FEDERAL MINISTRY OF HEALTH & SOCIAL WELFARE
FEDERAL REPUBLIC OF NIGERIA

Guideline

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

June, 2025

FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE
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JUNE, 2025

TABLE OF Contents

FOREWORD

The Basic Health Care Provision Fund (BHCPF), established under the National Health Act (2014), has become a foundational pillar of Nigeria's health financing reform, providing catalytic funding for strengthening primary health systems and improving access to quality health services for all Nigerians, especially the most vulnerable. Since its operationalisation, significant progress has been made, with improved access to quality care services and establishment of a viable health financing pathway for intergovernmental transfers from the federal level to frontline primary health care centres, targeted at improving the health of Nigerians.

Progress has, however largely been sub-optimal, necessitating reforms to guarantee greater accountability, transparency, and visibility in the administration of the Fund. This revised BHCPF Guideline responds to these imperatives by embedding robust oversight, fiduciary controls, and digital tracking systems, and placing citizens' voices at the centre of fund monitoring. It reflects our firm resolve to ensure that citizens obtain 'more health' for every Naira allocated to BHCPF, with measurable health outcomes and benefits to the Nigerian people by 'reducing pain and saving lives'.

This revised Guideline, further positions the BHCPF as the anchor for the Nigeria Health Sector Renewal Investment Initiative (NHSRII) and reinforces the adoption of a Sector-Wide Approach (SWAp) to health financing and programme implementation. Through this integration, the BHCPF is positioned for seamless coordinated planning with other national programmes, harmonised resource use, and joint accountability across federal, state, local governments, development partners, civil society organisations and other stakeholders. The diligent application of this Guideline will further accelerate our progress towards achieving the 'Presidential Commitment to Health' and universal health coverage.

One of the most notable reforms in this revised guideline is transformation of the transformation of the Ministerial Oversight Committee from its singular mandate over the BHCPF to a more inclusive platform that provides visibility and stewardship for all national priority donor and government-funded programmes. This transformation is in line with the sector-wide approach (SWAp) and principles of the NHSRII, enabling effective synchronisation and reduction of duplications across priority national programmes and interventions.

Furthermore, unique to the revised guideline is the inclusion of local government health authority participation in the BHCPF. The guideline promotes stronger

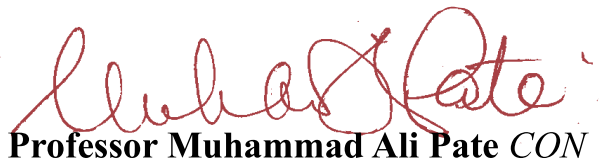
LGA leadership through enhanced roles in planning, supervision, and grievance redress while strengthening the primary health care under one roof (PHCUOR) approach. This is a critical step toward unlocking grassroots governance and ensuring that services truly reach the frontlines communities.

Looking ahead, this Guideline sets a bold national goal: to achieve 17,600 fully functional public or private primary health care facilities nationwide—with at least one in every political ward—by 2027. These facilities serve as the platform for the provision of quality facilities and community-based health services to Nigerians. It also sets targets for expanding emergency medical response, reducing out-of-pocket expenditure, and raising life expectancy. These ambitions are not merely aspirational—they are achievable with collective resolve, commitment and the active participation of all stakeholders.

This revised guideline is the product of rigorous technical work and broad consultation, led by the Ministerial Oversight Committee (MOC), chaired by the Honourable Coordinating Minister of Health and Social Welfare, with the past and present Honourable Minister of State for Health and Social Welfare and the Permanent Secretary playing key leadership roles. The MOC secretariat provided technical, coordination and editorial support, with technical inputs drawn from all implementing gateways – the NHIA, NPHCDA, NEMTC, and NCDC – and from subcommittees composed of representatives from federal, state and LGA institutions, civil society, and development partners. In addition, robust stakeholders' consultative meetings were held to harvest all possible inputs.

On behalf of the Federal Ministry of Health and Social Welfare, I extend sincere appreciation to all who contributed to this effort. Your dedication, expertise, and commitment to equity and a healthier Nigeria have shaped a document that not only consolidates past achievements but provides a stronger foundation for the future.

Let us now move forward together—to implement this Guideline with fidelity, uphold accountability at every level, and deliver on the promise of Universal Health Coverage for all Nigerians.



Professor Muhammad Ali Pate *CON*
Honourable Coordinating Minister of Health and Social Welfare
Federal Republic of Nigeria
July 2025

ACKNOWLEDGEMENT

The revision of the Basic Health Care Provision Fund (BHCPF) Guideline marks a significant milestone in Nigeria's ongoing efforts to strengthen health financing and service delivery. This document is the outcome of extensive collaboration, dedication, and technical contributions from a wide range of stakeholders across the health sector.

We express our profound appreciation to the Honourable Coordinating Minister of Health and Social Welfare, Professor Muhammad Ali Pate, whose leadership of the Ministerial Oversight Committee (MOC) provided the strategic direction and impetus for this review. We also acknowledge the invaluable inputs and support of the immediate past and current Honourable Minister of State for Health and Social Welfare and the Permanent Secretary of the Federal Ministry of Health and Social Welfare. The MOC's support and guidance were invaluable throughout the process.

Special thanks and appreciation goes to the Executive Director and Director Generals, of the implementing agencies—namely, the National Health Insurance Authority (NHIA), the National Primary Health Care Development Agency (NPHCDA), the National Emergency Medical Treatment Committee (NEMTC), and the Nigeria Centre for Disease Control and Prevention (NCDC); and the Directors of the FMoH, and all management and technical teams across the health sector for their critical technical contributions and invaluable insights. We extend sincere appreciation to the MOC Secretariat team, including the immediate past leadership, for its coordination, documentation, and editorial work. Collectively, the technical team ensured that this revision process was inclusive, evidence-based, and focused on performance outcomes over inputs.

This Guideline has also benefited from the insights and participation of subcommittees established by the MOC, which included representatives from federal, state and local government, civil society organisations, professional associations, and development partners. We are particularly grateful to the members of the Ministerial Subcommittees whose detailed reviews, expert inputs, and constructive debates shaped the content and structure of this document.

Furthermore, we commend the efforts of State Ministries of Health, State Social Health Insurance Agencies, State Primary Health Care Boards/Agencies, State Emergency Medical Treatment Committees, Local Government Authorities and Association of Local Governments of Nigeria (ALGON), and Ward Development

Committees, whose active involvement has brought grassroots realities into focus and enriched the Guideline.

The active participation of the Civil Society Organisations (CSOs), the health sector development partners, for their technical and funding support at various points of the review is very much appreciated. We similarly extend our gratitude to the Private Sector and Consultants from various organisations who participated and supported the process. We acknowledge the role of the SWAp Coordination Office for laying out the framework that ensured programme plans in the guideline align with the sector-wide approach.

We sincerely appreciate all contributors and we are confident that this revised Guideline will serve as a practical and transformative tool to enhance the implementation of the BHCPF and move Nigeria closer to the goal of Universal Health Coverage.

Dr O. Ogbe
Secretary, Ministerial Oversight Committee
July 2025

ABBREVIATIONS

BEmONC	Basic Emergency Obstetric and Newborn Care
BMPHS	Basic Minimum Package of Health Services
BHCPF	Basic Health Care Provision Fund
CBN	Central Bank of Nigeria
CBO	Community-Based Organisation
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CRF	Consolidated Revenue Fund
CSO	Civil Society Organisation
DFF	Direct Facility Financing
EMT	Emergency Medical Treatment
EMTRF	Emergency Medical Treatment Reimbursement Fund
FAAC	Federal Account Allocation Committee
FCT	Federal Capital Territory
GIFMIS	Government Integrated Financial Management Information System
LGHA	Local Government Health Authority
MOC	Ministerial Oversight Committee
NASS	National Assembly
NCDC	Nigeria Centre for Disease Control
NCH	National Council on Health
NHAct	National Health Act
NHIA	National Health Insurance Authority
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NPHCDA	National Primary Health Care Development Agency
OAGF	Office of the Accountant General of the Federation
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PHEOC	Public Health Emergency Operations Centre
RRT	Rapid Response Team
SHC	Secondary Health Care
SOC	State Oversight Committee
SPHCDA	State Primary Health Care Development Agency
SSHIA	State Social Health Insurance Agency
TSA	Treasury Single Account
UHC	Universal Health Coverage
WDC	Ward Development Committee

DEFINITIONS

Basic Health Care Provision Fund (BHCPF): a fund established under the National Health Act, 2014, aimed at ensuring all Nigerians, particularly vulnerable populations, have access to basic health care services. It is financed through at least 1% of the Consolidated Revenue Fund (CRF) and contributions from donors.

Consolidated Revenue Fund (CRF): a primary account used by the Federal Government to receive and manage all its revenues and incomes from various sources, except those that are required by law to be credited to a different fund.

Universal Health Coverage (UHC): a goal to ensure all individuals and communities receive the health services they need without financial hardship.

Basic Minimum Package of Health Services (BMPHS): a defined set of essential health services provided through the BHCPF, including promotive, preventive, curative, and rehabilitative services.

Direct Facility Financing (DFF): a funding mechanism that transfers resources directly to primary health care facilities to enable them to meet operational needs.

Treasury Single Account (TSA): This is a unified structure of government bank accounts that enables the consolidation and optimal utilisation of government cash resources. It is designed to bring all government revenues, receipts, and payments into a single account or series of linked accounts maintained at the Central Bank of Nigeria (CBN).

1. INTRODUCTION

1.1. Background

The Basic Health Care Provision Fund (BHCPF) is a significant milestone in Nigeria's journey towards achieving Universal Health Coverage (UHC) by revamping Primary Health Care (PHC) facilities and increasing access to quality healthcare, especially among the most vulnerable populations. The BHCPF was established under the National Health Act of 2014 (NHAct 2014), which is a landmark legislation that formalised the country's commitment to ensuring equitable access to quality healthcare services. The Act mandates that at least 1% of the Federal Consolidated Revenue Fund (CRF) be dedicated to financing the BHCPF and may be further supported by contributions from donors and development partners.

Since its inception, the BHCPF has undergone some strategic reviews to improve its effective utilisation in delivering health services. The *2018 Operations Manual* provided the initial framework for the implementation and management of the Fund. This was followed by the 2020 *Guideline for the Disbursement, Administration, and Monitoring of the BHCPF*, which introduced more detailed processes to enhance transparency, accountability, and efficiency in the utilisation of the Fund. However, the 2020 Guideline made a provision for a review within 3 years to ensure that the lessons learned during this period are incorporated in subsequent revisions.

In July 2023, a pivotal retreat was held with key stakeholders, including representatives from federal and state governments, development partners, and civil society organisations, to review the implementation of BHCPF in the country. Emerging health priorities and lessons learned from previous implementation phases were recognised, necessitating the need to align the Fund's operations with emerging health sector reforms.

The health sector in Nigeria has increasingly embraced a more integrated and coordinated approach to planning and implementing health interventions. The Nigeria Health Sector Renewal Investment Initiative (NHSRII), which was approved during the 64th National Council on Health (NCH) in 2023, represents a significant commitment by the government of Nigeria to reinvigorate the health sector through targeted investments in critical areas. It focuses on saving lives, reducing physical and financial pain, and providing health for all Nigerians.

The Sector-Wide Approach (SWAp) is central to the NHSRII and aims to ensure that all stakeholders work together under a unified framework to achieve common

health goals. SWAp promotes the alignment of resources, harmonisation of efforts, and joint accountability, thereby enhancing the overall impact of health investments.

In design, the BHCPF serves as the anchor of the NHSRII, and the governance structure of the BHCPF has been leveraged to ensure seamless integration and synergy, enhancing the BHCPF's ability to reach the most vulnerable citizenry. This revised BHCPF Guideline, therefore, not only reflects the operational lessons learned over the years but also aligns with the strategic objectives of the NHSRII. This alignment is crucial for maximising the impact of health investments and achieving the overarching goal of UHC in Nigeria. As a result, the Ministerial Oversight Committee (MOC) Chair established a subcommittee of the MOC to steer the process of the review of the 2020 Guideline, following the approval of reforms proposed by each gateway. This revised guideline is the concerted effort of the sub-committee, the individual gateways and a plethora of stakeholders across the health sector.

1.2. Purpose of the Guideline

This Guideline is designed to provide comprehensive guidance for the implementation of the BHCPF as well as effective and efficient use of the fund. It incorporates the lessons learned from previous implementation phases, addresses the gaps identified during the July 2023 retreat, and aligns with the broader health sector reforms under the NHSRII.

In developing this Guideline, the following factors were considered:

a. **Enhancing Transparency and Accountability:** Establish clear processes and responsibilities for the disbursement and utilisation of the Fund, ensuring that resources reach the intended beneficiaries.
b. **Promoting Equity:** Ensure that the most vulnerable populations, particularly those in underserved areas and groups, have access to essential health services.
c. **Strengthening Health Systems:** Support health institutions at all levels to improve the delivery of services.
d. **Fostering Collaboration:** Encourage partnership and coordination among federal, state, and local governments, development partners, and other stakeholders to achieve common health goals.
e. **Ensuring Sustainability:** Align the BHCPF's operations with long-term health sector strategies, including the NHSRII, to ensure sustained impact

and progress towards UHC.

1.3. Objectives of the BHCPF and Establishment of the Gateways

In accordance with the NHAct 2014, which mandates that a minimum of 1% of the CRF be allocated as a statutory contribution, the BHCPF is disbursed through designated channels. These funds are directed to and managed by the National Health Insurance Authority (NHIA), the National Primary Health Care Development Agency (NPHCDA), the National Emergency Medical Treatment Committee (NEMTC), and the Nigeria Centre for Disease Control and Prevention (NCDC).

The following are the aims and objectives of the BHCPF:

Aim:

The BHCPF aims to significantly move Nigeria towards achieving Universal Health Coverage (UHC).

Objectives:

1. To achieve 17,600 fully functional public or private primary health care (PHC) facilities nationwide, with at least one in each political ward by 2027.
2. To achieve at least 1 (One) fully functional secondary health care facility per LGA, benefiting from the BHCPF in all states by 2027.
3. To establish effective emergency medical response services in 36 states and the Federal Capital Territory (FCT) by 2027, including a national ambulance service.
4. To reduce out-of-pocket expenditure by 30% by 2027 and increase financial risk protection through health insurance.
5. To increase life expectancy to at least 60 years over the next 10 years

The specific fund distribution and roles of each gateway are outlined below:

1. **Provision of Basic Minimum Package of Health Services (BMPHS):** 48.75% of the Fund is allocated to purchasing a Basic Minimum Package of Health Services (BMPHS), which is managed by the National Health Insurance Authority (NHIA) Gateway. This ensures that essential health services are accessible to all citizens, particularly vulnerable populations.

2. **Strengthening Primary Health Care (PHC):** The fund supports the PHC system through the National Primary Health Care Development Agency (NPHCDA) Gateway with 45% of the Fund. This is distributed as follows: 20% for essential drugs, vaccines, and consumables for eligible Primary Health Care (PHC) facilities; 15% for the provision and maintenance of facilities, equipment, and transport for these facilities; and 10% for human resources. This allocation is critical for improving functionality and the capacity of PHC facilities to deliver quality health services across the country.
3. **Emergency Medical Treatment:** 5% of the Fund is designated for emergency medical treatment and is managed by the National Emergency Medical Treatment Committee (NEMTC) Gateway. This component ensures that life-saving emergency transport and care are available to those in critical need.
4. **National Health Security:** 1.25% of the Fund is allocated to national health security through the Nigeria Centre for Disease Control and Prevention (NCDC) Gateway, which includes activities related to disease surveillance, epidemic preparedness, and response. This allocation supports Nigeria's efforts to safeguard public health and respond effectively to public health emergencies, including disease outbreaks.

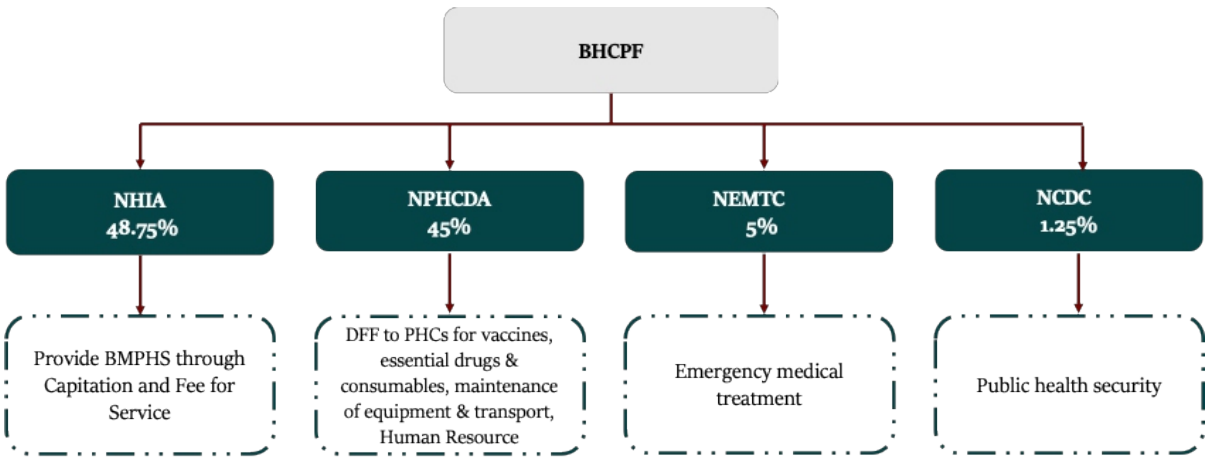


Figure 1-1: Fund Allocation per Gateway

1.4. Review of Guideline

1.4.1. Responsibility for Development and Review of the Guideline

Based on the tenets of the National Health Act (NHAct), and further legal counsel from the office of the Attorney General of the Federation (2024), the National Primary Health Care Development Agency (NPHCDA) shall be primarily responsible for the development and revision of the BHCPF Guideline. The revision of the guideline and future development shall, however, be done in full collaboration with the other Gateways, States, LGA representation and relevant stakeholders in the health sector. The Honourable Minister of Health may establish sub-committees to support the review with the NPHCDA as the anchor in accordance with the NHAct.

The MOC Secretariat will support this process to enhance coordination amongst the various gateways and subsequent presentation to the MOC. Following presentation of revisions to the MOC, final approval for the BHCPF Guideline shall be by the Honourable Minister of Health in accordance with the National Health Act.

1.4.2. Frequency of Review:

This Guideline shall be subject to review after 5 years, or earlier, at the instance of the Ministerial Oversight Committee. In addition, the MOC may approve addenda to the guideline based on lessons from implementation. The frequency of such addenda shall not be more than once in 12 months, based on specific recommendations to affected sections within the Guideline.

2. GOVERNANCE OF THE BASIC HEALTH CARE PROVISION FUND

Level	Governance	Administrative	Supporting Structure
Federal Level	Ministerial Oversight Committee (MOC)	NHIA, NPHCDA, NEMTC, NCDC	Partners, Civil Society Organizations (CSOs)
State Level	State Oversight Committee (SOC)	SSHIA, SPHCDA, SEMTC, PHEOC, Secondary Facilities	
Local Government Level	LG PHC Advisory committee	LGHA	
Ward Level	Ward Development Committee (WDC)	PHC facilities, EMT Service providers	

Table 2-1: Governance Structure of the Basic Health Care Provision Fund

2.1. Federal Government Level

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

2.1.1. The Ministerial Oversight Committee (MOC)

In line with the principle of the sector-wide approach (SWAp) and based on the objectives of the NHSRII, the Honourable Minister of Health shall provide governance oversight for all priority national government and donor-funded programmes. To enable effective streamlining of national governance for programmes and based on legal counsel from the office of the Attorney General of the Federation, the Ministerial Oversight Committee (MOC) shall serve as the central platform for oversight and governance of all priority programmes of the NHSRII (both government and donor-funded), inclusive of the SWAp Coordinating Office and the BHCPF.

To further foster the principles of one conversation under the sector-wide approach (SWAp); the membership of the MOC and attendance of meetings should be based on ministries, departments, agencies, institutions and partner organisations that are either contributing directly, providing significant support or actively participating in the implementation of NHSRII initiatives. This may,

from time to time require the invitation of representatives of organizations not listed below in section 2.1.1.1.1, to attend or become members of the MOC, at the instance of the Honourable Minister of Health.

Specifically, for the BHCPF, the MOC shall provide oversight, cross-functional leadership, strategic coordination, operational direction, and ensure overall programme visibility. It shall in addition, serve as an advocacy group for resource mobilisation and routine briefing of stakeholders on the progress of implementation of the BHCPF. The MOC shall ensure accountability of the funds at every level (Federal, State, LGA and Community) of BHCPF implementation.

2.1.1.1. Membership of the Ministerial Oversight Committee

The Ministerial Oversight Committee shall be comprised of the following:

a. Chair, Honourable Minister of Health
b. Alternate Chair, Honourable Minister of State for Health
c. 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
d. Secretary, an assigned Director in the Office of the Honourable Minister of Health, who shall serve as the head of the Secretariat of the MOC.

Members:

e. Representative, Minister of Finance
f. Representative, Federal Minister of Budget and Economic Planning (FMBEP)
g. Representative, Office of the Accountant General of the Federation (OAGF)
h. Director General, National Health Insurance Authority (NHIA)
i. Executive Director, National Primary Health Care Development Agency (NPHCDA)
j. Chair, National Emergency Medical Treatment Committee (NEMTC)
k. Director General, Nigeria Centre for Disease Control (NCDC)
l. Director, Department of Family Health, FMoH
m. Director, Department of Public Health, FMoH
n. Director, Department of Health Planning, Research and Statistics, FMoH
o. Director, Department of Hospital Services, FMoH
p. Chair or Representative, Committee of State Commissioners of Health
q. Chair or Representative, State Primary Health Care Board (SPHCB)

Executive Secretaries

r. Chair or Representative, State Social Health Insurance Agency (SSHIA) Executive Secretaries
s. Each Development Partner and Private Sector Organisation contributing to the BHCPF and/or NHSRII must have one representative, in accordance with SWAp.
t. Representative, World Health Organisation (WHO)
u. Representative, Civil Society Organisations (CSOs) focused on health (selected by CSOs)
v. Representative, Federal Competition and Consumer Protection Commission (FCCPC)
w. One Representative of a Health Security Partner.
x. Sector-Wide Program Management Unit (SW-PMU) National Coordinator
y. Representative, Association of Local Government in Nigeria (ALGON).

2.1.1.2. The Scope of the Ministerial Oversight Committee

a. Serve as the steering committee for all federal government or donor funded national priority programmes including SWAp Coordination and the BHCPF.
b. Promote robust collaboration among implementing gateways of the BHCPF program and other national and donor funded priority programmes.
c. Coordinates stakeholders' operations to ensure alignment with the objectives of the NHAct 2014 for the BHCPF, the NHSRII and SWAp implementation.
d. Approves timely disbursement of funds for the BHCPF and ensure funds are managed and accounted for in a transparent and accountable manner and in accordance with this guideline.
e. Receives programme implementation updates from federal and state entities implementing the BHCPF and other priority national government and donor funded programmes and interventions based on the NHSRII.
f. Approve work plans and budgets, as presented by implementing gateways and priority national programmes.

g. Receive and review updates on funds flow, performance management and verification of results, as presented by the implementing gateways and national programmes for guidance and feedback.

h. Evaluates periodic programme reports presented by the implementing agencies and programmes.

i. Review the performance dimensions of implementing gateways based on a clear set of Key Performance Indicators (KPIs) across the BHCPF.

j. Advocates for and ensure the provision of the required resources for planning and delivery of the BHCPF objectives.

k. Facilitates the implementation of financial audits by external auditors.

l. At the discretion of the Honourable Minister of Health as Chair of the MOC, the MOC may direct the engagement of an independent entity to review implementation of the BHCPF and other national programmes as required.

m. Prepares 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.

n. Resolves any disputes, discrepancies or issues arising from the implementation of the BHCPF.

o. Ensures compliance of all participating gateways and institutions with this guideline.

p. Advocacy and engagement with state Governors on resource mobilisation, resource deployment, strategy for program implementation and dispute resolution.

q. The MOC will ensure that climate and health vulnerability adaptation plans are incorporated into program implementation within the BHCPF and across the NHSRII and other relevant programmes.

r. The MOC will ensure that all gateways align with the national digital-in-health transformation agenda and states report on the national digital platform for health.

s. The Honourable Minister of Health, as Chair of the MOC, is the final approving authority for all matters relating to the BHCPF in line with the NHAct.

2.1.1.3. The MOC Secretariat

The MOC shall be supported by a secretariat headed by a Director in the office of the Honourable Minister of Health, who shall serve as its Secretary.

2.1.1.3.1. Functions of the MOC Secretariat

The MOC Secretariat shall:

a. **Serve as a Secretariat for the MOC** and carry out all necessary functions for the preparation and documentation of meetings of the MOC, and any additional assignments as directed by the Honourable Minister of Health and the MOC.

   The Secretariat will, in addition, provide direct support for the implementation of the BHCPF as further outlined below.

b. **BHCPF Program Coordination.**

   i. Ensure the MOC at its quarterly meetings reviews the BHCPF's performance, discuss strategic issues impacting performance and implementation, make disbursement decisions, and address any other relevant matters.

   ii. With approval of the MOC, convene joint annual technical review meetings of the BHCPF in collaboration with the gateways to discuss the progress of implementation.

   iii. Facilitate inter-gateway communications to support holistic administration of the BHCPF.

   iv. Coordinate and facilitate BHCPF stakeholder engagement sessions to promote alignment of program objectives with health sector reform initiatives.

   v. Periodically prepare BHCPF progress reports to the MOC.

   vi. Provide technical support/guidance to SOCs as required for the implementation of their functions.

   vii. Ensure all states and LGHA TSA accounts are operational and monitored.

   viii. Forecast and communicate annual 25% funds projections to all gateways and the State Oversight Committee (SOC) to make budgetary provisions.

c. **Fiduciary and Performance Management**

i. Prompt disbursement of BHCPF funds to the gateways in accordance with the disbursement criteria in NHAct.

ii. Maintain a global BHCPF M&E dashboard based on priority indicators from the gateways to track progress, outcomes, and impact of the BHCPF.

iii. Track the flow and utilisation of funds at all levels.

iv. Receive gateways' financial and programmatic reports on behalf of the MOC and provide feedback as appropriate.

v. Conduct periodic spot checks on the BHCPF programme in collaboration with the Gateways and implementing Partners and report findings to the MOC.

vi. Facilitate the conduct of annual financial audits by the Office of the Auditor General of the Federation.

vii. Review Audit reports with National Gateways and SOCs and support the development and tracking of remediation plans where required.

viii. Conduct periodic assessments, surveys, and evaluations of the BHCPF as directed by MOC.

d. **Communication and Knowledge Management**

i. Facilitate the harmonisation of an organised communication strategy for the BHCPF.

ii. Work to improve visibility and awareness of the BHCPF in collaboration with the gateways.

iii. Publication of quarterly disbursements to promote accountability and transparency.

iv. Develop publications, briefs, blogs and success stories to promote learning.

v. Support the MOC in improving the advocacy drive on the BHCPF to stakeholders (Donors, CSOs, implementing partners, private sector, etc.).

vi. Establish and coordinate the implementation of a Grievance Redress Mechanism (GRM) for BHCPF implementation (see section 10).

e. **Any other functions assigned to it by the MOC.**

2.1.1.4. Ministerial Oversight Committee Meetings

a. The MOC shall meet quarterly, or at the instance of the Chair of the MOC.

b. The MOC meeting shall serve as a platform for updates, appraisal, approval, and grievance resolution. Key activities shall include:

   i. **Updates Presentation:** each implementing gateway for the BHCPF, other programmes and interventions linked to the NHSRII and SWAp will provide updates for review by the MOC.

   ii. **Memos Presentation:** The secretariat shall collate and present memos for MOC deliberation and decision-making.

   iii. **Performance Review:** The previous quarter's performance review results shall be presented by the gateways and national programmes for evaluation by the MOC.

   iv. Ensuring all critical aspects of NHSRII implementation are addressed systematically during the meeting.

2.1.2. Basic Health Care Provision Fund (BHCPF) Gateways Forum

a. There shall be a Gateways Forum at the federal and state levels for the interaction of all the implementing gateways. The forum shall be chaired by the Chief Executives of the gateways on a rotational basis.

b. The fundamental objectives of the Gateways Forum shall be to:

   i. Ensure synergy, alignment and enable effective collaboration while implementing the BHCPF

   ii. Address common challenges to the implementation of the BHCPF

   iii. Leverage existing institutional resources for the BHCPF implementation by the gateways

2.1.2.1. Meeting of the BHCPF Gateways Forum

The forum shall meet at least quarterly, attended by a minimum of three (3) representatives from each gateway.

2.2. State Government Level

The Honourable Commissioner for Health shall provide leadership and supervision of the Basic Health Care Provision Fund (BHCPF) implementation in the state and endorse annual work plans and reports for submission to the national by the state implementing entities. The Honourable Commissioner shall serve as the chairman of the State Oversight Committee and shall endorse all formal reports emanating from the state prior to transmission to the federal level.

2.2.1. State Oversight Committee (SOC)

The State Oversight Committee (SOC) shall reflect the principles of the MOC at the state level. Based on the SWAP approach, the SOC will serve as a platform for oversight, coordination and governance of all priority health programmes and initiatives in the state, inclusive of SWAp implementation and the BHCPF.

Similarly, the SOC may co-opt or invite to meetings additional representatives of organisations and institutions at the state and LGA levels that are critical to the implementation of priority programmes in line with the state AOP and NHSRII. Meetings of the SOC shall be held quarterly, and a quorum shall be required for decisions to be taken during meetings.

2.2.1.1. Membership of the State Oversight Committee

The membership of the SOC shall include:

a. Chair, Honourable Commissioner for Health
b. Alternate Chair, Permanent Secretary, State Ministry of Health (SMoH)
c. Secretary, Director, Department of Health Planning, Research and Statistics, SMoH

Members:

d. Representative, Commissioner of Finance
e. Representative, Commissioner of the State Ministry of Budget and Economic Planning (SMBEP)
f. Representative of the State Office of Accountant General (OAG)
g. Executive Secretary, State Primary Health Care Development Agency (SPHCDA) or State Primary Health Care Board (SPHCB)
h. Executive Secretary or CEO, State Social Health Insurance Agency (SSHIA)
i. Chair, State Emergency Medical Treatment Committee (SEMTC)
j. Head Hospital Management Board
k. Director, Reproductive, Maternal, Neonatal, Child and Adolescent Health

(RMNCAH) SMoH

l. Director, Department of Public Health SMoH
m. Director, Department of Medical Services SMoH
n. Representative, Drug Management Agency (DMA)
o. State Coordinator, NPHCDA
p. State Coordinator, NHIA
q. Representative Community-Based Organisations (CBOs) and CSOs
r. One Representative of each of the Development Partners active in the State
s. Representative ALGON
t. State Epidemiologists SMoH
u. Sector-Wide Approach (SWAp) Desk Officer

2.2.1.2. The Scope for State Oversight Committees

The scope of work the SOC shall align with the principles stated in section 2.2.1. and specifically for the governance of the BHCPF, the SOC scope is as outlined below.

a. 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.
b. Ensure the disbursement of state counterpart funding and payment into the state BHCPF TSA of the gateways in accordance with the BHCPF guideline.
c. Submit evidence of payment of counterpart funding to the MOC secretariat
d. Provide the required support to ensure that all onboarding criteria, as required by the gateways, are met in a timely manner.
e. Review and endorse annual work plans and budgets of the state agencies and LGHA components as required under the implementing gateways prior to transmission to the national for approval, ensuring planned activities for fund utilisation are in compliance with this guideline.
f. Ensure that all LGHAs operate a TSA account for BHCPF operations
g. Receive quarterly briefings from all gateways, at the state level, on programme performance, fund utilisation, programme implementation and coverage.
h. Provide feedback to gateways for strengthening implementation at the sub-national level.
i. Coordinate operations of different stakeholders and resolve disputes or

issues arising from the implementation of the BHCPF at the state level.

j. Ensure compliance, conduct periodic performance management, and monitor and supervise activities within the state.

k. Submit quarterly implementation update reports to the MOC secretariat. This report should include a summary of each state's gateways update and SOC operational activities, using the specified template from the MOC secretariat.

l. Ensure the establishment of the LGHA Advisory Committee in all LGAs

m. Promote the inclusion of digital-in-health transformation and climate adaptation actions across all sub-national implementing agencies.

2.2.1.3. State Oversight Committee Secretariat

The SOC will be served by a secretariat headed by the Director of Planning, Research, and Statistics in the SMoH.

2.2.1.3.1. Functions of the SOC Secretariat

a. Coordinate quarterly SOC meetings and prepare relevant documents, memos, and reports to be presented during the meetings.

b. Support the SOC in developing an activity plan to support the conduct of statutory compliance, meetings, performance management, monitoring, and other SOC activities.

c. Follow up with implementing gateways on timely submission of annual and quarterly work plans, budgets and reports.

d. Ensure the timely endorsement by the SOC of the annual work plans from state agencies implementing within the various gateways

e. Prepare and submit on behalf of the SOC an operation an annual operation plan

f. Follow up on feedback from SOC meetings

g. On behalf of the SOC, compile and regularly update a joint list of eligible BHCPF facilities in states receiving Direct Facility Financing (DFF), Capitation, and Fee for Service.

h. Coordinate Grievance Redress Mechanism at the state level on behalf of the SOC.

2.2.1.4. State Oversight Committee Meetings

a. The SOC shall meet quarterly or at the instance of the Chair of the SOC.

b. The SOC meetings will review the Basic Health Care Provision Fund

(BHCPF) performance in the state, discuss strategic issues impacting performance and implementation, and discuss any other matters.

c. The quorum for the meeting shall be two-thirds of the attendees, including the Chair or an alternate Chair, unless otherwise decided at the SOC's inaugural meeting.

2.3. Local Government Area Level

At the LGA level, the Local Government Health Authority (LGHA) shall support BHCPF implementation at primary health care (PHC) facilities and the community. The LGHA Advisory Committee will support their activities.

2.3.1. Local Government Health Authority (LGHA) 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 PHCUOR and WHS documents (NPHCDA 2022).

2.3.1.1. The Composition of the LGHA Advisory Committee

a. Honourable Chairman of the LGA, who is the Chairman of the Advisory Committee
b. Health Secretary/PHC Coordinator/PHC Director, as Secretary of the LGHA Advisory Committee
c. LGA Supervisory Councillor for Health
d. Heads of other departments in the LGA (Works, Agriculture, Finance, Education, Community Development, Personnel, etc.)
e. One representative of the National Orientation Agency
f. One representative of the Traditional Council
g. One representative of Religious Leaders
h. Head of a referral public hospital, where available
i. One representative of the private health sector
j. One representative of women's groups
k. One representative of health training institutions where available
l. One representative of CSOs/CBOs
m. One representative of the Transport Union for Emergency Transport Service
n. Chairman of the LGA WDCs Forum

The LGHA Advisory Committee is to be constituted and managed in line with

the PHCUOR policy as published and updated by the NPHCDA.

2.3.1.2. Functions of the LGHA Advisory Committee

In addition to statutory functions, the following will be required as part of the implementation of the BHCPF within the LGA.

a. Advocate and mobilise resources for 25% counterpart funding by the LGA as required by the NHAct 2014.
b. Provide financial and technical support to ensure that health facilities are ready for NPHCDA assessment and NHIA accreditation.
c. Ensure delivery of quality services through LGA budgetary allocation to conduct joint supportive supervision, monitoring and mentoring.
d. Provide support to the facilities for the development and collation of their annual and quarterly operational plan.
e. Provide periodically aggregated financial and programmatic reports from supported facilities to the state.
f. Conduct quarterly LGHA meetings to review BHCPF implementation at the LGA level
g. Manage grievances at the LGA level
h. Ensure effective community advocacy, sensitisation and mobilisation

2.4. Ward Level

2.4.1. Ward Development Committee (WDC)

2.4.1.1. Composition of the Ward Development Committee (WDC)

a. The most senior traditional leader in the ward is to serve as Patron
b. One representative (the chairman) from every VDC (maximum of six) in the ward
c. The Councillor representing the ward in the LG Council
d. The officer-in-charge of the apex Primary Health Centre (Ward Focal Person/Supervisor)
e. The Community Engagement Focal Persons (CEFPs)
f. The Ward Community Development Officer, if available
g. A religious leader
h. One representative of an occupational group in the ward
i. Co-opt a member of health-related sectors, such as the headmaster of the primary school, Agricultural Extension Workers, Electricity personnel,

Water and Works staff, etc.

j. A representative of NGOs/CSOs/CBOs in the ward.

The WDC should have 15 to 20 members, representing all segments of the community, including influential leaders such as retired civil servants, military or police officers, businesspersons, and other notable figures. The executive officers (Chairman, Secretary, Assistant Secretary, Treasurer, and Women's Leader) are elected by the members, with the Chairman and Secretary requiring at least a Secondary School Certificate. Executive officers serve for a three-year term, with eligibility for one re-election. Women must make up at least 40% of the membership, and at least one woman must hold an executive position. Reference on the composition and functions of the WDC shall be the manuals on the Ward Health System as published and updated by the NPHCDA.

