commissioner shall approve all formal reports emanating from the state prior to transmission to the federal level.

2.2.1 State Oversight Committee (SOC) for the Basic Health Care Provision Fund (BHCPF)

Membership shall include:

1. Chair, Honourable Commissioner for Health

   Members:
2. Permanent Secretary, State Ministry of Health (SMoH)
3. Executive Secretary, State Primary Health Care Development Agency (SPHCDA) or State Primary Health Care Board (SPHCB)
4. Executive Secretary or CEO, State Health Insurance Agency (SHIA)
5. Chair, State Emergency Medical Treatment Committee (SEMTC)

6. Director, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) SMoH
7. Director, Department of Health Planning, Research and Statistics SMoH
8. Director, Department of Public Health SMoH
9. Director, Department of Hospital Services SMoH
10. Representative, State Ministry of Finance
11. Representative, State Ministry of Local Government and Chieftaincy Affairs
12. State Coordinator, NPHCDA
13. State Coordinator, NHIS
14. Representative, Community-Based Organisations (CBOs) and CSOs
15. 1 (one) Representative each of Development Partners active in the state
16. Representative, LGA PHC Coordinators
17. Representative, Secondary Health Facilities

2.2.1.1 Terms of Reference for State Oversight Committees

1. The Honourable Commissioner, supported by the State Oversight Committee (SOC), shall conduct advocacy, and ensure budgetary appropriation and release of state and local government 25% counterpart funding and any additional funding from other sources pursuant to the NHAct 2014.

2. Ensure that all onboarding criteria, as required by the gateways, are met and in a timely manner.

3. Ensure that implementation and use of funds within the state comply with this guideline, in a transparent and accountable manner.

4. Receive and review annual workplans and budgets from implementing gateways.

5. Receive quarterly briefing from all gateways, at the state level, on programme performance, fund utilisation, programme implementation and coverage.

6. Provide feedback to gateways for strengthening implementation.

7. Coordinate operations of different stakeholders and resolve disputes or issues arising from implementation of the BHCPF.

8. Ensure compliance, conduct periodic performance management, monitoring and supervision of activities within the state.

2.2.1.2 State Oversight Committee Meetings

The SOC shall meet quarterly or at the instance of the Honourable Commissioner for Health.

2.3 Local Government Level

Support for BHCPF implementation at the local government level, centres around the primary health care (PHC) facility and the community. The process shall be managed by the Local Government Health Authority (LGHA) with support from the Local Government Area (LGA) Advisory Committee.

2.3.1 Local Government Area (LGA) Primary Health Care (PHC) Advisory Committee

This committee is a statutory committee of the LGA and exists as an integral part of the Primary Health Care Under One Roof (PHCUOR) and Ward Health System (WHS). The composition and functions are as stated in the WHS documents *(NPHCDA 2018 and 2020 as revised)*. In addition to statutory functions, the following will be required as part of implementation of the BHCPF, within the LGA.

1. Advocate and mobilise resources for 25% counterpart funding in cash or kind by the LGA as required by the NHAct 2014

2. Ensure that health facilities are ready for NHIS and NPHCDA accreditation by providing technical support to the facilities

3. Ensure LGA budgetary allocation for supportive supervision, monitoring and mentoring

2.4 Partnership Framework

All partners, local, international, and private corporate organisations, may contribute to the Basic Health Care Provision Fund (BHCPF) and support implementation. Such contributions shall be financial grants to the government of Nigeria and technical support

to the BHCPF. The interventions of partners and the private sector shall be based on the NHAct 2014, other related extant laws and policies, and in line with this guideline for implementation of the BHCPF.

Organisations desiring to contribute to or support the BHCPF, shall officially communicate same to the Honourable Minister of Health. Financial contributions shall be preceded by a letter of credit to the Honourable Minister of Health notifying of the grant amount. Upon approval of the MOC, donor funds shall be pooled in a dedicated TSA managed by the FMoH and disbursed in the same proportion to the gateways as the 1% CRF. If donors have specifications for disbursement of their contributions, those funds will be domiciled in a separate account and disbursed by the MOC according to the donor stipulations.

Donor grants contributed to the BHCPF shall be accounted for based on the public financial regulations of the Federal Government of Nigeria. Partners may however also provide direct support selectively to states and gateways, such as infrastructure development, equipment, and technical assistance for programme implementation, in accordance with their organisational mandates and partnership agreements. Outlined below is a framework for partnership engagement and contribution for the BHCPF.

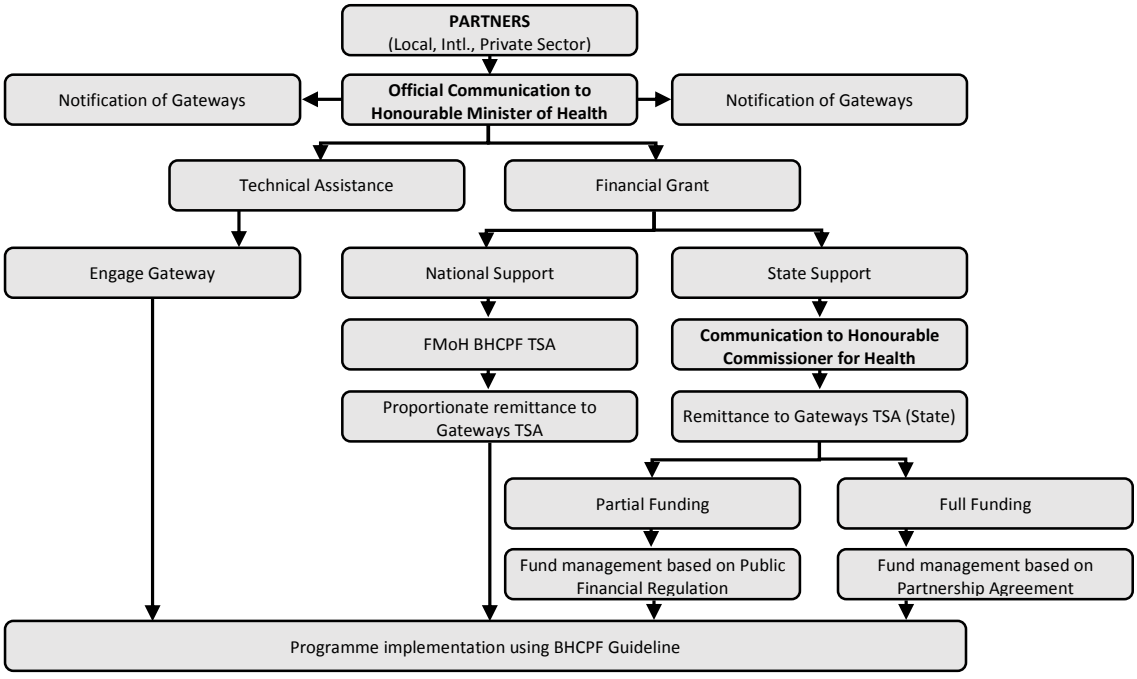

Figure 2: Framework for Partnership Engagement and Contribution to the BHCPF

2.5 Non-Governmental Organisations (NGOs) and Civil Society Organisations (CSOs)

Non-Governmental Organisations (NGOs) and Civil Society Organisations (CSOs) shall continue to play their role of promoting social accountability for the implementation of the BHCPF. The CSO representative on the Ministerial Oversight Committee of the BHCPF shall document and periodically consult with NGOs and CSOs with specific interest in the programme implementation. Through specific pre-agreed engagement frameworks, CSOs shall notify the various gateways, the Honourable Minister of Health or Commissioner for Health as appropriate, of their concerns, observations, and findings. CSOs may make their findings and reports public after submitting same to the relevant gateway and providing ample time for clarifications and response as stipulated in their engagement framework.

NGOs and CSOs may choose to engage in programme monitoring and supervision based on their organisational mandates. CSOs may provide financial or technical support at various levels of implementation and with appropriate clearance from the most relevant authority at their level of operations. In circumstances where funding is for specific programmatic activities, the partnership framework shall come into effect. Gateways shall be open to NGO and CSO participation in programme activities such as capacity building and surveys, based on their core competencies and engagement framework. Such participation shall, however, not place additional financial obligation on the gateways.

3.0 FINANCIAL MANAGEMENT OF THE BASIC HEALTH CARE PROVISION FUND

In line with the National Health Act (NHAct) 2014, at least 1% of the Consolidated Revenue Fund (CRF) account shall be dseducted as a first line charge and transferred to the Basic Health Care Provision Fund (BHCPF) Treasury Single Accounts (TSAs) of the National Health Insurance Scheme (NHIS), the National Primary Health Care Development Agency (NPHCDA) and the National Emergency Treatment Committee (NEMTC).

1. 50% will be used for the provision of a basic minimum package of healthcare services (BMPHS) to all citizens through the National Health Insurance Scheme (NHIS) towards universal health coverage (UHC).

2. 45% will be disbursed through the National Primary Health Development Agency (NPHCDA) to strengthen primary health care centres.

3. 5% will be administered by the National Emergencies Medical Treatment Committee (NEMTC) for the treatment of medical emergencies.

All funds from the BHCPF at federal and state levels shall be domiciled in the treasury single account (TSA) and PHC facilities shall operate a commercial bank account.

All organisations interested in contributing to or supporting the BHCPF shall officially communicate to the Honourable Minister of Health. Financial contributions shall be preceded by a letter of credit to the Honourable Minister of Health notifying of the grant amount. Upon approval of the MOC, donor funds shall be pooled in a dedicated TSA managed by the FMoH and disbursed in the same proportion to the gateways as the 1% CRF. If donors have specifications for disbursement of their contributions, those funds will be domiciled in a separate account and disbursed by the MOC according to the donor stipulations.

3.1 Disbursement of the Basic Health Care Provision Fund (BHCPF)

The gateways; the National Health Insurance Scheme (NHIS), the National Primary Health Care Development Agency (NPHCDA) and the National Emergency Medical Treatment Committee (NEMTC), shall open treasury single accounts (TSAs) entitled Basis Health Care Provision Fund (BHCPF) accounts. Statutory transfers will be made

to the gateway TSAs from the consolidated revenue fund (CRF), corresponding to the 50%, 45% and 5% allocations, as defined by the National Health Act (NHAct) 2014.

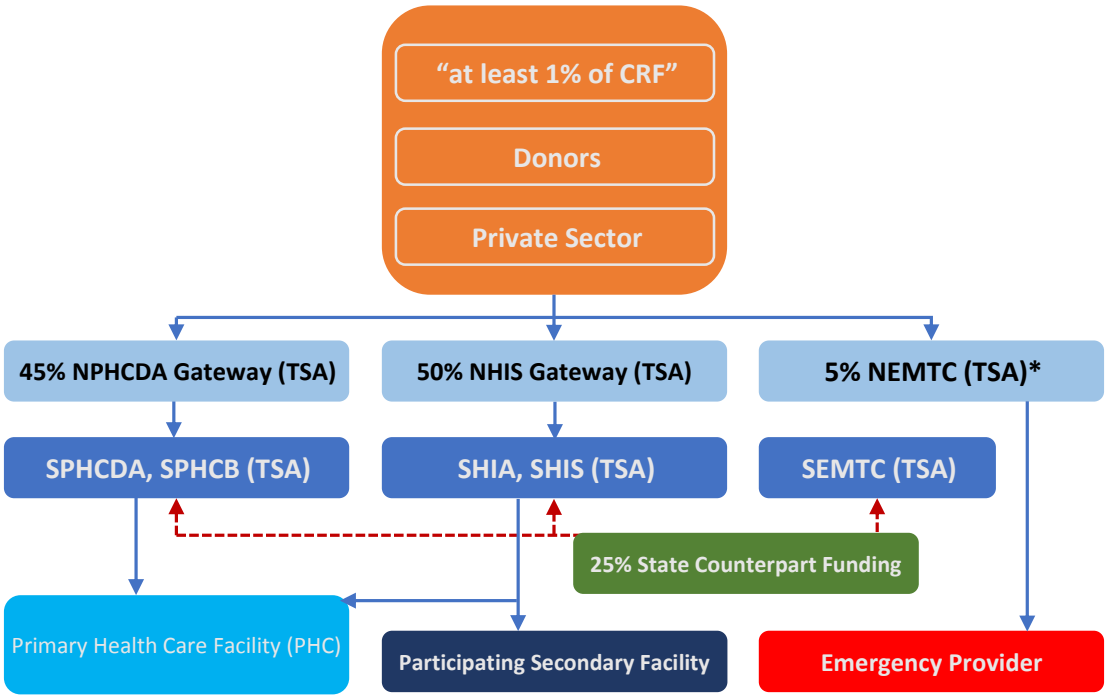

Figure 3: Fund Management Flow Chart

*In view of start-up exigencies and absence of defined geographical boundaries to emergencies, payment to providers shall initially be made centrally from the NEMTC.

3.2 Disbursement Process for the Basic Health Care Provision Fund (BHCPF)

The implementation gateways will approve all state proposals before the beginning of the next planned fiscal year. They will communicate approved programmes to qualified state governments, and funding will be disbursed to qualified states that fulfil the obligations mentioned in sections 4, 5 and 6 of this guideline (gateways).

For equity and fairness, the formula for calculating the disbursement of available funds will be the same for all states.

3.3 Counterpart Funding by State Governments

States are required to provide 25% of the total funds expected from the BHCPF disbursement. This 25% is the sum of contributions from the state; and constitutes the counterpart funding by the state as stipulated by section 11 subsection 5a and b of the NHAct 2014. States may wish to set aside 25% of the cost of the project from their annual budgetary provision as first line charge.

3.4 Administrative Costs for the Ministerial Oversight Committee (MOC) and the State Oversight Committee (SOC)

The operational and administrative costs of the gateways are as stated in the sections 4, 5 and 6 which detail the operations of the gateways. At the federal and state levels, funding shall be derived from the operational cost of the gateways, for effective functioning of the MOC and SOC, based on the terms of reference.

At the federal and state level, each gateway at shall transmit 5% of operation costs to a designated statutory account of the FMoH and SMoH, respectively. The approving authority for the funding to the MOC and SOC shall be in line with the extant public financial regulations. The SPHCDA or SPHCB and LGAs shall be responsible for funding the LGHA in line with the PHCUOR policy and LGA autonomy.

3.5 Audit

The Office of the Auditor General of Nigeria shall audit the accounts of the 3 gateways across the levels of implementation. Partners who have contributed to the BHCPF, may conduct audits in collaboration with the responsible gateway. The Auditor General of the state may conduct annual audits at state level. The Minister of Health and Commissioners of Health shall be empanelled as Viewers of the TSAs and can, at their discretion, monitor and audit the transactions of all gateways.