2.4.1.2. Functions of the Ward Development Committee

The functions of the WDC shall include:

a. Collaborating with PHC leadership to identify and plan for health and social needs in the ward.
b. Prioritising health needs in annual work plans.
c. Identifying local resources to address facility needs.
d. Forwarding health and community development plans to the LGA and relevant bodies.
e. Mobilising for community involvement in project planning, implementation, and evaluation.
f. Raising funds for community programs at various levels when necessary.
g. Participating in facility monitoring and financial accountability.
h. Ensure equitable fund utilisation and tracking of service delivery outcomes
i. Providing feedback to the community on fund usage.
j. Liaising with government and voluntary agencies to address ward health and social issues.
k. Supporting health facility activities.
l. Supporting Village Health Workers and Traditional Birth Attendants.
m. Nominating a WDC member for the facility's Quality Improvement Committee.
n. Collaborating with community health promoters to enhance community-based health demand and PHC linkages.
o. Managing community grievances.

2.5. Civil Society Organisations (CSOs)

Civil Society Organisations (CSOs) shall promote social accountability for the implementation of the BHCPF and act as the mouthpiece of the beneficiaries.

The following is the scope of the CSOs in BHCPF operations:

a. Representative at the MOC level.
b. Document and periodically consult with coalition of CSO groups to discuss and flag areas of underperformance.
c. Responsible for implementing the programme accountability framework in line with the provisions of this guideline.
d. Notify the various gateways, the Honourable Minister of Health or Commissioner for Health as appropriate through specific pre-agreed engagement frameworks of their concerns, observations, and findings.
e. Publish and furnish the public with findings and reports from implementation after submitting them to the relevant gateway and providing ample time for clarifications and responses as stipulated in their engagement framework.
f. Engage in programme monitoring and supervision based on organisational mandates with guidance from the MOC secretariat.
g. Provide financial or technical support at various implementation levels with appropriate clearance from the most relevant authority at their level of operations.
h. Community mobilization
i. In circumstances where funding is for specific programmatic activities, the partnership framework shall come into effect. Gateways shall be open to 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.

2.6. Beneficiaries/Citizens Feedback

Integrating Beneficiary/Citizens' Feedback to Improve Patient Satisfaction

a. The MOC secretariat shall set up a mechanism to harness and integrate the voices of beneficiaries in collaboration with the gateways.
b. This will provide the MOC with regular evidence to inform its decision-making to achieve the expected outcomes of the fund.

2.7. Partnership Framework

All donor and implementing partners (local & international), the organised private sector, and individuals/philanthropists may contribute to the Basic Health Care Provision Fund and support implementation. Such contributions shall be financial grants and technical support to the government of Nigeria for 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 the same to the Federal Ministry 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 the BHCPF TSA managed by the BHCPF Secretariat and disbursed in line with the NHAct 2014 to the gateways. If donors have specifications for the disbursement of their contributions, those funds will be domiciled in a separate account and disbursed by the MOC according to the donor's stipulations.

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

2.8. Gender Consideration and Inclusion

In implementing BHCPF, all implementation entities will consider gender inclusion, mainstreaming, and addressing gender inequalities. The program shall be implemented nationwide, with particular emphasis on poor and indigent Nigerians.

2.9. Climate and Health

The Nigerian health sector, through the NHSRII and the BHCPF implementation, recognises that climate change poses increasing risks to health systems, with extreme weather events such as floods, droughts, and heatwaves that disrupt service delivery and exacerbate disease burdens. To ensure continuity and quality of care, BHCPF-supported interventions will prioritise and integrate climate

resilience at its s a core. This will involve strengthening the primary health care and related secondary care systems and facilities to systematically become climate resilient, with the adaptation of innovative service delivery mechanisms that anticipate, prepare for, respond to, and recover from climate-related shocks.

Implementing entities of the BHCPF based on the sector-wide approach will align relevant activities, BHCPF-funded activities with the National Climate and Health Adaptation Plan, ensuring that infrastructure, supply chains, and service delivery remain functional under adverse environmental conditions. Climate resilience will be embedded across all gateways and levels of implementation, with a focus on sustainable health facility infrastructure, energy efficiency and resilient supply chains. In addition, efforts shall be made to build the capacity of health workers, institutions and relevant vendors operating at the facility level, to effectively manage climate-related health risks.

Key Climate Resilience Priorities will include:

- Upgrade and maintain PHC infrastructure to be energy efficient and climate resilient.
- Integrate renewable energy solutions (e.g., solar power) to ensure uninterrupted service delivery.
- Ensure the rehabilitation process itself did not pose adverse environmental and climate-health impacts, such as air pollution, amongst other climate-related actions.

2.10. Digital-in-Health Transformation on the BHCPF

The BHCPF implementation will align with the broader plan for the Nigerian Health Sector Renewal Initiative to promote a digitisation agenda in the health sector. This global age transformation to promote digitisation of health functions will improve the availability of system management information and administrative data and their use in decision-making across all levels of the health system. The MOC will encourage the digitisation of processes year-on-year on the BHCPF gateways to improve functions and ensure integration into the national digital-in-health architecture.

3. FINANCIAL MANAGEMENT AND DISBURSEMENT OF THE BASIC HEALTH CARE PROVISION FUND

Fund management and disbursement refer to the processes associated with accumulation, pooling, disbursement, and utilisation of funds for the purchase of services and designated operational and strategic initiatives across all gateways. They also involve the processes associated with financial risk management and ensuring accountability in fund utilisation.

In line with the NHAct 2014 and the NCDC Act 2022, an annual grant of not less than one per cent of CRF shall be deducted as a first-line charge and transferred to the BHCPF Treasury Single Account (TSA) in the Central Bank of Nigeria (CBN), and this BHCPF shall be known as the "FUND".

Fund releases shall be in accordance with the appropriation cycle and FAAC disbursement. Three government agencies and a Committee on Emergency Medical Treatment, regulated and oversighted by the Federal Ministry of Health and Social Welfare, will be responsible for implementing the Fund using gateway mechanisms to ensure the objectives of the BHCPF are met. The Gateways are the NHIA, NPHCDA, NCDC, and NEMTC.

3.1. Contribution to the Fund

This is based on the provision of the NHAct 2014 and the NCDC Act 2022 and will be tracked regularly.

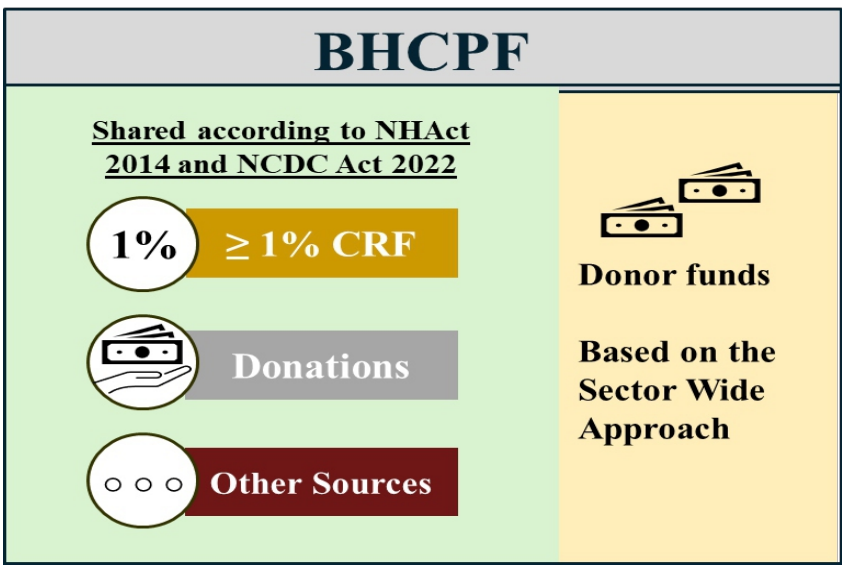


Figure 3-1: The sources of funds for the BHCPF

3.1.1. The expected contributions to the Fund shall be as follows:

a. Annual grant from the Federal Government of Nigeria amounting to not less than one per cent (1%) of its Consolidated Revenue Fund.
b. Grant from donors, international partners, the private sector, and
c. Other sources.

3.1.2. Use of the BHCPF:

Funds contributed to the BHCPF will be used to:

a. Provide programmatic support to be disbursed as specified in the NHAct 2014.
b. Provide operational support, which includes:
    i. Operations of the BHCPF
    ii. Capacity development
    iii. Information technology and innovation
    iv. Fiduciary and risk management
    v. Monitoring, evaluation and learning
    vi. Operational research and evidence synthesis
    vii. Other initiatives of relevance to the BHCPF and of interest to the donor, with the concurrence of the MOC
    viii. Donors can have specifications for the utilization of their contributions and donations for specific programs and operational requirements as delineated in the funding agreement with the government.
c. All organisations interested in contributing to or supporting the BHCPF shall officially communicate to the Honourable Minister of Health and Social Welfare and have their funds utilized in line with the Partnership framework as described in section 2.7 above.

3.2. Disbursement of the Fund

The BHCPF shall be disbursed as outlined in the table below:

BHCPF FUNDS DISTRIBUTION								
GATEWAY LEVEL	PROGRAMME	NATIONAL OPERATIONS		STATE OPERATIONS				REMARKS
		NATIONAL	MOC	ADMIN	STATE OPEX	SOC	LGHA	
NPHCDA GATEWAY								
National	90%	8%	2%					Proportion of total funds to Gateway
State	85%	-	-	-	6.375%	2.25%	6.375 %	Proportion of total funds to SPHCB. (SOC receives 15% of total state operations)
NHIA GATEWAY								
National	90%	8%	2%					Proportion of total funds to Gateway.
State	85%	-	-	4.75%	10%	0.25%	0	Proportion of total funds disbursed to SSHIA. (SOC receives 5% of state admin cost
NCDC GATEWAY								
National Level	*90%	10%						***Note:** 20% of the Programme fund retained at National level and 80% sent to states
State Level	85%	-	-	-	7.5%	-	7.5%	Proportions are of State's component of the fund.
EMT GATEWAY								
National Level	90%	10%						Proportion of total funds to Gateway.
State Level	-				5%		5%	Operation funds are shared based on equity (50%) and equality (50%). The denominator or multiplier is the proportion of states and LGAs that have commenced operations on NEMSAS and RESMAT respectively. Excess funds will be returned to the Emergency Medical Treatment Reimbursement Fund.

a. The NHIA and NPHCDA gateways shall disburse the program funds to the state gateways' BHCPF TSAs within seven (7) working days of receipt of funds from the federation account, subject to the states meeting the gateway's stipulated disbursement criteria.

b. The NCDC shall retain 20% of the total program fund for the Public Health Emergency and Outbreak Response Fund (PHEORF) and disburse 80% of the total program fund to state PHEOCs as stipulated in this guideline.

c. The NEMTC shall similarly utilise its funds as outlined in the EMT gateway section of the guideline.

Further details of funds disbursements and utilisation within each gateway are as stipulated in the relevant gateway's section of this Guideline.

The program funds disbursed to the gateways shall be used for the following:

a. Forty-eight and three-quarters per cent (48.75%) for the provision of a BMPHS to citizens, especially the vulnerable, through the NHIA, towards UHC.

b. Forty-five per cent (45%) for strengthening PHC facilities through the National NPHCDA.

c. Five percent (5%) for the treatment of medical emergencies through the NEMTC.

d. One and a quarter percent (1.25%) for public health emergencies and security, to be administered by the NCDC.

These are inclusive of the operational funds as stipulated in the disbursement table above.

The operations funds disbursed to the national and state gateways, LGHAs, SOCs, and MOC Secretariat shall be used in accordance with:

a. **MOC-approved workplans**. All funds from the BHCPF at the federal, state, and LGHA levels shall be domiciled in the TSA, and PHC facilities shall operate single cheque-based bank accounts in regulated financial institutions.

shall operate single cheque-based bank accounts in regulated financial institutions.

b. Any other disbursement other than the above shall be subject to approval by the MOC upon receipt of a detailed costed work plan and in accordance with the sharing formula.

3.2.1. Designated Accounts for the BHCPF

a. Each gateway (NHIA, NPHCDA, NEMTC and NCDC gateways) shall operate a programme and an operations account (TSA) at the CBN.

b. The fund's disbursements shall be made from the MOC Secretariat designated BHCPF program account as direct credits into the national accounts (both program and operations accounts) of the NHIA, NPHCDA, NEMTC, and NCDC.

c. Each sub-national gateway (SPHCB, SSHIA, SEMTC, PHEOC) and the SOC shall operate a program and operations account (TSA) at the CBN with the approval of the Office of the Accountant General of the Federation (OAGF), while LGHAs shall operate an operations account (TSA) only.

d. PHCs are required to have a singular designated chequing bank account in a regulated financial institution for their operations, and this will serve as the only account operated by the PHC.

e. All state counterpart funds shall be deposited in the TSAs of the SSHIA, SPHCB, SEMTC and PHEOC sub-accounts, as designated.

f. State counterpart funds shall be disbursed in accordance with this BHCPF operation guideline.

3.2.2. Signatories to BHCPF, NPHCDA, NHIA, NCDC, and NEMTC CBN Accounts

a. The approving authority for the BHCPF account shall be the Honourable Minister for Health and the Permanent Secretary of the Ministry of Health, with advice from the MOC. The disbursing signatories shall be the Director/Secretary of the BHCPF MOC and the Project Accountants of the Secretariat of the MOC.

b. The approving authority for the NPHCDA account shall be the Executive Director of the agency, while the signatories to the NPHCDA Account shall

be the same signatories as stipulated in the NPHCDA section of this guideline.

c. The approving authority for the NHIA account shall be the Director General of the authority, while the signatories for the NHIA accounts shall be the same signatories as stipulated in the NHIA section of this guideline.

d. The approving authority for the NEMTC account shall be the Honourable Minister for Health and the Permanent Secretary of the Ministry of Health, with advice from NEMTC. The disbursing signatories shall be the NEMTC Chairman and the Project Accountants of NEMSAS

e. The approving authority for the NCDC account shall be the Director General of the Centre, while the signatories for the NCDC account shall be the same signatories as stipulated in the NCDC section of this Guideline.

f. Bank Mandates submitted to the CBN, governing the operation, disbursement and monitoring of the account, shall be in line with the above and with the approval of the MOC.

3.2.3. Disbursement of funds from SPHCBs and SSHIAs to PHCs

a. SPHCBs and SSHIAs' funds transferred through the NPHCDA and NHIA gateways must be domiciled and operated as sub-accounts of the Treasury Single Account held at the CBN.

b. The SPHCBs, with concurrence with the LGHAs, shall disburse funds to the bank accounts of PHCs that are eligible to receive DFF no later than seven (7) working days from date of receipt.

c. The SSHIAs shall disburse their gateway funds as stipulated in the NHIA Gateway Fund Administration section of this guideline. Funds transfer to eligible PHCs shall be done into their bank accounts monthly, based on the number of enrolees listed for the facilities and not later than 5 days before the commencement of the month for which they are being paid.

3.2.4. Signatories to the SPHCB, SSHIA, SEMTC, PHEOC, LGHA, and PHC Facilities Accounts

a. The approving signatory to the SPHCB account must be the Executive Secretary/CEO or equivalent of the SPHCB. The Director, Finance and

Accounts, shall maintain the program and operations for the SPHCB Gateway funds. This account shall be a TSA.

b. The approving signatory to the SSHIA TSA account must be the Executive Secretary or equivalent of the SSHIA. The Director of Finance and Accounts shall maintain the program and operations for the SSHIA Gateway funds. The signatories to the state PHEOC TSA must be the accountants in the pool of the state's Office of the Accountant General.

c. The signatories to the SEMTC TSA must be the accountants in the state's Office of the Accountant General pool.

d. The approving authority for the SOC accounts shall be the Commissioners of Health and the Permanent Secretaries of the State Ministries of Health, while the signatories to the SOC TSA shall be accountants in the pool of the Office of the Accountant General of the state

e. The signatories to the LGHA TSA shall be accountants in the pool of the Office of the Accountant General of the State.

f. The signatories to PHC accounts must be the Officers in Charge, with the Assistant Officers in Charge as alternate signatories, and the Ward Development Committee (WDC) Chairpersons, with the Treasurers as alternate signatories.

3.2.5. Eligible use of funds by SPHCBs, SSHIAs, PHEOC, SEMTC, LGAs, and Healthcare Providers

a. SPHCBs shall disburse program funds to eligible health facilities based on disbursement criteria, withholding only funds for human resources. Operations funds will be utilised for BHCPF operations in the state.

b. SSHIAs shall expend programme funds in its entirety based on the criteria outlined in this guideline, while operations funds will be utilised for the BHCPF operations in the state.

c. The PHEOCs shall utilise their programme funds for outbreak response and investigation in their states, while the operations fund shall be used for operations of the PHEOCs.

d. The SEMTCs shall utilise their funds for the operations of the BHCPF.

e. The LGHAs shall utilize BHCPF operations funds to carry out mentoring and supervisory activities for the implementation of BHCPF in PHC

facilities and collaborate with CSOs to administer the BHCPF accountability tool.

f. The eligible use of funds by PHCs and SHCs shall be in accordance with this guideline.

g. All BHCPF implementing entities are expected to adhere to financial regulations in the implementation of the Fund.

3.2.6. Fund Access by National and State Level Gateways and PHCs

a. National-level gateways shall receive program and operations funds upon approval by the MOC at quarterly MOC meetings and subject to the gateways meeting disbursement criteria, including submission of relevant quarter program and consolidated financial reports and annual work plans.

b. State-level gateways shall receive their program and operations funds from respective national-level gateways upon meeting the criteria outlined in their sections of this guideline and their state's provision of the counterpart funds in the dedicated BHCPF TSA account at the CBN to satisfy the requirement for counterpart funding outlined in Section 11(5) of the National Health Act 2014.

c. Access to funds by health care providers would be upon meeting the criteria stated in this guideline by the respective disbursing gateways.

3.3. Counterpart Funding

a. Each state and the FCT shall make annual budgetary provisions and releases of 25% of the total projected BHCPF to be disbursed in the upcoming fiscal year as counterpart fund as prescribed by NHAct. States and the FCT shall be responsible for ensuring counterpart contributions from LGAs and the state are ultimately disbursed into the BHCPF TSA of the gateways at the state level.

b. Funds released as counterpart fund shall be subject to quarterly reporting and annual audit requirements of the BHCPF.

3.4. Administrative Expenses

a. Administrative expenses of the MOC Secretariat, SOCs, LGHAs, national and state level gateways shall be based on workplans and budgets as approved by the MOC.

b. To minimize operational/administrative cost, the BHCPF shall utilize and leverage existing organizational structures and mechanisms at the Federal, State and Local Government levels for administration, disbursement and monitoring.

c. All administrative expenses, including disbursement, monitoring, audit, and data collection costs to be incurred by the MOC Secretariat, the SOCs, LGHAs, NHIA, NPHCDA, NEMTC, NCDC, SSHIAs, SPHCDAs, SEMTCs, and PHEOCs shall be paid for through the delineation of an annual operational allowance. **This annual allowance for operational cost shall not exceed 10% of the available funds at the national level and 15% of the total available funds at the state level.** This sum shall be set aside for this purpose. The amount set for administrative/operational expenses shall be subject to amendments by the MOC.

3.5. Un-utilized Funds

a. Accumulation of unutilised funds in any given year by each of the BHCPF implementing entities shall be discouraged.

b. At the end of each financial year, where all unutilised funds due to poor uptake or any other development and having settled all outstanding claims and cash-calls, any such funds shall be utilised as follows:

    i. Cumulative BHCPF unutilized funds that are yet to be disbursed by the MOC Secretariat shall be disbursed according to NHAct upon approval by the MOC and subject to each gateway meeting its disbursement criteria.

    ii. Unutilised funds that have been disbursed to gateways shall be utilised according to the provisions of the national-level gateways in this guideline.

3.6. Financial Records

All recipients of BHCPF shall keep and maintain proper books of accounts that show the amount of funds received and how the funds were spent using the IPSAS

Accrual basis of accounting. The GIFMIS/REMITA system will be the system of record for the Fund.

The following are financial records and reports that are required at the minimum:

3.6.1. The MOC Secretariat shall:

a. Make an annual projection of fund availability from all sources for planning purposes and communicate the same to the gateways

b. Collate annual workplan/budget from the gateways for presentation and approval of the MOC. Reconcile the BHCPF accounts quarterly or as required.

c. Prepare quarterly interim financial statement on sources and uses of funds for the BHCPF for all gateways 45 days after the end of the quarter. This report shall be an aggregation of the reports from the NPHCDA, NHIA, NEMTC and NCDC Gateways. The report shall also include the operating cost of the MOC Secretariat.

d. At the end of each fiscal year, prepare consolidated annual financial statements for the BHCPF with accompanying notes. The report shall be submitted to the

e. MOC within 90 days of the end of the fiscal year.

f. Prepare variance analysis reports whenever indicated.

g. Prepare internal audit reports.

h. Prepare an overview of the status of the Fund annually and submit to the MOC. The report shall be discussed by the MOC and published on the website of the FMoH&SW before 30th June of the following year.

i. Ensure all financial records are made available on the deployed digital accounting system.

3.6.2. The NHIA, NPHCDA, NEMTC, and the NCDC shall:

a. Prepare consolidated quarterly interim and annual statement of sources and uses of funds.

b. Reconcile operating cost funds received and bank accounts within 30 days and 45 days of the quarter and fiscal year, respectively.

c. Prepare internal audit reports quarterly.

d. Ensure all financial records are made available on the digital accounting system.

3.6.3. SPHCDAs, SSHIAs, SOCs, and LGHAs shall:

a. Prepare quarterly interim and annual statement of sources and uses of funds.

b. For the gateways, financial statements shall be prepared by the states.

c. Reconcile operating cost funds received and bank accounts within 30 days and 45 days of the fiscal quarter and fiscal year, respectively.

d. The financial statements prepared shall include counterpart funds provided by each state as their contribution to the BHPCF.

e. Each entity shall ensure all financial records are made available on the digital accounting system.

3.6.4. Primary Health Care facilities shall:

a. Prepare a statement of funds received and uses of funds within 7 working days of the end of each quarter.

b. Generate bank account statements within 7 days of the end of each month

c. Ensure all financial records are made available on the digital accounting system.

3.6.5. Secondary Health Care facilities shall:

a. Prepare claims for secondary services provided to BHCPF beneficiaries and submit to SSHIAs for claims processing.

b. The MOC Secretariat's financial management team shall conduct quarterly review of the gateways' financial records, including an analysis of financial records entered on the digital accounting system.

3.7. Funds tracking

a. A customised digital financial tracking and reporting system shall be deployed across all BHCPF implementing entities. This system will

enhance visibility in the flow and utilisation of funds and enable real-time reporting. The systems shall complement any existing systems in use at the various implementing agencies and align with the NHSRII's digitalisation initiative.

b. Each BHCPF implementing entity shall be required to keep up-to-date financial records of the BHCPF on the digital tool as soon as they are operational at each level.

3.8. Financial Risk Management

Risk management is important in ensuring that implementing entities of the BHCPF achieve the National Health Act and BHCPF goals and objectives by continuously complying with the provisions of the Act and the BHCPF guideline. The following risk management measures shall be instituted in the implementation of the BHCPF:

a. Independent Monitoring and Verification: At the instance of the MOC, periodic independent monitoring and verification exercises may be conducted of the BHCPF implementation to ensure that provisions of the NHAct and the BHCPF guideline are adhered to.

b. The Secretary of the MOC and State Commissioners of Health shall be empanelled as viewers of the TSA.

c. External audit: The MOC Secretariat shall:

d. Work with gateways to implement a pre-audit review with gateways at the national and state levels.

e. Initiate the process of annual statutory audit of the BHCPF by the Office of the Auditor General for the Federation (OAuGF).

f. On an annual basis the OAuGF shall audit the accounts of the 4 gateways across the levels of implementation, and the accounts of LGHAs, SOCs, and the MOC Secretariat. Donor funding that is contributed to the BHCPF shall be audited by the OAuGF along with the 1% CRF. Donor funds supporting operational requirement of the BHCPF shall also be audited.

g. The OAuGF shall submit a preliminary report of audit findings to the gateways and the MOC Secretariat for appropriate responses within 21working days of receipt or as determined with the Auditors.

h. The MOC Secretariat, national Gateways, and the SOCs will collaborate to ensure that audit infraction (issues) remediation plans are developed and implemented at all levels.

i. Finalised financial audit reports shall be submitted to the Honourable Minister of Health and Social Welfare and subsequently published on the FMoH&SW website.

j. The MOC may institute specific sanctions and reward mechanisms to boost compliance in the implementation of the BHCPF as required.

3.9. Financial Accountability of the BHCPF

a. The roles, responsibilities and reporting arrangements of the BHCPF shall be designed to ensure maximum transparency and accountability for the use of Fund.

b. The MOC Secretariat shall publish online the dates, amounts and recipients of all transfers made to sub-national level on a quarterly basis within 15 days of the end of the quarter.

c. Through the accreditation process, continuous monitoring of compliance and processing of claims, the NPHCDA, NHIA, NEMTC, SPHCBs, and SSHIAs shall hold contracted healthcare providers accountable for the quality and quantity of services delivery.

d. There shall be an accountability framework for the BHCPF, jointly implemented by all entities, including CSOs (see transparency and accountability section of this guideline).

e. The MOC shall report to the National Council on Health (NCH) through presentation of annual reports on the performance of the BHCPF.

f. SOCs shall grant authorization for direct funds disbursements to LGHAs when eligibility criteria have been met, and TSA opened in the course of implementation of the BHCPF.

g. Disbursements to the Gateways and states shall be published on national dailies as well as on official government websites within 15 days of the disbursement.

h. The MOC Secretariat shall publish the annual audited financial statements on the FMOH website by May 31st of the following year.

4. GUIDELINE FOR THE IMPLEMENTATION OF THE NHIA GATEWAY

4.1. Introduction

The NHIA was established by the NHIA Act 2022 as a corporate body, with the mandate to regulate, promote and integrate health insurance in Nigeria, to ensure that Nigerians have financial access to healthcare. The mandate is reinforced by the existence of relevant legislative and policy instruments, including the National Health Act, the National Health Policy, the National Strategic Health Development Plan, and the National Health Financing Policy and Strategy. These instruments include appropriate provisions and clearly set objectives and targets for Nigeria's effort towards achieving UHC. The NHIA's vision, mission, core values and position statement are shown in Figure 4-1.

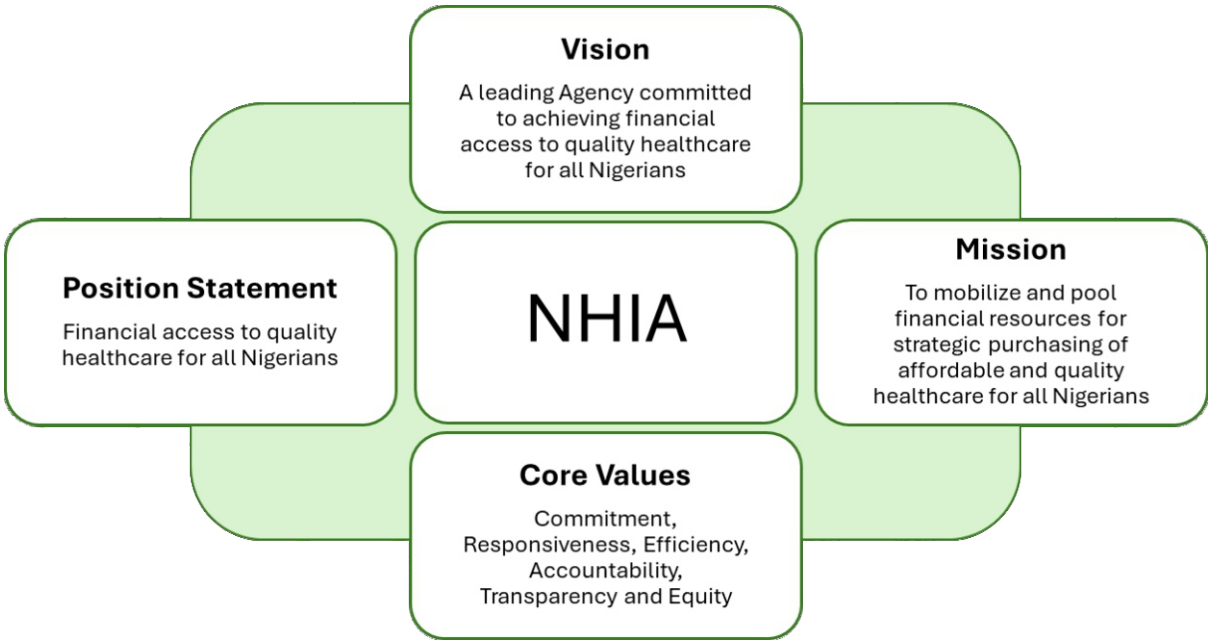


Figure 4-1: The mission, vision, position statement, and core values of NHIA

In line with its mandate, the core responsibilities of the NHIA include:

4.1.1. Promotion

a. Ensure that health insurance is mandatory for every Nigerian and legal resident.

b. Seek and advocate for funds for the Vulnerable Group Fund (including BHCPF).

c. Make proposals to the Council for the formulation of policies on health insurance.

d. Undertake on its own or in collaboration with other relevant bodies a sustained public education on health insurance.

e. Devise a mechanism for ensuring that indigents' basic health care needs are adequately provided for.

f. In conjunction with the states, devise a mechanism for ensuring that the basic health care needs of vulnerable persons are adequately provided for.

g. Ensure the manpower development of the Authority.

h. Undertake research and generate statistics on matters relating to the Authority.

4.1.2. Integration

a. Promote, support, and collaborate with states through State Social Health Insurance Schemes to ensure that Nigerians have access to quality health care that meets national health regulatory standards.

b. Provide technical and other relevant support to State Social Health Insurance Agencies.

c. Provide and maintain Information and Communication Technology (ICT) infrastructure and capability for the integration of all data on all health schemes in Nigeria.

d. Exchange information and data with the National Health Management Information System, Financial Institutions, Federal Inland Revenue Services, State Inland Revenue Services, National Bureau of Statistics, professional regulatory bodies, and other relevant bodies and individuals for research purposes upon their request.

e. Issue unique identifiers to all beneficiaries of health insurance in Nigeria

4.1.3. Regulation

a. Enforce the Basic Minimum Package of Health Services (BMPHS) for every Nigerian across all health insurance schemes operating within the country including federal, states, and the FCT as well as private health insurance schemes.

b. Ensure the implementation and utilisation of the Basic Health Care Provision Fund as required under the National Health Act 2014 and any guidelines as approved by the Minister under that Act.

c. Develop the guidelines and grant accreditation and re-accreditation to eligible Health Maintenance Organizations, Mutual Health Associations, Third Party Administrators, and health care facilities and monitor their performance.

d. Approve contributions to be made by members of various health insurance schemes.

e. Provide or request for the establishment of mechanisms for receiving and resolving complaints by members of the schemes and health care facilities, Health Maintenance Organisations, Mutual Health Associations, and Third-Party Administrators (TPAs).

f. Collaborate with the SSHIAs and relevant organisations to ensure the accreditation and empanelment of primary and secondary healthcare facilities using accreditation guidelines defined by the NHIA.

g. Maintain a register of licensed health insurance schemes and accredited health care facilities.

h. Evaluate any new proposal about extending the coverage of a health insurance scheme to any group of Nigerians.

i. Accredit insurance companies, insurance brokers, and banks desirous of participating in health insurance schemes under the Authority.

j. Regulate all health insurance schemes in Nigeria by the provisions of the Act.

k. Approve formats of contracts for health service purchasing.

l. Approve payment mechanisms for the health insurance ecosystem.

m. Develop operational guidelines for the Authority and ensure it is reviewed at least once every five years.

n. Sanction erring parties by the provision of the operational guidelines.

o. Ensure that tariffs agreed with healthcare facilities are reviewed on a three-yearly basis to the mutual satisfaction of Health Care Facilities, Health Maintenance Organisations, Health Insurance Schemes, and the Authority.

p. Carry out such other activities as are necessary or expedient for achieving the objectives of the Authority under the Act.

4.1.4. In line with the NHIA Act 2022, the key roles of the stakeholders involved in the NHIA Gateway include:

a. Purchaser - National Health Insurance Authority.

b. Payer/Administrator - State Social Health Insurance/Contributory Agencies (SSHIA) or other third-party payer where a SSHIA cannot carry out the required health insurance functions as determined by the regulator. The Payer/Administrator carries out such functions on behalf of the purchaser,

c. Provider - Accredited Public and Private Primary Health Care Centres (PHCs) and other Secondary Providers.

d. Regulator – The National Health Insurance Authority.

4.2. NHIA Gateway Structure

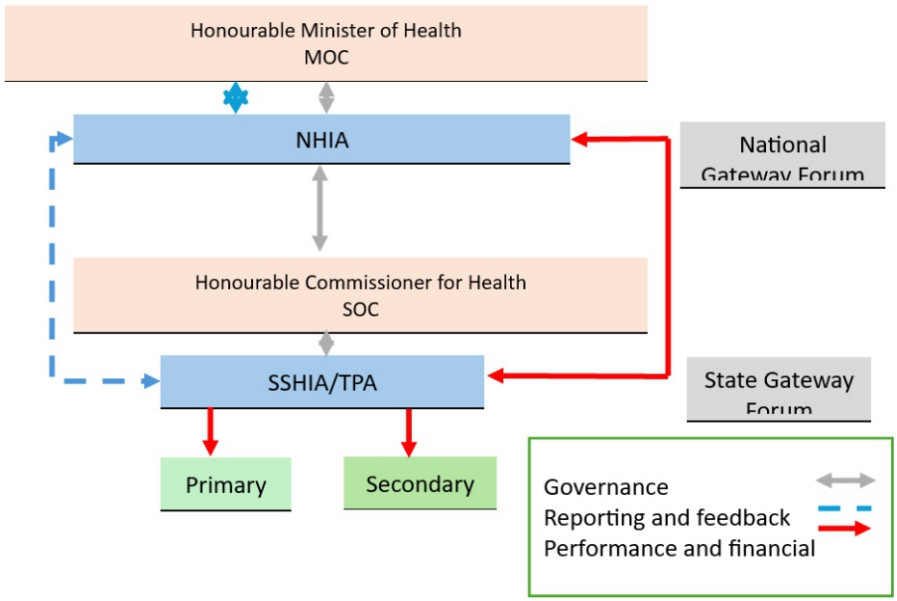


Figure 4-2: NHIA Gateway Structure

4.3. NHIA Gateway Programme Management

4.3.1. The Basic Minimum Package of Health Services (BMPHS)

The BMPHS is a set of preventive, protective, promotive, curative, and rehabilitative health services that will enable improvements in health outcomes,

approved by the Minister of Health in line with the National Health Act, 2014. It includes a set of primary and secondary health services that are to be provided with the Basic Health Care Provision Fund through the NHIA Gateway. ***The list of services included in the package is shown below, while further details are available in Annexe 1.***

4.3.1.1. Primary-level care and prevention services

a. Outpatient Care
b. Health Education
c. BEmONC Services
d. Maternal, Adolescent and Reproductive Health services, including Family Planning
e. Newborn Care
f. Child Health Care
g. HIV/AIDS
h. Tuberculosis
i. Sexually Transmitted Infections
j. Primary Medical Care (Adult)
k. Minor Surgical Care
l. Primary Eye Care
m. Primary Mental Health Care
n. Emergency Services
o. Basic Laboratory
p. Investigations
q. Annual medical checkup for disease prevention

4.3.1.2. Secondary-level Care

a. Secondary Level Consultation
b. Hospital admissions
c. Basic and Comprehensive Emergency Obstetric Care (BEmONC & CEmONC)
d. Newborn Care
e. Child Health Care
f. Maternal, Adolescent and Reproductive Health services including Family Planning
g. Neonatal Conditions
h. Management of communicable diseases and medical emergencies
i. Management of non-communicable diseases
j. HIV/AIDS

k. Gynaecological Intervention
l. Dental care
m. Eye Care
n. Ear, Nose & Throat
o. Common Surgical Interventions
p. Others
q. Physiotherapy

4.3.1.3. Laboratory Investigations

4.3.1.4. Radiological Investigations

4.3.2. Key roles of stakeholders in the NHIA Gateway

4.3.2.1. NHIA

As it relates to the BHCPF, the NHA Act 2014 and NHIA Act 2022 provide the framework for the use of a share of the BHCPF for demand-side financing of a package of health services for beneficiaries. Some of the basic provisions are as follows:

a. The NHIA deploys this fund to carry out its mandate of purchasing a Basic Minimum Package of Health Services (BMPHS) for benefiting Nigerians.

b. The NHIA is to enforce the BMPHS across all health insurance schemes operating within the country including Federal, States, and the Federal Capital Territory (FCT) as well as private health insurance schemes.

c. The NHIA purchases such services from eligible primary and secondary healthcare facilities.

d. The NHIA is responsible for ensuring the implementation and utilisation of the Basic Health Care Provision Fund as required under the National Health Act 2014 and any guidelines as approved by the Minister under the NHIA Gateway. Some of these functions include facility accreditation and quality assurance, providing guidance for enrollment, fund disbursement, data collation, monitoring and evaluation, fiduciary oversight, enforcement, and application of rewards and sanctions.

e. NHIA is to promote, support, and collaborate with states through State Social Health Insurance Agencies (SSHIA) to ensure that Nigerians have access to quality health care that meets national health regulatory

standards, to achieve the objectives of the BHCPF, and to provide the BMPHS as defined in the BHCPF guidelines.

f. Ensure that unique beneficiary identifiers are issued, a list of licensed health insurance schemes and accredited health providers is maintained, and data on health schemes are aggregated and available for research and analytics.

g. The NHIA shall determine the rates for payment of healthcare providers. Such rates shall be actuarially determined and be subject to review every 3 years.

h. NHIA shall establish the regulations governing quality management systems, especially accreditation, quality assurance and quality improvement.

i. The NHIA shall designate a department to coordinate the implementation of the NHIA Gateway. Its operations shall be administered through various departments, zonal and state offices which have specific responsibilities.

j. NHIA approves the work plan and budget on BHCPF implementation for SSHIA.

k. NHIA organised a joint review meeting and provided technical support to SSHIAs as required.

l. NHIA ensures interoperability with SSHIA on NHIA gateway operations.