4.0 GUIDELINE FOR THE IMPLEMENTATION OF THE 50% NATIONAL HEALTH INSURANCE SCHEME GATEWAY

The National Health Act 2014 provides that 50% of the BHCPF shall be used to provide a defined Basic Minimum Package of Health Services (BMPHS) to all Nigerians in eligible primary and secondary health care facilities.

In the disbursement and utilisation of the Fund, it is important to set rules and define clear criteria to enhance technical and allocative efficiency and ensure equity. This is to maximise efficiency in the implementation of the Fund and optimise value for money.

The following sections set out guidelines for effective implementation of the NHIS Gateway of the BHCPF. They describe the institutional and administrative frameworks; the flow of funds; define the Basic Minimum Package of Health Services (BMPHS); provider payment mechanisms; detail monitoring and evaluation plans to ensure transparency and accountability in implementation; and provides other guides relevant to the efficient and equitable use of the Fund.

4.1 Guideline for Funds Disbursement

The Fund shall be disbursed from the Consolidated Revenue Fund (CRF) to a treasury single account (TSA) domiciled at the NHIS. This account will represent the main pool for the purpose of the NHIS Gateway. The NHIS shall open another account, entitled “Administrative Account”, into which the administrative costs of the NHIS Gateway shall be transferred. The total deductible for administration by NHIS shall not exceed 5% of the total remittances from the Fund. The administrative charge for the SHIAs and SHISs will be included in the premium to the states.

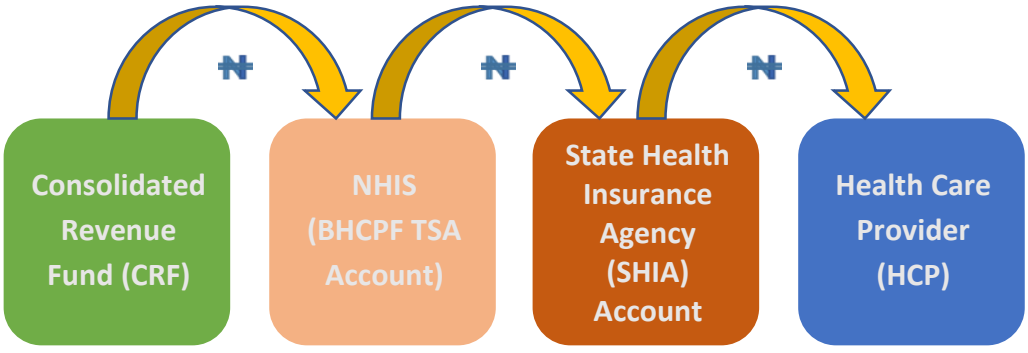

Figure 4: Framework for Funds Disbursement under the NHIS Gateway

4.2 Eligibility and Scope of Coverage

The Fund shall be used to provide the BMPHS for all Nigerians. The unit of coverage shall be individual persons.

4.3 Enrolment

Beneficiaries shall be enrolled into the programme. Enrolment activities shall be conducted by State Health Insurance Schemes and Agencies in collaboration with NHIS, to ensure enrolment data validity.

4.4 Benefit Package

The Basic Minimum Package of Health Services (BMPHS) as defined by NHIS, NPHCDA and partners, and approved by the Honourable Minister of Health consists of a package of preventive, promotive, curative, and rehabilitative services as detailed in section 4.14 of this guideline. The premium rate for the benefit package has been actuarially determined to cost ₦12,000.00 (twelve thousand naira).

4.5 Service Provision

Health care services shall be provided by primary health care (PHC) facilities registered by the SPHCDAs and SPHCBs, and by secondary facilities registered by SMoHs and accredited by SHIAs and SHISs in collaboration with NHIS. Public and private primary health care facilities shall be used as service delivery points. Secondary health care services shall be provided by public and private health care providers following referral from the PHCs.

4.6 Institutional and Administrative Framework (Governance)

1. The NHIS shall designate a department to coordinate the implementation of the NHIS Gateway.

2. As a prerequisite to benefit from the Fund, the Honourable Commissioner for Health shall ensure the establishment of a functional health insurance scheme administered by a State Health Insurance Agency or Scheme, backed by law.

3. The Honourable Commissioner of Health shall ensure the creation of an equity fund within the SHIA or SHIS and show evidence of budgetary release before participating in the BHCPF.

4. For sustenance of the Fund and expansion of the fiscal space for service delivery, each state shall make available a counterpart fund of 25% of the total value of coverage for the defined population, in line with the NHAct. The NHIS will provide the complementary 75% from the BHCPF based on the defined benefit package. This counterpart funding may be sourced from the equity fund of the state.

5. The State Health Insurance Agency or Scheme shall purchase services from health care providers from the Fund according to tariffs defined and published periodically by the NHIS. These rates shall be determined actuarially and be subject to review every 2 years by an NHIS accredited actuary. Provider payment shall be by capitation for primary health care facilities, and by fee-for-service for secondary health care facilities.

6. Payment for provision of the Basic Minimum Package of Health Services, as defined, shall be made only into accounts of health care providers in commercial banks.

4.7 Quality Assurance

The State Health Insurance Agency or Scheme shall monitor service quality using tools developed by the NHIS. The NHIS shall conduct validation exercises to reinforce the quality reporting from state health insurance organs.

4.8 Monitoring and Evaluation

Participating PHC and secondary health facilities shall submit routine NHMIS (National Health Management Information System) reports to the SPHCDA or SPHCB and SMoH, and monthly service utilisation (encounter), financial, morbidity and mortality reports to the state health insurance agency or scheme. The state health insurance agency or scheme shall submit a quarterly summary report, endorsed by the Honourable Commissioner for Health, to the NHIS. The NHIS shall submit quarterly summary utilisation, financial and mortality reports to the Honourable Minister of Health. The NHIS and SHIAs or SHISs shall deploy appropriate ICT (Information and Communications

Technology) platforms to ensure effective and efficient implementation, monitoring, evaluation, and reporting.`

The NHIS shall conduct quarterly monitoring and evaluation exercises with state health insurance agencies or schemes.

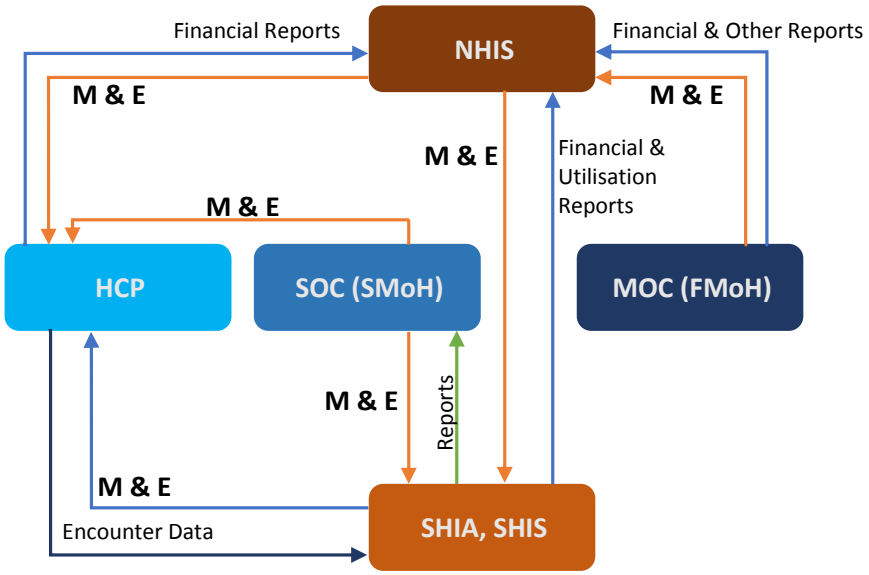

Figure 5: Monitoring and Evaluation Flow

4.9 Provider Accreditation

1. Provider accreditation under this guideline shall take place prior to enlistment of primary and secondary providers into the BHCPF; and shall assess a range of basic minimum criteria required for the provision of the continuum of the BMPHS; and provide satisfactory evidence on the suitability of providers to participate in the programme.

2. Secondary and private primary health care providers shall apply for enlistment into the BHCPF and undergo an accreditation assessment by the SHIA or SHIS in collaboration with NHIS using tools developed by NHIS in accordance with the operational guidelines. For public PHC facilities, notification, and application for accreditation under the NHIS gateway shall be the responsibility of the SPHCDA or SPHCB.

3. Providers who do not pass an initial assessment may request a repeat accreditation not earlier than 3 months after the initial assessment, at their own cost.

4.10 Ex-Post Verification of Utilisation at Provider Level

1. Ex-post verification of utilisation at provider level shall:

- **i.** Provide satisfactory validation to the NHIS, SHIA or SHIS M & E Managers, that the quantum of services reported by health facilities have in fact been rendered
- **ii.** Take place in at least 50% of facilities in 100% of participating states
- **iii.** Be completed no later than 4 (four) weeks from the end of each quarter

2. Completion of verification shall trigger the disbursement of further funds to health facilities from SHIAs or SHISs no later than 4 weeks from completion of verification.

3. The Honourable Commissioner for Health may also conduct monitoring and supervisory visits; and, based on findings, provide feedback and guidance to the NHIS and SHIA or SHIS (see Section 2 re: State Oversight Committee).

4.11 Assessment of Quality of Care at Provider Level

1. Shall take place at least once a quarter for a selected proportion of enlisted providers, to be determined by NHIS, to provide substantive evidence to the NHIS that the quality of care offered by providers is satisfactory.

2. Shall assess quality domains as defined by NHIS operational guidelines.

3. Shall not be linked to provider payment, however, shall attract a penalty, as outlined in the NHIS operational guidelines.

4.12 Health Care Provider Rights and Responsibilities

1. To be eligible and receive payment from the NHIS Gateway of the BHCPF, health care providers shall be empanelled by the SHIA or SHIS in collaboration with NHIS.

2. Selection and continued participation in the BHCPF is contingent on the health care provider maintaining an adequate quality standard of care.

4.13 Accreditation of Health Facilities

Accreditation for the NHIS Gateway shall be conducted by the SHIA or SHIS in collaboration with NHIS, using criteria developed by NHIS. Primary health care facilities shall be expected to meet the minimum standards for PHC in Nigeria as published by

the NPHCDA, and satisfy the accreditation criteria of the NHIS. Public PHC facilities eligible for accreditation shall be identified by the SPHCDA or SPHCB, following baseline assessments conducted by the NPHCDA and SPHCDA or SPHCB; and approved by the Honourable Commissioner for Health, before forwarding to the SHIA or SHIS for accreditation in collaboration with NHIS.

4.14 Basic Minimum Package of Health Services (BMPHS)

4.14.1 PRIMARY LEVEL CARE

1. **General Consultation** with prescribed drugs from accredited PHC facilities
2. **Health Education and Disease Prevention**
    i. Family planning education (use of safe period, pills, condoms, etc.)
    ii. Dental health
    iii. HIV, AIDS, Tuberculosis, Malaria
    iv. Immunization
    v. Vitamin A Supplementation
    vi. Essential Nutrients, especially for children and pregnant women
    vii. Basic Hygiene and Sanitation (personal, domestic, food and environmental)
3. **Surgery**
    i. Minor surgical procedures:
        - Incision and drainage
        - Laceration suturing
        - Minor burns
        - Simple abrasions
    ii. Minor wound debridement
    iii. Infant circumcision
    iv. Impacted faeces
    v. Urinary retention
4. **Primary eye care:**
        - Basic examination and visual acuity
        - Conjunctivitis
        - Parasitic and allergic ailments

- Simple contusion, abrasions, etc.

5. Paediatrics

i. Child Welfare Services:
   - Growth monitoring
   - Routine immunization (as defined by the NPHCDA)
   - Vitamin A supplementation
   - Nutritional advice
   - Health education, etc.

ii. Uncomplicated malnutrition

iii. Helminthiasis

iv. Common childhood illnesses:
   - Malaria
   - Diarrhoeal disease
   - Schistosomiasis
   - Upper respiratory tract infections and
   - Uncomplicated pneumonia

v. Uncomplicated urinary tract infections (UTIs)

vi. Simple otitis media, pharyngitis

vii. Childhood exanthemas, simple skin diseases and infestations, viral illnesses (i.e. mumps), etc.

viii. Anaemia, not requiring blood transfusion

6. Internal Medicine (Adult)

i. Scheduled routine basic medical examination

ii. Simple infections and infestations
   - Malaria
   - Upper respiratory tract infections
   - Urinary tract infections
   - Gastroenteritis
   - Primary ear, nose, and throat infections
   - Diarrhoeal diseases
   - Enteritis and typhoid fever

- Schistosomiasis
- Helminthiasis
- Skin infections and infestations (i.e. chicken pox) and fungal diseases (i.e. tinea versicolor, Malassezia furfur, tinea capitis, etc.)
- Bites and stings (snakes, scorpions, bees, spiders, etc.) first aid and emergency management, not including antivenom serum

iii. Management of simple anaemia (not requiring blood transfusion)

iv. Routine screening and referral for diabetes mellitus, hypertension, and other chronic diseases

v. Simple arthritis and other minor musculoskeletal diseases routine treatment

vi. Sickle cell disease (SCD) routine management

vii. Allergies

7. HIV/AIDS and Sexual Transmitted Diseases

i. Voluntary Counselling and Testing (VCT)

8. Mental Health Management

i. Anxiety neurosis counselling and referral

ii. Psychosomatic illnesses

iii. Insomnia

iv. Drug abuse identification

9. Maternal, Neonatal and Child Health (MNCH) Services

i. Antenatal care

- Routine antenatal clinic
- Routine drugs for the duration of pregnancy
- Routine urine and blood tests
- Referral services for complicated cases

ii. Postnatal services

- Eligible live births up to 6 weeks from date of birth (cord care, eye care, simple neonatal infections)

iii. Delivery services

- Spontaneous vaginal delivery by skilled attendant, including repair of birth injuries and episiotomy

- Essential drugs for Emergency Obstetric care (EmOC)

10. First Aid and Emergency Services

i. Airway assessment and use of airway adjuncts
ii. Basic airway aspiration and clearance
iii. Breathing assessment and use of simple equipment to aid and monitor breathing (i.e. ambu-bag)
iv. Pulse oximetry
v. Bleeding control using compression dressing
vi. Haemodynamic stability assessment
vii. Intravenous (IV) line
viii. Fluid resuscitation
ix. Basic cardiopulmonary resuscitation
x. Unconscious patient assessment and basic management
xi. Small laceration suturing (where resuscitation is not required)
xii. Fracture and cervical spine immobilisation

11. Basic Laboratory Investigation

i. Malaria Parasite
ii. Urinalysis
iii. HB/PCV
iv. Stool microscopy
v. Urine microscopy
vi. Pregnancy Test
vii. Blood Glucose Test
viii. Sputum for AFB

4.14.2 SECONDARY LEVEL CARE

1. Consultation with prescribed drugs from accredited Secondary Health Care facilities
2. Emergencies occurring outside the usual residence or accredited health care provider
3. Hospital Admission:

i. Medical admission: 15 days maximum, cumulative per year
ii. Surgical admission: 20 days maximum, cumulative per year

4. Treatment and procedures included in the BMPHS that cannot be handled at primary level

5. Surgery

i. Major lacerations
ii. Sprains and undisplaced fractures
iii. Appendicectomy
iv. Herniorrhaphy
v. Hydrocelectomy
vi. Testicular Torsion
vii. Excision of lipoma, atheroma, etc.