4.3.2.2. SSHIA

In the States, the NHIA gateway will be implemented through SSHIA set up in line with guidelines and support from the NHIA. The functions assigned to the SSHIAs include:

a. Mobilisation/Sensitisation of Health Care Providers, Enrollees and the General Public
b. Enrolment of eligible beneficiaries.
c. Contracting of Healthcare Providers for programme implementation.
d. Payment to Health Care Providers
e. Claims Management for secondary care
f. Conduct periodic Quality Assessment
g. Monitoring and evaluation

h. Monthly submission of financial and programmatic data/reports to NHIA
i. Liaison with NHIA State Offices

4.3.2.3. PHC Facilities

a. PHC facilities shall be the first point of contact for patients, providing the primary care of the BMPHS and serving as gatekeepers for the initiative.
b. Only designated public and private PHC facilities which meet the accreditation criteria shall be accredited under the NHIA gateway.
c. The designated public PHC facilities shall have functional cheque based bank accounts and signatories shall include the Officer in Charge (OIC) and the Chairman of the Ward Development Committee (WDC)
d. Private facilities may be contracted by the SSHIA to complement the activities of the public PHC facilities.
e. Provision of quality PHC services at the facility and community levels.
f. Ensure adequate display of relevant signage to create public awareness of the facility's participation in the BHCPF and the BMPHS available to the community.
g. Ensure prompt referral of all beneficiaries in need of secondary care

4.3.2.4. Secondary Health Care Providers (SHCPs)

a. The States shall designate identified Secondary Health Care Providers (SHCPs) to serve as referral Centres for the PHC facilities, which shall provide specialised care to referred beneficiaries.
b. Public and private SHCPs, that meet the accreditation criteria set out by the NHIA, shall provide specialist services to patients on referral from the participating public and private PHCs.
c. Ensure 2-way referral of beneficiaries from the secondary level back to the primary level after treatment.
d. SHCPs shall be paid retrospectively, following claims processing
e. Other functions of the SHC Providers (SHCPs) under the BHCPF are as stated in the NHIA Gateway section of this guideline.

4.3.2.5. Local Government Area (LGA)

a. Contribute to the payment of the counterpart fund for the State.
b. Participate in the sensitisation of the community for enrolment.

4.3.3. Criteria for Participation of States, Third-Party Administrators, Providers, and Beneficiaries

4.3.3.1. States

To participate in BHCPF implementation, states, the FCT, and any other subnational entity are required to fulfil the following conditions:

a. Operational requirement

i. The state shall set up a State Social Health Insurance/Contributory Agency (SSHIA), backed by law.

ii. The SSHIA shall have the capacity to carry out health insurance and payer functions as shall be assessed by the NHIA.

iii. The SSHIA would have commenced some form of health insurance coverage.

iv. The SSHIA should have established a basic ICT infrastructure to collate and manage data relevant to health insurance functions.

v. The State would have opened a designated Treasury Single Account (TSA) with CBN through OAGF for BHCPF purposes.

vi. The SSHIA would be required to sign a contractual agreement with the NHIA to implement the BHCPF. This agreement shall include terms and conditions that will empower the SSHIAs to purchase services from health care providers from the Fund according to tariffs defined and published periodically by the NHIA.

vii. SSHIAs will also be required to establish Quality Monitoring Systems to effectively ascertain the quality of care available provided by health facilities, as well as their development and implementation of quality improvement plans.

b. Financial requirement

i. The State shall release equity funds to the SSHIAs and show evidence of budgetary provision

ii. Each state shall release a 25% counterpart fund into a dedicated account and provide evidence of such disbursement to the NHIA.

The counterpart fund represents 25% of the total value of coverage for the defined population, in line with the NHAct. The NHIA will provide the complementary 75% from the BHCPF based on the defined benefit package. This counterpart funding may be sourced from the state's equity fund.

4.3.3.2. Third Party Administrators (TPA)

Where States do not meet the requirements for implementing the BHCPF, a TPA will be engaged by the NHIA to carry out necessary functions to ensure that the programme is not halted in such States.

a. Operational requirement

i. The TPA must be duly accredited by the NHIA

ii. The TPA shall have the capacity to carry out health insurance and payer functions as assessed by the NHIA.

iii. The TPA should have established a basic ICT infrastructure to collate and manage data relevant to health insurance functions.

iv. The TPA would be required to sign a contractual agreement with the NHIA to implement the BHCPF. This agreement shall include terms and conditions that will empower the TPA to purchase services from health care providers according to tariffs defined and published periodically by the NHIA.

v. The TPA will also be required to establish Quality Monitoring Systems to effectively ascertain the quality of care provided by health facilities, as well as their development and implementation of quality improvement plans.

b. Financial requirement

i. The TPA must meet minimum capital requirements as outlined in the NHIA operational guidelines.

4.3.3.3. Healthcare Providers

a. The following general conditions apply for providers to participate in the BHCPF implementation:

i. Providers from whom the BMPHS will be purchased for beneficiaries would have to satisfy NHIA accreditation criteria for

primary or secondary healthcare provision as specified in the NHIA operational guidelines.

ii. While the NHIA's responsibility is to assure such capability through its accreditation process, it is the responsibility of the SMOH and SPHCB/As (in collaboration with the NPHCDA) to ensure that facilities in the state meet the accreditation requirements.

iii. To serve as a provider, healthcare facilities must be accredited based on guidelines established by the NHIA.

iv. Public PHC providers to be accredited would have undergone processes established by overseeing agencies of government such as the SMoH, SPHCB, or NPHCDA before they can be recommended by the state commissioner of health to the NHIA through its state offices for accreditation.

v. Private providers also have the responsibility to meet the licensing requirements to operate in the state, as well as the accreditation requirements of the NHIA to serve as healthcare providers for a health insurance scheme.

vi. All NHIA-accredited providers under the FSSHIP need not undergo another accreditation but will be required to indicate their willingness to provide services under the BHCPF through NHIA.

vii. All providers shall possess a singular designated chequing bank account in a regulated financial institution into which payments will be made by SSHIAs.

viii. All accredited providers will sign a participative contractual agreement with the payer to provide the BMPHS.

ix. To carry out their mandate, primary healthcare providers shall receive capitation payments for every beneficiary assigned to them, while secondary healthcare providers shall be reimbursed using a fee-for-service payment system. These payments shall be transferred to designated accounts owned by these providers and guaranteed by effective public finance management systems at the sub-national level.

x. Selection and continued participation in the initiative is contingent on the healthcare provider maintaining adequate quality standards of care.

b. The following Rights apply to Healthcare Providers

i. To receive timely and fair reimbursement for services rendered to insured beneficiaries according to the stipulated BHCPF guideline.

ii. Entitled to fair and non-discriminatory treatment by NHIA/SSHIA in decisions related to accreditation, service coverage, and payments.

iii. To clear, consistent guidelines and protocols regarding service delivery and reporting requirements.

iv. To appeal or seek redress in case of disputes over claims, payments, or accreditation decisions.

4.3.3.4. Beneficiaries

a. The following general conditions apply to beneficiaries of the BHCPF

i. Beneficiaries are Nigerians for whom the Federal Government has opted to provide premium contributions to provide them with financial access to healthcare and protection from catastrophic health expenditures, as part of the government's measures towards achieving universal healthcare coverage.

ii. The premium contributions are used by the NHIA to purchase healthcare services for the beneficiaries.

iii. To be eligible as beneficiaries, such Nigerians shall fulfil the criteria for targeting as specified by the government at any point in time in line with its effort to progressively provide coverage for Nigerians. This may include the status of their vulnerability to the health-poverty trap and the consequent impact on household and national productivity.

iv. To be enrolled, such eligible beneficiaries must be identifiable by registering with and obtaining the National Identity Number (NIN) provided by the National Identity Management Commission (NIMC) of Nigeria.

v. To access care, enrolees must possess an Identity Card issued by the SSHIA, which they can use in a public or private primary care provider to which they have been assigned.

vi. Revisions to beneficiary eligibility, enrolment processes, and pathway to care shall be periodically communicated by the NHIA.

b. The following Rights apply to beneficiaries

i. To access a range of health services as outlined in the BMPHS of BHCPF

ii. To be provided with financial protection from high out-of-pocket costs, with clear information on what services are covered and what costs they may be responsible for

iii. To make informed decisions about their care

iv. To file complaints or appeals if they feel their rights have been violated, or if they face issues with accessing care.

v. Be treated with respect, dignity, and privacy.

vi. Receive information about the BMPHS, its benefits, policies, and participating providers.

vii. Access care, at no additional cost, for covered services from participating public or private providers after proper identification without any discrimination or prejudice.

viii. Receive a complete course of treatment and generic medications for covered services.

ix. Change primary health care provider/receive services from any designated PHC in the event of relocation, emergency, and out of station.

x. Voice complaints and grievances about the health care provided and receive timely responses.

xi. Participate in decision-making regarding their health care through the Village and Ward Development Committees.

xii. Confidential treatment of beneficiaries' medical information.

xiii. Access their medical records in accordance with the NHAct 2014.

xiv. All other rights as contained in the FMoH patients' bill of rights.

4.3.4. Quality Management System (QMS) for BHCPF

4.3.4.1. Overview

The QMS for the NHIA Gateway will focus on accreditation as an external assessment, periodic quality assurance, and the implementation of internally

focused quality improvement (HCF/SSHIA self-assessment) to sustain the quality of care under the BHCPF.

Accreditation is the process of assessing healthcare providers using commonly accepted standards. Consequently, the NHIA accreditation and reaccreditation process ensures the determination of health institutions that can provide health care for enrollees of health insurance programmes in Nigeria, as well as those that could participate in NHIA related programmes.

Quality Assurance involves setting quality standards, assessing the performance of professionals or institutions with respect to the standards, and taking corrective action when the divergence of the set standards exceeds acceptable limits. After the initial accreditation, every participating healthcare provider will be periodically assessed to ensure quality of care.

As part of the requirements for reaccreditation, every healthcare provider shall be required to develop and implement Quality Improvement Plan(s) (QIP) coordinated by a Quality Improvement Committee (QIC). The QIC shall comprise the medical officer/officer-in-charge (as chairperson), one nurse/midwife/CHEW, one member of the ward development committees (WDC), one Pharmacy personnel, one laboratory personnel, one non-medical worker from the facility and one beneficiary from the community. If these categories of health personnel are absent, the healthcare provider can appoint a key quality officer for the committee.

The key actors in the NHIA Gateway QMS include:

a. National Health Insurance Authority
b. State Social Health Insurance Agencies
c. Quality Improvement Committees (Facility Based)
d. Participating Health Care Providers (Primary and Secondary)
e. BHCPF Beneficiaries

4.3.4.2. The Roles and Responsibilities of the NHIA

a. Establish the regulations governing quality management systems, especially accreditation, quality assurance, and quality improvement.

b. Accredit healthcare facilities in collaboration with relevant institutions

c. Collaborate with NPHCDA or relevant institutions to ensure full implementation of quality management systems.

d. Provide technical support to the SSHIAs and healthcare providers to develop and implement internally focused Quality Improvement Plans for improved treatment outcomes in line with the NHIA quality improvement strategy.

e. Receive reports of quality assurance exercises carried out by the SSHIA every quarter.

f. Determine and operationalise performance indicators that will be used as incentives for quality improvements, for which providers will receive performance-based incentives.

g. Analyse utilisation data, performance indicators, and data generated from quality monitoring at regular intervals (bi-annually), and the outcome will inform accreditation and reaccreditation actions.

h. With relevant institutions, perform validation exercises (twice a year) to reinforce the quality of reporting from the SSHIA. These validation exercises shall also be used to ascertain the status of HCPs reported for delisting by the SSHIA.

i. Carry out an annual audit of SSHIA QMS.

j. Send Feedback to NPHCDA, SSHIAs, and HCPs biannually for quality improvement.

k. Publish data generated from the analysis of quality management systems biannually.

4.3.4.3. The Roles and Responsibilities of the SSHIAs

The roles of SSHIAs in the QMS under the BHCPF NHIA Gateway shall be as follows:

a. Establish State-level Quality Assurance Systems with a detailed approach to HCF monitoring, data collection, and analysis.

b. Monitor the quality of health services at PHCFs and SHCPs using tools jointly developed by the NHIA and NPHCDA.

c. Carry out quality assurance activities in HCPs at least once a year (25% of all participating facilities every quarter.

d. Assist all PHCFs and SHCPs to develop and implement internally focused quality improvement plans.

e. Conduct a bi-annual review of Quality Improvement Plans of PHCFs and SHCPs in conjunction with SPHCDA.

f. Identify facilities with poor quality indicators/outcomes from the QIP for possible intervention.

g. Liaise with the State Commissioner for Health, SMOH, and SPHCB/A for intervention and immediate redress, with clear recommendations and opportunities for improvement.

h. Submit quarterly QA reports to NHIA.

i. Feedback to SMoH, SPHCDA, and HCPs for performance management and quality improvement every quarter.

4.3.4.4. The Roles and Responsibilities of the Healthcare Providers

The role of PHCP/SHCP participating in the BHCPF shall include:

a. Institute a provider-based Quality Improvement Committee (PHCF/SHCP QIC) -through which it will carry out its quality improvement activities.

b. Develop a plan for the improvement of health services rendered at the PHCFs.

c. Design and implement an annual QIP.

d. Use indicators developed by NHIA and NPHCDA for self-assessment and monitoring of internal processes, outputs, and resulting health outcomes.

e. Establish mechanisms to receive/provide feedback from BHCPF beneficiaries (e.g. suggestion boxes, user satisfaction surveys).

f. Provide returns on utilisation of services and other data under the NHIA gateway to NHIA through SSHIAs. (see section)

g. Constantly identify common health needs of the local community, working with local organizations such as ward development committees, and civil society.

h. Designate the Officer-in-Charge or any other officer to act as desk officer for grievance redressal under the supervision of SSHIA.

4.3.4.5. The Roles and Responsibilities of the Beneficiaries

The role of beneficiaries of the BHCPF shall include:

a. Being aware of their rights and responsibilities.
b. Provide feedback to the provider and SSHIA.

c. Participating in user satisfaction surveys.
d. Seeking redress where necessary.

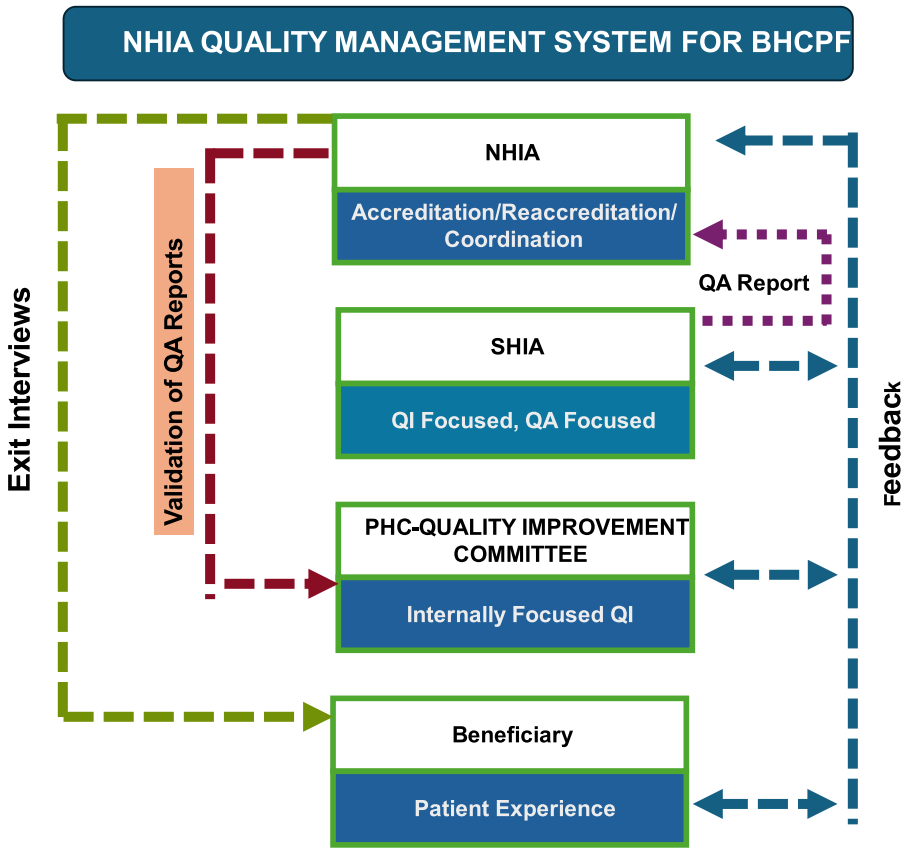


Figure 4-3: NHIA Gateway Quality Management Systems

4.3.5. Provider Accreditation and Quality Assurance

4.3.5.1. Purpose of Accreditation

The NHIA accreditation and reaccreditation process is one of the considerations used to determine health institutions that can provide health care for enrolees of all health insurance schemes in Nigeria. The accreditation process serves as a mechanism to ensure that providers offer quality health services to enrolees. Hence, the process allows the NHIA to assess the adequacy and capacity of human resources, physical infrastructure, equipment, commodities, and diagnostics available to the provider. It also enables an assessment of the operational processes necessary for ensuring positive programmatic outcomes.

4.3.5.2. Process of Accreditation

a. Prospective healthcare providers or their overseeing entities will be required to apply directly to the NHIA through its State Offices for accreditation.

b. All applications and accompanying documentation received by the NHIA will be analysed to determine suitability for possible physical inspection of the provider.

c. Based on the applications received, accreditation of public/private and primary/secondary providers for the NHIA Gateway is to be conducted by the NHIA State Office or other NHIA-approved entities, and where applicable, after payment of any accreditation fee.

d. Accreditation teams will perform an in-depth evaluation of the provider to determine whether the facilities meet the established standards.

e. All accredited providers shall be issued unique identifiers by the NHIA. Unique identifiers for primary care shall be different from that for secondary care.

f. All facilities that meet requirements for accreditation (including climate resilience and energy efficiency measures, etc.) shall be empanelled for a two-year period after which they will be subject to renewal of the accreditation, in line with NHIA operational guidelines. Services shall be purchased for beneficiaries from such providers.

g. NHIA shall maintain a list of accredited providers in any of its official organs of communication or databases.

h. Providers that do not meet the accreditation requirements shall be informed formally by documented communication, and a remediation process may be activated. Services shall not be purchased from such providers.

i. Provisional accreditation may be granted to providers that require minor remedial actions, and such providers shall be subject to a re-assessment within a 6-month period. Where such remedial actions have been met, the provider shall be granted full accreditation, and where not met, delisted.

j. At any time, NHIA officials may make spot/unscheduled checks to verify that personnel, equipment, and infrastructure requirements are maintained at the designated standards post-accreditation.

k. Human resource components are deemed to be critical irreducible minimums and non-scoreable.

4.3.5.3. Additional requirements for public and private secondary healthcare providers

The accreditation exercise shall assess general and speciality-specific personnel, climate-resilient and energy-efficient infrastructure, equipment, and process requirements for providing secondary healthcare as contained in the BMPHS.

Services for which interested SHCPs can apply are Surgery, Obstetrics & Gynaecology, Internal Medicine, ENT, Physiotherapy, Ophthalmology, Paediatrics, Radiology, Dentistry, Laboratory Services, and Pharmacy.

Critical for successful accreditation of any of the secondary healthcare services is the presence of skilled human resources for health.

All accredited SHCPs will also be subjected to all other periodic regulatory oversight actions as obtainable under the Formal Sector Social Health Insurance Program (FSSHIP).

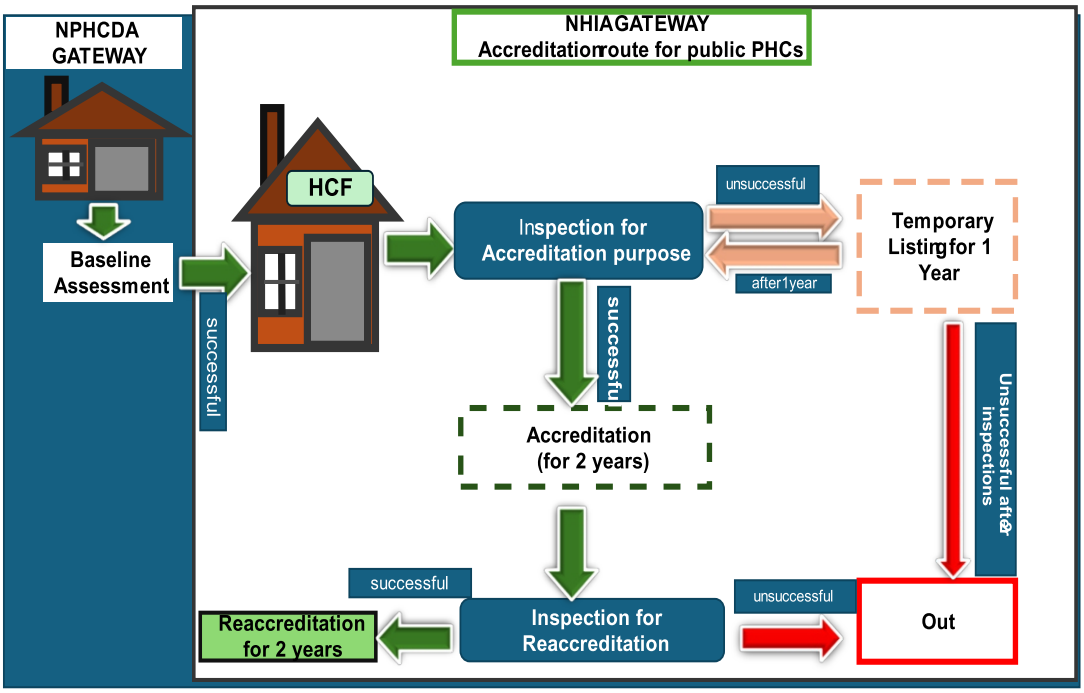


Figure 4-4: Process of Accreditation for Public Primary Healthcare Facilities

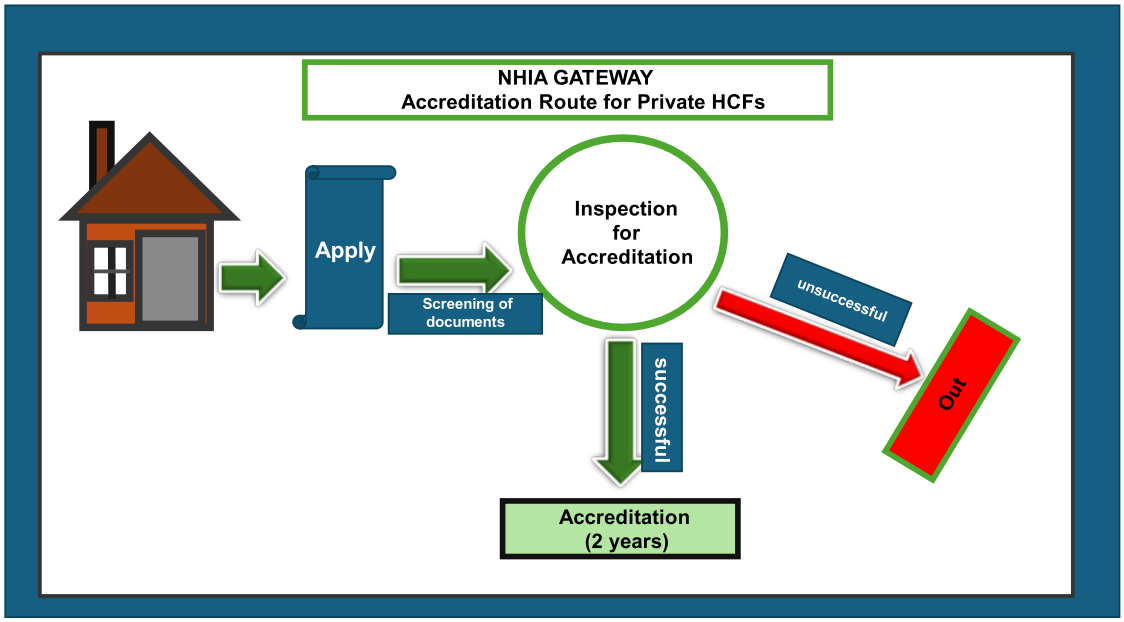


Figure 4-5: Process of Accreditation for Private PHCFs and SHCPs

4.3.5.4. Remediation Process for providers that do not meet accreditation requirements

a. Public and Private primary providers that do not meet the requirements for accreditation shall be informed formally within 7 days of the accreditation activity. The information shall include the specific gaps, the expected remedial action, and the timeline.

b. Where this concerns public providers, the SMOH, SPHCB/NPHCDA shall also be notified of facilities under their care. This information shall also clearly highlight the specific gaps, the expected remedial action, and the timeline.

c. Such facilities will be listed temporarily for 12 months to make amends, following which the accreditation process will be repeated to assess their capability for empanelment as a provider in the health insurance programme. During this enlistment, such facilities will not receive capitation thus will not provide services to enrolees.

d. Such facilities will be given 12 months to make amendments and then reassessed to determine their qualification for accreditation. The grant of the period for remediation will be on a case-by-case basis as determined by the NHIA through its state offices.

e. Private providers that do not meet accreditation requirements will be subject to any further action as specified in the Operational Guidelines of the NHIA schemes.

4.3.5.5. Conditions for Renewal of Accreditation

Accreditation of every Health Care Facility shall be renewable every two (2) years. Notification for renewal shall be provided by the NHIA State Office to healthcare facilities. Some of the criteria for renewal shall include:

a. Current provider licensure by the respective State Ministry of Health or other prescribed State entity, as applicable.
b. Possession of valid current licenses by health personnel.
c. Continued compliance with conditions for initial accreditation or as updated by the NHIA.
d. All necessary returns, including encounter/utilisation data.
e. Maintenance of a quality improvement team, an internal quality management system and quality improvement activities.
f. Maintenance of the basic criteria required for the functionality of a SSHIA.
g. Other criteria as may be announced by NHIA.

4.3.5.6. Conditions for withdrawal/Change in status of accreditation for a provider

a. All healthcare facilities that fail to comply with the requirements for reaccreditation will be delisted from the NHIA gateway.
b. Such providers will be informed via formal communication and publication on the NHIA/SSHIA website. In the case of public PHCs, SPHCDA and NPHCDA shall also be informed.
c. Beneficiaries in such affected PHCFs will be assigned to the nearest Primary Health Care Provider in the interim. They can subsequently be assigned to providers of their choice.
d. Delisted SHCPs will no longer be able to provide services to NHIA beneficiaries under any of its programmes. They can, however, upgrade and reapply to NHIA for accreditation.
e. For private providers, where such a provider wishes to voluntarily exit the programme, relocate the facility, or change its ownership, the requirements

and implications will be as prescribed by the NHIA Operational Guidelines.

f. For public providers, the NHIA shall determine the status in line with its requirements for accreditation.

4.3.5.7. The BHCPF Post-Accreditation Quality Assurance Process

a. Every accredited facility will be visited for quality assurance purposes at least once a year.
b. A minimum of two assessments will be undertaken before reaccreditation of the facility.
c. The quality assurance exercise will be conducted by joint teams from NHIA and NPHCDA.
d. An electronic tool comprising quality indicators relevant to both gateways will be used to conduct the assessment

4.3.5.8. The BHCPF Quality Assessment Tool

a. NHIA, in conjunction with NPHCDA or other relevant institutions shall be responsible for the development of the QA assessment tool. The NHIA shall train staff (quality officer(s)) of SSHIAs on the application of this tool and the reporting processes. The tool is to be deployed during quality assurance exercises.
b. The provider quality assessment tool shall focus on 10 priority areas as follows:
    i. Governance, Administrative Structure, and Infrastructure
    ii. Financial Management
    iii. Human Resources Management
    iv. Maternal and Child Health Services
    v. Patient Care Management
    vi. Essential Drugs and Commodities
    vii. Laboratory Services
    viii. Health Management Information Systems
    ix. Clinical Service Utilisation
    x. Community Involvement and Client Experience of Care

4.3.6. Beneficiary Enrolment

To access care, beneficiaries must be individually enrolled.

4.3.6.1. Criteria for Enrolment

a. The potential beneficiaries must be captured in a database adopted by NHIA, such as the National Social Register or an approved targeting mechanism for poor and vulnerable persons as defined in the NHIA Operational guidelines
b. Beneficiaries must be registered with NIMC and present their National Identification Number (NIN) to be eligible for enrolment.
c. Enrolment will be done by SSHIAs at the community, facility, and state levels using any suitable enrolment device while NHIA will validate enrolees.
d. Verification of beneficiaries based on enrolment criteria will be done at the point of enrolment
e. Validated beneficiaries shall be empanelled after fulfilling all enrolment requirements.

4.3.6.2. Required fields for enrolment (All fields are required except stated otherwise)

a. National Identification Number (NIN) – Unique Identifier
b. Name (First name, middle name, surname)
c. Date of enrolment
d. Date of Birth: (DD-MM-YYYY)
e. Location (State, LGA, Ward)
f. Phone number of enrolee and next of Kin
g. E-mail (optional)
h. Marital Status (Married, Widowed, Single, Separated, Single Parent, Divorced)
i. Gender (M/F)
j. Special needs? (PLWD, Pregnant Woman, CU5, Aged, NA)
k. Facility Code
l. Facility Name

4.3.6.3. Process of enrolment

a. An eligible beneficiary visits a SSHIA designated venue or agent with the necessary credentials.
b. The enrolment officer checks credentials against the beneficiary's NIN.

c. Enrolee details are captured.
d. An identification slip is issued to the enrolee.
e. The SSHIA will generate a monthly register of enrolees.
f. ID cards shall be provided to all enrollees by the SSHIA.
g. SSHIA and HCF shall retain an electronic copy of the enrolment register
h. Electronic copies of the register shall be synchronised to the NHIA database

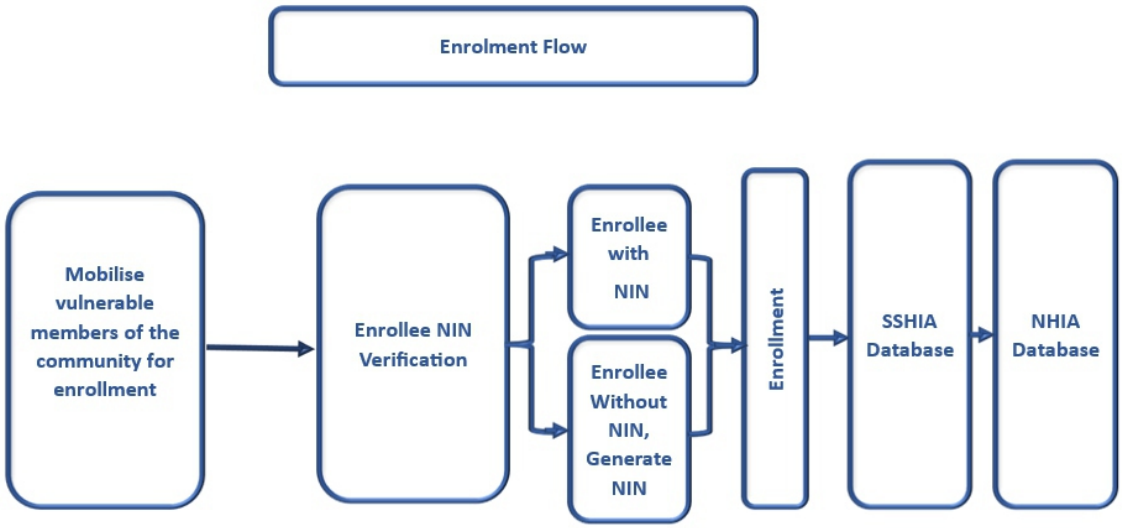


Figure 4-6: Enrolment Flow

4.3.6.4. Roles and responsibilities of various stakeholders in the enrolment process

a. **NHIA**
   i. Definition of criteria for beneficiary eligibility
   ii. Validation of enrolee records
   iii. Continuous engagement with NIMC to ensure seamless integration of databases for NIN linkage, and ensuring compliance with NIMC enrolment standards
   iv. Provision of guidelines on basic minimum ICT infrastructure requirements for SSHIAs and HCFs and ensure interoperability with NHIA/NIMC
   v. Provision of guidelines on enrollee fields to be captured for enrolment

vi. Provision of a central enrolment platform, including software solutions for effective management and aggregation of enrollee register
vii. Sharing of enrolment information with relevant stakeholders
viii. Support of SSHIAs for registration of beneficiaries of the BHCPF and setting coverage target as appropriate.

b. **SSHIA**
   i. Sensitisation and Mobilisation of HCFs, community organisations and potential beneficiaries for enrolment
   ii. Enrolment of beneficiaries
   iii. Provision of the enrollee register to HCP every month
   iv. Provision of at least quarterly update on enrolee records to NHIA; enrolee records should indicate new vs existing enrolees, updates to existing enrolee records e.g. number of deaths.
   v. Provision of basic minimum ICT infrastructure for enrolment
   vi. Integration of enrolment register with NHIA enrolment platform
   vii. End-to-end automation of SSHIA's Enrolment Processes.
   viii. Training of SSHIA enrolment officers

c. **Healthcare Providers**
   i. Keep enrollees' register for verification during access to healthcare as received from SSHIA
   ii. Monthly update of enrollee records in case of death, exit from the community, etc.

d. **Ward Development Committee and other community groups**
   i. Sensitisation and Mobilisation of potential enrollees
   ii. Support the SSHIA in validating enrolee information
   iii. Help in providing enrollee information on deaths, relocation, etc.

e. **Beneficiaries**
   i. Enrol with NIMC and obtain NIN
   ii. Enrol as beneficiaries of the BHCPF

4.3.7. Care Pathway

4.3.7.1. Scope of Coverage

The BHCPF shall be used to provide the BMPHS to eligible beneficiaries (Annexe 1). The unit of coverage shall be individual persons. Beneficiaries shall seek care at accredited public and private healthcare providers. Secondary healthcare services shall be provided by public and private healthcare providers

following referral from the primary healthcare providers. Facilities to be used will be registered with the State Ministry of Health or the SPHCB.

4.3.7.2. Primary Healthcare

a. Primary healthcare shall be obtainable from public and private primary healthcare facilities to which the beneficiary has been assigned.
b. Beneficiaries are expected to visit the primary provider when ill and cannot bypass the primary care provider to obtain similar services from the secondary healthcare provider.
c. Beneficiaries shall present their ID cards when they visit the healthcare provider.
d. A primary healthcare service shall typically be offered on an outpatient basis, apart from services such as delivery and perhaps observation for some childhood conditions, beyond which they should be referred to the secondary level of care.
e. There shall be no copayment or co-insurance by the beneficiary under the BHCPF for primary healthcare.
f. Enrolees may obtain services not included in the BMPHS from providers, but this shall only be if they are willing to pay the user fees designated by such providers for such services.
g. Beneficiaries can freely access other services normally provided free of charge in such facilities, e.g. childhood vaccination.

4.3.7.3. Referrals

The referral process between primary and secondary care providers shall follow the basic principles of referral as follows:

a. There must be a clinical basis for referrals.
b. A referral line must be established.
c. A referral letter must accompany every case.
d. Primary care providers are obliged to refer beneficiaries early enough to the next level of care.
e. Requests to refer a patient from primary healthcare facilities shall only be authorised by SSHIA or its agent within 6 hours of the request, and an authorisation code must be given within 6 hours to the requesting facility.
f. Relevant personal and medical details must be contained in the referral letter.

g. All investigations carried out at a lower level must be sent to a higher level.
h. The outcome of a referral should be satisfactorily and properly documented.
i. Referred cases must be sent back to the referring primary healthcare provider by the secondary healthcare provider after completion of treatment, with a medical report and instructions for follow-up management.
j. When referral requests are denied by SHIAs, the HCFs must be notified within 24 hours of the request, stating the reasons for the denial.

4.3.7.4. Secondary Healthcare

a. Secondary Healthcare shall only be accessible following an authorised referral from a beneficiary's primary healthcare provider.
b. The services shall include outpatient consultations as well as hospitalisation for conditions specified in the BMPHS.
c. BHCPF beneficiaries/enrolees are entitled to 21 cumulative days of hospitalisation in standard wards, with the exclusion of meals.
d. Hospitalisation days exceeding 21 days shall be on re-authorisation by SSHIA.
e. Where other conditions arise while seeking referral care (for unbundled services), the secondary provider shall seek authorisation for care from the SSHIA.
f. In case of emergencies, the enrolee can directly visit an accredited secondary healthcare facility with their ID cards. The emergency unit of the provider will verify the identity of the enrolee and provide care while seeking to obtain authorization from the SSHIA within 48 hours.
g. If the secondary provider realises that it is not an emergency, the provider shall ask the enrolee to go back to the primary provider. Where the enrollee insists on accessing care from the secondary provider, the enrollee can only utilise services by the provider's normal user fees, and this shall not be reimbursable by the SSHIA.
h. Enrolees may obtain services not included in the BMPHS from providers, but this shall only be if they are willing to pay the user fees designated by such providers for such services.
i. There shall be no copayment or co-insurance by the beneficiary under the BHCPF for secondary healthcare.

4.4. Financial Management

4.4.1. Approach to disbursement of Funds through the NHIA Gateway

The NHIA Gateway includes three layers for fund disbursement and management (Figure 4-7).

Layer 1: CRF and the other Sources to NHIA

The primary fund shall be disbursed from the Consolidated Revenue Fund (CRF) to the designated NHIA BHCPF account. Currently, this is a NHIA Treasury Single Account (TSA) domiciled with the Central Bank of Nigeria. This account will represent the main pool for the NHIA Gateway. Where additional funds are available from other sources as anticipated by the National Health Act 2014, such funds shall also be transferred into the NHIA TSA.