6. Paediatrics

i. Severe malnutrition
ii. Severe infections and infestations:
    - Severe malaria
    - Diarrhoeal disease with moderate to severe dehydration
    - Upper respiratory tract infections
    - Severe pneumonia
    - Enteric fever
    - Septicaemia
    - Meningitis
    - Severe measles
iii. Severe urinary tract infections
iv. Severe anaemia requiring blood transfusion
v. Childhood non-communicable diseases
vi. Neonatal infections (i.e. neonatal sepsis)
vii. Neonatal conditions:
    - Birth asphyxia
    - Neonatal jaundice
    - Child from diabetic mothers

7. Internal Medicine (Adult)

i. Moderate to severe infections and infestations
- Severe malaria
- Meningitis, septicaemia
- Complicated respiratory tract infections
- Complicated typhoid fever
- Tuberculosis
- Bites and stings (snakes, scorpions, bees, spiders etc.) emergency management, including antivenom serum

ii. Non-communicable diseases
- Diabetes and hypertension
- Severe musculoskeletal conditions
- Sickle cell disease crisis
- Cardiovascular conditions, renal diseases (i.e. nephritis, nephrotic syndrome), liver diseases (i.e. hepatitis, amoebic liver abscess)

iii. Severe anaemia

8. HIV/AIDS

i. Opportunistic infections as defined in the HIV Treatment Protocol

9. Obstetrics and Gynaecology

i. Basic and Comprehensive Emergency Obstetric Care
- Preterm and pre-labour Rupture of Membrane (P/PROM)
- Hypertensive diseases
- Bleeding
- Postpartum haemorrhage
- Eclampsia
- Caesarean section
- Operative management for ectopic gestation
- Intra-uterine foetal death
- Puerperal sepsis
- Instrumental delivery

- High risk delivery (1st delivery, after the 4th delivery, multiple delivery, mal-positioning and mal-presentation, any other complications)

ii. Gynaecological Intervention
- Hysterectomy for ruptured uterus, uncontrollable postpartum haemorrhage, procidentia etc.

10. Laboratory Investigation

i. Genotype
ii. Lumbar puncture
iii. Urea, electrolyte, creatinine
iv. Liver Function Test
v. Ketone bodies
vi. Microscopy, culture, sensitivity (urine, blood, stool, sputum, wound, urethral, ear, eye, throat, aspirate, cerebrovascular spinal fluid, endoscopy cervical swab, high vaginal swab)
vii. Occult blood in stool
viii. Skin snip for microfilaria
ix. Acid fast bacillus for Tuberculous Bacillus (blood)
x. Gram stain
xi. Mantoux test
xii. Blood groupings, cross matching
xiii. Hepatitis B surface antibody screening
xiv. Confirmatory test for HIV
xv. Full Blood Count
xvi. Platelets, reticulocyte count
xvii. Platelets concentration
xviii. Blood transfusion services, up to 3 pints of safe whole blood or blood products
xix. Radiology (X-ray of chest, abdomen, skull, and extremities, dental)
xx. Abdominopelvic and obstetric scan

11. Physiotherapy

i. Post-traumatic rehabilitation
ii. Palsy within 15 days of initial treatment, maximum of 5 sessions

iii. Post-cerebrovascular accident therapy within 15 days, maximum of 5 sessions

5.0 GUIDELINE FOR IMPLEMENTATION OF THE 45% NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY GATEWAY

5.1 Introduction

The National Health Act stipulates that 45% of the Basic Health Care Provision Fund (BHCPF) shall be disbursed through the National Primary Health Care Development Agency (NPHCDA): 20% of which shall be for essential drugs, vaccines and consumables; 15% for the provision and maintenance of primary healthcare facilities, equipment and transport; and 10% for the development of human resources for primary health care. NPHCDA shall disburse the funds (subsection 3(b), (c), and (d) of Section 11), through State Primary Health Care Development Agencies (SPHCDA) or State Primary Health Care Boards (SPHCB) for the implementation of health projects in the Local Government Health Authorities (LGHAs). Disbursement shall be subject to the provision of the requisite counterpart funding of 25% of the total project cost by the state government.

The processes, protocols, institutional and implementation structures by which this portion of the fund shall be disbursed, are to be known as the **NPHCDA GATEWAY.** The NPHCDA Gateway shall ensure funding to strengthen the delivery of primary care services across the entire country, prioritising rural public primary health care (PHC) facilities, to target poor households and populations in the lowest wealth bracket. The fund, however, does not in any form constitute a replacement for the routine funding of public PHCs by state and local governments. It is a catalytic supplement to facilitate population access to quality PHC services, a critical step towards attaining Universal Health Coverage (UHC). NPHCDA shall work with State Primary Health Care Development Agencies (SPHCDAs) and State Primary Health Care Boards (SPHCBs) to progressively ensure adequate infrastructure, equipment, and critical frontline human resources for the delivery of quality health care at the PHC facility and community levels. The NHAct 2014 assigns the NPHCDA responsibility for the development of necessary guidelines for implementation of all programmes funded by the BHCPF, in accordance with the objectives and priorities of the NHAct 2014, in a manner that enshrines

accountability, transparency and value for money. NPHCDA shall communicate and collaborate with state and local governments through the SPHCDA or SPHCB on project implementation activities such as needs assessments, technical support, training, financial management, reporting, monitoring, supervision, and evaluation of the 45% of the BHCPF.

5.2 Institutional Structure for the National Primary Health Care Development Agency (NPHCDA) Gateway

The existing institutional structures of the NPHCDA and the SPHCDAs or SPHCBs shall be deployed for the implementation of the NPHCDA Gateway. At the federal level, the management of NPHCDA shall designate a responsible department or unit to coordinate NPHCDA activities and implement management decisions on the operations of the NPHCDA Gateway. This structure shall be replicated within the SPHCDAs or SPHCBs to ensure seamless implementation of activities (see Figure 6).

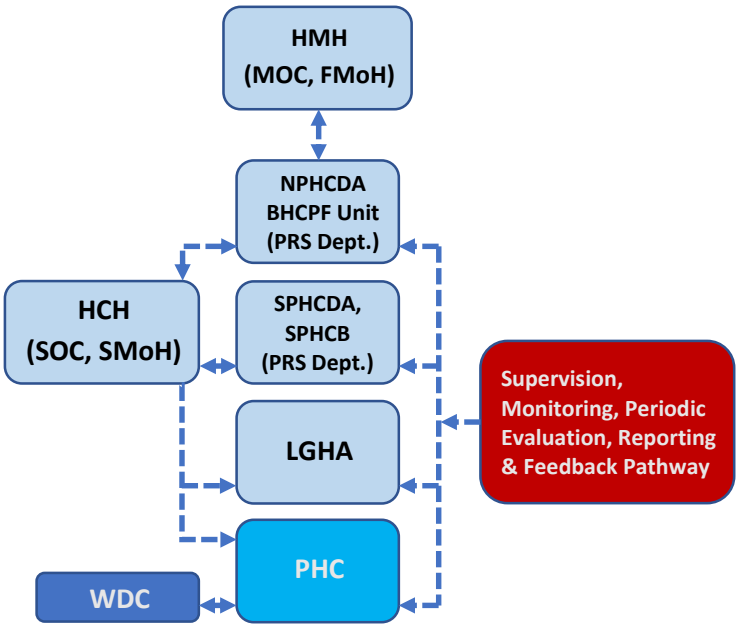

Figure 6: Institutional Structure for NPHCDA Gateway

5.3 Guiding Principles for the Implementation of the National Primary Health Care Development (NPHCDA) Gateway

The overall guiding principle of the gateway shall be Section 11 of the NHAct 2014. In keeping with prevailing national PHC policies, the NPHCDA Gateway shall be implemented in accordance with the principles of **Primary Health Care Under One Roof (PHCUOR) and the Ward Health System (WHS)**. NPHCDA shall support states to ensure at least 1 (one) functional PHC in every political ward -identified by the SPHCDAs or SPHCBs and LGHAs- that conforms to established minimum standards for PHC and is effectively positioned to serve as a primary health care provider to the NHIS and SHIA or SHIS.

Prior to commencement of implementation of the BHCPF, the NPHCDA shall work with states to conduct a baseline needs assessment, the results of which will determine beneficiary PHC facilities, priority investment and programme implementation options. States shall then be expected to make necessary investments to ensure that the selected PHC facilities meet the minimum standard for PHC human resource for health, service delivery, infrastructure, medicines, consumables, commodities, and equipment, as defined by the NPHCDA.

Funds from the NPHCDA Gateway shall be disbursed each quarter through the SPHCDAs or SPHCBs. The disbursement formulae at all levels of implementation will be same for equity and fairness, with associated disbursement linked indicators (DLIs) tracked using a quality scoring system to be developed according to defined health outcomes, needs assessment surveys, and national and state strategic health development plans. Smart surveys and supervision reports; monitoring and evaluation of predetermined indicators; and compliance with financial requirements and reporting shall be taken into stringent consideration prior to funds release to SPHCDAs and SPHCBs each quarter. Poor performing states that score below a pre-determined minimum cut off, may require technical intervention and support from NPHCDA to implement improvement recommendations prior to subsequent funds release.

5.3.1 Allocation of National Primary Health Care Development Agency (NPHCDA) Gateway Funds

The 45% of the BHCPF accruable to the NPHCDA Gateway is expected to be disbursed through the Treasury Single Account (TSA) and expended in line with the NHAct 2014:

5.3.1.1 20% for Vaccines, Essential Drugs and Medical Consumables:

This component of the fund shall be disbursed through the SPHCDA or SPHCB TSA to the commercial bank accounts of all eligible PHC facilities, as Decentralised Facility Financing (DFF). The PHC facilities shall apply the funds, using a Quarterly Business Plan, to purchase medicines, medical consumables, and other health commodities. It is anticipated that the PHC facilities shall incrementally improve the quality and coverage of PHC service delivery, by applying this fund pooled with disbursements from the NHIS Gateway and other sources, most importantly statutory LGHA funding.

Annually, in the event that there is a shortfall in the financial resource requirements for national procurement of routine bundled vaccines; up to 10% of this component of the NPHCDA Gateway shall be pooled at the national level for vaccine procurement.

5.3.1.2 15% for Provision and Maintenance of Health Facilities, Equipment and Transportation:

This component of the fund shall be used for the renovation and maintenance of PHC facility infrastructure, furniture, and equipment; and to support transportation for vaccine collection and returning vials, routine community outreach services and other daily operational costs. This shall be disbursed from the NPHCDA through the SPHCDA or SPHCB TSA to the eligible PHC facilities as DFF.

5.3.1.3 10% for Human Resource Development for PHC:

The utilisation of this portion of the fund is dedicated towards filling capacity gaps in human resources especially a minimum staff complement of skilled birth attendants including midwives for frontline PHC facilities, and community-based workers like Community Health Influencers and Promoters (CHIPS). Implementation shall be with technical guidance, support, and monitoring by the NPHCDA, and funding shall be retained in the NPHCDA TSA and disbursed after SPHCDA or SPHCB proposals, criteria and implementation steps are concluded and approved.

The overall priority and principal objective of this component is to ensure the adequacy of qualified human resources at the frontlines and fulfilment of the national minimum standard for PHC service delivery. Funding under this component may be utilised for other human resource interventions such as improvement of state midwifery training institutions to facilitate accreditation and local production. As standard requirements for skilled attendants are met by states, focus shall systematically shift to human resource needs at the frontlines.

5.4 Eligibility Criteria for States to Access Funding

The BHCPF shall be accessible to all 36 states and the FCT LGHAs and their PHCs for utilisation in the primary health care facilities. For states to benefit from the Fund through the NPHCDA Gateway, the following eligibility criteria must be met in compliance to section 11(4) NHAct 2014. The Honourable Commissioner of Health shall:

1. Ensure the establishment and effective functioning of a State Primary Health Care Board or Agency and LGHAs in accordance with the PHCUOR policy

2. Open a TSA account with the Central Bank titled 'SPHCDA BHCPF or SPHCB BHCPF.'

3. Show evidence of contribution of the state and LGHA 25% counterpart funding for the previous year.

4. Identify at least 1 (one) functional health facility in each ward, for assessment and subsequent accreditation to qualify for award of a Certificate of Standards and BHCPF participation.

5. Ensure compliance with prevailing health policies as communicated by the NPHCDA and the NHAct 2014.

6. Make initial investments based on need, prior to funds receipt, to ensure selected facilities conform to the minimum standards for PHC (human resources, infrastructure, and equipment) and are eligible for award of a Certificate of Standards.

5.4.1 Counterpart Funding

States and participating LGHAs shall allocate at least 25% counterpart funding (matching grant) as prescribed in the National Health Act (2014), for funding accruing to them from the BHCPF. The SPHCDA or SPHCB shall make annual budgetary provision for the counterpart funding, alongside other routine budgeting for PHC implementation.

At the beginning of each year, state governments and the FCT, through the SPHCDA or SPHCB, shall send electronic copies and hardcopies of the approved budget to the NPHCDA, indicating budgetary provisions for counterpart and routine operational funding for PHC.

5.5 National Primary Health Care Development Agency (NPHCDA) Gateway Operations

The NPHCDA is responsible for collaboration with state and local governments to ensure necessary implementation structures are provided, prior to the disbursement of funds for approved SPHCDA or SPHCB and LGHA proposals. NPHCDA will ensure the presence of an implementation framework for policy, budgeting, procurement, and planned activities at state and local government levels.