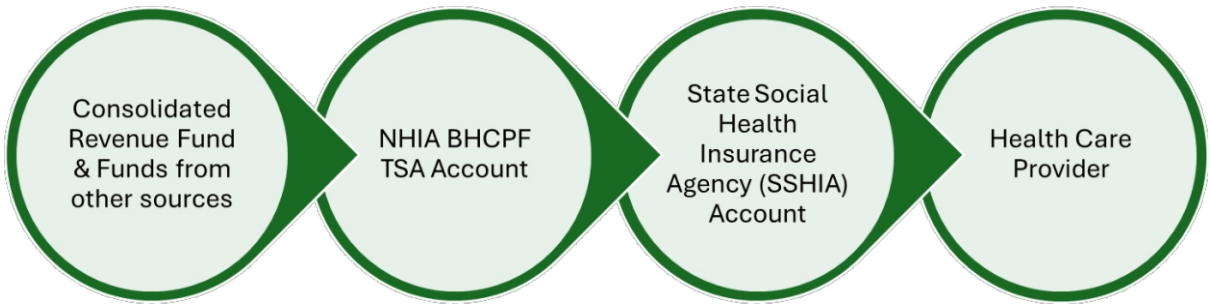


Figure 4-7: Framework for funds disbursement through the NHIA Gateway

Layer 2: NHIA disbursement to operational accounts and SSHIAs

This layer includes four components.

a. The NHIA shall operate another account with the CBN entitled "Administrative Account", into which the administrative costs of the NHIA Gateway shall be transferred. The total deductible for administration by NHIA shall be 10% of the total remittances from the Fund. The MOC will receive 20% of the administrative cost due to the NHIA. The remaining funds shall serve as premiums.
b. The NHIA shall disburse premiums to SSHIAs to enable them to pay providers on its behalf. This premium will include funds for capitation, fee-for-service payments, operations activities of the SSHIA as it concerns the BHCPF beneficiaries, and the maintenance of a reserve pool at the subnational level. Where the SSHIA is unable to carry out a health

insurance function, NHIA will carry out its purchasing mandate through third-party administrators as contained in NHIA Operational Guidelines.

c. This disbursement to the SSHIA will be based on the number of validated enrolees.

d. The NHIA shall maintain a share of the reserve fund which will serve as a reinsurance pool and risk buffer to ensure the sustainability and continuity of the fund. This fund shall be domiciled in an account with the CBN.

Layer 3: SSHIA disbursement to primary and secondary healthcare providers

This layer includes four components (Table 4-1).

The SSHIA shall disburse capitation funds monthly to eligible providers to provide primary care services included in the BMPHS. The capitation shall equal 71.25% of the total premium, which shall be for verified enrollees listed for the facility.

The SSHIA shall maintain and use 11.25% of the total premium to pay secondary providers as fee-for-service for enrolees referred by the primary provider after being duly authorised by SSHIA.

The SSHIA shall maintain a reserve pool of 50 million Naira to manage shocks arising from excess fee-for-service claims. This reserve shall be subject to periodic review by the NHIA depending on the enrolee base of the state.

The SSHIA shall retain the administrative cost of 5% and operations cost of 10% of the premium it receives to enable it to carry out administrative and operational activities necessary to ensure financial access for enrolled beneficiaries. The SOC will receive 5% of the 5% administrative cost of the SSHIA to enable them carry out their activities.

Portion of Premium	Purpose	Percentage (%)	Fund Recipients/Fund Managers
Administration	Administrative expenditure	5%	SSHIAs with 5% remitted to the SOC
Operations cost	(ICT, QA, and M&E)	10%	SSHIAs
Capitation	Primary care	71.25%	Primary Care Providers
Fee-For-Service	Secondary care	11.25%	SSHIAs
Reserve Fund	Financial Risk management	2.5%	SSHIAs (This shall be reserved with NHIA for reinsurance while 50m will be domiciled with SSHIAs)
		100%	

Table 4-1: BHCPF Premium Distribution

4.4.2. Management of the NHIA-BHCPF Gateway funds

To ensure that funds deployed through the NHIA-BHCPF gateway are used and accounted for, the following financial management processes have been established.

a. **Signatories to BHCPF Accounts**

The signatories to the BHCPF accounts are shown in Table xx.

Table 4-1: BHCPF Premium Distribution

Entity	Approvals	Authorized Signatories
NHIA	DG, NHIA	NHIA signatory authority (initiator reviewer and final approver)
SSHIA	ES, SSHIA	SSHIA signatory authority (initiator, reviewer and final approver)
Public SHCs	HHMB	MO in charge/Authorized Signatories
Public PHCs	PHC Coordinator	OIC and Ward Development Committee Chairman / Authorized Signatories
Private HCFs	Director or Trustee (as approved by the CAC and FRC.	Chief executive/Administrator of the private HCF

Table 4-2: Signatories to the various BHCPF accounts

b. **Guidance on the flow of premiums from NHIA to SSHIA**

i. **The NHIA-BHCPF Gateway premiums are paid quarterly**. They are calculated as premium cost per enrolee per quarter multiplied by the number of enrolees reported for the previous quarter. The premiums are transferred to states within 7 working days of the receipt of funds from the MOC secretariat if such SSHIAs meet the expected requirements as detailed below.

- Submission of quarterly enrolment records indicating existing and new enrollees and updates to existing enrollee records, for example, due to deaths and community exits.

- Submission of quarterly financial reports in compliance with outlined financial reporting standards.

ii. **Financial incentives are paid yearly or at a frequency to be determined by the NHIA**. The following requirements must be met to receive incentive:
   - Annual audited financial report.
   - Submission of required operational data such as: Enrolment register, Utilisation data
   - Timely claims processing.
   - Clients' satisfaction based on exit interviews, electronic polls, etc
   - Other criteria as may be determined by the NHIA.

iii. **Deductions due to infractions are reviewed quarterly, and the impact is reflected in the following quarter's disbursement.** Deductions are implemented as follows:
   - Non-submission of enrolment data would result in no payment for the quarter, but the NHIA will pay capitation for the enrollees in such state directly to the facilities using the validated enrollee data for the previous quarter.
   - Invalid enrolment data would result in a deduction of premium per invalid enrolment from the operational costs due to SSHIAs of the subsequent quarter.
   - Financial misappropriations would result in the deduction of the amount misappropriated from subsequent premiums due to SSHIAs.

c. **Guidance on the flow of funds from SSHIAs to Primary Healthcare Providers (Capitation)**

i. Using 71.25% of the total premium, SSHIAs are to pay a capitation fee (per enrollee) per month to accredited Primary care providers for all the enrollees listed for the facility.

ii. SSHIAs shall pay such capitation fee in advance not later than 5 days before the commencement of the month.

iii. The capitation fee shall be paid to the primary care provider through the designated chequing bank account in a regulated financial institution of the provider.

iv. NHIA shall introduce innovations including performance-based incentives (e.g. capitation plus) in collaboration with payers/administrators and providers.

d. **Guidance on the flow of funds from SSHIAs to Secondary Healthcare Providers (fee-for-service)**

i. Using the provisions made from pooling 11.25% of the total premium, SSHIAs are to make fee-for-service payments to secondary providers for services delivered to enrollees following a referral by the primary provider, duly authorised by the SSHIA.

ii. Referral for secondary service shall be for secondary healthcare benefits included in the BMPHS (Annexe 1). Whereas current claims are based on conventional fee-for-service models, NHIA will introduce bundled payments based on ICD codes.

iii. The BHCPF claims form shall be the format of the presentation of claims

iv. Claims from an accredited Secondary Provider will be submitted monthly to the SSHIA for processing, verifications, and payment.

v. Fee-for-service will be paid by SSHIA to an accredited Secondary Provider upon submission of claims using the Claims Form from the facility.

vi. All claims from a healthcare provider shall reach the SSHIA within 30 days of being incurred.

vii. All claims submitted by a secondary provider will be acknowledged by the SSHIA with a stamp, indicating the date and time of receipt.

viii. SSHIAs must adjudicate, verify, and process all submitted claims for payment to providers within 30 days of submission.

ix. All claims not submitted to SSHIAs after 90 days shall not be reimbursed.

x. NHIA will conduct periodic claims audits.

xi. Unused fee-for-service at the end of each year will be transferred to the reserve pool maintained by SSHIAs for its use as approved by the NHIA.

e. **Guidance on the use of administrative and operations costs by the SSHIAs**

i. An administrative cost of 5% and an operational cost of 10% of the premium will be paid to SSHIAs.

ii. This payment is meant to cover for administrative activities of SSHIA and operational costs such as ICT, M&E, and quality assurance.

iii. This prorated payment shall be made quarterly based on the number of people enrolled.

iv. The ICT component of this payment is meant to support the integration and uniformity of data collection from SSHIAs. Additionally, ID card production, development, and integration of BHCPF claims management software with SSHIAs and HCPs shall be funded from this pool.

v. Administrative charges shall only be used to facilitate activities to ensure enrolees gain financial access to healthcare. It shall not be used without commensurate action, progress with enrolment and beneficiary utilisation of services.

f. **Guidance on disbursement and use of reserve funds**

i. The NHIA shall set aside 2.5% of premiums to serve as reserve funds which shall be kept separate from other BHCPF funds.

ii. The reserve fund shall serve strictly as a reinsurance pool to fund the following:

- To reimburse excess but verifiable fee-for-service costs for utilisation of secondary healthcare services.
- To disburse funds to SSHIAs in case of delays in funds flow to ensure uninterrupted payment of providers and service delivery
- When approved by the NHIA, to enrol more beneficiaries to increase coverage based on effective risk management of the existing resources (capitation, FFS and SSHIA-level reserves).

iii. SSHIAs shall maintain a reserve pool of 50 million Naira at their level to serve to manage shocks arising from excess fee-for-service claims.

- When required for any purpose indicated in 2 above, the NHIA shall disburse reserve funds to SSHIAs.
- The procedure for requesting reserve funds from NHIA shall be as follows:
- Where verified and authorised fee-for-service exceeds the available revenue in the pool of SSHIAs, the SSHIA will make a request to the NHIA for the use of the Reserve Fund in their pool.

- The NHIA shall approve such request if the claims are justifiable as fee-for-service claims as specified in the BHCPF guidelines.
- The SSHIA updates the NHIA on the use of excess reserve funds, disbursements, utilisation during the monthly/quarterly joint review meetings, and the reserve fund gap.
- The NHIA shall review the claims for excess fee-for-service as for other claims to ensure alignment with guidelines.
- Once cleared, the NHIA shall refill the reserve pool of the SSHIA, and this shall be disbursed along with the next quarter's premium disbursements.
- Where the request for reserve funds is for the enrolment of new beneficiaries, the process shall also require approval by the NHIA at the review meetings to align on the enrolment target, and disbursement of accrued funds. Such beneficiaries shall be enrolled based on data-driven equity considerations around the level of vulnerability and disease burden in the proposed beneficiaries' geographic area.

g. **Guidance on financial reporting of funds disbursed through the NHIA-BHCPF Gateway**

Overall, the BHCPF disbursed through the NHIA gateway shall be utilised primarily for the purchase of the Basic Minimum Package of Health Services (BMPHS) specified by the NHIA, and for the associated operational costs of the NHIA and SSHIAs, as well as strategies to ensure the sustainability of the fund. Any financial expenditure beyond this mandate shall be considered invalid. Participating entities shall maintain financial records and provide financial reports as follows:

i. **Financial Records (see appendix)**

- All recipients of BHCPF shall maintain proper books of accounts that show the amount of funds received and how the funds were utilised using cash basis of accounting. NHIA will conduct a quarterly reconciliation exercise of all funds disbursed to SSHIAs.

ii. **NHIA financial reporting**

- Funds received by NHIA are operational costs and service costs from the CBN.
- The funds expended are contributions for the expected enrolled population disbursed to the states.

- NHIA shall prepare a statement of account based on funds received and expended to the Ministerial Oversight Committee on a quarterly basis.

iii. **SSHIA financial reporting**

- The SSHIAs shall maintain proper books of account as stipulated by NHIA.
- All reports shall include the date prepared, the period covered by the report, the descriptive label, and a title that will be understandable to any user.
- SSHIAs shall develop and submit financial reports monthly.
- The audited accounts are to be submitted to NHIA annually.

iv. **Healthcare Provider financial reporting**

- Public/Private healthcare providers shall maintain a database register and records of funds received and utilisation.
- Funds received should indicate the date and amount received.
- Records of utilization of funds should indicate the amount spent and the service for which it has been spent for benefiting enrolees.
- The SSHIA payment to health care providers shall never be used for any purpose other than to provide quality care for enrolees.

4.5. Monitoring and Evaluation

The performance of the NHIA gateway will be monitored in accordance with the gateway's theory of change and Monitoring & Evaluation (M&E) framework.

4.5.1. Purpose and Objectives

The overall purpose of the NHIA Gateway M&E is to assess the progress of implementation of the gateway and determine whether intended results are being achieved in addition to applying rigorous evaluations to assess programme efficiency, effectiveness, and performance.

The specific objectives are to:

a. Monitor activities as outlined in the NHIA gateway by measuring key input, output, and outcome indicators at both the National and State levels.
b. Promote learning, feedback, and knowledge sharing based on the results achieved.
c. Ensure transparency and accountability across all levels of implementation.

d. Produce evidence for operational/programmatic reviews and informed decision-making.
e. Outline the data management Plan for the NHIA gateway operations and establish the roles of each stakeholder.

4.5.2. Theory of change

The theory of change, which highlights key operations toward achieving the NHIA Gateway's goal, is shown in Figure 4-8.

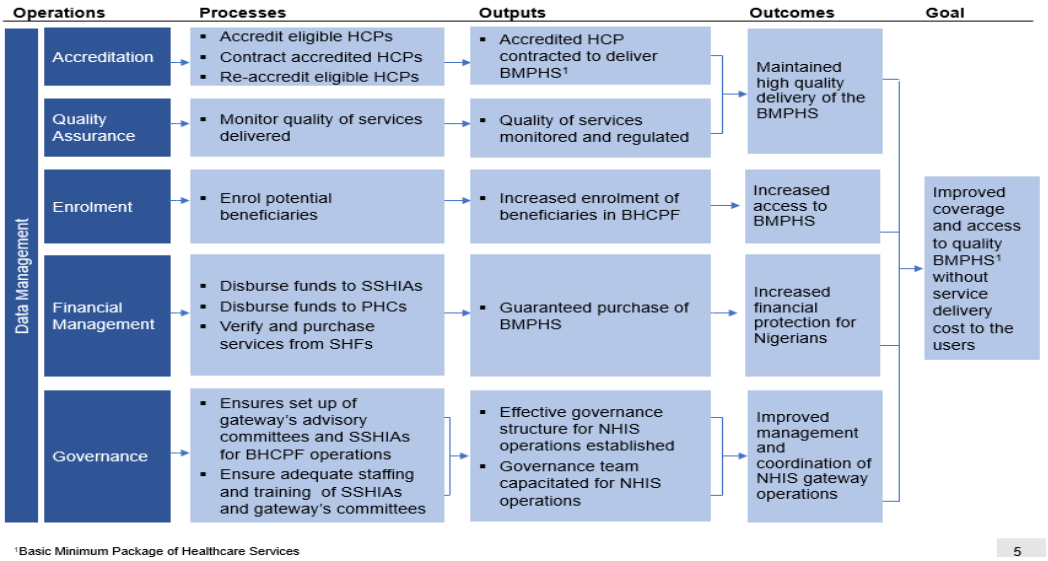


Figure 4-8: Key highlights of NHIA Gateway Theory of Change

4.5.3. Monitoring & Evaluation Framework

This M&E framework is structured to assess the performance of the BHCPF-NHIA Gateway. It provides a systematic way to track progress, measure outcomes, and ensure that the programmatic objectives are being met efficiently and effectively.

The M&E framework will facilitate the institutionalisation of M&E principles and practices to support decision-making and adaptive learning, planning and management across the gateway. It will also serve as a vital tool for timely and systematic data collection, analysis and reporting, thereby improving overall performance and accountability to all stakeholders and beneficiaries.

4.5.4. NHIA Gateway Indicators

a. *Impact of BHCPF-NHIA gateway*
   i. Total number of Enrolees
   ii. Percentage of vulnerable population covered under the NHIA gateway
   iii. Percentage contribution of each state to the total number of enrollees

iv. Percentage of enrollees that utilised the BMPHS at the primary care level
v. Percentage of enrollees that utilised the BMPHS at the secondary care level

b. Performance dimensions of stakeholders and indicators

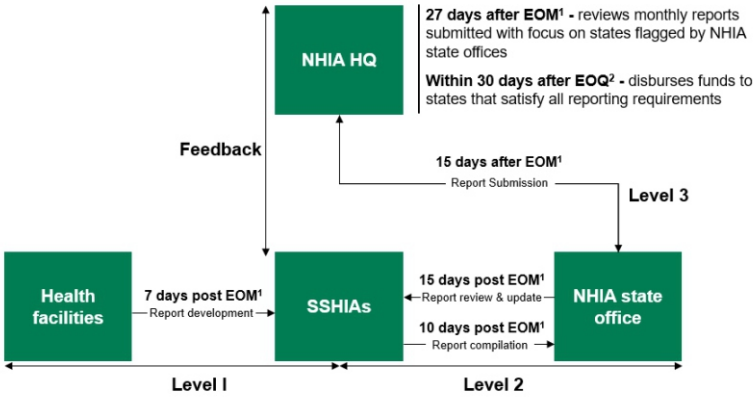
S/N	Performance Dimension	Key Indicators
1	Enrollment	Proportion of enrollees whose enrollment is linked to NIN Number of actual beneficiaries enrollees and validate per states
2	Service Utilization	Proportion of enrollees that have accessed the BMPHS
3	Accreditation	Number of public PHCFs per state enlisted into the BHCPF Number of private PHCFs per state enlisted into the BHCPF Number of SHCPs per state enlisted into the BHCPF
4	Quality Assurance	Proportion of BHCPF facilities that have an average quality assessment score of 70% Proportion of client complaints resolved
5	Data management	Proportion of SSHIAs submitting timely data Proportion of Facilities submitting timely data
6	Governance and Financial Management	Number of states with timely release of funds to state equity fund Proportion of SSHIAs that have received 25% Counterpart Funding Proportion of states who performed annual audit

Table 4-3: NHIA Gateway - Key performance indicators

The specific indicators to be tracked across the performance dimensions of stakeholders of the gateway can be found in Table 4-3. Further details on the tasks, outputs, and outcomes of the performance indicators listed above can be found in the NHIA Gateway's M&E framework.

4.5.5. Data reporting

Data reports for M&E purposes will follow the system indicated in Figure 4-9.



1. End of Month 2. End of Quarter

Figure 4-9: Data reporting for M&E

The BHCPF NHIA Gateway reporting process will occur at three levels as outlined below:

Level 1: SSHIA Level Report Development - Report Development (1st 7 Days of the Month)

Responsible Stakeholder: Health Providers (PHCPs and SHCPs)

a. Activity: Health Care Providers develop two key reports in alignment with the stipulated guidelines
    i. Financial statements
    ii. Utilisation data
b. These reports are then submitted to State Social Health Insurance Agencies (SSHIAs)

Level 2: SSHIA/NHIA State-Level Reporting and Review

1. **Report Compilation (1st to 10th Day of the Month)**

Responsible Stakeholder: State Social Health Insurance Agencies (SSHIA)

a. Activity: SSHIA compiles four key reports in alignment with stipulated standards:
    i. Enrolment Data: Details on the number of individuals enrolled.
    ii. Financial Status: Financial statements and status updates.
    iii. Utilisation: Data on the utilisation of health services.
    iv. Accredited Health Care Facilities: List and status of accredited facilities.

b. These reports are then submitted to the National Health Insurance Authority (NHIA) state offices.

2. **Monthly Review Session**

Responsible Stakeholder: NHIA State Offices/SSHIA

a. Activity: NHIA state offices hold monthly review sessions with SSHIA to discuss the submitted reports, identify issues, and suggest necessary updates.

3. **Report Update (10th – 15th Day of the Month)**

Responsible Stakeholder: SSHIA

a. Activity: Based on feedback from the monthly review sessions, SSHIA updates the reports and makes any necessary corrections or additions.

Level 3: National-level Reporting and Fund Disbursement

1. **Report Submission (15th Day of the Month)**

Responsible Stakeholder: SSHIA

a. Activity: SSHIA submits the updated reports to NHIA headquarters for national-level review and aggregation.

2. **Quarterly Report Review (16th – 27th Day of the Month)**

Responsible Stakeholder: NHIA Headquarters

a. Activity: NHIA headquarters reviews quarterly reports, particularly focusing on states flagged by NHIA state offices for potential issues or inconsistencies.

b. This review process aims to ensure accuracy, completeness, and compliance with reporting standards.

3. **Funds Disbursement (30 Days after end of Quarter)**

Responsible Stakeholder: NHIA Headquarters

a. Activity: NHIA disburses funds to states that meet all reporting requirements. This disbursement is based on the accuracy and completeness of the quarterly reports.

Summary of Timelines:
• **1st 7 Days of the Month: SSHIA Level Report Development - Report Development.** • **7th to 10th Day of The Month: SSHIA compiles and submits initial reports to NHIA state offices.** • **10th - 15th Day of The Month: SSHIA updates reports based on review sessions and submits updated reports to NHIA headquarters.** • **16th – 27th Day of The Month: NHIA headquarters reviews monthly reports.** • **30 Days After Quarter-End: NHIA disburses funds to compliant states.**

Monitoring and evaluation/verification reports will trigger penalties due to non-compliance with processes or performance standards.
NHIA will monitor and evaluate the audited financial reports using the Key Performance Indicators (KPIs) above. This will assess the performance of every SSHIA.

4.5.6. NHIA Gateway Outcome Evaluation

The NHIA shall design an outcome evaluation to determine whether the NHIA gateway has successfully improved access to healthcare, reduced financial barriers and led to better health outcomes for the vulnerable population. The outcome evaluation of the NHIA gateway shall be conducted every 2 years through an approved third-party research institution.

4.5.7. Roles and Responsibilities for M&E Functions

The roles and responsibilities of key agencies/stakeholders at national, state, facility levels are presented in Tables 4-4,5,6,7 and 8.

Key Areas	NHIA M&E functions under the BHCPF
Establishment of a common data architecture	• Define standards for sharing disaggregate BHCPF data. • Coordinate the development of data requirements for the BHCPF. • Create and maintain a repository of BHCPF data.

	• Conduct oversight functions in the management of BHCPF data across levels for informed policymaking.
Improve performance and review processes	• Use aggregate data to analyse findings for BHCPF priorities. • Compile reports at the National level to track implementation of BHCPF. • Verify the quality of data received and follow up for validity and reliability of the data. • Build capacity and provide technical support on BHCPF M&E functions at all levels (SSHIAs, PHCFs and SHCPs).
Enhance sharing of data and promote use of information for decision making	• Institutionalize data flow to meet BHCPF and MOC reporting obligations. • Prepare national annual and quarterly performance reports. • Disseminate the National and States BHCPF Data (reports) to the MOC/NHIA and SSHIAs respectively.

Table 4-4: Roles and responsibilities of National level (NHIA)

Key Areas	SSHIA M&E functions under the BHCPF
Establishment of a common data architecture	• Establishing data collection and management structures. • Create and maintain a repository of NHIA Gateway data and report to NHIA. • Collaborate with SMOH M&E Unit in providing data for policy formulation and decision making. • Build capacity and provide technical support to the facility level on use of M&E tools
Improve performance and review processes	• Work within the BHCPF NHIA M&E framework and guidelines to meet reporting requirements.

Enhance sharing of data and promote use of information for decision making	• Strengthening M&E Unit operations within the Agency • Prepare and submit annual workplan endorsed by SOC to the NHIA • Prepare and disseminate the NHIA Gateway and Facility BHCPF Data (reports) to the SOC and NHIA.

Table 4-5: Roles and responsibilities of SSHIA

Key Areas	PHCFs/SHCs functions under the BHCPF
Establishment of a common data architecture	• Create and maintain a repository of BHCPF NHIA Gateway data. • Assign a staff responsible for management of BHCPF NHIA Gateway data. • Routinely update the data information system for effective management of the gateway operations • Protect from unauthorized access to Gateway data. • Build capacity in Record Officers in the Facilities
Improve performance and review processes	• Work within the stipulated BHCPF NHIA Gateway guidelines to meet reporting requirements.
Enhance the sharing of data and promote the use of information for decision-making	• Fill NHIA Gateway M&E tools appropriately for routine submission to the SSHIAs

Table 4-6: Roles and responsibilities of Healthcare Facility (PHCFs/SHCs) Finance/Record office

Key Areas	**Partner functions at the national level**
Establishment of a common data architecture	• Provide technical, material, and financial support to strengthen monitoring and evaluation. • Promote a national integrated health information system for decision making.

	• Collaborate with NHIA to provide data from health-related research for decision making.
Improve performance and review processes	• Work within the existing NHIA Gateway's M&E framework and meet defined reporting requirements.
Enhance sharing of data and promote use of information for decision making	• Strengthening national-level M&E operations • Aid in the dissemination of data, research findings and performance reports.

Table 4-7: Roles and responsibilities of National Level Partners (Development Partners (DPs), CSOs, NGOs, FBOs)

Other Actors	Functions under BHCPF NHIA Gateway
Verifiers (Ex-post verification)	Provide satisfactory validation to the NHIA, SSHIA or M&E Managers, that the quantum of services reported by health facilities, have in fact, been rendered. Ensure data verification in at least 50% of facilities in all participating states have been completed, no later than 4 (four) weeks from the end of each quarter
Honourable Commissioner for Health	May also conduct monitoring and supervisory visits; provide feedback and guidance to the NHIA and SSHIA

Table 4-8: Roles and responsibilities of other Relevant Stakeholders (Independent Verification Agents, HCoH)

4.6. Infractions and Sanctions

The provisions of the Implementation Protocol for the NHIA Gateway require strict compliance by all the stakeholders. Therefore, for proper regulation of the Schemes, conducts that would constitute infractions of the Implementation Protocol and the appropriate sanctions have been provided hereunder.

4.6.1. Sources of Reports of Infractions

a. Monitoring and Evaluation reports
b. Report on Quality Assurance and Accreditation/Re-accreditation
c. Aggrieved persons who have complained through the Grievance Redressal Mechanism

4.6.2. Types of Sanctions

a. Warning
b. Withholding of a percentage from the administrative fund payable to the SSHIAs.

c. Suspension from further releases by NHIA
d. Suspension of healthcare providers with the transfer of enrolees
e. Impose Fine

Tables (4-9 and 10) provide the range of infractions and sanctions. Accordingly, persons, institutions, or healthcare facilities found to have breached the guidelines, shall be informed within a reasonable time (not exceeding 7 days) or such period as may be determined by NHIA from time to time. The person in breach shall comply forthwith with any sanctions imposed thereon. The SOC shall be notified by the NHIA of any offences, decisions and sanctions. The sanctions and offenses in this guideline are subject to periodic review by the NHIA.

Summary of offences and sanctions for Target Group: SSHIAs

S/No	Offenses	Sanctions	Enforcement
1	Delay to remit payment of capitation to facilities after receiving same from the Authority. Delay of capitation in this context means failure to pay fourteen (14) days before the following month	**1st default** - Warning letter and shall remit the appropriate capitation to the facility within seven (7) days of receipt of the warning. **2nd default** – Withdrawal of 10 % of administrative funds due to the SSHIA. **3rd default** – SSHIA is suspended from administrative fees due for the next quarter. **4th default** – The funding by NHIA to the SSHIA shall be suspended.	**NHIA**
2	Delay to remit payment of Fee-For-Service to facilities after receiving same from the Scheme. Delay of Fee-for-Service in this context means failure to pay within ninety (90) days.	**1st default** - Warning letter and shall remit the appropriate Fee-For-Service to the facility within seven (7) days of receipt of the warning. **2nd default** – Withdrawal of 10 % of administrative funds due to the SSHIA. **3rd default** – SSHIA is suspended from administrative fees due for the next quarter.	**NHIA**

		4th default – The funding by NHIA to the SSHIA shall be suspended.	
3	Refusal to remit payment of capitation and/or Fee-For-Service to providers after receiving the same from the Scheme. Refusal in this context means failure to comply with the warning to pay within seven (7) days.	**1st default** – Withdrawal of 20% of administrative funds due to the SSHIA. 2nd**default** – SSHIA is suspended from administrative fees due for the next quarter. **3rd default** – The funding by NHIA to the SSHIA shall be suspended.	**NHIA**
4	Underpayment of capitation and/or Fee-For-Service to healthcare providers	**1st default** - Warning letter and shall remit the appropriate capitation/fee-for-service to the facility within 7 days. **2nd default** - The officers involved in the fraud shall be handed over for prosecution.	**NHIA**
5	Diversion of BHCPF funds for purposes other than provision of healthcare	**1st default –** Warning letter and refund of the monies back to the account. **2nd default –** Refund of the monies back to the account and withdrawal of 50% of the administrative funds due to the SSHIA in the next quarter release. **3rd default -** The funding by NHIA to the SSHIA shall be suspended.	**NHIA**
6	Fraudulent bill-vetting process and procedure by officers involved in the vetting of submitted bills	**1st default** - Warning letter and shall remit the appropriate claim to the provider within 7 days. **2nd default** - The officers involved in the fraud shall be handed over for prosecution.	**NHIA**
7	Failure to provide evidence of audited financial reports	**1st default** - Warning letter **2nd default** – Suspension of BHCPF funds disbursement and	**NHIA**

		NHIA to take over operations pending resolution of outstanding issues with SSHIA	
8	Failure to conduct Quality Assurance visits to all accredited healthcare providers at least Once annually.	**1st default** - Warning letter and shall proceed to conduct inspection of the healthcare facilities within 7 days. **2nd default** - Withdrawal of 5% administrative funds due to the SSHIA in the next quarter's release.	**NHIA**
9	Failure to keep records and/or make quarterly returns of data to the Scheme.	**1st default** – Warning letter and the requisite data shall be forwarded to the Scheme within 7 days. **2nd default** - Withdrawal of 5% administrative funds due to the SSHIA in the next quarter's release.	**NHIA**
10	Failure to enforce any sanction against erring healthcare provider or enrollee as directed by NHIA.	**1st default –** Warning **2nd default –** Pay a fine of N100,000 to NHIA coffers.	**NHIA**

Table 4-9: Summary of offences and sanctions for Target Group: SSHIAs

Summary of offences and sanctions for Target Groups: Primary and Secondary Healthcare Providers (private and public)

S/No	Offenses	Action	Sanctions	Enforcement
1	Discriminates and/or refuses to treat or manage the enrollees registered with the facility.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Warning letter to the provider and pay the cost incurred according to the BHCPF tariffs. **2nd default** – Suspension for not	**NHIA**

			less than three months. **3rd default** – Withdrawal of accreditation of the provider.	
2	Receives, consults or manages any enrollee as a fee-paying patient for services covered by the BHCPF.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Warning letter to the provider and refund the amount collected. **2nd default** – Suspension for not less than three months. **3rd default** – Withdrawal of accreditation of the provider.	**NHIA**
3	Failure to refer an enrollee where secondary/tertiary service is required.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Suspension for not less than three months. **2nd default** - Withdrawal of accreditation of the provider.	**NHIA**
4	Referring an enrollee without clinical justification.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Suspension for not less than three months. **2nd default** – Withdrawal of accreditation of the provider.	**NHIA**
5	Failure to keep records and make quarterly returns of prescribed data.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Warning letter and the requisite data shall be forwarded within 7 days.	**NHIA**

			2nd default - Suspension for not less than three months	
6	Where a healthcare provider makes false claims for a treatment or procedure not carried out.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Payment of the monies collected and suspension for not less than three months. **2nd default** – Withdrawal of accreditation of the provider and report appropriate regulatory body.	**NHIA**
7	Where a healthcare provider operates against medical ethics and undermanages an enrollee	SSHIA reports to NHIA State Offices for appropriate sanction	Report to the appropriate regulatory body	**NHIA**
8	Diversion of BHCPF funds for purposes other than provision of healthcare	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** – Warning letter and refund of the monies back to the account. **2nd default** – Suspension for not less than 3 months. **3rd default** - Withdrawal of accreditation of the provider and notification of NHIA	**NHIA**
9	Where the healthcare provider fails to provide the prescribed drugs	SSHIA reports to NHIA State Offices for	**1st default** - Warning letter to the provider and refund to the enrollee the cost of	**NHIA**

	to the enrollee and the enrollee pays out-of-pocket for drugs covered by the BHCPF	appropriate sanction	the medication based on the program tariff. **2nd default** – refund to the enrollee the cost of the medication based on the program tariff and pay a fine of N100, 000.	
10	Where the facility makes false claims of non-payment by SSHIA for services rendered.	SSHIA reports to NHIA State Offices for appropriate sanction	**1st default** - Warning letter to the provider **2nd default** – Pay a fine of N100, 000.	**NHIA**
11	Failure to formally notify the SSHIA, NHIA, and the enrolees registered with it within three months of its intention to exit as a provider.	SSHIA reports to NHIA State Offices for appropriate sanction	**Default** - To pay a fine of N100,000	**NHIA**

Table 4-10: Summary of offences and sanctions for Target Groups: Primary and Secondary Healthcare Providers (private and public)

4.6.3. Grievance Redressal Mechanism

a. The NHIA shall set up a grievance redressal mechanism to be responsible for receiving complaints/grievances, investigating same and resolving them accordingly.

b. Multiple channels for complaint submission: beneficiaries and providers can submit grievances through various channels such as in-person at designated offices, via a toll-free helpline, through an online portal or by email

c. Initial complaint review: upon receiving a complaint, the NHIA designated grievance officer acknowledges receipt and conducts an initial review to assess the validity and urgency of the issue

d. Resolution process: the grievance is categorised based on its nature (e.g. service denial, delayed reimbursement, poor quality of care). Depending on the category, it is assigned to the appropriate department or committee for resolution.

e. Timely response: a resolution is provided within a specified time frame, ensuring that grievances are addressed promptly to minimise any adverse impact on the complainant

f. Appeal mechanism: if the complainant is unsatisfied with the resolution, they have the right to appeal the decision. The appeal is reviewed by a higher-level committee established by NHIA

g. Communication of outcome: the outcome of the grievance, including any corrective actions or compensations, is communicated clearly to the complainant. Steps taken to resolve the issues are documented for transparency and future reference

h. Monitoring and reporting: the NHIA gateway regularly monitors grievance trends and reports on the number and types of grievances received, the resolution times, and any systemic issues identified, to improve the overall quality of the BHCPF NHIA gateway

4.6.4. Infractions Constituting Economic Crime

Notwithstanding the content of the foregoing tables, a person (juristic or otherwise), whether acting alone or otherwise, who commits or omits to carry out a prescribed act under BHCPF, which constitutes a crime under any law, shall be handed over to the appropriate body for prosecution. This includes, but is not limited to, diversion, misappropriation, and embezzlement of the released funds to the SSHIAs or Healthcare facility.

4.6.5. Consequences of Suspension of Healthcare Providers

a. Any Healthcare facility suspended due to infraction of the provisions of this guideline shall have its lives transferred to the nearest accredited Healthcare facility.

b. Where any party on whom the provisions of these guidelines apply conducts or omits to carry out an act that is not listed as an offense, but the conduct or omissions negate the primary objective of the BHCPF, the NHIA shall take any remedial step it considers just and appropriate having regard to the facts and circumstances of the act or omission.

5. GUIDELINE FOR THE IMPLEMENTATION OF THE NPHCDA GATEWAY

5.1. Introduction

The National Health Act (NHAct, 2014) in Section 11 stipulates that 45% of the Basic Health Care Provision Fund (BHCPF) shall be disbursed through the National Primary Health Care Development Agency (NPHCDA) to strengthen the effective delivery of quality primary health care (PHC) services. The Act stipulates that 20% of the fund shall be used for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities; 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.

Based on the NHAct 2014, the NPHCDA will disburses 45% of the BHCPF through State and Federal Capital Territory Primary Health Care Board/Agency (SPHCB/A) for the implementation of primary health care in the Local Government Areas, subject to the provision of the prerequisite counterpart funding of 25% of the total programme funds allocated to the benefitting States and LGAs. For effective implementation of the 45% of the BHCPF in a manner that enshrines accountability, transparency, and value for money, the NPHCDA will communicate and collaborate with the States and LGAs through the SPHCB/A, and relevant stakeholders on relevant decisions pertaining to programme design, implementation and evaluation. The institutions, processes and protocols associated with the implementation of the 45% of the BHCPF constitute the **NPHCDA GATEWAY**.

5.1.1. NPHCDA Gateway Reforms

As part of health sector-wide reforms, the BHCPF and by extension the NPHCDA Gateway is central to achieving the PHC components of the Presidential Commitment to Health under the Nigeria Health Sector Renewal Investment Initiative (NHSRII), which is being implemented using the sector-wide approach (SWAp). To effectively re-position the NPHCDA Gateway to deliver within the NHSRII and based on an in-depth evaluation four (4) years post implementation of BHCPF, critical reforms have been introduced within the Gateway. The reforms refocus the Gateway from its prior input-based orientation to a performance-based system that incentivises results. The reforms are mainly centred on strengthening the fiduciary process for accountability and visibility, performance tracking, mechanisms to improve the availability of skilled birth attendants at the frontlines and expanding physical access to quality PHC services

by increasing the number of functional PHC facilities. This revised Guideline for the NPHCDA Gateway is based on these reforms and details the various components in the subsequent sections.