Operations of the NPHCDA Gateway shall be through a bottom-to-top approach, with communities encouraged to actively participate at all stages of the process.

1. Identification of Ward Health Centres:

The SPHCDA or SPHCB, through the LGHAs, shall confer with the WDCs to identify suitable PHC facilities to implement the BHCPF, and secure approval of the Honourable Commissioner of Health. The SPHCDA or SPHCB, with support from the NPHCDA, shall conduct a baseline assessment to determine the status of the PHC system and priority

health needs across the state. Based on findings, a final listing of at least 1 (one) PHC per ward shall be determined.

2. Capacity Building:

Using modules and protocols developed by the NPHCDA and NHIS, capacity building using basic training-of-trainers (TOT) methodology shall be conducted for PHC facility health workers, WDC members and LGHA supervisory staff. This commencement training shall focus primarily on quality improvement, managerial processes, and financial management, routine in-service clinical and programme-based training of health workers shall continue unabated. Training will be coordinated at state level by the SPHCDA or SPHCB, in collaboration with the NHIS. NPHCDA and NHIS staff shall serve as facilitators for the state training-of-trainers (TOT) and as mentors during the cascade process. Module details are as contained in the BHCPF Training Manual jointly developed by the NPHCDA, NHIS and partners.

3. Development of PHC Facility Work Plans:

PHCs, in consultation with the WDC and with technical support from the LGHA, shall develop annual quality improvement plans aimed at improving user experience of the PHC facility following BHCPF investments. These workplans, and health service delivery needs and targets, shall inform the Quarterly Business Plan, which is to be approved by the SPHCDA or SPHCB via the LGHA. Only after approval shall a disbursement go to the PHC facility account.

PHC facilities shall constitute 2 teams to facilitate plan development, 1) a management team made up of the officer-in-charge (OIC) and heads of all units in the facility and 2) a Quality Improvement Team (QIT) comprising the OIC, additional health workers, heads of pharmacy and laboratory, and representatives of the WDC. The QIT shall be responsible for finalising and forwarding the quarterly business plan and ensuring the submission of quarterly expense reports. The protocols for this process are outlined in detail in a supportive handbook to be published by the NPHCDA.

4. Provision of a Basic Minimum Package of Health Services (BMPHS):

PHCs shall utilise funds received to deliver the BMPHS as outlined in this guideline. This shall entail demand generating activities, community outreach, health promotion and prevention activities, purchase of essential medicines and health commodities from accredited pharmacies and distributors within geographical proximity, collecting and returning vaccines, and facility-based care. For states with established state drug and medical supply agencies, modalities may be explored on a case-by-case basis for drug supply mechanisms that align with the overall implementation of the BHCPF and do not contradict the principle of DFF. Service statistics shall be recorded and transmitted using the established NHMIS mechanism. The SPHCDA or SPHCB shall be responsible for ensuring that all health workers providing services are certified as qualified for their cadre and duties.

5. Retirement of Expenditure:

At the end of each quarter, PHCs shall use provided formats for retirement of expenditure for that quarter, prior to receipt of additional funding. The process shall indicate all funding received and sources, expenditure, and expectations of funding for the next quarter. PHC facilities shall be held accountable by the SPHCDA or SPHCB and shall not remit funding back to the LGHA or the state government under any circumstances.

6. LGHA Support to PHC Facilities:

Trained LGHA staff shall be assigned to PHC facilities as mentors. They shall supervise, support plan development, periodically check fund management and be responsible for timely transmission of plans and expenditure statements. On receipt of Quarterly Business Plans, the LGHA shall endorse and forward copies with a covering summary sheet to the SPHCDA or SPHCB for approval. The SPHCDA or SPHCB shall be responsible for technical and operational support to the LGHA to effectively execute its role.

7. State Level Actions:

The SPHCDA or SPHCB shall review and approve plans based on need and outcomes of preceding supervisory visits. The summary of funding requirements for the PHC facilities, based on annual quality improvement plans, and plans for human resources, infrastructure, supportive programmes and operations, shall inform the annual workplan submitted through the HCH to the NPHCDA for consideration and approval. The SPHCDA or SPHCB shall submit quarterly programmatic and financial reports, and funding expectations for the following quarter. The SPHCDA or SPHCB shall conduct quarterly quality assessments of the PHC facilities along with routine PHC integrated supportive supervision and other system strengthening actions. All state proposals, workplans and reports shall be submitted to the Honourable Commissioner for Health and presented to the SOC (comprises the SMoH and stakeholders). Following approval by the SOC, submissions shall be forwarded by the HCH to the NPHCDA. NPHCDA shall present collated state plans to the MOC for review and endorsement.

5.6 Structure of State Proposals

All SPHCDA or SPHCB annual proposals should include a current analysis of primary health care delivery and proposed mitigation actions to address them in line with the BHCPF. The proposal shall highlight the following amongst others:

- Analysis of the state needs assessment for intervention for the year, identifying at least 1 (one) PHC per ward.
- State PHC priorities demonstrating linkage to the State Strategic Health Development Plan and national objectives and priorities.
- Health needs, especially those covered under the BMPHS to be purchased through the NHIS Gateway.
- Defined indicators and expected health outcomes, implementation timelines and detailed costing of the interventions.
- Strategies to address identified challenges.
- Investment plan for these strategies inclusive of timelines and detailed costing.
- Costing of decentralised facility financing to eligible PHCs.
- Plans for supervision, routine quality assessment, monitoring and evaluation.

The SPHCDA or SPHCB should ensure that proposed investments are proportioned in accordance with the NHAct 2014, maintaining the formula stated in the NHAct and components as indicated in this guideline.

Each state government shall submit 1 (one) consolidated proposal per year, collating all proposals from LGHAs and PHCs. The annual proposal shall be the basis of quarterly reports, requests, and disbursements. Annual plans shall be cleared by the Honourable Commissioner for Health prior to submission by the SPHCDA or SPHCB for approval by the NPHCDA. Annual plans may be amended during the year, with appropriate justification and approval from the NPHCDA. Such amendments must be reflected in quarterly submissions.

All annual state proposals for the following year must be submitted on or before the 15th of October each year (i.e. 2021 plan must be submitted on or before 15th October, 2020). Following approval of state proposals, the NPHCDA will communicate to state governments through the Honourable Commissioner of Health. Funding will be disbursed to SPHCDAs or SPHCBs that have fulfilled the requirements as stipulated in this guideline.

5.6.1 Process for Quarterly and Annual Submissions

Proposals shall be submitted to vetted through the administrative structures of the NPHCDA Gateway. The health facilities shall submit quarterly business plans to the LGHA for vetting and onward transmission to the SPHCDA or SPHCB for approval. The SPHCDA or SPHCB shall forward business plans to the Honourable Commissioner for Health for approval and prepare necessary submission to the NPHCDA. Quarterly and annual reports shall undergo the same process and final state submissions must be approved by the Honourable Commissioner for Health, prior to transmission to the NPHCDA. The NPHCDA shall approve state submissions and forward a summarised national plan of action to the Honourable Minister of Health and present same to the Ministerial Oversight Committee (see section 2).

5.7 Roles and Responsibilities of the National Primary Health Care Development Agency (NPHCDA) Gateway

Outlined below are the specific roles and responsibilities of the various institutional actors for the implementation of the NPHCDA Gateway.

5.7.1 National Primary Health Care Development Agency (NPHCDA)

1. Provide technical support to the SPHCDA or SPHCB for state, local government, and community level implementation.

2. Consider and approve annual consolidated state proposals from the SPHCDA or SPHCB, and forward same to the MOC for review and endorsement.

3. Confirm the release of state 25% counterpart funding for the previous year, as criteria for disbursement of NPHCDA Gateway funds to states.

4. Disburse allocated resources of the BHCPF to the states through the SPHCDA or SPHCB as and when due, as stated in the financial sub-section of this guideline.

5. Analyse and provide feedback on quarterly programme implementation reports from the SPHCDA or SPHCB.

6. Communicate recommendations and decisions on quarterly financial reports to the SPHCDA or SPHCB.

7. Submit quarterly financial and programme reports of activities, progress, and achievements to the Honourable Minister of Health and present same to the Ministerial Oversight Committee.

8. Communicate with states and advocate conformity standards for PHC facilities and service delivery by SPHCDAs or SPHCBs and Local Government Health Authorities (LGHAs), and sanction non-compliance.

9. Conduct routine supervision, monitoring and periodic evaluation of operations, utilising appropriate tools.

10. Build capacity at all levels, including partners and stakeholders, for effective implementation of the NPHCDA Gateway.

11. Conduct implementation research to generate evidence for improvement in implementation of the NPHCDA Gateway and PHC.

12. Work with the SPHCDA or SPHCB to determine the baseline of PHC services prior to the commencement of state level operations and track progress in quality improvement.

13. Develop, publish, and disseminate a handbook of protocols, processes, and tools for the NPHCDA Gateway to further guide PHC workers, particularly at LGHA and facility level.

14. Collaborate with stakeholders to advocate, publicise, and mobilise resources for the NPHCDA Gateway and BHCPF.

15. Conduct routine national review meetings on activities of the NPHCDA Gateway.

5.7.2 State Primary Health Care Development Agencies (SPHCDAs) or State Primary Health Care Boards (SPHCBs)

1. Provide state level capacity and implementation of the NPHCDA Gateway activities with support from and in collaboration with the NPHCDA.

2. Provide direct technical support to the LGHAs for implementation at state, local government, and community levels.

3. Collaborate with the NPHCDA for capacity building on the BHCPF.

4. Develop a consolidated state proposal for utilisation of the BHCPF and submit same to the Honourable Commissioner for Health for approval and onward forwarding to the NPHCDA.

5. Establish a Top Management Meeting (TMM) with donors and partners working on PHC in the state, to support the work of the gateway in the state.

6. Provide support to the Honourable Commissioner for Health, State Oversight Committee, SMoH and all stakeholders to mobilise the requisite 25% counterpart funding and any additional funding requirements for the gateway at state level.

7. Submit quarterly financial and programme reports of activities, progress, and achievements to the Honourable Commissioner of Health for approval prior to transmission to the NPHCDA and present same to the State Oversight Committee.

8. Disburse allocated NPHCDA Gateway resources to PHC facilities, LGHA and projects in accordance with this guideline.

9. Compile quarterly programme implementation reports, including status of project implementation, PHC service utilisation, supervision, monitoring and administration. Submit to the Honourable Commissioner for Health and present same to SOC for transmission to the NPHCDA.

10. Compile quarterly financial reports, including budgeting reports, status of funds disbursement, statements of accounts, and statements of financial retirements and audits, as appropriate. Submit to the Honourable Commissioner for Health and present to the SOC for transmission to the NPHCDA after approval.

11. Ensure adherence to NPHCDA prescribed standards for PHC facilities and service delivery, and to criteria for accreditation by the National Health Insurance Scheme.

12. Conduct routine monitoring, supervision, and periodic evaluation of NPHCDA Gateway operations using prescribed tools.

13. Using baseline needs assessment, identify at least 1 (one) PHC per political ward, to benefit from the NPHCDA Gateway funds.

14. Ensure all participating health care facilities open and maintain accounts with commercial banks that are in the Nigeria bankers clearing house system to enable electronic receipt of funds from the SPHCDAs or SPHCBs.

15. Accredit local distributors and pharmacies, including state central drug stores, from which PHCs may procure NAFDAC (National Agency for Food and Drug Administration and Control) certified drugs. NPHCDA in collaboration with NAFDAC and State Department of Pharmaceutical Services, may support this process.

16. Sign a Memorandum of Understanding (MoU) with the NPHCDA and enter into service delivery contracts with PHC facilities.

5.7.3 Local Government Health Authority (LGHA)

1. The Local Government Health Authorities will work with the SPHCDA or SPHCB for implementation of the NPHCDA Gateway.

2. Work with the LGA PHC Management and Advisory Committees to prioritise health and secure prerequisite counterpart funding from the local government or Chairperson.

3. Provide direct technical support for implementation of BHCPF activities in the PHC.

4. Conduct routine supportive supervision and monitoring of PHCs in the LGA and ensure that:

i. PHCs are staffed, equipped and functional in order to deliver quality PHC services.

ii. Community members have access to the BMPHS as defined in this guideline, and at no additional cost.

iii. BHCPF funds received by the PHC facilities from the SPHCDA or SPHCB are utilised judiciously and transparently to supplement the operational budget of the PHC for improvement in quality of care.

5. Ensure that medicines purchased by PHC facilities are from state accredited pharmacies or distribution channels.

6. Provide technical support and mentoring to the PHCs for the development of Quarterly Business Plans and related plans and effective transmission to the SPHCDA or SPHCB for approval.

7. Ensure all records, including routine service utilisation data, are maintained, and transmitted as appropriate.

5.7.4 Ward Development Committee (WDC)

The Ward Development Committee (WDC) exists at the community level as part of the implementation of the Ward Health System (WHS), to enable mobilisation and governance of community resources. In line with national policy, the Ward Development Committees are involved in co-management of the PHC facilities and service delivery, together with health workers.

The composition of the WDC is as stated in the national policy document on the Ward Health System as published by the NPHCDA (NPHCDA: Ward Health System, 2nd Ed. August 2018).

The roles and responsibilities of the WDC within implementation of the BHCPF include:

1. Collaboration with the PHC facility leadership in identification of and planning for health and social needs of the ward.

2. Prioritisation of identified health needs for inclusion in the business plan of the PHC facility and other related plans and documents.

3. Mobilising additional community resources for the PHC facility and quality service delivery.

4. Serve as members of the PHC Facility Quality Improvement Committee.

5. Provide a co-signatory to the PHC facility account in line with the financial management section of this guideline.

6. Continue to conduct all other business of the WDC as enshrined in the Ward Health System manual.

5.7.5 Primary Health Care Centres (PHCs)

1. Provide quality services included in the BMPHS, to enrolled community members.

2. Maintain 1 (one) functional **current** bank account which shall have the Officer-in-Charge and WDC Chair (or designate) as co-signatories as outlined in this guideline.

3. Develop annual Quality Improvement Plans, Quarterly Business Plans and related documentation, and submission of same to the SPHCDA or SPHCB, through the LGHA for approval and funding.

4. Utilise BHCPF funds as an operational budget for the provision of quality PHC services at facility and community levels.