5.1.2. The Guiding Principles for the Implementation of the NPHCDA Gateway

The overall guiding principle of the Gateway shall be Section 11 of the National Health Act 2014. In addition, 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). The PHCUOR policy is currently under review to adapt and align with LGA autonomy. The funding of the PHC facilities shall be based on the principles of decentralised facility financing (DFF), which expects the PHCs to operate with significant autonomy for decision-making on their needs and expenditure, focusing on outputs and sound financial management in collaboration with the community through the Ward Development Committee (WDC).

Investments through the BHCPF under the NPHCDA Gateway will be aligned to the NHSRII with a clear focus on achieving the Presidential commitment on health and adhering to the sector-wide approach (SWAp) framework, with all investment opportunities and communications appropriately channelled through the SWAp coordinating apparatus at the NPHCDA and Federal Ministry of Health. Likewise, all implementation activities under the NPHCDA Gateway will leverage all available resources using the sector-wide approach and be based on the Strategic Blueprint for PHC in Nigeria. ***The NPHCDA Gateway will focus on systematically improving the functionality of PHC facilities, starting with at least one (1) BHCPF Facility per Ward (based on federal INEC political wards) and scaling up to meet a national target of 17,600 functional PHCs nationwide.*** Scale-up shall be data-driven and evidence-based to ensure equity in physical access to care, as well as addressing population needs and disease burden.

The NPHCDA Gateway shall leverage its funding to strengthen the delivery of primary health care services across the entire country, prioritizing rural public primary health care (PHC) facilities, as a means of targeting poor households and populations in the lowest wealth quintile.

The BHCPF fund however, shall not in any form constitute a replacement for the routine budgetary funding of primary healthcare Sector by states and LGAs; but is instead to serve as a catalytic funding supplement to leapfrog population access

to quality PHC services, the BHCPF will serve as a fundamental pillar to delivering on presidential commitments for primary Heath care, a critical towards Nigeria attaining its Universal Health Coverage (UHC) goals. To achieve this, the NPHCDA would continue to work with SPHCB/As to progressively ensure adequate infrastructure, equipment, and the presence of critical frontline human resources for the delivery of quality healthcare at the PHC facility and community levels.

Investments in these BHCPF facilities will be targeted to enable the delivery of qualitative services in a conducive physical environment, with the required complement of skilled birth attendants, standard equipment, essential medicines, and commodities, while leveraging technology for service delivery and data management. The BHCPF facilities under the NPHCDA Gateway will benefit from operational cost as decentralised facility financing (DFF) and be positioned to serve as Primary Providers to State Social Health Insurance Agencies (SSHIA). Furthermore, funding BHCPF PHC facilities under the NPHCDA Gateway will be based on the principles of performance-based financing, reiterating a critical shift from the BHCPF focusing on inputs to instead paying for outcomes-based performance. In line with this principle, benefitting BHCPF PHC will be classified into two (2) DFF tiers and will be paid a differential operational cost. The DFF tier amount for operational funding will be based on service delivery outputs and outcomes (see section 5.3.2.1). In addition, BHCPF facilities will benefit from discretionary performance incentives upon achieving pre-requisite scores on key performance indicators (KPIs) measuring quality and outcomes. Details of the performance management systems are discussed in section 5.5.

Disbursement-linked criteria and KPI indicators will be the same for all states for equity and fairness and will be tracked using a quality scoring system on a routine basis. When required, needs assessment surveys, smart surveys and quarterly verification processes will be deployed to assess the performance of states and PHC facilities under the NPHCDA Gateway. In addition, reports of supervision, monitoring and evaluation of predetermined indicators, and compliance with financial requirements and reporting shall be taken into stringent consideration prior to fund release to SPHCB/as each quarter, amongst other criteria that may be included as necessary, following appropriate notifications, consultations and approvals.

Poor performing states that score below a pre-determined minimum KPI cutoff score, or breach fiduciary processes may be required to seek technical intervention/support from the NPHCDA and Partners (under the SWAp

arrangement), to implement improvement recommendations and remediation prior to subsequent fund release.

5.1.3. Classification of PHC Facilities based on level of Functionality and Performance

For effective performance-based funding under the BHCPF, PHC facilities are to be classified based on their level of functionality, i.e. **Level one (L1), Level two (L2) and Level 3.** However, the focus of the Strategic Blueprint for PHC is to ensure that PHC facilities are revitalised to at least Level 2.

The PHC functionality levels: An **L2** PHC is a PHC facility that is validated to have the ability to safely deliver a woman at childbirth 24 hours a day. It presupposes that the facility has the capacity to effectively operate for 24 hours daily having the required compliment of skilled staff i.e. skilled birth attendants (SBAs), other relevant health care workers and staff, standard infrastructural spaces (Including staff accommodation), medical equipment, source of electricity power supply, WASH facilities and is able to provide the full complement of PHC services expected to be offered (based on the facility level), in accordance with the Ward Health Systems document (NPHCDA: Ward Health System Document 2021).

Similarly, **L1** facilities are PHC facilities providing facility-based PHC services, but do not have the required number and mix of skilled staff, guaranteed electricity power supply or infrastructural spaces to deliver services for 24 hours. Therefore, due to L1 facilities' inability to provide overnight services, they will not be able to provide safe delivery services on demand for 24 hours. Arrangements should be in place for clients receiving ANC services in L1 PHCs to plan for delivery in nearby L2 PHCs as appropriate. PHCs that fall below the standard for L1, particularly as it relates to the number of skilled birth attendants, shall be classified as **'Partially Functional'**. While facilities not delivering any services, irrespective of the state of the infrastructure, shall be considered **'Non-Functional'** till revitalised, or the challenge preventing service delivery is resolved, e.g. lack of human resources or non-completion of construction/handover. Figure 5.1 below outlines the various functionality levels, indicating core staffing and infrastructure requirements.

Based on the reforms, PHC Facilities are now classified according to functionality

	Partially functional	Functional Level 1	Functional Level 2
Description	Provide some services but not meet the functional L1 criteria	"Capable of providing antenatal and immunization services"	"Everything in place for a pregnant woman to deliver a baby safely 24/7"
Tracer services		• Antenatal care and • Routine immunization	• Level 1 tracer plan (ANC and RI) and • Facility-based deliveries
Functionality criteria			
1. HRH and staff accommodation		• 1-3 SBAs	• 4 – 6 SBAs with accommodation OR • >6 SBAs (without accommodation)
2. Infrastructure[1] (including Power)		• Access to primary power source	• 24/7 access to reliable power supply and back up solar power • WASH facility

Figure 5-1: Classification of PHC based on functionality

The two-tier performance levels are based on service delivery outputs and outcomes for each facility, irrespective of their functional classification, i.e. L2 and L1. Facilities assessed based on data evidence, to have more workload and better outputs, outcomes and quality index above the 75th percentile at the state level, or assesses as climate vulnerable in terms of its location, will be tagged as "**High Tier**" and will receive higher amounts of operational cost to be paid as decentralised facility financing (DFF). While facilities operating below the 75th percentile at the state level will be tagged as "**Low Tier**". Periodically, the NPHCDA, in collaboration with states, will review the criteria for tiering of facilities and communicate such to all stakeholders. The quarterly DFF amount for the operational cost to be received by each tier shall be determined annually by the NPHCDA and approved by the Ministerial Oversight Committee for the BHCPF (MOC), based on the adequacy of the funding under the NPHCDA Gateway component of the BHCPF.

Partially functional PHC facilities that may be benefitting from the BHCPF, in the absence of an L2 or L1 BHCPF PHC within the political ward will receive the Lower Tier DFF.

5.2. Structure of NPHCDA Gateway

The existing institutional structures of the NPHCDA, the SPHCB/As and the LGHA shall be deployed for the implementation of the NPHCDA Gateway. At the national level, the management of NPHCDA shall designate a responsible department within which there will be a BHCPF division to coordinate all NPHCDA Gateway activities and implement management decisions on the operations of the NPHCDA Gateway, with compulsory reporting to the

Ministerial Oversight Committee. This shall be done leveraging the NPHCDA's zonal structure and its technical officers at the state level. Similarly, SPHCB/As will designate a responsible department to coordinate BHCPF activities within the SPHCB/A and ensure reporting to the State Oversight Committee and the NPHCDA. In addition, the Local Government Health Authority will be responsible for coordinating, mentoring, and supervising all BHCPF PHCs in the various local government areas, under the SPHCB/A, in line with the PHCUOR principle. Figure 5.2 below outlines a schematic of the institutional arrangement of the NPHCDA Gateway.

As part of the institutional arrangements, BHCPF PHCs will be monitored and tracked by Performance and Financial Management officers (PFMOs), who will be deployed by the NPHCDA to LGAs across the country. The PFMOs will provide this function independently and report to the NPHCDA through determined channels. See section 5.3.6.3 for the description of performance and financial management officers. Figure 5.2 below outlines the broad implementation structure for the NPHCDA Gateway.

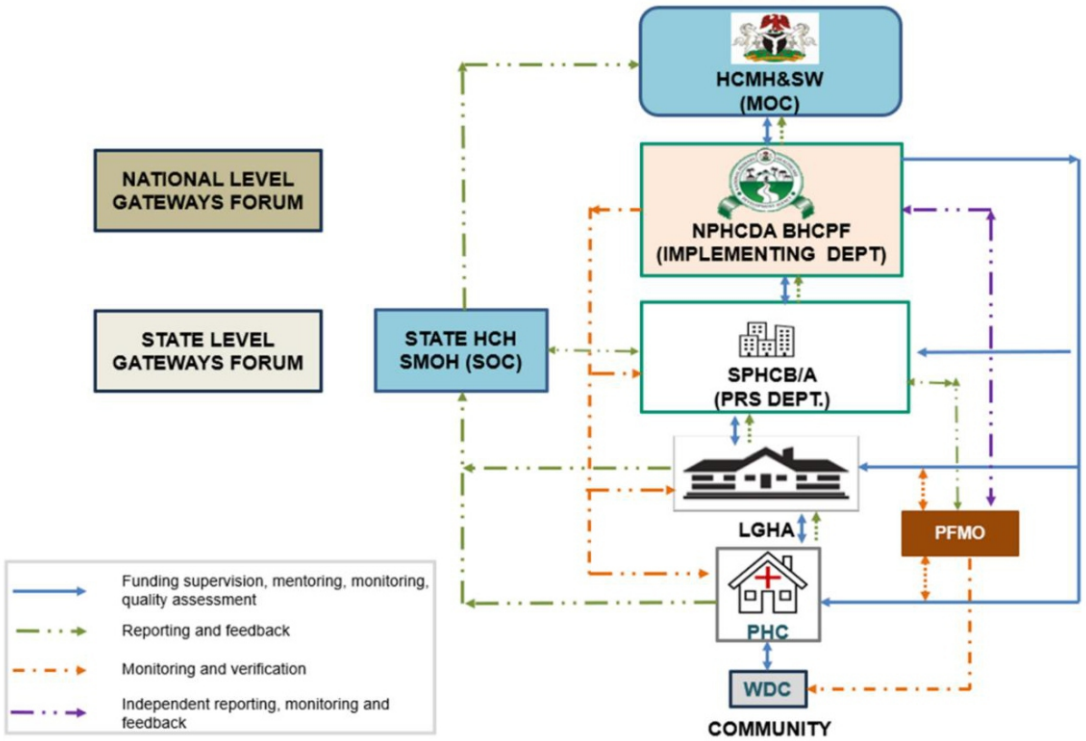


Figure 5-2: The Structure of NPHCDA Gateway

5.3. NPHCDA Gateway Program Management

5.3.1. Allocation of NPHCDA Gateway Fund

All funding accruable to the BHCPF and by extension the NPHCDA Gateway will be subject to the same allocation formulae in line with the NHAct 2014 and

as detailed in this guideline. Based on the NHAct, funding allocation to the NPHCDA Gateway consists of three (3) parts as outlined below:

- 20% for the provision of essential drugs, vaccines, and medical consumables.
- 15% for the provision of facility infrastructure, equipment and transportation.
- 10% for the Development of Human Resource for primary health care

5.3.1.1. 20% for the provision of essential drugs, vaccines, and medical consumables

This part of the fund, which consists of 20% of the BHCPF, is to be used for the purchase of essential medicines and vaccine-related expenditure. For the implementation of the BHCPF, the entirety of this fund is to be utilised for essential medicines and commodities, as scheduled routine bundle vaccines will continue to be funded centrally from the federal budget. However, in the unlikely event of a shortfall in the financial resource requirements for the procurement of routine bundled vaccines at the federal level, the Honourable Minister of Health, through the MOC, may approve for up to 10% of this component of the NPHCDA Gateway to be centrally pooled at the national level for vaccine procurement.

5.3.1.2. 15% for the provision of facility infrastructure, equipment and transportation

This part of the BHCPF comprising 15%, is for the provision of infrastructure, maintenance of health facilities, health equipment, furniture, and transportation. Transportation relates to transportation at the facility level for activities related to patient care and service delivery.

5.3.1.3. 10% for PHC Human Resource Development:

This part of the BHCPF (10%) is dedicated towards filling the gaps in human resources for PHC based on state needs, particularly to address gaps in the availability of skilled birth attendants (SBA). Implementation of this component shall be a collaborative effort with technical guidance, support, and monitoring by the NPHCDA.

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; specifically, skilled birth attendants (SBAs) at the PHC facilities and community-based health workers for community and home interventions. As standard requirements for skilled attendants and community-based workers are met by states over time, future

focus may systematically shift to addressing other PHC human resource needs, including funding human resource interventions such as improving state-based Nursing and midwifery training institutions to facilitate accreditation and local production, as may be approved by the BHCPF MOC.

5.3.2. Components of NPHCDA Gateway Funds

Fund allocation for the implementation of the NPHCDA Gateway is further structured into four (4) components to ensure the direct funding of needs, ease of administration and improved accountability. The components and purpose of the funds under each component are outlined below:

- Programmatic Fund
- Operational Fund (Opex)
- Performance-Based Incentive Fund
- Funding for PHC Revitalisation

The programmatic, operations, and performance-based incentive funds are routine funds under the NPHCDA Gateway, and disbursement and authorization for fund utilization will be made quarterly. The funding for PHC revitalization is not routine but ad hoc, based on need and availability of funds under the Gateway.

5.3.2.1. Programmatic Fund

This comprises two (2) components: (i) the Human Resource for PHC components funded with the 10% BHCPF human resource fund and (ii) the Decentralised Financing (DFF) component funded from the 20% BHCPF for essential medicines, commodities fund and the 15% infrastructure, equipment and transportation fund, making up the 35% equivalent of the BHCPF allocated as DFF.

Decentralised Facility Financing (DFF) Fund

This component of the programme fund will be disbursed from the NPHCDA BHCPF TSA through the SPHCB TSA to the bank accounts of all eligible PHC facilities on a quarterly basis. The PHC facilities are to apply the funds using an approved Quarterly Business Plan for their operational activities and delivery of quality PHC services based on community need. The quarterly disbursement will be backed with authorisation from NPHCDA, the list of eligible BHCPF PHCs, their DFF tiers and those entitled to performance bonus payments.

The DFF is to be spent only on eligible items, including the purchase of essential medicines, health commodities, low-level maintenance of the PHC facility's infrastructure, equipment, furniture, and to support transportation for the collection of vaccines and returning of vials, routine community outreach services, utility bills and other daily facility operational costs. Figure 5.3 below outlines the eligible items for which DFF, and capitation paid to the facility can be expended.

All DFF received by the PHC cannot be utilised for payment of officials of the LGHA, SPHCB or any government officials or returned upwards to the LGHA or SPHCB under any guise. The list of eligible items may be periodically reviewed by the NPHCDA and NHIA in consultation with states and stakeholders, if required and communicated officially to states for implementation.

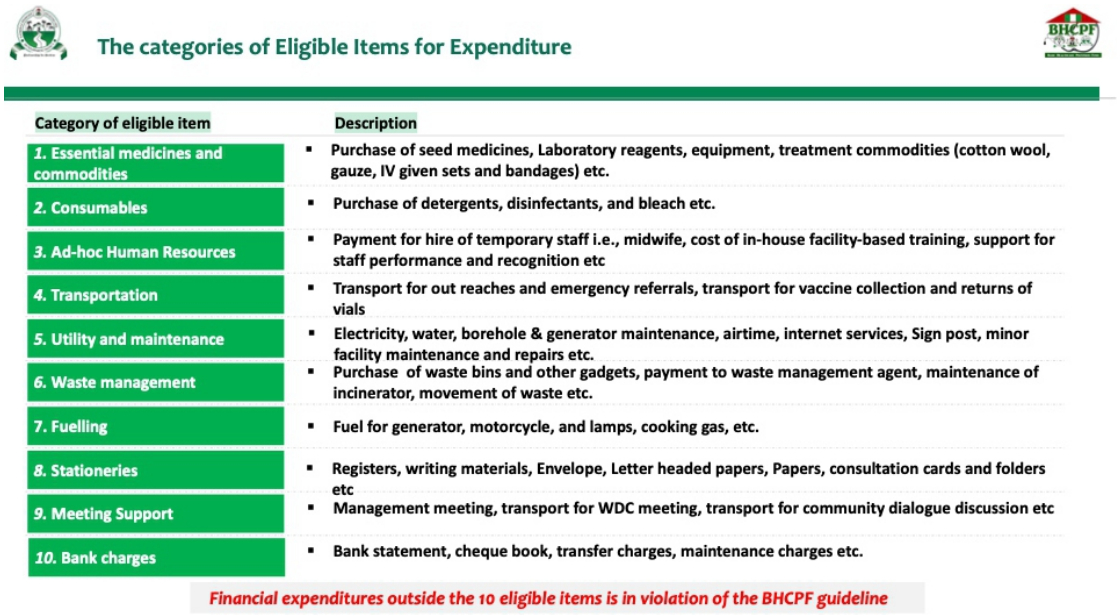


Figure 5-3: List of Eligible items for expenditure under BHCPF Programme

The PHC facilities will utilize all their funds based on a singular business plan developed on a quarterly basis. Funds from all sources will be pooled pool in one (1) bank account inclusive of DFF, capitation from the State's Social Health Insurance Agency (SSHIA) under the National Health Insurance Authority's (NHIA) Gateway, funding from all other sources (most importantly statutory LGHA funding) and will be utilized to incrementally improve the quality and coverage of PHC service delivery.

Purchase of Essential medicines at PHC Level: A critical aspect of the PHC facility expenditure is the purchase of medicines. In alignment with the NHSRII, the NPHCDA will collaborate with the Presidential Initiative for Unlocking Healthcare Value Chain (PVAC) and states to leverage the operations of

MEDIPOOL, the federal government-approved Group Purchasing Organisations (GPO) and ensure that high-quality and low-cost essential medicines and commodities are made available across all PHC facilities.

Medipool, a federal government public-private organisation, will aggregate demand for essential medicines and commodities and match the same with supplies from local manufacturers and others and serves as a 'one-stop' shop for Drug Management Agencies (DMAs). BHCPF PHC facilities and other health facilities will be required to purchase their medicines and commodities from Medipool through their DMAs, where the DMAs are functional, and meet set standards.

On a bi-annual basis, Medipool will provide detailed accounting on cumulative national reports on its operations including reports on cumulative purchase of medicines and commodities, distribution data and financial transactions to the Honourable Minister of Health at the MOC. Medipool operations will be fully consistent with extant national regulations, guaranteeing quality and cost-effectiveness.

Table 5.1: Framework for the purchase of Essential medicines by PHC Facilities.

SN	Drug Management	Mandatory Actions	Responsible	Further Details
1.	**Forecast/ Selection of Essential Medicine**	• BHCPF facility will forecast their essential medicine, and commodity needs quarterly (by the 3rd week of the last month of the quarter), and submit to the DMA and simultaneously to Medipool (or directly to Medipool where the DMA is not functional). This will be followed by actual monthly requisitions to the DMA/Medipool on a monthly or quarterly basis using the designated electronic platform. The forecast and requisitions shall be reviewed electronically by the SPHCB to ensure adherence to SOPs. • DMAs, SPHCBs or SMOHs are not to send prepackaged drugs to PHC and deduct at source or demand facilities to	PHC Facility supported by LGHA/SPHCB.	Drugs selection and quantification should be based on previous quarter consumption and projected utilizations for the next quarter.

		send back funds for medicines without the initial requisition from the PHC facilities based on their need. The exemption may be when medicines and commodities are donated or granted to the PHCs at no cost to the PHC.		
2.	**Purchasing**	• Based on the requisitions, DMAs would transmit invoices to the PHCs within one week of receipt of requested list of selected Essential Medicines, with Medipool in copy. • BHCPF PHCs on receipt of invoices pays directly to the DMA where functional or directly to Medipool.	PHC/DMA/ Medipool	Electronic transmission to be utilized to reduce transaction time and enable transparency and visibility to all authorized stakeholders.
5.	**Pricing**	• DMA are to utilize the negotiated national GPO (Medipool) pricing for invoicing PHC facilities. • Medipool will conduct a biannual market price survey to ensure the final pricing of essential medicines and commodities to PHCs does not exceed open market pricing.	DMA/Medipool/	Good pricing while ensuring quality will help to preserve DMA reputation and encourage continuous patronage by the facilities
6	**Distribution and storage**	• DMAs where functional will operate a 'PUSH' system to minimize logistic cost to the PHCs. Where DMA is not functional, Medipool will provide distribution services. • Medipool will ensure the DMAs are stocked with essential medicines required for delivery of the BMPHS. • Medicines paid for by the BHCPF PHCs must be delivered within 7 days of requisition.	DMA /Medi pool	DMAs/Medipool should ensure that geographical location of the warehouses minimize delivery times and cost of transportation.

Implementation of 2 Tier DFF Payments: DFF payments to eligible BHCPF PHCs will be in two (2) tiers. The amount of DFF to be received by each PHC facility will be dependent on its workload, outputs, health outcomes and climate vulnerability. Facilities will be systematically assessed on a biannual basis based on their utilization/output and community outcome data to determine if they will receive DFF at a 'High or Low Tier'. Using data evidence, facilities above the state's 75th percentiles in terms of output/utilization will be considered as **'High tier'** while those below the state level 75th percentiles will be considered as **'Low tier'**. Facilities reported to be climate vulnerable based on assessments will be classified as High tier.

- **High Tier** facilities will receive higher DFF disbursement on a quarterly basis from the NPHCDA through the SPHCB.
- **Low-tier** facilities will likewise receive less DFF as a quarterly disbursement.

The specific amount to be paid in each DFF Tier shall be determined and published by the NPHCDA biannually. In addition, reclassification of PHC facilities into high or low tiers based on data evidence shall be conducted biannual and results communicated to the SHCBs for implementation.

Human Resource (HRH) for PHC Fund

This component of the fund is allocated for engagement of human resources for health (HRH) by states as a 'stopgap' measure for PHC facilities and the communities. The utilisation of the HRH component by the states will be reasonably flexible, and enable states, with technical support from the NPHCDA, to determine the 'most viable option' to meet their workforce needs both within the PHC facility and the community. The NPHCDA will disburse the HRH funds on an annual or quarterly basis from Gateway's national TSA to the SPHCB TSA based on approved state HRH workplans, which are submitted as a part of the state's BHCPF annual proposal/workplan.

To ensure adequacy of skilled birth attendance (SBAs) in PHC facilities, states will utilise not **less than 50%** of their HRH funds for the engagement of SBAs as approved in their annual workplans. In the event a State is unable to source nurse/midwives for engagement to fulfil SBA needs, states are to notify the NPHCDA officially and following a systematic review to confirm non-availability, states may be authorised to engage CHEWs and CHOs who must be task-shifted through MLSS training (or other trainings as approved).

Similarly, states will adopt a 'model' of Community-based Health Workers Program with JCHEW and trained auxiliary community-based workers that is best suited to the state's context. These models will serve in lieu of the previous community health influencers and promoters (CHIPS) programme implemented under the BHCPF. States will spend **no more than 50%** of their HRH fund on the implementation of their chosen Community Health Workers Program.

The NPHCDA will review SPHCB's criteria for selection of the SBAs, the Community- Health Workers Program, the planned implementation steps and assess fund availability for same, prior to the provision of necessary authorization.

5.3.2.2. Operational (Opex) Fund

This is funding provided at the national and sub-national levels to enable daily management and oversight of BHCPF implementation. Implementation. It is derived from setting aside a percentage of the total funds accrued to the NPHCDA Gateway as follows:

At the national level, i.e. the NPHCDA, **10%** of the total NPHCDA Gateway funds is set aside as operational funds (Opex). This fund is for daily management activities of the gateway, inclusive of the implementation of an enhanced fiduciary responsibilities based on the BHCPF reforms. These include funding the recruitment, deployment and payment of monthly allowance of Performance and Finance Management Officers (PFMOs); and engagement of independent third-party agents (TPAs) for verification of Gateway expenditure and performance as may be required. Furthermore, **80%** of the total Opex will be retained by the NPHCDA, while **20%** is allocated to the Secretariat of the BHCPF MOC as part of their operational cost.

At the Subnational level, i.e. the SPHCB, **15%** of the total NPHCDA Gateway funds accruing to the SPHCB (post-national level deductions) is set aside as OPEX for the SPHCB, LGHA and SOC. In addition, the core purpose of the state OPEX is to ensure adequate funding of the LGHAs to undertake effective supervision, mentoring and monitoring of the BHCPF PHC facilities, including ensuring timely and accurate reporting of expenditure (see section 3.6). Likewise, **15%** of the total OPEX due to the State under NPHCDA Gateway is allocated to the State's BHCPF oversight Committee as part of their operational cost, while out of the remaining 85%, 50% will be retained at the SPHCB as operational fund, while the remaining 50% will be shared for LGHAs operations. The operation fund will be disbursed on a quarterly basis to SPHCBs, SOC and LGHAs.

5.3.2.3. Performance-Based Incentive

All PHCs benefitting from the BHCPF will be eligible for a quarterly performance-based incentive if earned based on scores achieved during the quarterly evaluation of the facilities' key performance indicators (KPIs) as outlined in Figure 5-4 below. To qualify and earn the performance-based incentive, PHC facilities must score not less than 60% on their performance scorecard. PHC with scores less than 60% will not be entitled to any performance bonus. PHC facilities may proportionally earn up to **10%** of their total DFF amounts as a performance bonus, e.g. a score of 60% on the KPI will earn the facility 6% of their quarterly DFF and a 100% performance score will earn the PHC facility the maximum bonus of 10% of their DFF.

Data for each KPI is primarily obtained from the DHIS, verification exercises and the PHC national database, and will, over time, be obtained directly from the PHC through digital platforms to be deployed. PFMOs assigned to the LGA will verify assigned scores for the KPIs, following which computation and award of bonuses will be made. Calculation of the performance bonus will subsequently be automated and visible on a PHC performance dashboard visible at the state and national levels. Performance incentives earned by PHC facilities are discretionary and awarded to all staff of the facility. The OIC of the facility is mandated to bring the earnings to the attention of all staff and expend same as determined by agreement reached with the staff.

Funding for the performance-based incentive will be derived from DFF funding accruing to each state quarterly. An estimated 10% of the total DFF funds (or prorated for the states based on previous performances) shall be reserved by the

BHCPF Facilities will earn a discretionary performance-based incentives up to a maximum 10% of their DFF quarterly on fulfilling key KPIs scores

Category		Indicators	Data Source	Frequency	Weight
Utilization		Number of ANC 1 visits	DHIS-2 & NPHCDA QA	Monthly / Quarterly	10%
		Number of facility-based deliveries	DHIS-2 & NPHCDA QA	Monthly / Quarterly	15%
		Number of Penta 1 administered	DHIS-2	Monthly / Quarterly	10%
Quality of care	Retention of care	Proportion of pregnant patients with 4 ANC visits	DHIS-2, supplemented by state-provided catchment population data	Monthly / Quarterly	15%
		Proportion of children that receive Penta 3	DHIS-2, supplemented by state-provided catchment population data	Monthly / Quarterly	15%
	Patient feedback	Patient satisfaction survey score (%)	PHC outpatient satisfaction survey	Monthly / Quarterly	15%
Financial management		Submission of timely and complete financial retirements by facility	NPHCDA QA & PFMO	Monthly / Quarterly	10%
		Facility spend is in accordance with approved business plan	NPHCDA QA & PFMO	Quarterly	10%

Utilization used for DFF to ensure needs-based financing

To ensure facilities are incentivized to maximize utilization, utilization as a % of a target will be incorporated into the performance bonus

In parallel, to mitigate incentive to push quantity over quality, performance bonus will be linked to quality-of-care metrics

To maximize intended impact of incentives, minimum threshold of **60%** could be set for PHC to become eligible for incentive bonus

Figure 5-4: Facility-level Performance-based incentive

SPHCB in their BHCPF TSA account for the payments of performance bonuses for qualifying PHCs each quarter. The NPHCDA shall, each quarter, notify in writing the states of facilities that have earned bonuses based on outputs from the performance dashboard, for accountability purposes. Monitoring of the BHCPF PHCs by the PFMOs, SPHCB and the NPHCDA will include confirming that earned performance incentives are received, and utilisation is inclusive.

5.3.2.4. Funding for PHC Revitalisation

Implementation of the BHCPF under the NPHCDA gateway will prioritise the revitalisation of PHCs as a core objective of the Strategic Blueprint for primary health care. In furtherance of this objective, the NPHCDA will actively explore all avenues to mobilise funding, leveraging the SWAp in line with the NHSRII through domestic and donor fund mechanisms.

Furthermore, on an annual basis, detailed budgetary and expenditure estimates/projections will be made for the NPHCDA Gateway. Should it be determined that the annual funding requirement of the Gateway has been met by federal government budgetary sources, inclusive of a six (6) months buffer funding (i.e. funding requirement for 18 months); the BHCPF MOC upon the recommendation of the NPHCDA may allocate any additional available funding towards targeted revitalisation of BHCPF PHC facilities, amongst other intervention as recommended by the Gateway. The process for the revitalisation of the PHC facilities is to be developed by the NPHCDA in collaboration with states to ensure seamless implementation and overall coordination of PHC revitalisation efforts.

Decisions on the number and locations of BHCPF facilities to be targeted for revitalisation shall be data-driven, with consideration for equity, population density, disease burden, and suitability of the location. PHCs under the NPHCDA Gateway that are yet to meet NHIA Accreditation will also be prioritised for the revitalisation.

All PHC revitalisation efforts will take into consideration climate vulnerability and resilience and use the best available evidence in determining the scope of work for the revitalisation. Revitalization will integrate climate consideration such as use non-fossil energy sources, mitigation of flooding, use of appropriate materials to enhance temperature regulation, provision of sustainable portable water and implementation of environmental safeguards amongst others.

5.3.3. Eligibility Criteria for accessing NPHCDA Gateway Funds

5.3.3.1. Eligibility Criteria for States to Access Funding

The BHCPF shall be accessible to all 36 states, FCT and LGHAs for utilisation at designated Primary health Care facilities and communities within the wards. Over the years of implementation, all states have been on board the NPHCDA Gateway. However, for states to continue benefitting from the BHCPF through the NPHCDA Gateway, the following eligibility criteria outlined within this section are required and will be mandatory for states. The NPHCDA, through its enhanced oversight function, will ensure the enforcement of these criteria, in compliance with section 11(4) NHAct 2014. The core criteria are:

1. The continued effective functioning of the State Primary Health Care Board/Agency and LGHAs in accordance with the PHCUOR policy.
2. Use of the Treasury Single Account with the Central Bank titled 'SPHCB/A BHCPF' for all BHCPF transactions, with no co-mingling with funds meant for other purposes (i.e., non-BHCPF funds). In addition, the state shall not make use of commercial bank accounts to manage the BHCPF fund.
3. Annual contribution of the state and LGHA, 25% counterpart funding into the state's BHCPF TSA by the state government.
4. Timely and completed expenditure retirements of disbursed funds for all preceding quarters, including submission of quarterly programmatic and financial reports. This will entail the SPHCB enforcing the prerequisite for PHC facility funding.
5. Ensure that all outstanding state financial/audit remediation plans (if any) are completed and verified.

5.3.3.2. Counterpart Funding

Based on the NHAct (2014), States and participating LGHAs are required to allocate at least twenty-five per cent (25%) matching grant counterpart funding as prescribed in the National Health Act (2014), for all funding accruing to the State from the BHCPF. It is therefore expected that states will, on an annual basis, make budgetary provision and release into the state BHCPF TSA account for the counterpart, alongside other routine budgets for PHC implementation across the state. This will be a core criterion and prerequisite for the disbursement of BHCPF funding to states. State Governments and the FCT, through their SPHCB/A at the beginning of each year, shall send electronic copies and hard copies of their approved budget to the NPHCDA, indicating budgetary provisions for both counterpart and routine operational expenditure for PHC. The NPHCDA will

annually communicate projections for counterpart funding to the state by the end of the 3rd quarter of the preceding year. The counterpart funding is to be pooled together with the BHCPF fund and will be utilised for both programmatic (DFF and HRH) and Operational activities.

5.3.3.3. Eligibility Criteria for PHC Facilities to Access DFF Funds

For BHCPF PHC facilities to benefit and receive their quarterly DFF, the OIC, in collaboration with the community members through the ward development committee (WDC), must likewise meet the following criteria:

1. Baseline Assessment conducted jointly by NPHCDA and States prior to onboarding PHC on the Gateway.
2. The OIC and Quality Improvement Team (QIT), in collaboration with the WDC, have developed and submitted a business plan for the subsequent quarter.
3. Completed expense retirements, inclusive of all receipts, quarterly financial reporting and the facility bank statement for all the preceding quarters to the SPHCB through the LGHA.
4. The PHC facility must have adhered to the maximum 10% cash withdrawal cap and other fiduciary measures as outlined within this guideline.
5. The PHC facility expenditure has been reviewed (by the LGHA and the assigned PFMO) and reported to be eligible under the BHCPF program.
6. Evidence of quality improvement from the previous quarter quality assessment.

5.3.4. NPHCDA Gateway Operations

The NPHCDA, in collaboration with the states, will be responsible for ensuring necessary implementation structures are in place prior to the disbursement of funds for approved workplans and expenditure by the SPHCB, LGHAs and BHCPF PHC facilities. The NPHCDA will ensure the presence of an implementation framework that supports the policy, budgeting, procurements, and planned activities of the Gateway at national and sub-national levels, inclusive of the periodic release of addenda to this guideline as may be approved by the MOC. Operations of the NPHCDA Gateway shall leverage a bottom-to-top approach, with communities encouraged to actively participate at all stages of the process. As digitalisation of the process scales up across the NPHCDA Gateway, the process will migrate from paper format to online electronic formats at all levels.

5.3.4.1. Routine Operational Processes:

The following processes constitute the core implementation processes undertaken under the NPHCDA Gateway. Although some processes were intensely implemented at the point of onboarding states on the NPHCDA Gateway, it is expected that these activities will continue as the BHCPF programme coverage and policy expand.

Identification of BHCPF Facilities Per Federal INEC Ward:

In wards that do not have a BHCPF PHC facility, the SPHCB working through the LGHAs shall confer with the WDCs across such wards in identifying the most suitable PHC facilities to serve as the BHCPF facility and benefit from implementation of the NPHCDA Gateway (and by extension the NHIA gateway). The SPHCB will secure the approval of the Honourable Commissioner of Health and submit the identified PHC facilities to the NPHCDA, which will conduct a baseline assessment/validation of the PHC facility, prior to empanelling it as a BHCPF PHC. The goal remains to ensure at least one BHCPF PHC per ward (based on federal INEC political wards), with systematic scale up based on resource availability and need to meet national targets and objectives of the BHCPF. The systematic scale-up of DFF/BHCPF PHCs across states will be based on data evidence, equity considerations including climate vulnerability, population density, disease burden, and ease of geographical access to health care services. The NPHCDA will determine the modalities and scale of DFF facility expansion working in collaboration with the states and LGAs.

Capacity Building:

Using manuals, modules and protocols developed by the NPHCDA in collaboration with the NHIA, states, partners and stakeholders, the NPHCDA will build initial capacity of the SPHCB to effectively implement the BHCPF under the NPHCDA gateway and ensure update trainings are conducted for the SPHCB where significant reforms or changes are approved for implementation. Likewise, the SPHCB will take primary responsibility for building the capacity of LGHA and PHC facility staff for the implementation of the BHCPF within the states, with facilitation support from the national. State may be supported in this function by the national and partners at all levels, including the private sector.

The ultimate beneficiaries of all capacity are the PHC facility health workers, WDC members and LGHA supervisory staff. The content and scope of the training for all levels will be determined by the NPHCDA and published in the recommended training manual and slides. It is expected that the training of health

workers on BHCPF implementation will not in any way negate routine clinical in-service and other programme-based training of health workers, which should continue unabated. All state-based training for PHC health workers on the BHCPF will be coordinated at the state level by the SPHCB and done in collaboration with the SSHIA. This is to ensure synergy with the NHIA Gateway, as the target beneficiaries are the same. NPHCDA and NHIA would serve as national Facilitators for the state training of trainers (STOT) and subsequently as Supervisors during cascade training. The training would be well planned to ensure minimum interruption to routine service delivery across LGAs and States.

Development of PHC Facility Workplans (Annual Quality Improvement Plan):

On an annual basis, benefiting BHCPF PHCs under the NPHCA Gateway in consultation with the WDCs and with technical support from the LGHA will develop Quality Improvement Plans (QIP) aimed at improving the quality of care at the facility and client experience of care with BHCPF investments. The annual QIP alongside routine health service delivery requirements and community health coverage targets would then form the basis of developing a costed Quarterly Business Plan (QBP). The QBP are submitted to the SPHCB through the LGHA for approval and forms the basis for disbursement of DFF to the PHC facility. In preparing the QBP, the PHC facilities are expected to pool together all their different funding sources and have a projected estimate from all revenue sources and the likely amounts to be received from the SPHCB (as DFF) and SSHIA (as capitation), as well as other sources of funding to the facility. The projected estimated amount would now be the basis upon which the Business plan would be developed for the quarter.