5. Submit quarterly expenditure statements as requirements for subsequent funding.

6. Ensure adequate display of relevant signage to inform the community of the availability of BHCPF services and the BMPHS.

7. Ensure effective management of the PHC facility by constituting a) a management committee comprising of the officer-in-charge (as chairperson) and the unit heads in the PHC facility and b) Quality Improvement Committee.

8. In addition to the BMPHS, continue to conduct all expected PHC actions and provide all routine PHC services based on the Ward Minimum Health Care Package as published by the NPHCDA (or as adopted by the SPHCDA or SPHCB) and in line with the prevailing service delivery policy of the state.

9. Ensure prompt referral of clients, in line with the standard operating procedures (SOPs) for PHC workers as published by the NPHCDA.

5.7.6 Secondary Health Care (SHC) Facilities

1. State governments shall designate identified Secondary Health Care (SHC) facilities to serve as referral centres for the PHC facilities, to provide specialised care.

2. Ensure 2-way referral of clients from the SHC system back to their PHC facility.

3. Other functions of the SHC under the BHCPF are as stated in the NHIS Gateway section of this guideline.

5.8 Referral Services

The State Ministry of Health, in collaboration with the SPHCDA or SPHCB and the LGHA, shall ensure mapping of referral facilities for the PHC facilities and the necessary managerial linkages established. Working with the State Emergency Medical Service and Ambulance System, the PHC facilities and communities shall institute mechanisms to facilitate prompt referral and transportation of urgent cases. The SPHCDA or SPHCB should ensure the availability and use of 2-way referral forms as codified in the NHMIS by PHC workers (including any additional information that may be required to ensure transparent purchasing of services through the BHCPF).

5.9 Financial Management of the National Primary Health Care Development Agency (NPHCDA) Gateway

All funds disbursements shall be via electronic transfer. At federal and state levels, TSAs shall be operated based on regulations stipulated by the Office of the Accountant General of the Federation (OAGF).

The NPHCDA and SPHCDA or SPHCB shall operate 2 (two) TSA accounts each: a BHCPF Programme Account and a BHCPF Operations Account. At the PHC facility level, a singular cheque-based account shall be opened with a commercial bank that is part of the clearing house system. LGHAs shall maintain their statutory accounts.

The disbursement uses and retirement of funds across the NPHCDA Gateway shall be in accordance with the public financial regulations of the Federal Government of Nigeria.

5.9.1 Funds Disbursement

Upon receipt of the 45% component of the BHCPF from the federation account, the NPHCDA shall, within 10 (ten) days, disburse funds to all qualifying SPHCDAs or SPHCBs, who shall in turn disburse electronically directly to PHC facilities within 10 (ten) days of receipt.

Funding shall be released in quarterly tranches. An initial 50% shall be released to states to cover the first 2 quarters of the year, 25% shall be released for the third and fourth quarters respectively, after submission and approval of required reports and financial statements.

5.9.2 Operational Costs

Operational costs of implementing the NPHCDA Gateway shall include administration, supervision, monitoring, capacity building and data generation, and evidence for decision making and quality improvement of service delivery and operations. At state level, this shall include funding for activities of the LGHA for BHCPF. All participating institutions shall however leverage their routine budgets and ensure synergy with other funded activities to ensure cost savings.

The NPHCDA shall retain not more than 5% of Gateway funds for operational costs based on an annual workplan. At state level, the SPHCDA or SPHCB shall similarly retain not more than 5% of the total funds accrued (i.e. federal funds and state counterpart funds) to supplement the operational needs of the SPHCDA or SPHCB and the LGHA; utilising a plan of action approved by the NPHCDA.

5.9.3 Financial Reporting

Financing reporting for the NPHCDA Gateway at federal and state levels shall be as outlined in this guideline. Quarterly financial reports shall be a prerequisite for the SPHCDA or SPHCB to receive quarterly disbursements from the NPHCDA.

LGHAs shall prepare quarterly proposals and retirements to the SPHCDA or SPHCB for funding in subsequent quarters. LGAs shall support the PHCs to adequately prepare and transmit quarterly expenditure statements and business plans to the SPHCDA or SPHCB

for the next quarter. PHC expenditure statements shall be due within 15 (fifteen) days of the end of the quarter.

In line with the public financial regulations, all institutions shall appropriately store financial records for at least 10 (ten) years.

5.9.4 Signatories to NPHCDA Gateway Accounts

Signatories to the BHCPF accounts under the NPHCDA Gateway shall be as outlined in the table below. For each category, alternate signatories shall exist in line with public financial regulations.

	Operational Level	Funding Approval	TSA Signatories		
			Initiator	Reviewer	Approval
1.	NPHCDA	ED NPHCDA	Accountant	Accountant	NPHCDA Director Finance and Accounts
2.	SPHCDA, SPHCB	ES SPHCDA or SPHCB	Accountant	Accountant	SPHCDA or SPHCB Director Finance and Accounts
	Operational Level		**Signatories**	**Signatories**	**Comment**
3.	LGHA		Director of Health	LGHA Accountant	The regular existing account of the LGHA and applicable signatories
4.	Facility Level		Officer-in-charge Alternate: Facility Accountant OR Health Worker	WDC Chairperson Alternate: Treasurer OR Secretary	

5.10 Monitoring and Evaluation for the National Primary Health Care Development Agency (NPHCDA) Gateway

The monitoring and evaluation (M & E) framework for the NPHCDA Gateway shall ensure a robust mechanism for information collection and analysis. Information will be captured as quickly as possible, focusing primarily on the process for funds disbursement and utilisation; governance integrity; outputs, particularly of service delivery; and long-term outcomes and socio-economic impact.

Monitoring of the gateway shall include:

1. Verification visits to all states to ascertain preparedness prior to funds disbursement.

2. Ex-Post Verification by the NPHCDA to confirm financial, programmatic, and quality assessment reports from the SPHCDA or SPHCB. This shall occur in a minimum of 25% of randomly selected LGAs, and 25% of PHC facilities randomly selected within the selected LGAs. This visit shall be conducted at least quarterly to all states.

3. The SPHCDA or SPHCB shall conduct the monitoring, supervisory and assessment visits prior to national verification assessments.

4. Honourable Commissioners for Health and SOCs, through the SMoH, may conduct monitoring and supervisory visits and provide relevant guidance and directives to the SPHCDA or SPHCB, and feedback to the NPHCDA.

5. State governments shall transmit quarterly reports of utilisation data for key indicators, including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits, and immunization visits, via the NHMIS.

5.11 Quality Assurance and Improvement

Fundamental to the implementation of the BHCPF is the theory of change that continuous direct investment in BHCPF facilities through DFF, shall yield exponential increases in service delivery quality, which will drive up utilisation and therefore improve morbidity and mortality indicators. Through the NPHCDA gateway, mechanisms shall be instituted to ensure adherence to standards of PHC practice as determined by the NPHCDA (Quality Assurance), and institute a process for continuous service quality improvement through targeted capacity building, mentoring, routine quality assessments and performance management. The NPHCDA, in collaboration with stakeholders, shall establish a national

framework, tools and protocols to drive this process and guarantee quality service delivery.

This process shall be managed and supported across the tiers of the NPHCDA gateway, with established state and LGHA Quality Improvement Teams mentoring and supporting the PHC facilities. At the PHC level, the Facility Quality Improvement Team (QIT) comprising the OIC, midwife, other health workers, and representatives of the WDC, shall co-own and drive the process.

Non-compliance with established quality protocols shall negatively impact the 'quality associated KPI' for the state and may attract sanctions based on the accountability framework as detailed in this guideline.

5.11.1 Instituting Quality Improvement in BHCPF Facilities

Instituting quality improvement shall be measured by structure, process, and outcomes, to ensure that BHCPF facilities meet and maintain the minimum standards for PHC as published by the NPHCDA; and ensure continuous improvement in the quality of service delivery. The PHCs shall utilise the annual quality improvement plan and the quarterly business plans for systematic identification and implementation of interventions to improve service delivery quality.

Structure:

The BHCPF, through the NPHCDA gateway, shall work with SPHCDAs or SPHCBs to support PHC facilities to improve structural quality i.e. infrastructure, medical equipment, and human resources. DFF shall, in the first 2 quarters, be applied as a block grants to implement moderate infrastructural upgrades, and for the repair and acquisition of critical medical equipment. Human resource gaps shall be addressed through the application of the 10% human resources for health (HRH) component by the states, with technical guidance and support from the NPHCDA.

Process:

Improving processes that impact care quality shall focus on adherence to clinical SOPs (that define the expected quality standards) by PHC workers, and implementation of

review systems that effectively track quality trends, identify gaps and facilitate the implementation of corrective measures. This shall be managed in 3-steps:

- **Capacity building** of QITs across board (PHC, LGHA and SPHCDA or SPHCB); focused on-the-job capacity building and mentoring of officers on quality improvement process and strategies. This on-the-job capacity development shall build on the quality improvement training provided to participating PHCs at the commencement of the programme in each state.

- **Facility-based quality improvement** by PHC QITs trained to implement an 'internal facility-based' continuous quality improvement system utilising tools and protocols to be developed by the NPHCDA. This shall enable improved facility management and organisation, and ensure clinical safety and effectiveness by motivating adherence to protocols in the PHC facilities.

- **Quarterly quality assessments** and scoring which, in addition to routine supportive supervision and monitoring exercises, shall be conducted jointly by the SPHCDA or SPHCB and LGHA teams with verification of results by the NPHCDA. Feedback from the assessments and recommendation shall inform the PHC quarterly business plans to address quality gaps. The assessed performance by PHCs and states shall reflect on key performance indicators (KPIs), as outlined in this guideline. Poor KPI performance may trigger the accountability framework.

Outcomes:

This shall track clinical output and outcomes, and community perception of the quality of care. Tracking shall include routine administrative NHMIS and DHIS, and institutional surveys such as the LQAS and smart surveys. Enhancing community perception shall leverage on the ward development committee, who are members of the PHC QIT, to provide input to care based on communal feedback; and evidence generated during the quarterly quality assessments.

5.11.2 Assessment of Quality Improvement

On a quarterly basis, a joint team of SPHCDA or SPHCB and LGHA officers will conduct a quality assessment using a checklist developed by the NPHCDA. This team shall assess availability, delivery, overall improvement in quality of care, and community perception of BHCPF implementation in the PHCs, for the preceding quarter. On conclusion of the assessment, each facility visited will be awarded a quality score which will be translated to a poster-sized scorecard (pictured below) and displayed within the facility. Using a template provided by the gateway, the SPHCDA or SPHCB will submit a summarised report which NPHCDA will verify, along with the integrity of the quality data and report.

The quality assessment tool shall assess the 10 (ten) priority areas of the BHCPF, which also inform the baseline assessment for each state. The priority areas are:

- Administrative Systems and Infrastructure
- Financial Systems
- Human Resources Management
- Reproductive, Maternal and Newborn, Child, and Adolescent Health and Nutrition Services (RMNCAH+N)
- Patient Care Management
- Essential Drugs and Commodities
- Laboratory
- Health Management Information Systems
- Utilisation and Clinical Outcomes
- Community Involvement or Client Perception

Results of the quality assessment for each quarter shall inform the business plan for the subsequent quarter and serve as intrinsic motivation for the PHC workers and WDC members to improve the quality of service delivery.

ROUTINE BHCPF FACILITY QUALITY IMPROVEMENT SCORE CARD										
Name of Facility:										
Priority Areas	Baseline	QUARTER 1		QUARTER 2		QUARTER 3		QUARTER 4		YEAR:
		Score (%)	Colour code	Score (%)	Colour code	Score (%)	Colour code	Score (%)	Colour code	
Administrative System and Infrastructure										• Score range is from 0-10
Financial System										
Human Resources Management										• – 0 - 4: Poor (Red)
Maternal and Child Health Services										• – 4.1 – 6: Acceptable (yellow)
Patient Care Management										
Essential Drugs										• – 6.1 - 8: Good (Light green)
Laboratory										
Health Management Information System										• PHCs that score above 8.0 (Very good) will be addressed as model centers (Dark green)
Utilization and Clinical Outcomes										
Community Involvement/Client Views										• To encourage evenness of attention to all priority areas, if a priority area scores less than 50%, there is a deduction of 5% from the strongest domain
	Name of Accessor									
	Designation:									
	Signature:									
>8.0	6.1 - 8.0			4.1 - 6.0				0.0 - 4.0		
The goal is to get health facilities to move from red to green on all priority areas										

Figure 7: Scorecard Template

5.12 Penalties for Non-Compliance

Monitoring, evaluation, and verification reports will trigger penalties due to non-compliance with processes or performance standards. Where non-compliance is established via a verification report, penalties shall be applied for the following infractions:

Non-Payment to Health Facilities by SPHCDA or SPHCB

Verification team establishes that disbursements (in part or full) have not gone from states to facilities. This includes part payments of funds to facilities or payment only to a proportion of enlisted health facilities.

1. Non-payment to facilities and shortfall of 10% or more shall earn a written query to the state.

2. A second offense by the state due to non-payment or embezzlement shall be followed by a signed letter to the Executive Governor, requesting financial redress and appropriate sanctions to the erring officers.

3. Subsequent infraction or non-payment to over 25% (twenty-five percent) of facilities will lead to suspension of the SPHCDA or SPHCB. The NPHCDA, with the approval of the Honourable Minister, may choose to implement direct payment to health facilities in the affected state, if PHC facilities are not complicit.

4. At the LGHA and PHC facilities, the SPHCDA or SPHCB shall be responsible for taking disciplinary actions against erring officers in line with the public financial regulations. Such infractions and corrective actions must be included in the quarterly reports.

5. Failure to act by the SPHCDA or SPHCB shall necessitate escalation to the Office of the Governor or suspension of state funding as appropriate.

5.13 Deployment of Appropriate Technology

Deployment of technology for the NPHCDA Gateway shall be focused on reducing transaction times and improving transparency and accountability. The NPHCDA, in collaboration with partners, shall work to adopt and scale the use of ICT infrastructure. This shall eventually cover the electronic submission of business plans, quarterly reports, and financial retirements, the maintenance of a comprehensive database and the deployment of dashboards for real time monitoring.

Transactions between the LGHA, PHCs, SHCs and their vendors are required to be via the banking system.

6.0 GUIDELINE FOR THE IMPLEMENTATION OF 5% EMERGENCY MEDICAL TREATMENT GATEWAY

6.1 Background

Section 11 Subsection (3c) of the National Health Act states that 5% of the Basic Health Care Provision Fund shall be used for Emergency Medical Treatment to be administered by a committee appointed by the National Council on Health. Pursuant to this provision, the National Emergency Medical Treatment Committee (NEMTC) was approved by the 61st National Council on Health in June 2018 and subsequently inaugurated by the Honourable Minister of Health in February 2019. This is a novel concept in national health service delivery.

An Emergency Medical Service (EMS) system is now being constituted, it is the platform from which emergency medical services shall be provided and will develop into a comprehensive National Emergency Medical Services and Ambulance System (NEMSAS). The emergency medical service will provide urgent attention to persons with acute illness or injury, and prompt and efficient transport to an appropriate health facility, without hindrances such as police reports or payment before service. The goal of emergency care is to get people quickly and safely from the scene to the hospital (National Policy on Emergency Medical Services) for immediate initial care, followed by definitive care.

Emergency medical services respond to all types of emergencies such as medical, trauma or accidents, disaster and mass casualty situations. It should be noted that emergency health care cuts across all aspects of medical response and the establishment of a coordinated mechanism of response is imperative.

To provide immediate care, providers require formal guarantee of reimbursement for services and should have adequate training and equipment for providing emergency medical services. EMS thus involves a continuum of pre-hospital and in-hospital care and the linkages between these components, including an emergency call system, emergency communication system, integrated ambulance system, functional hospital emergency department and facilities for definitive care. Significant attention is also necessary for

public education to prevent emergencies; this is the most practical method of reducing morbidity and mortality from health-related emergencies.

6.2 Justification

Nigeria has experienced a rise in trauma-related morbidity and mortality due to terrorism and civil unrest, accidents, natural disasters and amongst others (NPEMS 2016 FMoH). The establishment of a national emergency medical service system will ensure that emergency medical care is available when and where it is required, irrespective of ability to pay. Delay in service provision, most often due to payment, is the cause of many instances of permanent disability and death; on the spot payment is a very inefficient method of reimbursement for health care services. It is essential that health care providers under the emergency medical services scheme are assured of prompt reimbursement and loss protection. The 5% of the Basic Health Care Provision Fund in the National Health Act 2014 is intended to guarantee such reimbursements.

Emergency medical services is a necessary lifesaving provision in Nigeria. The plan for the emergency medical service is to stabilise and transport the patient to a health care facility, and guarantee payment for up to the first 48 hours of care, or until financial responsibility is established and assumed by the patient, family, employer or other means.

6.3 Governance Structure

6.3.1 Composition of the National Emergency Medical Treatment Committee

The NEMTC is to be chaired by a Medical Doctor with at least 15 (fifteen) years post basic qualification and experience in emergency care and systems management. The membership of the committee is as follows:

1. Chair
2. Secretary, Representative of Federal Ministry of Health (FMoH)

Members:

3. Focal Person, United Nations Decade of Action on Road Safety and Traffic Injury Prevention (UNDARSTIP)

4. National Blood Transfusion Service (NBTS)

5. National Health Insurance Scheme (NHIS)

6. Nigeria Centre for Disease Control (NCDC)

7. Chairman, Committee of Chief Medical Directors (CMDs)

8. President, Nigeria Medical Association (NMA)

9. President, National Association of Nigerian Nurses and Midwives (NANNM)

10. President, Association of Medical Social Workers of Nigeria (AMSWoN)

11. President, Association of General and Private Medical Practitioners of Nigeria (AGPMPN)

12. President, Guild of Medical Directors (GMD)

13. Commissioners of Health, 1 (one) from each geopolitical zone

14. Representative, Federal Ministry of Information and Culture

15. Representative, Federal Ministry of Transportation

16. Representative, Federal Ministry of Works

17. Representative, Federal Fire Service

18. Representative, Federal Road Safety Commission (FRSC)

19. Representative, National Emergency Management Agency (NEMA)

20. Representative, Nigeria Police Force (NPF)

21. Representative, Nigerian Communications Commission (NCC)

22. Representative, Nigerian Insurance Commission

23. President, National Union of Road Transport Workers (NURTW)

24. President, Nigerian Association of Road Transport Owners (NARTO)

25. Representative of Media

The NEMTC may, as required by operational exigencies, recommend modifications to the committee to the Honourable Minister of Health, and by extension to the National Council on Health.

6.3.2 State Emergency Medical Treatment Committee (SEMTC)

There shall be an equivalent State Emergency Medical Treatment Committee established in each state -FCT EMTC in the FCT, to be inaugurated by the Honourable Commissioner for Health. The Chair, to be appointed by the state, shall be Medical Doctor with at least 15 (fifteen) years post basic qualification and experience in emergency care and systems management. The composition of the State Emergency Medical Treatment Committee (SEMTC) shall be as follows:

1. Chair
2. Secretary, Rep. of SMoH
3. Rep. State Blood Transfusion Service
4. Representative of the SHIA or SHIS
5. Rep. of Committee of CMDs
6. Rep. of NMA
7. Rep. of NANNM
8. Rep. of GMD
9. Rep. of AGPMPN
10. Rep. State Emergency Management Agency
11. Rep. Nigeria Police Force
12. Rep. of NURTW
13. Representative of Media

The SEMTC may be domiciled within the existing emergency service or response agencies, where one exists, and work to develop the agency into a comprehensive State Emergency Medical Service and Ambulance Service (SEMSAS). In this instance a senior representative of such an agency, shall be co-opted into the SEMTC. The role of the SEMTC is to enhance emergency service delivery at state level and effective mobilisation of state and NEMTC resources for the state. Upon proper establishment of the SEMTC, it shall continuously identify and update a database of providers within the state for accreditation, expedite verification of claims using the SHIA or SHIS mechanism, and ensure timely transmission of verified claims from providers to the NEMTC for prompt settlement.

6.4 Criteria for State Participation in the Emergency Medical Treatment (EMT) Gateway

The following are the criteria for states to be on-boarded to the EMT Gateway by the NEMTC:

1. The Honourable Commissioner for Health shall ensure the establishment of a SEMTC and transmit membership for approval by the NEMTC.

2. Evidence of 25% counterpart funding.

3. Mapping of state level emergency assets and infrastructure i.e. ambulances (public and private), designated facilities etc.

4. Provision of infrastructure, equipment, and personnel for operation of a medical emergency response centre as stipulated in guidelines to be provided by the NEMTC.

5. A functional SHIA or SHIS to support claim management.

6.4.1 Operational Costs for State Emergency Medical Treatment Committees (SEMTCs)

The SEMTC shall be responsible to the NEMTC, SEMTC offices and operational costs shall be funded out of the 25% counterpart funding provided by the state. This funding may be reviewed by the NEMTC as funding increases over time. SEMTCs shall work in accordance with the guidelines provided by the NEMTC.

6.5 Mission and Vision

Vision

An Effective and Efficient Emergency Medical Service for Nigeria.

Mission

To use available resources to provide a high-quality integrated emergency medical service and ambulance system in Nigeria.

6.6 Terms of Reference

These terms of reference shall guide operations and the establishment of an Emergency Medical Service for Nigeria:

1. Creation of the National Emergency Medical Services and Ambulance System (NEMSAS), and start-up operationalisation.

2. Establishment of a governance structure and reporting lines at federal, zonal, state, and local levels.

3. Administration of the stipulated 5% of the Basic Health Care Provision Fund.

4. Set up and operationalise fund management systems.

5. Identification and integration of existing EMS and ambulance schemes to the NEMSAS.

6. Identification of human resource requirements and administer human resource development for emergency medical services.

7. Completion of ongoing nationwide resource mapping for emergency medical services.

8. Integration of existing national toll-free emergency numbers and communication channels for all stakeholders.

9. Development of infrastructure requirements, including equipment and ambulance standards, personal protective equipment (PPE), dress codes and uniforms, SOPs, and logos.

10. Collaboration on the establishment, integration and-or upgrading of emergency care centres where required.

11. Classification of emergencies (minor, intermediate, major) and definition of appropriate providers.

12. Classification of available health care personal to be adapted as emergency responders, prior to the availability of certified paramedics.

13. Creation of an emergency services database including assessment, registration and mapping of emergency centres and ambulance service providers; and incorporate data acquisition, system automation, integration, and warehousing.

14. Development of a system for tariffs, claims validation and payment for emergency medical services.

15. Establishment of innovative funding streams in addition to the 5% of the BHCPF.

16. Development of cost recovery mechanisms.

17. Monitoring and evaluation of services by providers (calls, responses, ambulance services, medical services, and outcomes) for quality improvement, using measurable benchmarks.

18. Extensive public education on prevention of medical emergencies in general, use of toll-free emergency numbers, access to emergency care, etc.

19. Inspection and accreditation of provider of health services and the issuance of certificates of standards in line with published guidelines for emergency ambulance services.

20. Provision of periodic (quarterly, audited accounts and performance reports to the Honourable Minister of Health.

21. Coordination and regulation of EMS services in Nigeria.

22. Identification of federal, zonal, state, and local coverage, and regional and international collaboration on emergency medical services.

6.7 Office and Administration (Operational Centre)

1. The National Office shall be located within the FCT. The national office shall engage and retain such requisite staff as are needed for the smooth running of the NEMTC and NEMSAS.

2. A National Emergency Medical Response Centre (NEMRC) shall be co-located with the National Emergency Call Centre.

3. The state offices shall be located within each state capital. The Honourable Commissioner shall ensure State Emergency Medical Response Centres are co-located with the Emergency Call Centre in the state capitals.

6.8 Operations of the Emergency Medical Treatment (EMT) Gateway

1. The NEMTC shall establish the National Emergency Medical Services and Ambulance System (NEMSAS).

2. A National Office shall be created in the FCT to serve as the national coordination centre for the NEMTC and the NEMSAS.

3. The Honourable Commissioners of Health shall establish the State Emergency Medical Treatment Committees (SEMTCs) to coordinate the provision of emergency medical services at the state level.

4. The NEMTC shall coordinate all ambulance services and emergency centres.

5. The National Emergency Medical Response Centre (NEMRC) shall be established in the FCT and linked with the Emergency Communication Centre of the NCC and NEMA.

6. State Emergency Medical Response Centres shall be formed and co-located or linked with the Emergency Communication Centres in the states run by NCC or NEMA, where they exist.

7. The NEMTC shall be headed by the Chair and supported by a responsible Programme Manager (PM), while the state offices will have coordinators.

Further details, protocols, and standards of practice on the operations of the EMT Gateway shall be as documented in the policy documents as published by the Federal Ministry of Health and the NEMTC.

6.9 Categories of Services

6.9.1 The ambulance service providers and receiving health facilities shall be classified and categorised as follows:

1. **Ambulance Services**
   - i. Basic
   - ii. Advanced
   - iii. Specialised
2. **Emergency Centres**
   - i. **Level 1**: All facilities including primary health care centres that can receive walk-in cases or cases conveyed by non-EMS personnel (i.e. family, bystanders), with minor emergency conditions. These facilities may not have a designated emergency

unit and do not need to be formally accredited by the NEMTC. They shall attend to minor emergencies using SOPs developed by the NEMTC.

ii. **Level 2**: General Emergency Centres, these require formal NEMTC accreditation to receive cases transported by ambulance and must have the requisite equipment and trained human resources to respond to emergencies. These centres shall attend to intermediate and major emergencies.

iii. **Level 3**: Specialised Emergency Centres, these require formal NEMTC accreditation to receive cases transported by ambulance and must have the requisite equipment and trained human resources to respond to specific specialised conditions e.g. burns, infectious diseases, major trauma, cardiac arrest, etc. These centres shall attend to intermediate, major, and specialised emergencies.

The ambulance services and level 2 and 3 emergency centres shall constitute a **national network of emergency referral centres**, which will be used to refer patients according to diagnosis and care needs. Mechanisms to ensure efficient and safe transfer between centres shall be established.

6.9.2 A listing of emergency medical conditions shall be maintained and routinely updated. The following categorisation shall be applied:

1. Minor medical emergency conditions.
2. Intermediate medical emergency conditions.
3. Major medical emergency conditions.
4. Specialised medical emergency conditions.
5. Emergencies of public health importance.

6.9.3 Categories of transfer include the following:

1. **Critical Transfer:** critically ill patients with life-threatening status, accompanied by senior specialist staff.
2. **Immediate Transfer:** ambulance dispatch within 1 (one) hour to save life or limb.
3. **Cold or Non-Urgent Transfer:** patient does not meet critical or immediate transfer criteria, but ambulance conveyance is required.

4. **Intra- or Inter- Facility Medical Transfer:** patient transfer within a health facility (between units of the same facility) or between different health facilities.

Note: the cost of intra-facility transfer **not for the purpose of referral** of emergency cases, shall be the responsibility of the transferring facility, or the patient.

6.10 Accreditation and Certification of Providers for Emergency Ambulance Services and Emergency Centre Services

Providers shall include the following categories:

1. Emergency ambulance service providers
2. Emergency centres

NEMTC, in conjunction with SEMTCs, shall accredit and certify providers in line with the guidelines of the National Policy on Emergency Medical Services (FMoH 2016). NEMTC shall maintain a database of all providers. Certification shall take place annually, state facilities to be accredited by the NEMTC shall be screened by the Honourable Commissioner for Health prior to transmission to the NEMTC.

6.11 Tariff and Reimbursement

Tariff and reimbursement shall be on a fee-for-service basis using the EMT Tariff. This tariff may be reviewed annually in consultation with stakeholders and may be scaled to accommodate variances in location and terrain. NEMTC will guarantee payment to providers for services rendered.

NEMTC and SEMTC shall leverage the claims management mechanism already established by the NHIS and SHIA or SHIS in each state. The SHIA or SHIS shall collate and verify claims for EMT services and promptly forward same to the NEMTC through the SEMTC for payment.

6.12 Emergency Medical Service Database

Each emergency patient encounter shall be entered into a database to be used for analyses, planning and research. Patients already registered in other health-related databases can also be enrolled into the emergency medical services database.

NEMTC shall request linkage to the NHIS, National Identity Management Commission (NIMC) and National Population Commission (NPopC) databases. All beneficiaries of ambulance and emergency services shall be appropriately documented.

6.13 Monitoring and Evaluation

Monthly reports of all emergency encounters handled by each state shall be sent to the NEMTC, as well as data of the immediate disposition of all cases, including death. Routine quarterly programme implementation reports, as approved by the Honourable Commissioner, shall also be sent to the NEMTC. Patient data shall be tracked from entrance to exit of emergency services, collated data will form an annual report that shall be submitted to the Honourable Minister of Health; and further linked to the National Health Management Information System.