To facilitate the process of annual QIP and QBP development, PHC facilities would constitute 2 teams 1) A facility management team made up of the officer in charge (OIC) and heads of all units in the facility and 2) Quality Improvement Team (QIT) comprising the OIC, an additional health worker(s), heads of pharmacy and laboratory and representative/s of the WDC. The QIT, following consultation with all members of staff, is responsible for finalising and forwarding the Quarterly Business Plans and ensuring the submission of quarterly financial reports of all expenditures (retirements) to the SPHCB through the LGHA. The protocols and tools for this process are outlined in detail in the BHCPF training manual and the supportive 'BHCPF Handbook for PHC Workers' for the implementation of the NPHCDA Gateway, published by the NPHCDA.

5.3.4.2. Provision of BMPHS:

The BHCPF PHC facilities will utilize the DFF funds received from SPHCDA, capitation payment from the SSHIA and funding from any other sources for their Business Plans to facilitate the delivery of the Basic Minimum Package of Health Services (BMPHS) as outlines in the NHIA section of this Guideline which is inclusive of services covering Reproductive, Maternal, newborn, child and adolescent health services (ANC, Delivery, Newborn, postnatal); Post Abortive Care and Family Planning, Immunization, Nutrition and Adult care (including NCD screening basic management and follow-up care). This package is to be provided at no cost to facility clients who are enrolled as BHCPF beneficiaries under the NHIA Gateway by the SSHIA. The BMPHS is to be delivered alongside all other services that the PHC is expected and able to provide. Effective delivery of the BMPHS will entail demand-generating activities, community outreaches, health promotion and prevention activities, purchase of essential medicines and health commodities from the state's DMA or accredited pharmacies and distributors within geographical proximity, collection and return of vaccines and facility-based care. In addition, service delivery statistics would be recorded and transmitted using the established NHMIS mechanism with a shift to digital capture and transmission of data as implementation progresses.

The SPHCB will ensure that all health workers providing services are certified as qualified for their cadre and duties, particularly as it relates to skilled birth attendants and the use of task-shifting. Emphasis will be made to ensure the BHCPF PHC facilities not currently providing other components of Sexual and Reproductive Health Services (SRH) as an integral part of RMNCAEH+N services at the start of BHCPF 2.0, have their health workers upskilled, and necessary equipment and medicines made available for provision of the RMNCAEH+N, Inclusive of all components of the SRH services package, which include:

1. Family planning services (including contraceptive counselling, provision of contraceptives)
2. Antenatal care and Postnatal care
3. Basic obstetric and newborn care (normal delivery, newborn care)
4. STI/HIV prevention and treatment, and Syndromic management of STIs
5. HIV counselling and testing, and PMTCT (Prevention of Mother-to-Child Transmission of HIV)
6. Basic fertility services, including Reproductive health counselling
7. Adolescents' SRH services (including contraception, STI prevention and treatment)

8. Post Abortion Care
9. Gender-based violence (GBV) prevention and response services.

5.3.4.3. Retirement of Expenditure:

On a quarterly basis, prior to receiving additional DFF funding for a new quarter, PHCs would use the provided tools and templates developed by the NPHCDA for the retirement of their expenditure for the previous quarter. The process would indicate all funding received and sources, expenditure and expectations of funding for the next quarter. PHC facilities shall not remit funding received back to LGHA or the state under any circumstances and shall be held accountable by the SPHCB. The SPHCB will be responsible for ensuring funding for LGHA activities from the operational funds provided, to facilitate retirement from the PHC facilities, among others. The key requirements, steps for retirement, and timelines are as outlined in Figure 5-5 below. Detailed protocol for retirement is as contained in the Joint manual developed by the NPHCDA and NHIA Gateway, i.e. Protocol for Retirement of BHCPF funds.

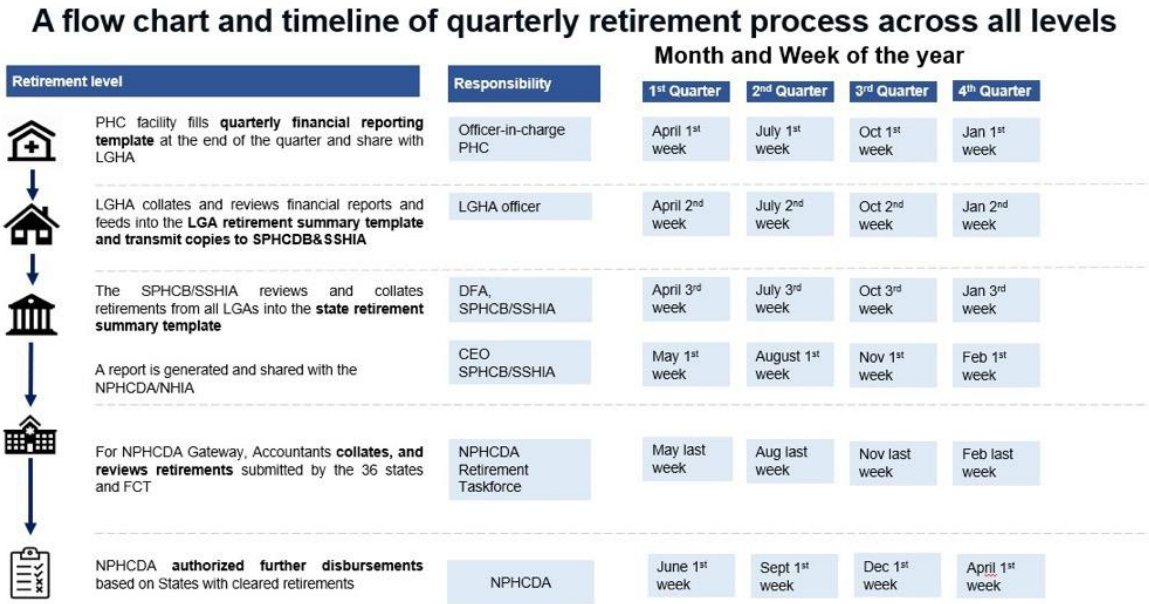


Figure 5-5: Quarterly retirement steps and timelines

5.3.4.4. Quality of Care Assessment

On a quarterly basis, the SPHCB, in collaboration with SSHIA, will conduct a quality-of-care assessment of the PHC facilities utilising the Quality Assessment Tool jointly developed by NPHCDA and NHIA Gateways. This shall be followed by the joint verification of a subset of the PHC facilities by the national team to validate the assessment, scores assigned, and report generated by the States. The details of this process are in section 5.5.3.1 (Quality Assessment).

5.3.5. LGHA Level Processes

Technical staff of the LGHA, trained on the BHCPF, will be assigned to benefiting PHC facilities as mentors in collaboration with the PFMOs deployed by the NPHCDA. The LGHA officers will support QIP and QBP development as a statutory function, periodically check fund management and be responsible for the timely transmission of PHC facility plans and expenditure retirements to the SPHCB for approval and clearance, respectively. On receipt of Quarterly Business Plans, the LGHA will endorse (or make recommendations for improvement to the PHC prior to endorsement) and forward copies with a covering summary sheet to the SPHCB/ for approval.

Similarly, on receipt of the quarterly expenditure report (retirement), the LGHA in collaboration with the LGA accounts department and/or with the support of the SPHCB, will review the reports alongside receipts and related accounting documentation, prior to clearing and forwarding the facility retirement to the SPHCB. The LGHA may decline to clear a PHC with clear evidence of funds misuse and equally forward the same evidence to the SPHCB for confirmation. BHCPF facilities not cleared by the SPHCB will not receive DFF funding for the subsequent quarter till remediation is made and the facility is cleared or sanctioned as appropriate.

Furthermore, to reduce the bureaucratic burden on the facilities, the LGHA will ensure that submitted QBP and retirement reports are in triplicate (paper-based). One copy to be retained at the LGHA and one copy each to be forwarded to the SPHCB and SSHIA. The SPHCB and SSHIA will, at the state level meeting of the Gateway Forum, or as required, resolve any documentation needs required from the facility and transmit the same to the facility through the SPHCB. The SPHCB shall be responsible for technical and operational support to the LGHA to effectively execute its role. It is expected that with the implementation of BHCPF 2.0, fund management will become digitalised using appropriate financial apps and electronic tools. Once deployed, states will be required to immediately transition from the paper-based formats to the electronic platforms.

5.3.6. State Level Processes:

On an annual basis, SPHCBs shall submit an annual BHCPF workplan for approval by the NPHCDA. The summary of funding requirements for the PHC facilities based on their annual quality improvement plans (i.e. projections for DFF payments), alongside other plans for human resources, infrastructural improvement, and operational needs such as routine quality assessments and supervision, will form the basis for the SPHCB's annual work plan. The work

plan is to be presented to the BHCPF State Oversight Committee (SOC) and endorsed by the Honourable Commissioner for Health prior to submission to the NPHCDA for financial approval.

On a quarterly basis, following the receipt of quarterly business plans from the lower levels, the SPHCB will review the same based on known needs, findings from preceding supervisory visits and quality assessments and approve the QBPs as appropriate. Likewise, the SPHCB will review the quarterly expenditure reports (Retirement) forwarded by the LGHA and clear same for onward submission to the NPHCDA. In addition, the SPHCB would, on a quarterly basis, submit programmatic and financial reports to the NPHCDA as part of the requirements for receipt of quarterly disbursements and/or authorisation from the NPHCDA.

Furthermore, SPHCBs are required to conduct quarterly quality assessments of the PHC facilities in tandem with routine PHC Integrated Supportive Supervision and other system-strengthening actions. Facility scores from the quarterly quality assessments are to be displayed in the facility and guide the development of future business plans. The quarterly assessments are to be planned and conducted jointly with the SSHIA using a singular quality assessment tool jointly adopted by the NPHCDA and NHIA Gateways.

5.3.6.1. Structure of State Workplan Proposals:

All annual SPHCB workplan proposals should include a summary analysis of the current situation of primary health care in the respective states and proposed actions to address them in line with the principles of the Gateway. The work plan proposal would highlight the following in two parts:

Part 1: Focused on state actions to strengthen PHC, including expectations from any MOU signed with national particularly if related to the BHCPF. This will mainly be in narrative form with a table for interventions and timelines, etc.

Part 2: Focuses on areas of expenditure for the BHCPF Funds.

- Indicating the number of authorised and projected BHCPF PHCs expansion for the year and the DFF fund requirement.
- Plan for HRH engagement and costs, including training and allowances.
- Plans for supervision, routine quality assessment, monitoring and evaluation.

The SPHCB/A should ensure that the proportions of proposed expenditure in Part 2 of the work plans are in accordance with those detailed in the NHAct 2014 and this Guideline.

Each State submits one (1) annual workplan proposal per year, which should address all the BHCPF related needs across all LGAs and BHCPF PHCs in the state. The annual plan would be one of the bases for quarterly reporting, requests for authorisation and disbursement. Annual plans should be endorsed by the State Commissioner for Health and by extension SOC prior to submission to the NPHCDA for further approval and authorisation to incur expenditure from the SPHCB BHCPF TSA. During the year, changes may be made with appropriate justification and approval from the NPHCDA. Such changes would be discussed and reflected in the state's quarterly reports. All annual state workplan proposals are required to be submitted by the **10th of December** each year for implementation in the following year. The NPHCDA would provide necessary formats for workplans, related templates and budget estimates for the upcoming year.

National Level Process

The NPHCDA, upon receipt of a state-level submission, will review, engage the states for clarification if required and approve or decline authorisation to SPHCB as appropriate. Aspects of the approved state work plans related to the direct funding under the NPHCDA Gateway will be summarised and a constituent part of national work plan for the Gateway for presentation to the BHCPF MOC.

The NPHCDA will communicate approval of all states' work plans to the SPHCB through the Honourable Commissioners of Health. Similarly, quarterly disbursement to the states and/or authorisation for disbursement of DFF to BHCPF PHC facilities will be officially transmitted to the state through the HCHs. Approval to SPHCB by the NPHCDA will be based on the states fulfilling the requirements relating to submission of reports and retirements, among others, as stated in this guideline.

5.3.6.2. Programme Monitoring, Verification and Auditing:

A core function of the NPHCDA is the monitoring and verification of activities and reports under the NPHCDA Gateway. On a quarterly basis, spot checks will be conducted across states to: (i) monitor and supervise implementation, (ii) verify quality assessment, facility performance scores and programmatic reports from states (iii) DFF verification to ascertain that requirement for disbursements have been made and there is some evidence of expenditure as a measure of

outputs and (iv) continuous auditing at all levels (NPHCDA, SPHCDA, and PHCs) in collaboration with the office of the auditor general of the federation, as part of actions to mitigate against misuse of the BHCPF. These processes are detailed in the monitoring and evaluation, quality assessment and financial management sections of this guideline. The NPHCDA may, as required, engage third-party agents (TPAs) to support aspects of its responsibilities in managing the gateway.

5.3.6.3. Deployment of Performance and Financial Management Officers (PFMOs):

The NPHCDA, as part of the reforms to improve fiduciary transparency, accountability, value for money and performance outcomes of the BHCPF facilities, will engage PFMOs who will be deployed to 774 LGAs. The role of the PFMO is critical to ensuring adherence to the guiding principle for implementation of the NPHCDA Gateway in tracking performance and outputs. The PFMOs will work independently, reporting directly to NPHCDA. They will, however, provide periodic briefings to the LGHAs and SPHCBs on their work and inform them of recommendations and guidance received from the NPHCDA, which will also be officially transmitted to the states by the NPHCDA.

The Key functions of the PFMOs shall include:

1. **Fiduciary Tracking and Verification**

- Track receipt of fund disbursement to the PHC (DFF, capitation and other sources)
- Monitor and report ineligible expenditure, including adherence to cash withdrawal limits.
- Verify if reported income and expenses accurately reflect on-ground realities (e.g., checking if reported expenses for medication align with the actual stock of medications).
- Support the Implementation of corrective action plans based on performance and financial audits as directed/required by the NPHCDA and other Gateways.

2. **Programmatic tracking**

- Monitor and report on the implementation of targeted interventions at the PHC level (e.g., PHC Revitalisation, HRH deployment).

- Report on facility operational and programme readiness to receive BHCPF funding.
- Data collection for routine updates of the PHC database (HRH, equipment, Infrastructure and services delivered, etc).
- Form an opinion on reported utilisation data and observed facility client traffic, and report the same for various services.
- Verify PHC performance data based on assigned key performance indicators.

Additional Responsibilities:

Participate in related surveys and PHC-related activities within their assigned LGAs as directed by the NPHCDA and other Gateways as may be required.

The PFMOs will be funded by the NPHCDA from the operational cost of the NPHCDA or from any other source following recommendation by the NPHCDA to the MOC.

5.3.7. Roles and Responsibilities of the NPHCDA Gateway

Outlined below are the specific roles and responsibilities of the various institutional actors for the implementation of the NPHCDA Gateway, details of which are highlighted in the relevant session of the guideline.

5.3.7.1. National Primary Health Care Development Agency (NPHCDA)

1. Provide technical support to the SPHCB for the implementation of the Gateway at the state, LGAs and community levels.
2. Receive, consider and approve on an annual basis, consolidated state workplan proposals from the SPHCB, for planned utilisation of the portion of the BHCPF accruing to the state under the Gateway.
3. Confirm the state and LGA 25% counterpart funding for programme implementation as a criterion for disbursing NPHCDA Gateway funds to states.
4. Disburse allocated resources of the BHCPF to the states through the SPHCB as and when due, as stated in the financial sub-section of these guidelines.
5. Receive, analyse and provide feedback on quarterly programme implementation and financial reports from the SPHCB.
6. Submit as required annual plans and quarterly financial and programme reports of activities, progress and achievements of the Gateway to the BHCPF MOC via the MOC secretariat.

7. Communicate with states, advocate for conformity to prescribed standards for PHC facility functionality and service delivery by SPHCB and Local Government Health Authorities (LGHAs), and sanction non-compliance.
8. Conduct routine supervision, monitoring, verification and periodic evaluation of NPHCDA Gateway operations across the country, utilising appropriate tools.
9. Build Capacity across all levels and amongst Partners and stakeholders for effective implementation of the NPHCDA Gateway.
10. Conduct implementation research to generate evidence for improvement in the implementation of the NPHCDA Gateway and PHC.
11. Work with the SPHCB to determine the baseline of PHC services, prior to the commencement of state-level operations and subsequently track progress in functionality and quality improvement.
12. Develop, publish, periodically review, and disseminate a 'Handbook' of protocols, processes, and tools for the NPHCDA Gateway to further guide PHC workers, particularly at the LGHA and Facility levels.
13. Collaborate with all stakeholders to advocate, publicise and mobilise resources for the NPHCDA Gateways and BHCPF.
14. Conduct routine national review meetings on activities of the NPHCDA Gateway.
15. In collaboration with the Auditor General of the Federation, conduct 'continuous auditing' of the NPHCDA Gateway.
16. Engage, deploy and manage performance and financial management officers across all LGAs nationally.

5.3.7.2. State Primary Health Care Boards (SPHCBs)

1. Provide state level capacity and implementation of the NPHCDA Gateway activities within the state with support from and in collaboration with the NPHCDA.
2. Provide direct technical support and financial allocation to the LGHAs for the implementation of the Gateway at the state, LGAs and community levels.
3. Collaborate with the NPHCDA for capacity building of all relevant actors within the state on the BHCPF.
4. Develop a consolidated state workplan proposal from the SPHCB/A, for planned utilisation of the portion of the BHCPF accruing to the state under the Gateway; and submit same to the Honourable Commissioner for Health for approval and onward forwarding to NPHCDA.

5. Establish a Top Management Meeting (TMM) with all relevant Donors and Partners working on PHC in the state to support the work of the Gateway in the state in line with SWAp.
6. Work with the State Honourable Commissioner for Health, State Oversight Committee, SMoH, and all stakeholders to mobilize the pre-requisite 25% counterpart funding and any additional funding requirements for Gateway at the state level.
7. Disburse allocated NPHCDA Gateway resources to benefitting PHC facilities, LGHA and projects in accordance with these guidelines.
8. Submit on a quarterly basis programme implementation report to the NPHCDA, (following submission to the HCH and presentation at the quarterly SOC): inclusive of status of project implementation across the state, PHC service utilisation, supervision, monitoring and administrative actions, amongst others.
9. Submit on a quarterly basis programme implementation report to the NPHCDA (following submission to the HCH and presentation at the quarterly SOC): on a quarterly basis, vetted financial reports to the NPHCDA. Inclusive of budgeting reports, status of funds disbursement at all levels across the state, statements of accounts at the state level and statements of financial retirements/audit as appropriate.
10. Ensure adherence to prescribed standards for PHC facilities in terms of functionality and service delivery as communicated by the NPHCDA and to the criteria for accreditation by the National Health Insurance Authority Gateway.
11. Conduct routine monitoring, supervision and periodic evaluation of NPHCDA Gateway operations across the state using prescribed tools for the Gateway.
12. Identify (based on baseline/needs assessment) and forward to the NPHCDA the required list of PHC facilities for onboarding on the Gateway based on need.
13. Ensure all participating healthcare facilities open and maintain a singular designated chequing bank account in a regulated financial institution for their operations, to enable electronic receipt of funds from the SPHCB/As.
14. Work with support from the NPHCDA in collaboration with NAFDAC and the State Department of Pharmaceutical Services, to accredit local distributors and pharmacies, inclusive of state central drug stores, from which PHCs may procure NAFDAC-certified drugs directly in the event of non-participation of the state Drug Management Agencies (DMA).

15. Engage with the NEMSAS Gateway as appropriate to ensure emergency ambulance services for the PHC facilities.
16. Sign an MoU with the NPHCDA and enter service delivery contracts with PHC facilities.

5.3.7.3. Local Government Health Authority

1. The Local Government Health Authorities will work with direct support from the SPHCB/A for the 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 Authority/Chairperson.
3. Provide direct technical support for the implementation of BHCPF activities in the PHC.
4. Collaborate with the SPHCB/A (in line with PHCOUR0 to conduct routine supportive supervision and monitoring of PHCs in the LGA and ensure that:
    a. PHCs are staffed, equipped and functional to deliver quality PHC services to Nigerians.
    b. Community members have effective access to the BMPHS as defined in this guideline and at no additional cost.
    c. Funds received by the PHC facilities from the SPHCB/A through the NPHCDA Gateway, the NHIA Gateway and other sources are utilized 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 the state DMA, or 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 their effective transmission to the SPHCB/A for approval.
7. Ensure financial and non-financial records, including routine service utilisation data, are maintained and transmitted as appropriate.
8. Engage with the Operators of the NEMSAS Gateway as appropriate to ensure emergency ambulance services for the PHC facilities.

5.3.7.4. Ward Development Committee

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

ward/community. 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, November 2012). The Roles and Responsibilities of the WDC within implementation of the NPHCDA Gateway and BHCPF include:

1. Collaboration with the PHC facility leadership in the identification of health and social needs of the ward and planning for them.
2. Prioritisation of identified health needs for inclusion in the PHC facility's Business Plan 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 Team
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.

5.3.7.5. Primary Healthcare (PHC) Facility

1. Provide quality services to the community members and at no cost to persons enrolled by the NHIA Gateway based on the BMPHS.
2. Maintain only one (1) functional cheque-based bank account in a regulated financial institution, which shall have both the health workers and WDC members 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 SPHCB/A through the LGHA for approval and funding.
4. Utilise funds received through the NPHCDA Gateway as an operational budget, together with funds received from the NHIA Gateway and all other sources, for the provision of quality PHC services at the facility and community levels.
5. Submit quarterly expenditure statements as requirements for subsequent funding.
6. Ensure adequate display of relevant signage to ensure the public is aware of the facility's participation in the BHCPF and BMPHS available to the community. These include: the Facility Sign Post (indicating that the PHC facility is a beneficiary of BHCPF), list of BMHSP services provided, posting Quality Scorecard, User Charges if fees are charged.

7. Ensure effective management of the PHC facility by constituting a) Management committee comprising the officer-in-charge (as chairperson) and the unit heads/heads within the PHC facility, and b) Quality Improvement Committee.
8. 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 SPHCB/A) and in line with the prevailing service delivery policy of the state.
9. Ensure prompt referral of all needy clients in line with the SOP for PHC workers as published by the NPHCDA, by activating relevant NEMSAS Gateway protocols as appropriate.
10. Secure all BHCPF asserts, including digital infrastructure that will be deployed to the PHCs.

5.3.7.6. Performance and Financial Management Officers (PFMOs)

Refer to section 5.3.6.3 under deployment of PFMOs for the roles and responsibilities of PFMOs

5.3.7.7. Secondary Health Care (SHC) Facilities

1. The States shall designate identified Secondary Health Care (SHC) facilities to serve as referral centres for the PHC facilities, based on proximity for the provision of specialised care to referred clients.
2. Ensure 2-way referral of clients from the PHC system back to their PHC facility and community health workers.
3. Other functions of the SHC under the BHCPF are as stated in the NHIA Gateway section of this guideline.

5.3.8. Referral Services

The State Ministry of Health, in collaboration with the SPHCB and the LGHA, would ensure that appropriate mapping of referral facilities for the PHC Centres is done, and the necessary managerial linkages are established between designated secondary health facilities (referral centres) and the originating PHC facility. Working with the State Emergency Medical Treatment System, the SPHCB will support the PHC facilities and communities to put mechanisms in place to facilitate prompt referral and transportation of needy persons. This includes ensuring that BHCPF facilities are utilising NEMSAS and issuance of vouchers to ambulance providers, the facilities and community know the exact emergency phone numbers to use (refer to the section on EMT Gateway), and conditionalities for use of the emergency ambulance systems.

In addition, the SPHCB should ensure the availability and use of 2-way referral forms as codified in the NHMIS by PHC workers (inclusive of any additional information they may be required of the NHIA Gateway to ensure transparent purchasing of services).

5.4. Financial Management of the NPHCDA Gateway

All fund disbursements at every level of the NPHCDA Gateway shall be via electronic transfers. At national and state levels, TSAs would be utilised with Operators and Viewers based on regulations stipulated by the Accountant General of the Federation.

The NPHCDA and SPHCB/A shall operate two (2) TSA accounts each, namely: BHCPF Programme Account and BHCPF Operations Account. At the PHC facility level, a singular cheque-based account would be opened with a regulated financial institution.

LGHA shall continue to maintain their statutory accounts. It shall be considered a major financial infraction should BHCPF funds be warehoused in any account other than the TSA, and for other non-BHCPF funds to be paid into the BHCPF TSA accounts. The disbursement and retirement processes for BHCPF funds across the entire NPHCDA Gateway shall be in accordance with the public financial regulations of the Federal Government of Nigeria and this Guideline. As part of the new reforms, States are expected to deploy trained Project Management Accountants from the state accountant general to the state primary healthcare agency to support the financial management of BHCPF.

5.4.1. Digitalisation of Financial Management Process

As part of the reforms to BHCPF, the payment process of the NPHCDA Gateway is to be digitalised, aligning with the digitalisation agenda for primary health care in line with the NHSRII and the strategic blueprint for PHC. The NPHCDA will deploy appropriate financial software that will enable visibility across all levels of the Gateway operation as it relates to disbursement and expenditure. The financial software will be compatible with other electronic platforms to be deployed across the NPHCDA Gateway for more efficient management of processes, including electronic medical records platforms for the PHC facilities.

Once deployed, SPHCBs will ensure compliance by adopting the software and electronic platforms and ensure necessary supportive infrastructure and subscriptions are in place for seamless connectively by the PHC facilities.

5.4.2. Funds Disbursement and Retirements for the NPHCDA Gateway

Upon receipt of the 45% component of the BHCPF from the federation account, the NPHCDA shall, within seven (7) working days, disburse funds to all qualifying SPHCB, who shall, in turn, disburse electronically directly to benefiting and eligible PHC facilities, also no later than seven (7) days from the date of receipt. The SPHCB/A shall officially notify the LGA of all disbursements made to the BHCPF PHC facilities and LGHA as appropriate. Disbursement shall be on a quarterly basis which will be backed with an authorization from NPHCDA and list of eligible PHCs, their DFF tiers and if they are entitled to performance bonus payments). and disbursement to states shall be premised on them fulfil necessary disbursement/eligibility criteria i.e. after submission and approval of relevant quarterly retirements, conducting quality assessment, programme and financial reports as stated in this guideline.

Figure 5-6 below outlines the quarterly retirement and disbursement cycle for funds under the NPHCDA gateway. Under the reformed BHCPF, non-adherence to retirement deadlines will be sanctioned. With the BHCPF reforms, the following three (3) criteria must be met during the retirement process:

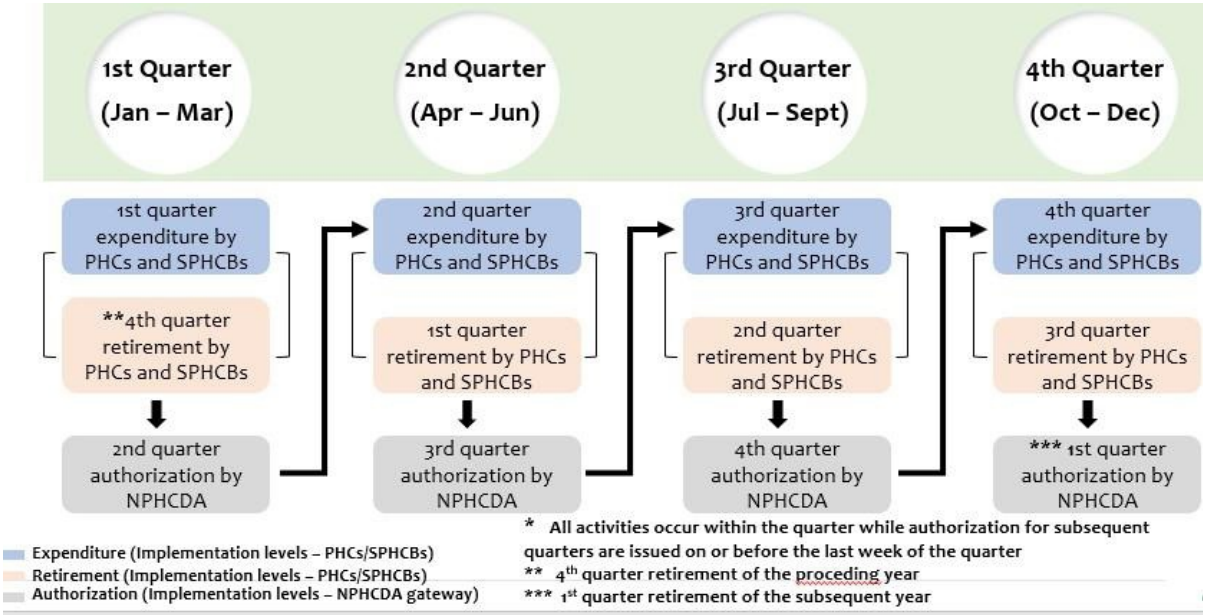
- **Timeliness**: Retirement must be submitted on time in line with the published schedule.
- **Completeness**: Retirement must be complete from all the BHCPF PHCs, LGHAs, and states in terms of all required documents, inclusive of programmatic and financial reports, bank statements, receipts from the state level, summary forms (LGA and State) reports, etc.
- **Validation**: Based on timeliness and completeness, states will be initially cleared for disbursement pending validation of the retirement submission. Retirement documentation will then be validated through a process of 'continuous auditing' conducted by the NPHCDA in collaboration with the Office of the Auditor General. Should any infraction be identified, states would be considered ineligible for subsequent disbursements till the audit issue is cleared.

The retirement documentation is inclusive of expenditure reporting templates, summary sheets at the LGA and state levels, receipts, reports of activities, attendance sheets, payment sheets, TSA remit outflow printout and bank statements at all levels, amongst others. The detailed processes and tools for the retirement of funds, i.e. expenditure reporting, are contained in the 'Protocol for Retirement of BHCPF Funds'. Based on the protocol, PHC facilities' retirement,

once done using tools provided by the NPHCDA Gateway, will be shared with the NHIA Gateway at the level of the LGA.

5.4.3. Operation and Programmatic Cost

Operational cost within the NPHCDA Gateway would include all costs incurred in the process of administering, supervising, monitoring, building capacity and



generating data and evidence for decision making as it relates to improving the quality of service delivery and operations of the Gateway. At the subnational level, this would be inclusive of funding for similar activities by the states and LGHA for BHCPF-related activities. However, institutions at all levels would leverage their routine budgets and ensure synergy with other funded activities, e.g. supervision, to ensure cost savings.

At the national level, the NPHCDA would retain not more than 10% of the Gateway funds for its operational expenses. At the state level, the SPHCB/A would similarly retain not more than 15% of the total funds accrued to the state (i.e. federal funds and state counterpart) to supplement the operation needs of the SPHCB/A and the LGHA, backed by a work plan approved by the NPHCDA. The SPHCB will fund the operational cost of the LGHA for implementation of the BHCPF and indicate the same in their annual BHCPF workplans. Similarly, post deduction of operational costs at national and state levels, programme cost will be disbursed proportionately to the assigned percentages, i.e. 35% for DFF and 10% for human resource interventions.

5.4.4. Financial Reporting

Financial reporting for the NPHCDA Gateway at the national and state levels shall be as outlined in this guideline. Quarterly consolidated financial reports shall be a prerequisite for SPHCB/A to receive quarterly disbursements from the NPHCDA.

LGHA shall prepare quarterly expenditure proposal and retirements to the SPHCB for funding in subsequent quarters. In addition, the LGHAs would support the PHC facilities to adequately prepare and transmit quarterly expenditure statements to the SPHCB/A alongside their Business Plans for the next quarter. PHC expenditure statements shall be due within 7 days following the end of the quarter. It is to be noted that financial reporting (particularly PHC facility expenditure reports) is 'time-bound and not expenditure-bound', i.e. retirement at all levels must be done at the end of each quarter, irrespective of the amount of allocated funds that have been disbursed and utilised.

In line with public financial regulations, all levels within the Gateway, including PHC Facilities, will appropriately store financial records for a minimum of ten (10) years and make them available for review and audit by authorised officers.

5.4.5. Quarterly and Annual Roll-over and Management of Unused Funds

At the end of each financial year, unexpended programmatic funds at the national and state levels will be determined, and a decision will be made on their utilisation. Unused funds across the Gateway will be determined annually through bank statements, book balances, and a verification check by the NPHCDA.

National:

Gateway programmatic funds at the national level, that is, projected to remain undisbursed by the end of the financial year, plus a 6-month buffer period (i.e., 18 months), will be re-purposed in line with the objectives of the BHCPF. The NPHCDA will work with states to develop a proposal for the utilisation of such funds and present the same to the MOC for consideration and approval.

States:

At the state level, quarterly funds already disbursed to states but unexpended will be determined and verified every six (6) months. The funds may be unspent due to non-authorisation secondarily to non-compliance by the SPHCB or BHCPF PHC facilities, or balances from previous disbursements to the states by the national. Having determined the available balance at the state level, the gap in funding requirement for the DFF component for the subsequent quarter will be

computed, and additional disbursement will be made to the state to 'top up' the existing balance and meet the funding requirement for DFF. The balances of operational funds and HRH funds will be rolled over in addition to the full disbursement for operational and HRH funds in the new quarter.

PHC Facilities:

BHCPF funds disbursed to the PHC facility as DFF or capitation are to be utilised at the PHC based on their approved business plans, for service delivery at the facility level and the community. Funds unspent at the end of each quarter will be rolled over and captured in the Business plan for the subsequent quarter. In any event where financial misappropriation is confirmed at the facility, or the facility has ceased to be functional, under such circumstances, the SPHCB will notify the NPHCDA officially of the need to stop funding or withdraw funding from the BHCPF facility.

5.4.6. Signatories to NPHCDA Gateway Accounts

Signatories to the various BHCPF accounts under the NPHCDA Gateway shall be as outlined in the table below. For each category alternate signatures would exist in line with the federal public financial regulations also outlined below. The signatures are further based on guidance from the office of the Accountant General of the Federation as it relates to the use of TSA.

S/No	Operational Level	Funding Approval	TSA Account Signatories		
			Initiator	Reviewer	Finalization
1	NPHCDA	ED/CEO, NPHCDA	Accountant	Accountant	NPHCDA Director, Finance and Accounts
2	SPHCB	ES, SPHCB	Accountant	Accountant	SPHCB Director Finance and Accounts
	Operational Level		Signatories	Signatories	Comment
3	LGHA		Director of Health	LGHA Accountant	The operations of an LGHA account will be based on the subsequent

				opening of TSAs or other designated processes as implementation progresses
4	Facility level	Officer- in Charge (OIC) ***Alternate:*** Facility Accountant **OR** Deputy OIC	WDC Chairperson ***Alternate***: Treasurer OR Secretary	

5.4.7. Enhanced Fiduciary Measures

In line with the BHCPF reforms, enhanced fiduciary measures will be deployed across the NPHCDA Gateway. The measures will include the following.

Deployment of PFMOs:

The PFMOs, along with other functions (as outlined in section 3.3.7.2), will primarily serve as third-party verifiers for tracking funds disbursed to the PHC facility and its utilisation. They will confirm receipt of disbursement from SPHCBs, track expenditures in line with business plans, conduct random checks on stock accounting books, and track WDC participation in Facility account management.

Continuous Auditing Process:

The NPHCDA, in line with its internal audit function, with support from the Office of the Auditor General for the Federation, will implement a system of continuous auditing at all levels (NPHCDA, SPHCDA, and PHCs). This will involve a team of auditors visiting all levels to audit reports submitted, quarterly retirements and all BHCPF-related activities. Where a state's retirements (even if initially cleared based on timeliness and completeness of submissions) are identified to have breached the BHCPF Guidelines and federal financial regulations, the state will be deemed ineligible for future disbursements till the audit issue is rectified and the state is duly cleared officially. This rule will hold

even if significant time has lapsed since the submission of the retirement document and there was an initial clearance by the NPHCDA. Continuous auditing is distinct from the statutory annual audit to be conducted for the entire BHCPF by the Office of the Auditor General of the Federation. Furthermore, it is expected that the digitisation of the NPHCDA Gateway process at the PHC level will enhance the visibility of financial processes.

5.5. Monitoring and Evaluation for the NPHCDA Gateway

5.5.1. The Approach

The M&E framework for the NPHCDA Gateway shall ensure a robust mechanism for information collection and analysis. It will focus primarily on the following: Process for funds disbursement and utilisation, governance integrity, PHC facility performance and outputs, particularly as it relates to service delivery, with impact evaluation on longer-term outcomes and socio-economic impact on the communities. M&E process under the NPHCDA gateway will be digitalised as a subset of the global digitalisation of the BHCPF. Data collection for M&E will be in two (2) categories:

Data collection from the BHCPF PHC Facility:

This will be premised on the roll out of the digitalisation agenda that will enable PHC facilities to submit data directly to a centralised system accessible at all levels. The PHC will submit utilisation data monthly based on the NHMIS and using a DHIS-2 compatible application where deployed. The data will include data from utilisation registers and electronic medical record systems (EMR), and from data harvested from the Gateway online platforms for business planning and expenditure reporting. Data submission from the PHC will be done in the first week of the succeeding month.

Quarterly data collection:

This is done quarterly principally by the LGA M&E officer from the PHC facility using an assigned digital platform which is analysed nationally with a performance dashboard that is accessible at all levels. Quarterly data collection for M&E shall commence in the first week of the month after the quarter under review and be concluded by the end of the 3rd week to enable national analysis and preparation of the national quarterly report by the ends of the first month after the quarter under review. At the end of each year the national shall prepare a national programme report of the NPHCDA Gateway.

Data collection and analysis will focus on the prioritized indicators that address the presidential commitment on health as it relates to primary health care. The set of indicators for which data is to be collected by the Gateway are indicated in Table 1-2 below.

S/N	Thematic Area	Indicators	Frequency	Data Source	Level Of Data Collection
1	Governance & Administration	Proportion of SPHCBs that have contributed the component of 25% counterpart fund for BHCPF	Quarterly/ Annually	NPHCDA Performance Dashboard	State
2		Proportion of States with SOC meeting in the last quarter	Quarterly	NPHCDA Performance Dashboard	State
3		Proportion of PHCs with active WDCs (evident by at least one meeting in the last quarter)	Quarterly	NPHCDA Performance Dashboard	PHC
4	Service Readiness	Number of BHCPF PHCs that meet PHC standards (Level 2)	Quarterly	BHCPF HFA Assessment Data	PHC
5		Number of wards with fully functional PHCs (level 2)	Quarterly	BHCPF HFA Assessment Data	PHC
6		Number of PHCs facilities revitalized	Annually	NPHCDA Performance Dashboard	PHC
7	Service Utilization	Number of ANC 1 visits by pregnant women	Quarterly	DHIS2	PHC
8		Proportion of the population accessing PHC services	Quarterly	DHIS2	PHC

9		Number of Penta 1 vaccine administrations to children	Quarterly	DHIS2	PHC
10		Number of facility-based deliveries	Quarterly	DHIS2	PHC
11		Percentage increase in utilization of PHC services [all attendance] across BHCPF facilities - (Rate of utilization of BHCPF services)	Annually/ Quarterly	DHIS2	PHC
12		Facility Maternal Mortality in BHCPF PHCs	Quarterly	DHIS2	PHC
13		Facility Under-5 Mortality in BHCPF PHCs	Quarterly	DHIS2	PHC
14	**Quality of service and**	Proportion of BHCPF PHCs with at least four (4) SBAs	Quarterly	NPHCDA Performance Dashboard	PHC
15	**Quality of service and care**	Proportion of PHCs with 24hrs power supply	Quarterly	NPHCDA Performance Dashboard	PHC
16		Proportion of Children that received Penta 3 vaccines	Quarterly	DHIS2	PHC
17		Proportion of pregnant women who complete 4th ANC visit	Quarterly	DHIS2	PHC
18		Proportion of deliveries conducted by skilled birth attendants (SBAs)	Quarterly	DHIS2	PHC
19		Proportion of BHCPF PHCs with minimum quality assessment (QA) score of 80%	Biannual (6 months)	NPHCDA Performance Dashboard	PHC

20		Proportion of PHCs with client satisfaction survey score at least 80%	Quarterly	DHIS2	PHC
21		Proportion of PHCs with stockout of essential (tracer) drugs within the quarter under review	Quarterly	NPHCDA Performance Dashboard	PHC
22		Proportion of BHCPF facilities providing BMPHS	Quarterly	NPHCDA Performance Dashboard	PHC
23		Proportion of PHCs that conduct sensitization and awareness creation services	Quarterly	NPHCDA Performance Dashboard	PHC
24		Proportion of PHCs visited by State/LGHA team for supportive supervision	Quarterly	NPHCDA Performance Dashboard	PHC
25	**Financial Management**	Proportion of SPHCBs receiving quarterly disbursement from NPHCDA	Quarterly	NPHCDA Performance Dashboard	State
26	**Financial Management**	Proportion of BHCPF PHCs that received DFF disbursement from SPHCB	Quarterly	NPHCDA Performance Dashboard	State
27		Proportion of BHCPF PHCs that received timely DFF disbursement from SPHCB	Quarterly	NPHCDA Performance Dashboard	State
28		Proportion of SPHCB that submitted complete retirement documents to NPHCDA.	Quarterly	NPHCDA Finance	State
29		Proportion of PHCs that submit and complete their financial retirement reports on time	Quarterly	NPHCDA Finance	State

30		Proportion of PHCs that spend in accordance with the approved business plan	Quarterly	NPHCDA Finance	PHC

Table 5-1: Key Performance Indicators

5.5.2. Verification of Data and Reports

The NPHCDA shall be responsible for the verification of data and reports under the NPHCDA Gateway. This shall be conducted by systematic sampling of states across the nation to verify reports through physical field visits by staff of the NPHCDA. Verification may be conducted jointly with Partners and other Gateways or by third-party agents as may be assigned by the NPHCDA. The conduct of the verification and reporting shall be guided by the following:

- Quarterly M&E data and state reports
- Quality Assessment reports
- DFF utilization
- PFMO reports and data submissions
- PHC performance score cards

The NPHCDA will ensure the integration of the various electronic platforms in use within the Gateway and the availability of a performance dashboard that is accessible at all levels. The verification visits, which will be done in an integrated manner, shall include:

- Functionality assessment visit by NPHCDA and states to all PHC facilities prior to onboarding on the NPHCDA Gateway.
- Quarterly Ex Post verification by the NPHCDA of financial, programmatic, and quality assessment reports from the SPHCB. This shall occur in a minimum of 25% of LGAs and 25% of PHC facilities within the LGA in states visited each quarter. This visit would be conducted at least quarterly to identified states.

The SPHCB would equally conduct the monitoring, supervisory and assessment visits prior to the national verification assessments. Likewise, the Honourable Commissioners for Health and the state oversight committees for BHCPF may equally conduct monitoring and supervisory visits across the Gateway and provide relevant guidance/directives to the SPHCB and feedback to the NPHCDA. States and LGHAs shall routinely, irrespective of M&E actions on the NPHCDA gateway, ensure that BHCPF PHCs continue to transmit reports on utilisation data for key indicators, including outpatient visits (inclusive of

children under five), antenatal visits, skilled deliveries, postnatal visits, and immunisation, etc., via the NHMIS as per health policy.

5.5.3. Quality Assessment and Improvement

Fundamental to the implementation of the BHCPF is the theory of change that continuous direct investment in BHCPF facilities through DFF and capitation payments 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 all levels 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, heads of units in the PHC, 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' as indicated in the section on performance management.

5.5.3.1. 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 resource. The PHC revitalization initiative shall be leveraged to upgrade PHCs while the DFF fund disbursed to the PHCs will be utilized for maintenance as required. 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 developed by the NPHCDA in collaboration with all stakeholders. This will enable improved facility management and ensure clinical safety and effectiveness by motivating adherence to protocols in the PHC facilities.
- **Quarterly quality assessments and scoring**, in addition to routine supportive supervision and monitoring exercises, shall be conducted jointly by the SPHCDA or SPHCB and LGHA teams together with their SSHIA counterparts, with verification of results by the NPHCDA in joint visits with the NHIA. Feedback and recommendations from the assessments and recommendations shall inform the PHC's 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. Joint visits are required to occur quarterly, but at a minimum twice annually.

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.

5.5.3.2. Assessment of Quality Improvement

Every quarter, 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 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:

- Governance, Administration 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
- Service Utilisation and Clinical Outcomes
- Community Involvement and Client experience of care

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.

5.6. Programme and Fiduciary Sanctions

Monitoring and evaluation/verification reports and financial audit reports will trigger penalties due to non-compliance with processes, performance standards or breaches of this Guideline. Where infractions have been established to have occurred, the following sanctions shall apply:

5.6.1. Fiduciary Sanctions

As a rule, all major infractions will be reported by the NPHCDA to the Executive Governors of the state. Financial infractions that are not related to embezzlement involving a breach of guidelines or public financial rules are to be dealt with by the SPHCB in line with the public service rules and regulations. In the event that a state is suspended, the state may only be re-admitted into the Gateway following full remediation, including refunding to the NPHCDA Gateway BHCPF TSA any federal government funds deemed to be misused. Major incidents involving financial loss or embezzlement may be referred to the relevant agencies post audit evidence. Specifically, the following sanctions shall apply:

5.6.1.1. Late or Non-Submission of Retirement Documentation

States are required to submit retirement reports, which include all necessary program and financial reports and evidence of remediation activities (if applicable). The timely submission of these reports is crucial, as delays or failures in submission will result in sanctions. The retirement process has a one-quarter lag as outlined in section 5.4.2, which offers a buffer period to ensure service continuity and minimise delays.

- **Standard Submission Deadline:** Retirement reports for the preceding quarter, inclusive of all necessary program reports and any applicable remediation activities, must be submitted by the end of the 2nd week of the 2nd month of the current quarter. For example, retirement reports for Q2 (April-June) must be submitted by the 2nd week of August (Q3). Meeting this deadline ensures the timely disbursement and authorisation of Q4 funds.
- **Late Submission Grace Period:** If a state misses this initial deadline but submits the retirement reports (Q2) within the current quarter (Q3), the state remains eligible for Q4 disbursement. This grace period allows for some flexibility while still encouraging timely submission.
- **Final Deadline and Penalties:** If a state fails to submit the required outstanding retirement report by the time the retirement reports for the subsequent quarter is due, the state forfeits disbursement for the outstanding quarter. No exceptions will be made for reports submitted beyond this final deadline.
- **Disbursement Conditions:** Funds will only be disbursed to states that have cleared their retirement documentation within the designated timeline. States with outstanding retirement reports beyond the deadline will not receive quarterly disbursements.

5.6.1.2. Non-payment to PHC Facilities by SPHCB for NPHCDA Gateway

Should verification establish that disbursements have not gone from states to eligible PHC facilities in part or in full, i.e., non or part payments of funds due to facilities, or payments only to a proportion of enlisted health facilities, the following sanctions shall apply:

- Non-payments to facilities and/or a shortfall in payment of 10% or more shall earn a written query to the state, for immediate remediation and correction.
- A second offense by the state either due to non-payment or embezzlement would be followed by a signed letter to the Executive Governor, requesting financial redress and appropriate sanctions to the erring officers.
- Subsequent infraction or non-payment to over twenty-five per cent (25%) of facilities will lead to suspension of the State's SPHCB or LGHA, as relevant to the offence.
- Where breaches are at the level of the PHC facilities, the SPHCB/LGHA would 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.
- Failure to act by the SPHCB would necessitate escalation to the Office of the Governor or suspension of state funding as appropriate.

5.6.1.3. Other Financial Infractions

- Repeated financial violations, as identified through reports over a period of three (3) consecutive quarters, will lead to suspension of the state from the NPHCDA Gateway.
- Major financial infractions resulting in non-disbursement of funds to PHC resulting from misuse and/or embezzlements at any level will lead to suspension of the state and referral to relevant anti-corruption/investigative agencies.

5.6.1.4. State Suspension

In the event where a state is suspended due fiduciary misconduct, the NPHCDA will suspend all funding to the state including DFF to the PHC facilities in the state.

5.6.2. Sanctions for Non-Financial Breaches:

If non-fiduciary breaches are made to the Guideline, the SPHCB shall be responsible to addresses such breaches in line with the state civil service rules and regulation and report same to the SOC and the NPHCDA.

5.7. Digitalisation of PHC Facility Management and NPHCDA Gateway Processes

Critical to the reforms of the NPHCDA Gateway is improving effectiveness and efficiency, reducing transaction time for processes, and enhancing transparency, accountability, visibility, and effective oversight at all levels. Key to achieving this is the digitalisation of PHC facility management and processes across the NPHCDA Gateway, which would be leveraged by the other Gateways, particularly the NHIA.

The NPHCDA, leveraging the SWAp approach, will collaboratively work with States, partners and stakeholders to implement the digitalisation strategy in line with the Strategic Blueprint for PHC and the overall sector digitalisation strategy anchored in the Federal Ministry of Health, requiring the adoption and scale-up of ICT infrastructure across the NPHCDA Gateway, particularly at the PHC facility level. Deployment of technology for the NPHCDA Gateway would be focused on reducing transaction times and improving transparency and accountability. Digitalisation within the BHCPF will focus on three (3) core operations:

- **Financial Transactions:** End-to-end visibility of financial transactions to enhance visibility and accountability in the disbursement and utilisation of funds, through the deployment of an electronic financial management application/platform.
- **NPHCDA Gateway Operations:** to enable migration from paper-based to digital management of the Gateway process, from quarterly business plan preparation and submissions, approval processes at the LGHA, state and national levels, fund expenditure reporting (financial retirement) and integration of monitoring, verification, and supervisory processes into a seamless operating digital platform. This will significantly improve the efficiency and speed of the retirement and approval process, eliminate delays and enhance visibility and transparency across Gateway operations.
- **Electronic Medical Records (EMR):** This will be deployed to enhance clinical operations and enable real-time data capture of service provision and disease incidence trends, providing data evidence for decision-making at LGHA, state and national levels. The EMR system will also be linked to opportunities for innovation, teaching and care delivery systems using telemedicine and other relevant platforms.

The implementation of digitalisation across the NPHCDA Gateway and BHCPF will ensure seamless integration into the DHIS platform for data reporting and

analysis at all levels. Comprehensive databases and interactive dashboards will be deployed at the national and state levels for effective monitoring and management of the Gateway in near real-time.

Implementation of the digital strategy will require significant investment, particularly for the digitalisation of the PHC facilities to ensure the availability of required ICT devices for effective operations. Funding for the digitalisation will leverage the SWAp process and the BHCPF, which were made possible with mandatory approvals and authorisations. The migration to electronic processes is also expected to be further emphasised as it relates to bank transactions at all levels. PHC facility transactions are equally expected to be electronic via the banking system, with literally zero cash transactions except as permitted under section 3.8 (financial risk management).

5.8. Grievance Redress Mechanism

A Standard Grievance Redress Mechanism (GRM) and framework will be developed and deployed under the NPHCDA gateway in collaboration with states, partners and all stakeholders. This will be aligned with the broader GRM at the national level for the BHCPF. The framework will enable grievance resolution starting at the PHC facility and community level with a clear mechanism for escalation to and tracking at the LGA, state and national levels. Its implementation will involve establishing a uniform system for receiving, processing, and resolving complaints at all levels, in a manner that ensures that grievances are addressed efficiently and fairly, contributing to the continuous improvement of quality service provision.

Multiple grievance submission channels will be set up and communicated to the public, including dedicated phone lines at the subnational level, an online platform, and physical addresses for written/in-person complaints related to service delivery, Client experience and financial management. The grievance Handling and resolutions, response timeline, as well as escalation procedures would be detailed in the SOP for GRM in the Implementation manual/Handbook of the NPHCDA Gateway.

Monitoring and evaluating the GRM process will generate the relevant data to determine the pattern of grievances, which will serve as data evidence for service improvement. Once the GRM is activated, grievance reports indicating the number of issues, the number resolved or escalated, and trends will be required as part of quarterly reporting.

5.9. Knowledge management and communication (KMC) for NPHCDA Gateway

5.9.1. Overview

The Knowledge Management and Communication (KMC) strategy for the NPHCDA Gateway will focus on creating public awareness, improve citizen engagement with the BHCPF to enhance transparency and accountability and improve utilisation of BHCPF services. The KMC strategy will leverage modern solutions alongside traditional communication methods at all levels, from the PHC facility and communities to the LGA, state and national levels.

5.9.2. Objectives of the KMC Strategy

1. **Increase Public Awareness:** Inform citizens about BHCPF initiatives, healthcare services, and their rights and responsibilities.
2. **Enhance Knowledge Sharing:** Create robust mechanisms for the creation, storage, sharing, and application of knowledge to facilitate continuous learning and improvement within the BHCPF implementation.
3. **Promote Evidence-Based Decision-Making:** Generate and disseminate data and best practices that inform decisions at all levels of healthcare delivery.
4. **Strengthen Collaboration:** Foster partnerships among stakeholders through effective communication, ensuring a unified approach to health service delivery.

5.9.3. Knowledge Management Component

The knowledge management aspect focuses on systematically managing knowledge to improve BHCPF implementation outcomes. Key activities include:

A. **Creation of Knowledge Resources:**
   - The NPHCDA, in collaboration with states and partners, will develop comprehensive guides, toolkits, and templates to standardise practices across all levels. States and LGAs may then reproduce KMC tools and items based on the designed national template to suit the local context.
   - Conduct regular training and capacity-building sessions for stakeholders to ensure they are equipped with the latest information and skills.

B. **Storage and Retrieval Systems:**
   - Establish a centralised digital repository to store all relevant documents, research findings, training materials, and best practices.

- Deploy a suitable electronic user-friendly platform that allows all stakeholders access and share knowledge efficiently.

C. **Best Practices Identification:**

- Regularly collect data and feedback from BHCPF implementation activities to identify effective practices.
- Create case studies showcasing successful initiatives, which can be shared across states and localities to encourage replication.

D. Monitoring and Evaluation of Knowledge Use:

- Track the application of knowledge in decision-making processes to assess impact.
- Regularly review KMC practices to ensure they meet the evolving needs of the healthcare system, and the communities served.

5.9.4. Communication Strategy

The communication strategy will utilise both digital and traditional media channels to enhance the visibility and utilisation of BHCPF services. Key components include:

- **Diverse Media Utilisation**:

  Employ a mix of communication methods, including:

  - **Digital Media**: Leverage social media platforms, websites, and mobile applications to disseminate information and engage the public.
  - **Traditional Media**: Utilise radio, television jingles, billboards, flyers, and posters to reach broader audiences, especially in underserved areas.
  - Develop engaging content such as FAQs, infographics, and educational videos that simplify complex health information.
- **Targeted Campaigns:**
  - Design campaigns to address specific health issues or service offerings related to the BHCPF, tailored to the needs and characteristics of different communities.
  - Use testimonials and success stories from beneficiaries to build trust and encourage service utilisation.
- **Stakeholder Engagement:**
  - Facilitate regular communication with stakeholders, including healthcare providers, community leaders, and civil society organisations, to ensure alignment and collaboration.

- Organise community forums and town hall meetings to provide updates on BHCPF initiatives and gather feedback.

- **Feedback Mechanisms:**
  - Establish channels for stakeholders to provide input on communication efforts, ensuring that the KMC strategy remains responsive and effective.
  - Monitor the effectiveness of communication initiatives through surveys and feedback forms, adjusting strategies as necessary.

5.9.5. Guidance for States

To ensure consistency and effectiveness in KMC across all levels, the NPHCDA will develop and disseminate a comprehensive guide and template for KMC that states can utilise. This guide will include:

Guidance Area	Action	Details
Establish a State KMC Unit	Each state should establish a dedicated KMC unit within the State Primary Health Care Development Agency (SPHCDA) as an integral part of their advocacy and communication strategy or department.	This unit will coordinate KMC activities, implement communication strategies, and monitor KMC performance.
Develop a State KMC Plan	States must create a comprehensive KMC plan aligned with national objectives and local health needs.	Include goals, target audiences, and specified communication channels based on audience preferences.
Implement Knowledge Sharing Mechanisms	Establish platforms for knowledge sharing among stakeholders.	Conduct regular stakeholder meetings and create a digital repository for resources, best practices, and training materials related to BHCPF.

Conduct Training and Capacity Building	Organize training sessions for healthcare providers and local officials on effective communication and knowledge management practices.	Focus on enhancing communication skills and data management capabilities.
Utilize Standardized Messaging	Adopt standardized messaging guidelines provided by the NPHCDA for consistency.	Use nationally developed tools and templates for core messaging on key BHCPF initiatives and programs.
Engage in Community Outreach	Actively engage communities to promote awareness of BHCPF services and encourage utilization.	Host community forums and conduct outreach campaigns using local influencers.
Establish Feedback Mechanisms	Implement mechanisms for community members to provide feedback on BHCPF services and KMC activities.	Use surveys, questionnaires, and suggestion boxes in healthcare facilities and community centers to collect feedback.
Monitor and Evaluate KMC Activities	Regularly assess the effectiveness of KMC strategies through data collection and analysis.	Track service utilization rates and measure community awareness through pre-and post-campaign surveys.
Report Progress Regularly	Provide quarterly reports to the NPHCDA on KMC activities, challenges faced, and progress made toward objectives.	Summarize key KMC activities undertaken and include data on outcomes such as increases in service utilization or community engagement.

6. GUIDELINES FOR THE IMPLEMENTATION OF THE EMTC GATEWAY

6.1. Introduction

An Emergency Medical Service (EMS) System is increasingly essential for Nigeria to confront the full range of urgent medical situations that impact its prospects to attain the Sustainable Development Goals by 2030. Nearly one-half of Nigeria's population resides in rural areas where poverty is widespread, and access to quality health care is limited. A lack of properly equipped ambulances, adequately trained staff, reliable communication equipment, and poorly coordinated response between incidents and healthcare facilities presents major shortcomings to the country's health systems. Coordinated and well-equipped ambulance services are therefore critical for improving health outcomes and reducing preventable deaths in rural areas of the country.

The Federal Government of Nigeria has committed to address this missing link in the health system by providing statutory funding to Emergency Medical Treatment enshrined in section 11 Subsection (3c) of the National Health Act which states that 5% of the Basic Health Care Provision Fund shall be used for Emergency Medical Treatment, administered by a committee appointed by the Coordinating Minister for Health and Social Welfare (CMHSW). The measures for equity considerations shall be considered in the distribution of rural emergency services and maternal transport. These considerations shall be driven by data and evidence of a high burden of maternal and infant mortality.

6.2. Gateway Structure

The Emergency Medical Treatment gateway funds are administered by a committee called National Emergency Medical Treatment Committee (NEMTC) comprising of representatives of relevant stakeholders within the health sector and emergency ecosystem, nominations of representatives are forwarded from these Ministries/Departments and Agencies while the post of chairman and co-chairman are appointed by the Coordinating Minister of Health and Social Welfare. The post of chairman must be a medical doctor with at least 15 years' experience in Emergency medical service post NYSC.

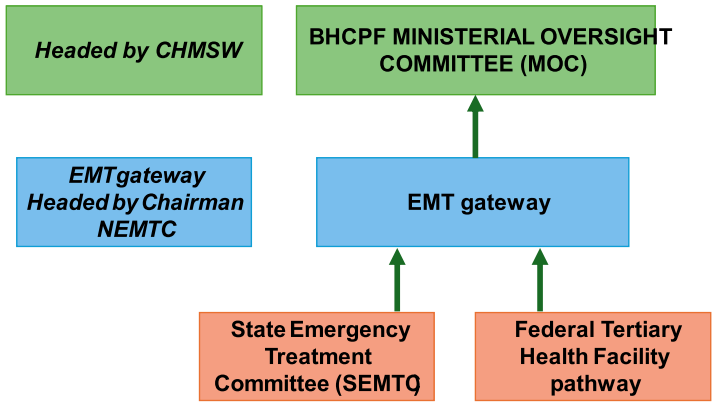


Figure 6-1: Structure of the EMT Gateway

6.2.1. Composition

6.2.1.1. NEMTC

a. Chairperson
b. Co-Chairperson
c. Representative National Blood Service Agency (NBSA)
d. Representative National Health Insurance Agency (NHIA)
e. Representative National Primary Health Care Development Agency (NPHCDA)
f. Representative of Nigeria Centre for Disease Control (NCDC)
g. Chairman Committee of CEOs/SSHIA
h. Chairman Committee of ES SPHCDA
i. Chairman, Committee of Chief Medical Directors (CMDs)
j. Chairman Guild of Medical Directors
k. Representative, Federal Fire Service
l. Representative, Federal Road Safety Commission (FRSC)
m. Representative, National Emergency Management Agency (NEMA)
n. Representative of Media
o. Representative of Civil Society Organisation
p. President Association of Social Workers of Nigeria
q. Chairman Honourable Commissioners of Health Forum
r. Representative of World Health Organisation
s. Representative of World Bank
t. Representative, Nigeria Police Force (NPF)

u. Representative, Nigerian Communications Commission (NCC)
v. President, National Union of Road Transport Workers (NURTW)
w. Representative of Association of Nigerian Private Sector Medical Practitioners (ANPMP)
x. National Programme Manager (National Emergency Medical Service and Ambulance System (NEMSAS) – Secretary

6.2.1.2. Analogous to NEMTC, each of the 36 states and FCT shall establish State Emergency Medical Treatment Committees (SEMTC) to partner with the NEMTC to provide oversight at the state and community level.

a. Chairman – appointed by Honourable Commissioner of Health (Medical Doctor with at least 10 years' experience in Emergency medical services post NYSC)
b. Representative State Blood Transfusion Service Agency
c. Chief Executive Officer, State Health Insurance Agency
d. Executive Secretary State Primary Health Care Development Agency
e. Representative of Committee of Chief Medical Directors
f. Representative of Association of Nigerian Private Sector Medical Practitioners (ANPMP)
g. Representative State Emergency Management Agency
h. Representative Nigeria Police Force
i. Representative Federal Fire Service
j. Representative of National Union of Road Transport Workers (NURTW)
k. Representative of Media
l. Representative of Civil Society Organisation
m. FRSC Sector Commander
n. State Emergency Medical Service and Ambulance System (SEMSAS) Coordinator – Secretary
o. Federal Road Safety Corps (FRSC) State Sector Commander

6.2.2. Terms of Reference for NEMTC

i. Policy, Governance, and Compliance

a. Develop and approve policies, legal frameworks, and operational standards for the National Emergency Medical Scheme (NEMSAS).

b. Ensure compliance with national laws, patient rights, and healthcare regulations.

c. Oversee stakeholder engagement for the EMT gateway

d. Approve the annual work plan for the administration of the 5% Basic Health Care Provision Fund.

ii. Financing and Resource Mobilization

a. Design sustainable funding and resource allocation strategies.

b. Establish fair tariff structures and strengthen collaboration with insurers to ensure coverage and reimbursement.

c. Implement indigent support programs and optimize billing/payment systems through automation.

d. Provide quarterly audited accounts and performance reports to the Ministerial Oversight Committee.

iii. Service Delivery and Partnerships

a. Expand state enrollment, accredited ambulances, and treatment centers.

b. Foster public–private partnerships to enhance service quality.

c. Coordinate Emergency Medical Services nationwide to ensure effective, efficient, and timely delivery.

iv. Operations and Technology

a. Standardize ambulance dispatch protocols and optimize call centers.

b. Integrate mobile technology, data systems, and interoperability standards to improve efficiency and response times.

c. Continuously refine operational processes to strengthen service delivery.

v. . Capacity Building and Standards

a. Establish licensing and accreditation requirements for ambulances, facilities, and personnel.

b. Develop training programs for emergency personnel, first responders, and community members.

c. Set and enforce patient care standards for high-quality emergency treatment.

vi. Monitoring, Evaluation, and Quality Assurance

a. Establish M&E frameworks, performance metrics, and benchmarking tools.

b. Collect and analyze data on emergency call handling and service outcomes.

c. Use findings for continuous improvement, transparency, and accountability.

vii. Public Awareness and Engagement

a. Conduct education campaigns to increase public awareness of emergency services.

b. Strengthen communication and advocacy with stakeholders, insurers, and communities.

c. Establish community feedback systems to guide service improvements.

d. Operational Modality

e. The NEMTC shall meet bi-monthly to review progress, approve reports, and guide implementation

6.2.3. Terms of Reference for SEMTC

i. **Policy and Governance**

a. Implement EMT gateway strategies and operations frameworks, and guidelines through State Emergency Medical Service and Ambulance system (SEMSAS)

b. To provide quarterly performance reports to the State Oversight Committee

ii. **Service Delivery Coordination**

a. Expand and oversee accredited ambulances service providers and Emergency treatment centres in the state.

b. Ensure delivery of timely, efficient, and equitable SEMSAS and RESMAT operations.

iii. **Financing and Resource Management**

a. Manage allocated funds, ensuring transparency and accountability.

b. Monitor tariff compliance and support indigent patient programs.

c. Submit quarterly financial and performance reports to the NEMTC.

iv. **Operations and Technology**

a. Strengthen state emergency call centers and ensure interoperability with national systems.

b. Support mobile technology integration and data-driven service delivery.

v. **Capacity Building and Standards**

a. Facilitate licensing, accreditation, and training of SEMSAS and RESMAT personnel

b. Promote continuous professional development and adherence to patient care standards.

vi. **Public Engagement and Advocacy**

a. Conduct public education campaigns

b. Strengthen collaboration with Local Government Authorities, NGOs, private operators, and communities

Operational Modality

c. The SEMTC shall meet monthly to review progress, approve reports, and guide implementation in the state.

Emergency Medical Treatment Gateway - Federal Tertiary Health Facility Gateway

Emergency medical treatment is a critical component of the health system, ensuring timely and equitable care for all individuals regardless of socio-economic status. Federal Tertiary Health Facilities (FTHFs) are strategically positioned to serve as referral Emergency Medical Treatment centers, particularly for indigent patients and good Samaritan cases.

This framework provides guidance on the operational, financial, and governance mechanisms for the delivery of EMT services in FTHFs across Nigeria.

Objectives

- To designate Federal Tertiary Health Facilities as referral Emergency Medical Treatment centers in all states.
- To guarantee access to emergency care for indigent patients and good Samaritan cases.

- To establish a direct and transparent reimbursement mechanism through the EMT Gateway.
- To strengthen fiduciary accountability through collaboration with NHIA and SSHIAs.
- To institutionalize Hospital Emergency Medical Treatment Committees (HEMTCs) for coordination and oversight.

Hospital Emergency Medical Treatment Committee

Chairman - shall be appointed by the Chief Medical Director/Medical Director and should be a Chief Medical Advisory Committee or Deputy Chief Medical Advisory Committee or a Consultant Physician with at least 5-years' post fellowship experience. Other members include:

i. Heads of Paediatrics Department,
ii. Heads of Orthopaedic and Trauma Department
iii. Heads of Obstetric & Gynaecology Department
iv. Heads of Nursing Department
v. Heads of Pharmacy Department
vi. Chairman Hospital Blood Transfusion Committee
vii. Head of Transport unit
viii. Representative of Medical Records
ix. Head of Social Welfare
x. Representative of Director of Administration who shall be the Secretary of the Committee
xi. Representative HOD Finance
xii. Hospital Desk Officer NHIA

Terms of Reference

i. Provide quarterly performance reports to the Hospital Management Committee
ii. Coordinate emergency Medical Services in the Hospital.
iii. Review services and ensure delivery of quality, effective, efficient and timely Emergency medical services in the Hospital

iv. Ensure strict compliance with guidelines and standards established by the NEMTC

6.3. Gateway Operations

The Emergency Medical Treatment gateway is operationalised via a programme called National Emergency Medical Service and Ambulance System (NEMSAS), as a national coordination entity for 36 +1 State Emergency Medical Service and Ambulance System (SEMSAS) programmes.

6.3.1. Goal

To drive demand for, and increase access to quality, effective and efficient emergency medical service for all Nigerians, especially for pregnant women and neonates in low economic settings.

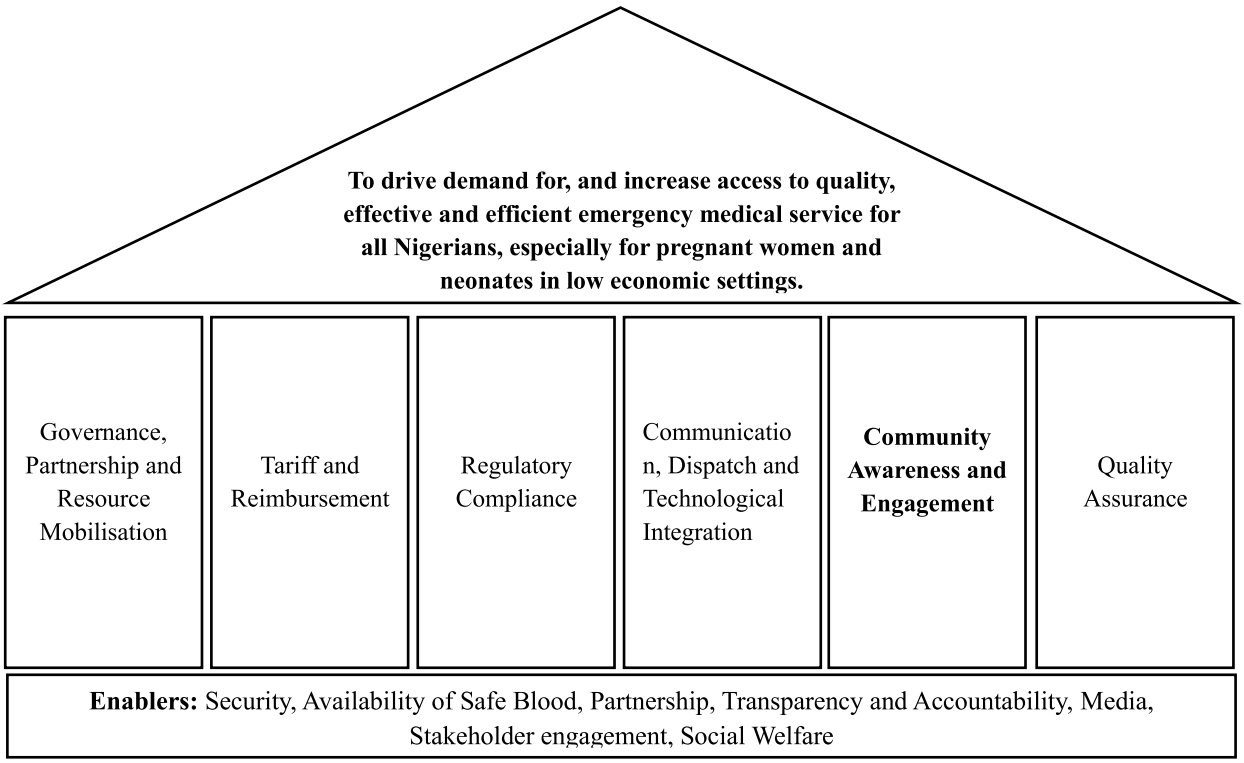


Figure 6-2: Operational pillars of the Gateway

6.3.2. Pillar 1: *Governance, Partnership and Resource Mobilisation*

Specific objectives:

a. Establishing clear policies for emergency medical service in collaboration with stakeholders in Nigeria.
b. Engaging government agencies, NGOs, and private sector partners
c. Develop strategies for sustainable funding and resource allocation.
d. Develop specific frameworks for collaboration with the private sector to enhance service delivery

6.3.3. Pillar II: *Tariff and Reimbursement*

Specific Objectives:

a. Establish fair & competitive pricing for emergency and ambulance services.
b. Collaborate with the National Health Insurance Agency for coverage and reimbursement.
c. Develop financial assistance mechanisms for low-income patients accessing emergency. medical services especially pregnant women and children under five (5).
d. Streamline systems for processing payments and claims.

6.3.4. Pillar III: *Regulatory Compliance*

Specific Objective:

a. Standardise accreditation of ambulances, treatment centres and personnel.
b. Ensure adherence to the operational guidelines of emergency medical services
c. Promote compliance with national laws and regulations governing healthcare and emergency medical service.
d. Ensure that patient rights are prioritised and protected in emergency situations
e. Institutionalise systems for regular audits and assessments of services

6.3.5. Pillar IV: *Communication, Dispatch and Technological Integration*

Specific Objective:

a. Efficient systems for receiving and responding to emergency calls
b. Standardise procedures for ambulance dispatch and coordination
c. Promote the use of apps and systems for real-time communication and tracking

d. Ensure communication systems can work across different agencies and regions in the country
e. Implement electronic recording and reporting tools.

6.3.6. Pillar V: *Community Awareness and Engagement*

Specific Objective:

a. Create Initiatives to inform the public about emergency and ambulance services.
b. Implement First aid, Cardio-Pulmonary Resuscitation (CPR) training for community members
c. Build local volunteer groups for emergency and maternal transport response
d. Develop Systems for community input on services and improvements.

6.3.7. Pillar VI: *Quality Assurance*

Specific Objectives:

a. Establish benchmarks for measuring service effectiveness
b. Develop protocols for ensuring high-quality medical care in emergencies.
c. Comparing performance metrics with leading emergency services globally
d. Conduct systemic evaluation and refinement of services based on feedback and data.
e. Conduct regular training to maintain and improve personnel skills.
f. Develop protocols and training on the enablers.

National Ambulance Service

The National Ambulance Service (NAS), coordinated by NEMSAS, shall function as a centralized platform to coordinate a nationwide network of Private Ambulance Service providers. This will complement State Emergency Medical Service and Ambulance Systems (SEMSAS) in expanding access to efficient and effective pre-hospital care across Nigeria. Members of the public shall be able to request ambulance services through designated state emergency numbers or via a NEMSAS ambulance request application.