6.14 Cost Recovery

The cost recovery shall be categorised as follows:

1. For persons who have health insurance coverage, invoices will be sent to their insurance companies or health maintenance organisations (HMOs).

2. For persons who do not have health insurance coverage but are able to pay, they will be invoiced directly.

3. For persons who do not have health insurance coverage and are unable to pay, their services will be covered by the NEMTC.

6.15 Deployment of Appropriate Technology

The emergency response system shall be run using an electronic dispatch software system for the coordination of call outs, responses, monitoring, dispatch, reimbursement, and general administration. The NEMTC shall adopt a uniform information and communications technology (ICT) platform for the integration and deployment of ambulances.

6.16 Fund Management and Disbursement

The main operative strategy is to pay for emergency ambulance and emergency centre services that will be provided by certified and accredited private and public providers. All service providers will receive formal accreditation by the NEMTC in collaboration with State Emergency Medical Treatment Committees (SEMTCs) based on the National Emergency Medical Services guideline (FMoH 2014).

The 5% BHCPF funds for the NEMTC shall be maintained in a TSA. Signatories to the TSA shall be as stipulated by the office of the Accountant General of the Federation: the Chair of the NEMTC shall be the approving authority; designated accountants as initiators, and reviewers. The emergency care providers shall have accounts with registered commercial banks for the NEMTC.

Funds disbursed from the NEMTC TSA will be utilised as follows:

1. To pay for and reimburse pre-hospital (emergency ambulance) and immediate in-hospital (emergency centre) services.

2. Payment to providers shall be by fee-for-service. In view of the unpredictability of emergencies, it shall be imperative for payment to be centrally coordinated at the initial phases of the EMT Gateway implementation. However, as state capacity develops and the funding envelope for the EMT Gateway expands from additional sources, fund disbursement for some services shall systematically be decentralised to state level

3. Payment shall be based on verified claims channelled through the SEMTC.

4. States shall process claims for emergency services rendered by providers in their states through the SHIA or SHIS mechanism and forward same to the NEMTC head office for settlement, using the prescribed system or software.

5. Funds will be transferred into the providers bank accounts using registration documents provided to the NEMTC through the SEMTC.

6. 5% of the NEMTC BHCPF funds will be spent on administrative costs by the NEMTC.

6.17 Quality Assurance

Internationally accepted quality benchmarks adapted to country context, will be used to assess the performance of the scheme, and guide quality improvement.

6.18 Research

Data pooled from this innovation will be used to thoroughly research service delivery, quality improvement and sustainability models for emergency medical services. All research shall be subject to due ethnical clearance as stipulated by the FMoH.

6.19 Emergency Medical Care Providers Rights and Responsibilities

Service providers enrolled in NEMTC shall be held to the highest standards of care as outlined in the guidelines of this scheme, FMoH manuals and from related agencies.

Collaborative efforts will be made, working with relevant agencies, including Federal Fire Service and NEMA, to ensure that patients are rescued and protected from ongoing or further harm. It is the responsibility of emergency providers to ensure their personnel and patients are kept out of harm's way while in the line of duty.

Emergency providers must keep all patient information confidential. It is the right of all providers to be paid for their services and the scheme will guarantee this payment.

Providers shall pass unresolved grievances to the SEMTC and NEMTC offices, where these will be compiled and investigated. All complaints from patients shall be afforded the utmost seriousness and diligently investigated.

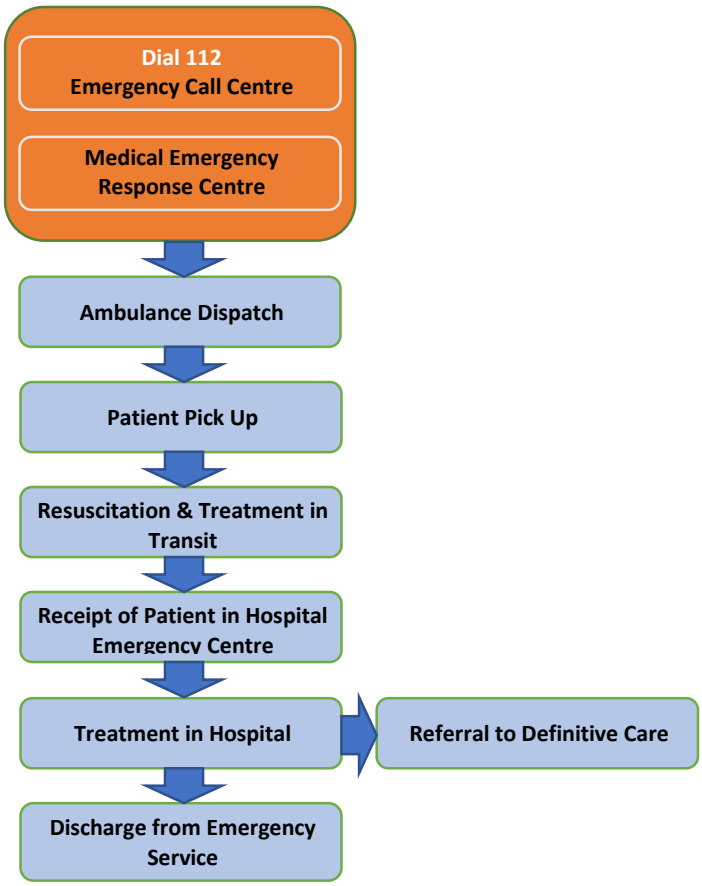

Figure 8: Schematic for Emergency Medical Response for National and States

The 112-emergency number is already established and domiciled with the NCC and NEMA. Incoming calls for medical emergency assistance will be automatically routed to the Medical Emergency Response Centre at national and state levels. Call responses will be jointly coordinated as required with collaborating agencies including NEMA and Federal Fire Service, at federal and state levels.

6.20 National Emergency Medical Treatment Committee (NEMTC) Operational Guideline

Further details about the administration, management and operation of the 5% BHCPF EMT Gateway; funds flow and disbursement; collaboration with stakeholders, including state governments, partners and donors, and private sector; provide accreditation, certification and reimbursement; auditing, quality assurance and research; will be detailed in a comprehensive NEMTC Operational Guideline that is being developed under the leadership of the NEMTC Chair.

7.0 MONITORING AND EVALUATION OF THE BASIC HEALTH CARE PROVISION FUN

Monitoring and evaluation (M & E) of the Basic Health Care Provision Fund (BHCPF) shall span all stakeholders, their interdependencies, processes, and performance across the 3 gateways: the National Health Insurance Scheme (NHIS) Gateway, the National Primary Health Care Development Agency (NPHCDA) Gateway and the Emergency Medical Treatment (EMT) Gateway. The Honourable Minister may constitute a committee to monitor the implementation of any or all the projects biannually.

7.1 Scope of the Basic Health Care Provision Fund (BHCPF) Monitoring and Evaluation (M & E)

1. Processes: How compliant are federal, state and facility entities with the governance, administrative, financial, operational, and service delivery processes of the BHCPF?

2. Outputs: What has been the utilisation of designated services by target groups?

3. Outcomes: What is the health and socioeconomic impact of these interventions?

7.2 Approach

The M & E structure shall ensure a robust mechanism for information collection and analysis. It will capture information as quickly as possible and will focus primarily on process measures, flow of funds, verification of routinely reported data and invoices, and other aspects of implementation.

7.3 Indicators

Periodic M & E will be conducted to access inputs, processes, outcomes, and impact indicators, based on the NSHDP II and the indicators tracked by the 3 (three) gateways. Specific key performance indicators (KPIs) *(see section 7.7.2 below)* shall be routinely used to track state performance.

7.4 Data Sources

Sources of data employed to implement the M & E shall include:

1. TSA Statements of Accounts
2. NHMIS
3. National and State Health Accounts
4. SMART Surveys and M & E reports from the Gateways
5. Other national surveys, such as Multiple Indicator Cluster Survey (MICS), National Demographic and Health Survey (NDHS)

7.5 Impact Evaluation

A rigorous Impact Evaluation (IE) shall be designed with the gateways to assess the impact of the fund. Conducting the impact evaluation shall be the responsibility of the Federal Ministry of Health in collaboration with the National Bureau of Statistics (NBS). The impact evaluation shall be designed to measure progress in utilisation of the BMPHS and will be tied to the objectives of implementing the fund. Sample indicators will include:

1. Number of maternal lives saved
2. Number of under-five deaths averted
3. Level of increase of people with financial risk protection
4. Level of reduction in use of out-of-pocket spending
5. Reduction in delays in seeking care
6. Disability adjusted life years gained
7. Availability, utilisation, and coverage of key maternal and neonatal health services, especially for the poor
8. Reduction in inequities in access and health (related) expenditure
9. Quality of care, in public and private health facilities
10. Changes in health seeking behaviour over time

The impact evaluation shall be expected to generate lessons on the effectiveness of the fund; and inform reviews and improvements for implementation. Findings and data from the evaluation shall be made available to the MOC for advocacy and public dissemination.

7.6 Evaluating Results from Health Investments

A checklist will be used to evaluate the progress made by the state and local governments, and health facilities. This checklist will be developed according to NPHCDA standards for PHC and NHIS accreditation requirements. It will be made available to all state and local governments, and PHCs to plan and work towards a full score on the checklist.

All project proposals are to include M & E frameworks, which will be vetted by the NHIS, NPHCDA and NEMTC during the approval of the project proposal. The proposal should outline a clear timeframe for the investment and for the expected results. This timeframe will be used by the monitoring institutions (NHIS, SHIS, NPHCDA, SPHCDA or SPHCB, and LGHA) to plan for M & E exercises.

7.6.1 Parameters for Monitoring and Evaluation Framework

Investment Category	Current Situation	Objective	Cost	Indicators
Essential drugs, vaccines & consumables	Monthly & quarterly dispensing; stock levels; unmet dispensing needs	Monthly & quarterly dispensing; stock levels	Monthly, quarterly, & lump-sum cost (by individual item)	Security stock levels, balanced purchase & dispensing of consumables, quantity & quality of services dispensed
Maintenance of facilities, laboratory, equipment & transport	State of facilities, equipment; need for equipment or transport	Intended renovation of facilities, equipment & estimated effects; purpose of equipment or transport to be purchased	Itemised cost of renovation, purchase	Quantity & quality of services dispensed
Human Resources Development	Identified lack of skills capacity	Description of capacity building activities	Capacity building costs (overall and per person)	Quantity & quality of services dispensed
Governance and Stewardship	Identified gaps in governance structures and organisational capacity	Strengthening governance structures for sustainability of the health system at state & federal levels	Organisational capacity assessment & strengthening costs	Quantity & quality of technical assistance & equipment provided
Health Financing and Financial Management Systems	Identified gaps in health financing & financial management systems	Sustainable funding for health services; fund pooling structures; value for money of funds managed and utilised	Capacity building, establishment of health financing progs. including health insurance & strategic purchasing mechanisms	Amount of funds mobilised for health; no. of citizens covered by health insurance, access BMPHS, esp. poor & vulnerable; reduction in OOP expenditure on health; efficiency in health spending
ICT, Health Information Management, and Innovations	Identified gaps in health information management systems, ICT, & innovations	Efficient management of health data from health facilities; use of innovation & new technology	Capacity building, provision of appropriate equipment, tools & new technology	No. of health facilities reporting appropriately & on time

7.6.2 Key Performance Indicators for the Basic Health Care Provision Fund (BHCPF)

	Indicator	Data Frequency	Data Source	KPI Target	National Programme Target	Ownership
National Level: To be Tracked at Ministerial Oversight Committee						
1.	Percentage of annual BHCPF budget released	Annual	Annual Budget, FMoF	100% Annually	100%	MOC
2.	Percentage annual increase in national BHCPF population coverage	Annual	NHIS Gateway Reports, UHC Surveys	20% by Q4 2021	60%	NHIS
3.	Number of States receiving DFF disbursements from the NPHCDA as and when due	Quarterly	TSA analysis, financial reports	100% by Q4 2021	100%	NPHCDA
4.	Proportion of states where all wards have at least 1 functional PHC benefitting from BHCPF	Quarterly	NPHCDA Gateway Reports	60% in 3 years, 100% in 5 years	100%	NPHCDA
5.	Proportion of states with at least 3 fully functional public and private secondary health care facilities benefitting from BHCPF	Annual	NHIS Gateway Reports	50% in 3 years	100%	NHIS
6.	Proportion of states with functional Emergency Medical Response Service	Quarterly	EMT Gateway Reports	50% in 3 years	75% in 5 years	EMT
7.	Percentage annual decrease in out-of-pocket expenditure on health	Annual	National Health Account	10% Annually	less than20%	NHIS

	Indicator	Data Frequency	Data Source	KPI Target	National Programme Target	Ownership
NHIS Gateway: To be Tracked by NHIS						
1.	Percentage annual release of earmarked equity funds by states to SHIS or SHIA	Annual	State reports	100%	100%	SHIA
2.	Percentage annual increase in State Health Expenditure from health insurance	Annual	National Health Account	10% annual increase	70%	NHIS, SHIS or SHIA
3.	Percentage of enrolees satisfied with services rendered by participating health facilities	Bi-annually	Survey reports	70%	80%	NHIS
4.	Percentage of health facilities paid within specified timeframes for services rendered	Quarterly	TSA analysis, State financial reports	90%	100%	SHIS or SHIA
5.	Percentage annual increase in enrolment of beneficiaries	Quarterly	NHIS Gateway Reports	20% annually		SHIS or SHIA
6.	Percentage annual increase in utilisation of essential services by enrolled populations	Quarterly	DHIS, State programmatic reports	20% annually		NHIS, SHIS or SHIA
NPHCDA Gateway: To be Tracked by NPHCDA						
1.	Proportion of BHCPF facilities receiving timely DFF disbursement from states based on annual plans	Quarterly	TSA analysis, State financial reports	90% per quarter	100%	SPHCDA or SPHCB
2.	Timely submission of quarterly financial retirements by states	Quarterly	State financial reports	100% per quarter	100%	SPHCDA or SPHCB
3.	Percentage increase in utilisation of PHC services (all attendance) across BHCPF facilities per state	Annually	DHIS	30% annually		SPHCDA or SPHCB, LGHA

	Indicator	Data Frequency	Data Source	KPI Target	National Programme Target	Ownership
4.	Percentage of BHCPF facilities within with at least 2 midwives offering RMNCAH services	Quarterly	DHIS; State programmatic reports	75% in 3 years	100%	SPHCDA or SPHCB
5.	Proportion of wards and PHCs per state attaining 80% of deliveries attended by skilled birth attendants	Monthly, Annually	DHIS, Survey (PAPA)	at least 20% increase per annum	80%	SPHCDA or SPHCB
6.	Percentage increment in Penta 3 coverage within state	Quarterly, Annually	LQAS, Survey	at least 10% increase per annum	80%	SPHCDA or SPHCB
7.	Percentage of wards per state with at least 10 CHIPS Agents trained, equipped, and deployed.	Quarterly	DHIS; State programmatic reports	25% of Wards per Annum	100%	SPHCDA or SPHCB
8.	Percentage of PHC facilities reporting no stock-out of essential medicines	Quarterly	Quality assessment reports, Surveys	75%	100%	SPHCDA or SPHCB
9.	Proportion of wards per state with at least 1 BHCPF PHC facility upgraded (or new) that conforms to national PHC standards (human resource, equipment, and infrastructure)	Bi-annually	Monitoring and supervisory reports; Surveys	30% in year 3, 70% in year 5	100%	SPHCDA or SPHCB
10.	Proportion of BHCPF facilities per state achieving at least 20% improvement in quality scores based on assessments	Quarterly	Quality Assessment Report	At least 25% per quarter	100%	SPHCDA or SPHCB

	Indicator	Data Frequency	Data Source	KPI Target	National Programme Target	Ownership
EMT Gateway: To be tracked by NEMTC						
1.	Number of states with functional State EMT Committees	Quarterly	State reports	100% by 2021	100%	NEMTC
2.	Number of states with functional and accredited ambulance services	Annually	EMT Gateway Reports	50% in 3 years	100%	NEMTC, SEMTC
3.	Proportion of states with functional and accredited emergency centres	Annually	EMT Gateway Reports	50% in 3 years	100%	NEMTC, SEMTC
4.	Percentage increase in utilisation of EMT services	Quarterly	Programmatic report	10% annually		NEMTC, SEMTC

7.7 Reporting

Reporting is an essential aspect for assessment during the verification process. Project reports are passed on to the supervisory authority at each level i.e. LGHA and state government for onward transmission to the federal level.

Financial reports will be prepared by the SPHCDA or SPHCB, SHIS or SHIA, SEMTC, LGHA, and PHC, and on a regular basis, dispatched upwards through the gateways for national collation.

7.8 Transparency and Accountability

The use of TSAs is expected to enhance transparency as it can be viewed nationally, by all authorised persons. In addition, the implementing institutions for the gateways shall endeavour to routinely communicate funds receipt, disbursements, and utilisation to the public. The gateways shall implement an accountability framework that shall hold responsible persons and institutions at all levels accountable for inaction and misconduct that threatens programme success. The table in 7.8.4 below, outlines an overarching accountability framework to be deployed for the BHCPF. The gateways are expected to further drill down and expatiate on this framework for interventions peculiar to the various gateways, for routine implementation.

7.8.1 Objective of the Accountability Framework

The core objectives of the accountability framework are:

- To ensure compliance with the BHCPF Guideline; and
- To ensure that eligible health facilities benefitting from the programme are funded in a timely, transparent, and accountable manner, that ensures incremental quality improvement and effective service delivery.

7.8.2 Reporting for Accountability Framework

Reporting for the framework shall emanate from routine reports from the gateways, including financial and supervisory reports. Quarterly reports from all levels of implementation shall clearly highlight aspects of the framework pertinent to their level, indicating successes, commendations and sanctions invoked based on the framework.

All reports shall be compiled quarterly, additional reports for the gateways are as indicated in the indicated sections of this guideline or as may be published by the gateways in subsequent SOPs.

7.8.3 Rewards and Sanctions

Specific rewards and sanctions for aspects of the accountability frameworks shall be based on each gateway and guided by consensus with stakeholders to ensure compliance. However, rewards and sanction shall not contravene the public civil service rules and regulations, public financial regulations, and the national Procurement Act. For private sector entities, particularly for the NHIS and EMT gateways, extant federal and state laws shall apply as relevant, for financial matters.

7.8.4 Accountability Framework

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
1.	**FUNDING**	National	Proportion of CRF allocated in FGoN budget for BHCPF	Measure of FGoN commitment to implementation of the BHCPF	i = on track: funds allocated ii = slightly off-track: funds appropriated < 1% CRF; immediate advocacy action & corrective measures required iii= severely off-track: no appropriation; immediate national intervention required	Annual Appropriation Act of FGoN	NASS, HMH, FMoF
2.		National	Proportion of appropriated BHCPF funds released per quarter	Release of BHCPF funds is proxy for measuring availability of funding at the frontlines for implementation	i = on track: quarterly funds fully allocated ii = slightly off-track: funds < appropriated for quarter; immediate action to FMoF, Budget Office iii = severely off-track: no release for quarter; immediate national intervention required	TSA, Govt. Integrated Financial Management Information System (GIFMIS) Report	FMoF, Budget Office, HMH, ED NPHCDA, ES NHIS, Chairperson NEMTC

3.		National	Proportion of released funds disbursed to states within 10 working days of receipt		i = on track: funds fully disbursed ii = slightly off-track: partial disbursement; immediate corrective action required iii = severely off-track: no disbursement; urgent intervention required		NHIS, NPHCDA, NEMTC, Responsible Lead Officers

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
4.		State	Proportion of eligible health facilities receiving quarterly funds with 10 working days of release or approval & payment for services rendered within specified timeframe	Receipt of funding by health facilities is a pre-requisite for service provision and quality improvement	i = on track: funds fully disbursed ii = slightly off-track: partial disbursement to eligible health facilities; immediate corrective action required iii = severely off-track: no disbursement; urgent intervention required.	TSA, GIFMIS Report, Supervisory Reports, Reports by State Officers, routine financial reports	State Agencies or Boards, NEMTC
5.		State	Proportion of states that paid 25% of proposal	Required counterpart funding to be eligible for national funding	i = on track: counterpart paid ii = off track: counterpart not paid or partially paid; urgent national intervention required	TSA, Financial Report	HCH, ES SHIAs or SHISs

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
6.		State	Proportion of State Agencies or Boards and LGAs releasing funds for PHC under routine annual budget	BHCPF is a catalytic fund, not a replacement funding for PHC	i = on track: funding released, comparable to previous year ii = slightly off-track: funding released, significantly < previous releases; intervention required iii = severely off-track: no disbursement; urgent intervention required	State Financial Reports	HCH, SMoF
7.	**GOVERNANCE**	State	Proportion of states implementing PHCUOR; functional State Health Insurance Agencies of Schemes	Tracking PHC repositioning, to eliminate verticalization of PHC progs. Ensures readiness & ability to effectively implement the BHCPF	i = on track: ii = slightly off-track: state agencies at intermediate stage of functionality; immediate intervention, national support, or sanction iii = severely off-track: agencies or boards not functional; urgent intervention or sanction	PHCUOR Scorecard (national score for repositioning), Baseline Assessment reports, etc.	HCH, State Assembly, State ES

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
8.		National	Regularity of meetings: MOC and Gateways Forum	Ensure synergy and coordination	i = on track: ii = slightly off-track: missed 1 quarter; immediate corrective measures required iii = severely off-track: more than 1 quarter missed; urgent action required	Meeting Minutes and Reports	HMH, ES, ED, Chair NEMTC
9.		State	Regularity of meetings: SOC and Gateways Forum	Ensure synergy and coordination	i = on track: ii = slightly off-track: missed 1 quarter; immediate corrective measures required iii = severely off-track: more than 1 quarter missed; urgent action required	Routine Reports, Reports by State Officers	HCH, ES State Agencies and Boards
10.	**PROGRAMME MANAGEMENT**	State	Timely submission state of proposals, workplans & projections	Timely submissions have a domino effect on the timeliness of subsequent activities	i = on track: ii = off-track: submission later than pre-determined 'grace' period; immediate national intervention or sanction	Programme Report, document trackers	ES State Agencies and Boards

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
11.		National	Regularity of submission of quarterly programmatic & financial reports	Ensure compliance with guidelines, for HMH & MOC update	i = on track submission on time & complete ii = off-track: submission later than pre-determined 'grace' period; immediate national intervention	Reports, document trackers, TSA	HMH, ES, ED, Chair NEMTC, Responsible Programme Leads
12.		State	Proportion of states submitted programmatic & financial reports, including retirements	State submissions are a prerequisite to earn funding for subsequent quarter	i = on track: submission on time & complete ii = off-track: submission later than pre-determined 'grace' period; immediate national intervention	Report, document trackers, TSA	Responsible National Programme Leads, ES State Agencies and Boards
13.		LGHA	Proportion of LGHAs submitted collated Quarterly Business Plans & operational requirements to State Agencies and Boards	Quarterly Business Plans inform state submissions & subsequent funding	i = on track: submission on time & complete ii = off-track: submission later than pre-determined 'grace' period; immediate state intervention iii = severely off-track: submission < 50% of LGHA; urgent national support & intervention required	Proposal, reports from states	SPHCDA, SPHCB

	Theme	Level	Broad Indicator	Description/ Comment	Tracker Rating/ Required Action	Report	Responsibility
14.		State	Proportion of PHCs submitting Quarterly Business Plans & previous quarter retirements through LGHA to SPHCDA or SPHCB	PHC submissions to states required for timely disbursement to PHCs & funding	i = on track: submission on time & complete with evidence of community participation ii = off-track: submission later than pre-determined 'grace' period; immediate LGHA intervention iii = severely off-track: submission < 50% of PHCs; urgent state support & intervention required	Reports submitted by LGHA	SPHCDA, SPHCB, LGHA PHC Advisory Committee, LGHA
15.		State	Proportion of WDCs meeting regularly & interfacing with PHCs	PHC facilities are co-managed with WDCs, also signatories to the Facilities Account	i = on track: meeting regularly with quorum & participation of health staff ii = slightly off-track: 2 meetings missed; immediate corrective measures required iii = severely off-track: no meeting in 3 consecutive months; immediate LGHA intervention required	Meeting Minutes & Reports, Supervisory Visit Reports	LGHA, OIC PHC, Chairperson WDC

7.9 Fraud

The inability to account for or reconcilable funds, shall be subject to investigative audit. Where fraud is detected in the form of embezzlement or outright diversion of funds, report shall be made to relevant antigraft agencies for appropriate investigations and prosecution. All levels of implementation shall be held liable for fraud and fraudulent practices.

CONTRIBUTORS

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Members of the Ministerial Committee for Review of the BHCPF Operations Manual 2018

S/N	Name	Designation	Organisation	Role
1.	Alh. Abdulazziz Mashi Abdullahi	Permanent Secretary	FMoH	**Chairman**
2.	Dr. Faisal Shuaib	ED	NPHCDA	
3.	Prof. Sambo	ES	NHIS	
4.	Dr. Chikwe Ihekweazu	DG	NCDC	
5.	Dr. Adebimpe Adebiyi	DHS	FMoH	
6.	Barr. G. F. Zi	Director, Legal	FMoH	
7.	Dr. Morenike Alex-Okoh	Director, PHS	FMoH	
8.	Dr. Sydney Ibeanusi	Director, TEDR	FMoH	
9.	Dr. F. Ogedegbe	Chairman	NEMTC	
10.	Dr. Abba Umar Zakari	Chairman, Committee of Commissioner (States for Health)	Jigawa SMoH	
11.	Dr. Ahmad Danfulani	Rep. Forum of CEOs SHIA	FCT SHIA	
12.	Dr. Mohammed U. Adis	Forum of CEOs SPHCDA/B	Nasarawa SPHCB	
13.	Itohan Ehanire	SA-HMH	FMoH	

14.	Dr. David Atuwo	STA-HMSH	FMoH	
15.	Barr. Danladi Salisu	TA-Legal, HMH	FMoH	
16.	Dr. Ahmed Baba	TA-PSH	FMoH	
17.	Dr. Francis Ukwuije	Health Economist	WHO	
18.	Dr. Emmanuel Meribole	Director, HPRS	FMoH	**Secretary**

Members of the Ministerial Sub-Committee for Development of Revised BHCPF 2018

S/N	Name	Designation	Organisation	Role
1.	Dr. Faisal Shuaib	ED/CEO	NPHCDA	Chairman
2.	Prof. Sambo	ES/CEO	NHIS	Member
3.	Dr. Felix Ogedegbe	Chairman/NEMTC	Private Sector	Member
4.	Dr. A. B. Garba	DPRS	NPHCDA	Member
5.	Dr. O. Ogbe	CMO	NPHCDA	Member
6.	Dr. John Oladejo	Director HEPR	NCDC	Member
7.	Barr. G. F. Zi	DLS	FMoH	Member
8.	Dr. Nnennaya Kalu-Umeh	TA ES/CEO	NHIS	Member
9.	Dr. Ahmad Danfulani	Forum of CEOs SHIA	FCT SHIA	Member
10.	Bolaji Oladejo	Director M & E	FMoH	Member
11.	Dr. Mohammed U. Adis	Forum of ES	Nasarawa SPHCB	Member
12.	Dr. Mordi Ononye	Comm. of Health, Delta	Delta SMoH	Member
13.	Dr. Saka Audu	Comm. of Health, Kogi	Kogi SMoH	Member
14.	Dr. Jonathan Eke	GM, Formal Sector	NHIS	Member
15.	Dr. Sydney Ibeanusi	Director, TEDR	FMoH, Abuja	Member
16.	Dr. Francis Ukwuije	Health Economist	WHO	Member
17.	Dr. Akanbiemu Francis	ES	Ondo SPHCB	Member
18.	Christopher Okoh	DGM, Informal Sector	NHIS	Member
19.	Dr. Priscilla Ibekwe	Deputy Director	NCDC	Member
1.	Nurudeen Basheer	M & E Officer	NPHCDA	Secretariat
2.	Sakina Hamza D.	Capacity Building Officer	NPHCDA	Secretariat
3.	Muhammad Awwal Abdullahi	TA	R4D/Sydani	Secretariat

4.	Rabiu M. Kamal	Administrative Officer	NPHCDA	Secretariat
Other Contributors				
1.	Dr. Akin Oyemakinde		Lafiya Project	
2.	Dr. Chris Osa Isokpunwu	STA-HMH	FMoH	
3.	Dr. Anthony Adoghe	M & E Division	FMoH	
4.	Dr. Olusola Ayoola	MO	FMoH	

FEDERAL MINISTRY OF HEALTH
FEDERAL REPUBLIC OF NIGERIA