6.4. Categories of Services

6.4.1. Basic Life Support (BLS) Ambulances

Basic Life Support (BLS) Ambulances must be designed to provide transportation and basic medical assistance to patients who are experiencing non-life-threatening conditions but still require timely medical attention. Here's an overview of its features and the care it can provide:

a. Ambulance Equipment:
   i. **Basic Medical Supplies**: BLS ambulances must be equipped with essential tools, such as oxygen cylinders, bandages, splints, and suction units, to manage airway obstructions.
   ii. **Communication Systems:** Ambulances shall be equipped with communication systems (such as radios or satellite phones) to stay in contact with hospitals and coordinate care.
   iii. **Oxygen Delivery Systems:** For patients with respiratory distress, the ambulance has nasal cannulas, face masks, and bag-valve masks (BVMs) for oxygen administration.
   iv. **Automated External Defibrillator (AED):** Must have an AED to provide an electrical shock in case of life-threatening arrhythmias.
   v. **Stretcher and Immobilisation Devices:** BLS ambulances must carry stretchers and spine boards to safely transport and stabilise patients, especially those with suspected spinal injuries.
   vi. **First Aid Kits:** Stocked with supplies for wound care, bleeding control, and minor injuries.
   vii. **Communication Equipment:** Radios and mobile devices for communication with dispatchers and hospitals.

b. Personnel:

Emergency Medical Technicians: BLS ambulances shall be staffed by EMT or health workers who are sufficiently trained to provide basic emergency care. They are certified to perform:

   i. Cardiopulmonary resuscitation (CPR)
   ii. Administer oxygen therapy
   iii. Manage fractures, dislocations, and minor trauma
   iv. Control bleeding and treat shock
   v. Administer and manage BEMONC medications
   vi. Basic airway management
   vii. Patient assessment and triage

c. Scope of Care

i. **Non-Invasive Procedures:** BLS ambulances shall focus on non-invasive care, which means they do not perform advanced procedures such as intubation or intravenous therapy. These interventions are usually left to Advanced Life Support (ALS) units.
ii. **Stabilization:** BLS ambulance shall be used to stabilize the patient for safe transport to the nearest medical facility. This includes ensuring the patient's airway is clear, controlling bleeding, and immobilising injuries.
iii. Basic Life Support Ambulances shall be empanelled from public secondary health facilities and shall be equipped with NEMSAS quality assurance. tracking and communication devices, and then assigned to a location in each state under the direct supervision of the state emergency medical service and ambulance system

6.4.2. Advanced Life Support Ambulances

Advanced Life Support (ALS) ambulances must be equipped to handle more severe medical emergencies than a Basic Life Support (BLS) ambulance. ALS ambulances shall provide a higher level of care for critical and life-threatening conditions, with the ability to perform advanced medical interventions en route to the hospital.

a. Ambulance Equipment:
   i. **Advanced Airway Equipment:** Includes endotracheal tubes, laryngoscopes, and other tools to manage and secure a patient's airway in cases of respiratory failure or obstruction.
   ii. **Communication Systems:** Ambulances shall be equipped with communication systems (such as radios or satellite phones) to stay in contact with hospitals and coordinate care.
   iii. **Cardiac Monitoring & Defibrillation:** ALS ambulances must have advanced cardiac monitors that can perform 12-lead electrocardiograms (ECGs) and monitor heart rhythms. They shall also carry defibrillators and be able to provide synchronised cardioversion and manual defibrillation.
   iv. **Intravenous (IV) Therapy Supplies:** Equipment for starting IV lines to administer fluids and medications directly into the bloodstream.
   v. **Medications:** ALS units shall carry a range of medications, including those for pain management, cardiac emergencies (e.g., epinephrine, nitro-glycerine), seizures, diabetic emergencies, and more.

vi. **Syringes and Needles:** For administering injections or medications intravenously.

vii. **Advanced Oxygen Systems:** In addition to basic oxygen supplies, ALS ambulances shall have advanced equipment like Continuous Positive Airway Pressure and BiPAP Bilevel Positive Airway Pressure devices to assist with more complex respiratory issues.

b. Personnel:

Paramedics: ALS ambulances must be staffed by two (2) paramedics or other health workers who have extensive training and are licensed to perform advanced medical procedures. They shall have in-depth knowledge of pharmacology, advanced cardiac life support (ACLS), and emergency trauma care.

c. Scope of Care:

i. **Advanced Airway Management:** Paramedics on ALS ambulances would perform advanced procedures like intubation or using a laryngeal mask airway to help patients breathe.

ii. **Cardiac Arrest Care:** Paramedics would administer advanced life-saving treatments such as manual defibrillation, use of advanced cardiac drugs (e.g., epinephrine, amiodarone), and perform ACLS protocols during cardiac arrest.

iii. **Medication Administration:** ALS teams would administer a broad range of medications, including those for heart attacks, severe allergic reactions (anaphylaxis), seizures, shock, and more.

iv. **Advanced Trauma Care:** For patients with severe injuries, ALS paramedics would provide pain relief, perform advanced wound care, and manage traumatic shock using IV fluids and medication.

v. **Intravenous Therapy:** ALS personnel would insert IV lines to administer fluids and medications to manage dehydration, shock, or serious medical conditions.

vi. **Advanced Monitoring:** In addition to heart monitoring, ALS ambulances shall monitor oxygen levels, carbon dioxide (CO2) levels, and other vital signs with advanced equipment.

vii. **Interfacility Transport:** ALS units would be used to transfer critically ill patients between Health facilities, particularly if the patient requires ongoing advanced monitoring and care during the trip.

viii. **Advanced life support ambulances and teams** shall be empanelled from Federal and State Tertiary Health Facilities, equipped with NEMSAS quality assurance, tracking and communication devices,

6.4.3. Tricycle Ambulances

Tricycle Ambulances shall be prepositioned in BHCPF Primary Health Care facilities to provide basic medical transport and emergency care.

a. Key Features and Components of a Tricycle Ambulance:
    i. **Motorcycle or Bicycle Base:** Built on a motorcycle or bicycle base and includes a sidecar or a rear compartment, which is equipped to transport patients.
    ii. **Patient Compartment:** The patient rides in a small enclosed or semi-enclosed compartment that may contain a stretcher or bench
b. **Medical Equipment:**
    i. **Basic Medical Supplies:** Must possess basic medical equipment such as first aid kits, bandages, splints, oxygen cylinders and a stretcher for transporting patients in a lying-down position.
c. **Personnel:**
    i. **Community Health Worker:** Community health worker, or a trained volunteer with basic first-aid knowledge.
d. **Scope of Care:**
    i. **Basic Life Support (BLS):** Provide Basic Life Support (BLS), which includes basic first aid, CPR, wound care, and emergency transport and transportation of pregnant women for delivery in rural communities at Primary Health Care facilities.
    ii. **Patient Stabilisation:** Stabilise and transport the patient

6.4.4. Boat Ambulances

Boat Ambulance service shall be used in riverine communities where road-based ambulances cannot access remote or isolated locations. Boat ambulances shall be equipped to provide medical care and rapid transport over water, helping communities that are separated by large water bodies reach hospitals or clinics in emergencies.

a. **Design and Structure:**
    i. **Motorised Boats:** They may vary in size from small speedboats to larger vessels, depending on the geographical area and the extent of the service.

ii. **Patient Cabin:** The boat is fitted with a cabin or enclosed area where patients can be safely transported. The cabin may include a stretcher or space for seated patients.

iii. **Weatherproofing:** Given that these boats must operate in different weather conditions, many shall be designed to be weatherproof, offering protection from rain, wind, and rough waters.

b. **Medical Equipment:**

i. **Basic Life Support (BLS) Equipment:** Similar to ground- based ambulances, boat ambulances must carry basic medical supplies, including oxygen cylinders, first aid kits, bandages, splints, and automated external defibrillators (AEDs).

ii. **Stretcher and Immobilisation Devices:** The boat must be equipped with a stretcher to transport the patient in a lying position and immobilisation devices to stabilise patients with potential spinal or head injuries.

iii. **Oxygen Delivery Systems:** Boats must have oxygen tanks and masks for patients who are experiencing respiratory distress.

iv. **Communication Systems:** Boat ambulances shall be equipped with communication systems (such as radios or satellite phones) to stay in contact with hospitals and coordinate care.

c. **Personnel:**

The Boat shall be staffed by one (1) Emergency Medical Technician or Nurse who provides pre-hospital care.

A trained boat operator, who may also have basic emergency medical training, is responsible for navigating and operating the vessel during emergencies.

d. **Scope of Care:**

i. **Basic Life Support (BLS):** Boat ambulances shall offer BLS services and maternal transportation in riverine communities

ii. **Medical Transfers:** Shall also be used for medical transfers, taking patients from communities to appropriate health facilities.

iii. **Boat ambulances** shall be procured by NEMSAS and pre-positioned at jetties of riverine communities, equipped with quality assurance, tracking and Communication devices

Emergency Medical Treatment gateway funds are used to finance ambulance transport to the following levels of care

Level 1: All Basic Emergency Obstetric and Newborn Care (BEMONC) facilities are primary health care centres that can receive pregnant women for delivery and other minor emergencies.

Level 2: All Comprehensive Emergency Obstetric and Newborn Care (CEMONC) facilities cum secondary health care and provide Basic Life Support Ambulance services.

Level 3: Tertiary Health Facilities and Speciality hospitals, these facilities shall deploy Advanced Life support ambulances to respond to specific specialised conditions. ***These centres shall attend to intermediate, major, and specialised emergencies.***

Referral Medical Transport to CEMONC and tertiary facilities: NEMTC shall pay for medical and maternal transport for referral of BEMONC patients to CEMONC or tertiary facilities and CEMONC patients to tertiary facilities. However, this shall be limited to maternal and newborn cases.

Rural Emergency Service and Maternal Transport (RESMAT)

Rural Emergency Service and Maternal Transport (RESMAT) is a dedicated programme established to address the second delay to accessing emergency obstetric care for pregnant women. It is designed to strengthen access to timely and safe emergency care for pregnant women and newborns in hard-to-reach rural communities. RESMAT is also designed to bridge the gap between rural populations and Level 2 BEMONC and CEMONC health facilities by providing reliable, coordinated, and sustainable Emergency Transport options

Through a network of Community Emergency Medical Transport Triage Officers (CEMTTO), functional ambulance services, and referral linkages, RESMAT ensures that no woman or child is left behind due to geographical, financial, or infrastructural barriers. By integrating with state and national emergency medical systems, RESMAT enhances maternal and neonatal survival while contributing to the overall strengthening of Nigeria's health system**.**

RESMAT shall be coordinated through the State Emergency Medical Service and Ambulance system (SEMSAS) at the state level through Local Government SEMSAS officers deployed from the Local Government Health Authority. At the community level, the Ward Development Committee (WDC) shall oversee governance and operations within the communities of its jurisdiction.

Operational Model

Decentralised Community-based Model
Services are outsourced to Emergency Transport Operators (ETO); both public and private tricycle ambulances, commercial drivers and registered private volunteers in communities for maternal and newborn emergency transport services. Using this decentralised community-based model, emergency medical service and medical transport for obstetrics and neonatal emergencies shall be provided using the SAVEMAMA communication, dispatch, and payment platform

6.5. Categories of Beneficiaries

The Emergency Treatment Reimbursement fund in section 6.10.1 shall be utilised to pay for ambulance transport and emergency treatment for the first 48 hours in an accredited treatment centre for vulnerable beneficiaries with the following conditions:

a. Obstetric emergencies and complications during labour and puerperium
b. Under 5 emergencies
c. Road traffic accidents
d. Gunshot injuries
e. Snake bite emergencies

- NEMTC from time to time can add or remove emergency conditions covered to avoid duplication with NHIA and reduce risk of facilities double-claiming from multiple funding sources.
- This flexibility ensures the list of emergencies remains **dynamic** and responsive to both funding realities and emerging health needs.

6.6. Deployment of Appropriate Technology

NEMTC shall deploy an integrated technology solution to enhance the delivery of its services, including call centre, dispatch, fleet management, clinical protocols, claim management and payment systems.

6.7. Establishment and Operationalisation of a National Emergency Medical Team (NEMT)

6.7.1. Scope and Objectives

This provision applies to all stakeholders involved in emergency medical response in Nigeria, including government agencies, healthcare providers, NGOs, and community organisations. The primary objectives are to:

a. Establish a well-structured NEMT to coordinate medical responses.
b. Enhance training and capacity building for emergency medical personnel.
c. Ensure efficient operational procedures for disaster response.
d. Promote public health considerations in emergency situations.

6.7.2. Definition and Framework

Definition of a National Emergency Medical Team. A National Emergency Medical Team (NEMT) is a specialised group of healthcare professionals and support staff organised to provide medical care and support during disasters and public health emergencies. The team will operate under a unified command structure to ensure coordinated response efforts.

6.7.3. Legal and Institutional Framework

a. Relevant Laws and Regulations

The establishment of the NEMT will be guided by:

i. The National Health Act
ii. The National Emergency Management Agency (NEMA) Act
iii. Public Health Laws and Regulations

6.7.4. Institutional Roles and Responsibilities

a. The NEMTC Chairman will oversee the NEMT's operations, providing guidance on training, deployment, and coordination with other agencies. Key coordination includes:
   i. Coordinating with NEMA for emergency response.
   ii. Liaising with the NCDC for public health initiatives.
   iii. Engaging with local governments for community-based responses

6.7.5. Alignment with National and International Standards

a. The NEMT will adhere to the World Health Organisation's guidelines for emergency medical teams, ensuring that practices align with international best practices for disaster response.

b. Regional Protocols. The NEMT will collaborate with regional health organisations and neighbouring countries to strengthen cross-border emergency response capabilities.

6.7.6. Structure of the National Emergency Medical Team

The Honourable CMH&SW shall appoint members of the NEMT

a. Composition of the NEMT
    i. Healthcare Professionals. The NEMT will include:
        - The NEMTC Chairman will lead the NEMT
        - NEMSAS National Programme Manager
        - NEMSAS Head of Operations
        - Physicians (various specialities)
        - Nurses (including emergency and trauma care)
        - Paramedics and emergency medical technicians (EMTs)
    ii. Support Personnel. Support staff will consist of:
        - Logistics coordinators
        - Administrative personnel
        - IT specialists for communication and data management
    iii. Mental Health and Psychosocial Support Teams: specialized teams will provide mental health support to both responders and affected communities, addressing psychological impacts during emergencies.
b. Terms of Reference for the NEMT
    i. When activated, the NEMT shall respond to national or international disaster situations of natural or man-made types.
        - Natural disasters include earthquakes, floods, wildfires, droughts, landslides, volcanic eruptions, tsunamis, Public Health emergencies (pandemics, epidemics, emerging infectious diseases, bioterrorism, etc.), and extreme heat waves. These events are typically caused by environmental factors and can lead to loss of life, injuries, and extensive property damage.
        - Man-made disasters, on the other hand, arise from human actions or negligence. Examples include industrial accidents, oil spills, terrorist attacks, banditry, civil unrest, infrastructure failures, cyber-attacks, environmental degradation, armed conflicts, and food insecurity. These incidents often stem from poor planning, inadequate safety measures, or intentional acts of violence, resulting in significant societal and economic impacts.

ii. Provide emergency medical services to disaster victims equitably, efficiently and in compliance with national and international standards
iii. Handle themselves in the most professional manner
iv. Create detailed medical response plans that outline roles and procedures for emergency medical response during disasters, coordinating with NEMA to integrate these plans into broader disaster strategies.
v. Conduct Public Health education campaigns to inform communities about health risks and preventive measures, leveraging outreach capabilities in partnership with other entities
vi. Organise simulation exercises and drills tailored to medical response scenarios, collaborating with SEMAs and SEMSASs to reflect local contexts.
vii. Provide mental health support services for both responders and affected victims and coordinate efforts with NCFRMI to address the needs of displaced individuals within the first 48 hours.

6.7.7. Funding and Resource Allocation

a. Budgeting for NEMT Operations. A comprehensive budget will be developed to cover training, equipment, personnel, and operational costs associated with the NEMT and presented to the Honourable CMH&SW.
b. Resource Mobilisation Strategies. The NEMT will explore various funding sources, including government allocations, private sector partnerships, and international grants.
c. NEMTC shall provide funding through its established channels for NEMT activities within Nigeria, and which also meet NEMTC's funding eligibility
d. Partnerships and Collaborations. Collaborations with NGOs, international organizations, and private sector entities will be pursued to enhance resource availability and support.

6.8. Cross Gateway Collaboration

The EMT gateway shall collaborate with other BHCPF gateways on several fronts to achieve its goal.

a. **National Primary Health Care Development Agency (NPHCDA) gateway**: To implement the rural emergency service and maternal transport between rural communities and BHCPF primary health care facilities.
b. **National Health Insurance Agency (NHIA) gateway**: Leverage State Health Insurance Agency claims management and reimbursement mechanism to administer EMT gateway funds to tertiary health facilities that have provided emergency treatment for road traffic accident victims brought in by Federal Road Safety Corps, and most importantly, obstetric and perinatal emergencies managed at these facilities.
c. **Nigeria Centre for Disease Control (NCDC)gateway**: Collaborate to develop and implement protocols for multi-hazard situations, establish multi- hazard Emergency medical Teams to provide emergency medical services during public health emergencies, major nationwide hazardous materials incidents, building collapses, contamination-related incidents, terrorism-related disasters, and a variety of other incidents in which their services may be needed.

6.9. Financial Management

The 5% BHCPF funds for the NEMTC shall be administered through TSA following the government fiduciary system. Signatories to the TSA shall be as stipulated by the office of the Accountant General of the Federation (AGF). The permanent secretary Federal Ministry of Health and Social Welfare shall be the approving authority; designated accountants from AGF will serve as initiators, reviewers and final approval on the payment platform, while the Chairman of the NEMTC will be a viewer on the platform. The NEMTC shall have the fiduciary responsibility of administering the funds, and the chairman is required to review and approve all claims and expenditures before disbursements. The private emergency treatment and ambulance service providers shall have accounts with registered commercial banks for the NEMTC, while payments to PHC facilities shall be in their designated BHCPF accounts.

The funds for the NEMTC TSA shall be disbursed as follows:

6.9.1. Emergency Medical Treatment Reimbursement (80%)

This portion shall be used as follows:

a. For payment of pre-hospital (emergency ambulance) services according to the tariff approved by NEMTC

i. Ambulance service reimbursement through the NEMSAS claims management office

b. For payment for emergency services provided at accredited treatment centres on a fee-for-service basis and according to the prevailing NHIA tariff

i. The emergency medical treatment funds shall be used for patients in emergencies, whose status is uninsured or unknown at the time of evaluation

ii. If payment is made for persons who have health insurance coverage, invoices will be sent to their insurance companies or health maintenance organisations (HMOs) for reimbursement

iii. **State Social Health Insurance Agencies (SSHIAs)** will conduct *primary electronic vetting* of claims.

iv. To avoid conflict of interest, claims may be vetted **across states.**

v. NEMTC retains the authority to conduct **random audits** and beneficiary verification for quality assurance

vi. NEMTC shall administer EMT funds through State Health Insurance Agencies pending full operations of the Integrated Emergency Medical Service Software that connects

vii. NEMTC shall pay all accredited and enrolled Federal Tertiary Hospitals directly based on fee-for-service for medical emergency and ambulance services through the authorised claims and payment platform following verification of the delivery of service

6.9.2. Operational Funds at Federal Level (10%)

a. Ten per cent (10%) of total EMT gateway funds shall be set aside for NEMTC activities and NEMSAS operations.

6.9.3. Operational Funds at State/LGA Levels (10%)

a. Five per cent (5%) of total gateway funds shall be set aside for disbursement to the 36 States and Federal Capital Territory with operational SEMSAS, 50% shared equally while 50% shall be shared on equity basis i.e. volume of SEMSAS managed ambulance services.

b. The other five per cent (5%) of total gateway funds shall be set aside for disbursement to the 774 Local Government Health Authorities with

operational RESMAT; 50% shared equally, while 50% shall be shared on equity basis i.e. volume of RESMAT services.

c. The funds shall be disbursed to States through the Treasury Single Account (TSA) and blended with the State's counterpart funding to form 100% of available funds for EMT gateway operations at the subnational level.

6.10. Monitoring and Evaluation Section for NEMTC Guideline

The M&E framework is designed to facilitate informed decision-making and continuous improvement of emergency medical services with the following specific objectives:

a. To track the progress of EMT interventions and services against established goals and benchmarks.
b. To assess the quality and effectiveness of emergency medical services delivered.
c. To identify challenges and areas for improvement in service delivery.
d. To ensure accountability in the use of funds and resources allocated to the EMT gateway.

6.10.1. Key Indicators

Service Delivery Metrics

I. Number of emergency calls received and responded to.
II. Average response time for emergency services.
III. Percentage of patients stabilised before transport.

Quality of Care Metrics

I. Patient satisfaction scores.
II. Compliance rates with clinical protocols and guidelines.
III. Rates of adverse events during transport.

Financial Management Metrics

I. Timeliness of fund disbursements to service providers.
II. Percentage of funds utilised for operational vs. reimbursement needs.

Training and Capacity Building Metrics

I. Number of personnel trained in emergency medical services.
II. Frequency and quality of refresher training sessions.

6.10.2. Roles And Responsibilities

National Emergency Medical Treatment Committee (NEMTC)

I. Oversees the M&E framework and ensures alignment with national health goals.
II. Reviews and analyses performance reports bi-monthly.

State Emergency Medical Treatment Committees (SEMTC)

I. Collects data at the state and community levels.
II. Provides quarterly performance reports to the NEMTC.

Health Care Providers

I. Maintains accurate records of service delivery and patient outcomes.
II. Participates in training and capacity-building initiatives.

6.10.3. Reporting

a. Monthly reports of all emergency data handled by each state shall be sent to the NEMTC through NEMSAS, as well as data on the immediate disposition of all cases, including deaths.
b. Routine monthly programme implementation reports, as approved by the Honourable Commissioner, shall be sent to the NEMTC through NEMSAS.
c. NEMTC shall produce consolidated quarterly reports summarising data on service delivery, financial management, and patient outcomes.
d. NEMTC shall conduct an annual evaluation to assess the EMT gateway's overall impact on health outcomes and service efficiency.

6.10.4. Continuous Improvement

a. NEMTC shall utilise the findings from M&E activities to foster an adaptive management approach.
b. NEMTC shall implement changes to protocols and services based on evaluation results to enhance the quality and effectiveness of emergency medical services.

6.10.5. Quality Assurance

a. Internationally accepted quality benchmarks adapted to country context will be used to assess the performance of the scheme, and guide quality improvement. The NEMTC shall, in conjunction with relevant stakeholders, be responsible for quality assurance at service delivery points.
   NEMSAS/SEMSAS shall train staff on the application of a quality assurance tool, which will be jointly created with other relevant gateways.

b. This tool shall focus on the following priority areas:

   i. Governance, administrative structure, and infrastructure
   ii. Financial management
   iii. Response time
   iv. Quality of transportation
   v. Human resources management
   vi. Patient care
   vii. Patient satisfaction

6.10.6. 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 activity shall be subject to due ethical clearance as stipulated by the Federal Ministry of Health and Social Welfare.

6.11. Sanctions for Non-Compliance

See NHIA section on non-compliance

6.12. Grievance Redress Mechanisms

See NHIA section on GRM

7. GUIDELINE FOR IMPLEMENTATION OF THE NCDC GATEWAY

7.1. Introduction

The Nigeria Centre for Disease Control and Prevention (NCDC) is the national public health institute with the mandate to lead the prevention, detection and response to infectious disease outbreaks and public health emergencies.

The NCDC Basic Health Care Provision Fund (BHCPF) Gateway provides strategic funding to strengthen Nigeria's health security by enhancing the country's capacity to prevent, detect, and respond to public health emergencies at both national and subnational levels. Key areas of support include disease outbreaks and public health emergencies (PHEs), health promotion, advocacy, surveillance, public health laboratory systems, and other activities aligned with the International Health Regulations (IHR). In accordance with the International Health Regulation (IHR) 2005, response must be timely, comprehensive, and involve a multisectoral approach across all levels.

To improve the timeliness of outbreak response, NCDC has piloted and adopted the global 7-1-7 timeliness metrics, which measures:

Detection: Public health events should be detected within 7 days of emergence.
Notification: Events should be reported within 1 day of detection.
Response: Effective response actions should be completed within 7 days of notification.

The NCDC BHCPF Gateway funding allocation consists of:

- Operations Fund
- Programmatic Fund
    - Public Health Emergency and Outbreak Response Fund (PHEORF)
    - State Outbreak Investigation and Response Fund (S-OIRF)

7.1.1. Objectives of the NCDC BHCPF Gateway

The objectives of the NCDC Gateway are to:

a. Establish a sustainable funding mechanism for public health emergency management at both national and subnational levels.
b. Provide public health guidance at the subnational level, strengthen core capacities under the International Health Regulations (IHR), and support

investments to improve disease surveillance and response systems to effectively manage public health emergencies.

c. Provide technical guidance to the other gateways on Public Health Emergency Management.

7.1.2. NCDC Gateway Structure

The NCDC Gateway governance structure is as captured in the schema below:

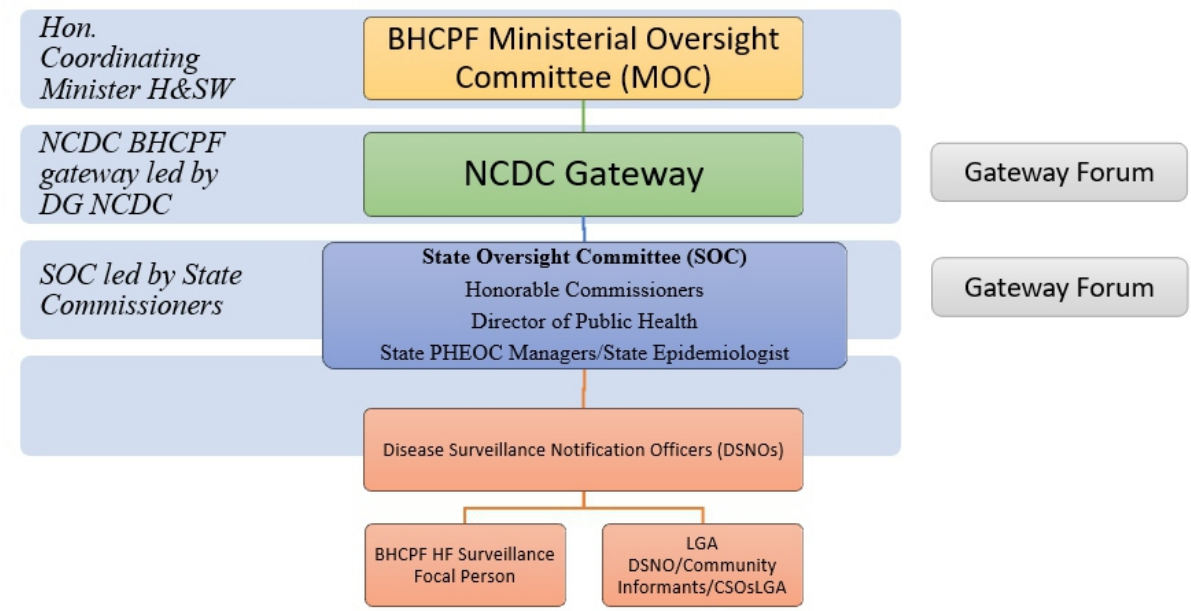


Figure 7-1: NCDC Gateway Governance Structure

7.2. NCDC Gateway Operations

7.2.1. Project Implementation Unit (PIU)

At the national level, 10% of the total NCDC Gateway funds is set aside as operational funds (Opex).

The operations fund is dedicated to supporting the day-to-day management activities of the NCDC BHCPF Gateway. The Project Implementation Unit (PIU) oversees the operational and strategic execution of the Gateway, ensuring full compliance with established guidelines and Standard Operating Procedures (SOPs). Key responsibilities include financial management, including opening Treasury Single Accounts (TSAs), fund disbursement, financial reporting, expenditure verification, and audits, as well as procurement and asset management to maintain transparency and accountability.

The PIU also houses Knowledge Management, Communication, and Advocacy (KMC), which drives the implementation of the KMC strategy, enhances stakeholder engagement, and supports communication efforts at both national and

subnational levels. Additionally, the PIU manages the Grievance Redress System to ensure the timely resolution of concerns from stakeholders and beneficiaries. The Monitoring, Evaluation, Accountability, and Learning (MEAL) unit conducts routine performance assessments, using insights to guide continuous improvement and inform decision-making across the Gateway's operations.

At the state level, 15% of the total funds disbursed to states will be allocated as operations funds. This amount will be evenly split, with 7.5% designated for state-level activities and the remaining 7.5% allocated to support Local Government Area (LGA) operations. These funds will be disbursed on a quarterly basis into the states' designated NCDC BHCPF Treasury Single Accounts (TSAs).

Approval Process for Fund Utilisation & Disbursement Requests

All approvals (operations & programs) from the Director General, NCDC, must be sought through memos raised by the NCDC BHCPF Focal Point or their delegate, to ensure effective monitoring and tracking of fund utilization and to confirm alignment with the intended purposes outlined in this document.

7.3. Programmatic Fund

This comprises of two components:

- Public Health Emergency and Outbreak Response Fund (PHEORF)
- States Outbreak Investigation & Response Fund (S-OIRF)

7.3.1. Public Health Emergency and Outbreak Response Fund (PHEORF)

Twenty per cent (20%) of the NCDC gateway's programmatic allocation will be embedded in NCDC as the Public Health Emergency Outbreak Response Fund (PHEORF). This fund enables rapid access to resources, facilitating the early deployment of Rapid Response Team, technical staff, and response supplies from the national level during infectious disease outbreaks and public health emergencies. The PHEORF can also support procurement of goods and services related to outbreak preparedness and response.

Reporting lines from the community level start with the community informant, who notifies the facility focal person and/or the Local Government Area Disease Surveillance and Notification Officer (LGA DSNO) of any suspected infectious disease cases. The LGA DSNO reports to the State DSNO and the State Epidemiologist (SE). Once the SE notifies NCDC, the Director General (DG) forwards the request to the Health Emergency Response Operations and

Management Committee (HERO-M), which recommends action measures to the DG. If the HERO-M recommends the utilisation of the PHEORF, a concept note will be submitted to the PIU. The PIU will develop a memo for the DG to approve the activation of the utilisation of the PHEORF. The NCDC DG will notify the Honourable Coordinating Minister of Health and Social Welfare within 24 hours of activation of the PHEORF.

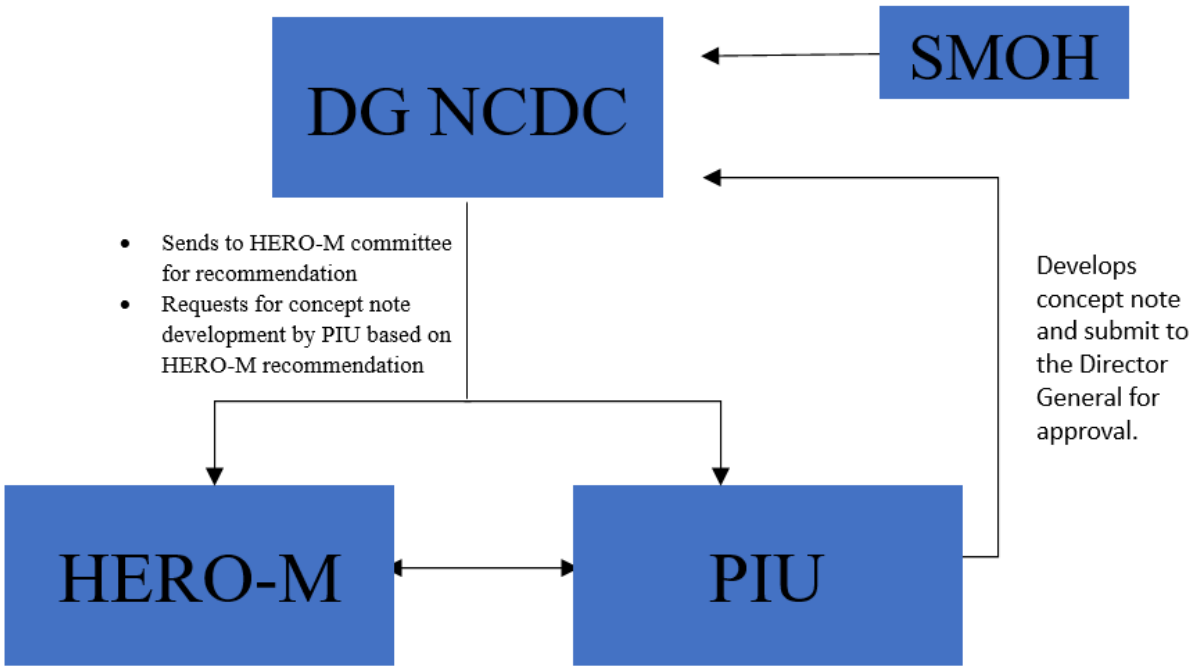


Figure 7-2: PHEORF Activation Mechanism

7.3.1.1. Assessment Criteria for PHEORF Activation

Key risk assessment criteria that inform the decision to activate the PHEORF include:

a. Potential threat of public health importance.
b. High number of people at risk.
c. Severity of the incident
d. Affected persons, wards/LGAs reaching alert thresholds and/or crossing the epidemic threshold.
e. Geographical spread of the incident /events
f. Heightened public media interest
g. Need for additional capacities beyond the local capacity to control the outbreak.
h. Uncertain conditions, emerging or re-emerging infections (including the possibility of escalation of the event, limited knowledge of the extent of the damage).

i. Multiple emergency sites.
j. Declaration of state of local emergency.

Aside from these, the usual Public Health Emergency Management (PHEM) procedures will continue to be followed including the preliminary and dynamic risk assessments to maintain daily situational awareness and activation of Incident Management System (IMS) upon the confirmation of an incident using 7-1-7 approach.

Risk Levels and Actions		
Level of Overall Risk	**Actions**	**Remarks**
Very High Risk 19-24	• Immediate response required, even if the event is reported out of normal working hours • Immediate Senior Management attention needed, the implementation of control measures with serious consequences is highly needed.	The command-and control structure should be established within 2hrs and switch to response mode.
High Risk 13-18	• Senior Management attention needed. • May need to activate EOC.	Command & Control structure should be in Alert or Response depending on incident.
Moderate Risk 7-12	• Roles and responsibility for response specific. • Specific control measures required.	Should be in Alert mode/ Enhanced surveillance.
Low Risk 0-6	• Routine control. • Manage according to standard protocols & regulations.	Watch mode- Routine surveillance system & secondary sources.

Table 7-1: Risk Assessment Matrix

7.3.2. State Outbreak Investigation and Response Fund (S-OIRF)

The State Investigation & Response Fund (S-OIRF), which constitutes eighty per cent (80%) of the programmatic fund, is designed to enhance states' capacity for public health emergency prevention, preparedness, and response (EPR).

The NCDC BHCPF gateway disburses these funds directly to the Treasury Single Account (TSA) of States that meet the eligibility criteria, with the State Public Health Emergency Operations Centre (PHEOC) managing the funds under the oversight of the Commissioner of Health or their delegate.

The disbursement of S-OIRF follows two funding principles: **Equality** and **Equity**. Resource allocation is reviewed annually, with fifty per cent (50%) based on Equality and fifty per cent (50%) on evidence from the national seasonal disease calendar.

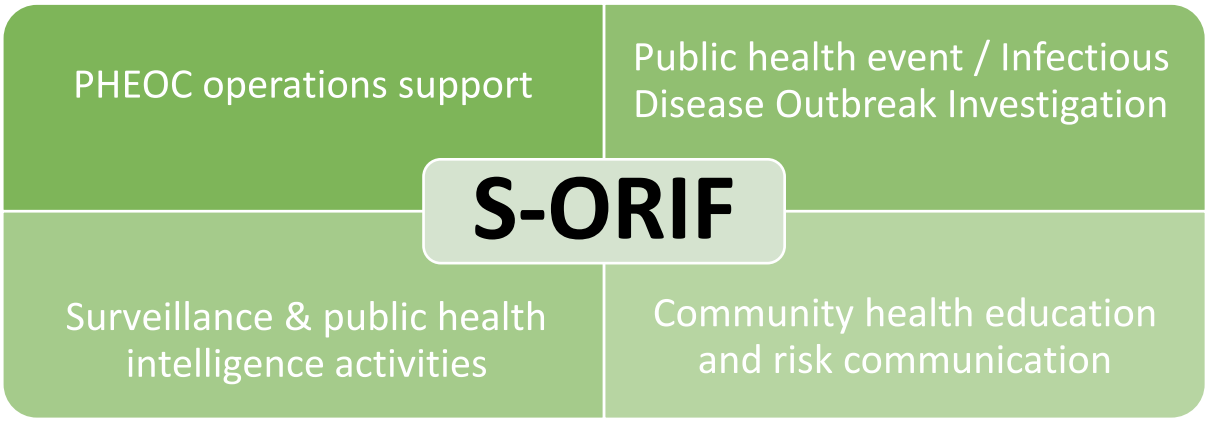
States must designate the following three (3) signatories to the State NCDC BHCPF TSA:

1. The Project Accountant as Initiator,
2. An Accountant from the Project Financial Management Unit (PFMU) as the Verifier, and
3. The Head of PFMU Finaliser.

7.3.2.1. Workplan Thematic Areas

States are required to develop their work plans to suit the four (4) thematic areas below. This recommended allocation formula serves as a guideline; however, states have the flexibility to adjust it based on their specific public health burden and needs, following no objection from the Subnational Support Departments (SSD).

a. Public Health Emergency Operations Support -7.5%
b. Public Health event/infectious Disease Outbreak Investigation and response – 22.5%
c. Surveillance and public health intelligence activities -50%
d. Community health education and risk communication – 20%



7.4. Roles and Responsibilities of the NCDC Gateway

7.4.1. Health Emergency Response Operations and Management (HERO-M)

The Health Emergency Response Operations and Management (HERO-M) is tasked with monitoring infectious disease trends through Public Health Emergency Operations Centres (PHEOCs). Comprised of technical professionals from the NCDC, it provides recommendations to the NCDC DG on the activation and use of the Public Health Emergency/Outbreak Response Fund (PHEORF) during outbreaks or public health events.

Key responsibilities of HERO-M include:

- Monitoring disease outbreaks and public health threats using multi-hazard plans and risk calendars at national and subnational levels.
- Confirming and managing disease outbreaks in coordination with states, local governments, and stakeholders, including deploying rapid response teams and implementing control measures.
- Ensuring the NCDC DG has all necessary information to activate the PHEORF when needed.
- Collaborate with disease-specific Technical Working Groups (TWGs) and One Health stakeholders such as Groups for One-Health, the National Action Plan on Health Security, Nigeria One Health Coordinating Unit (NOHCU), National One Health Risk Surveillance and Information Sharing (NOHRSIS) Group, Nigeria Antimicrobial Resistance Coordinating Committee (AMRCC), and the more recently recommended Chemical Events TWG and Poisons Information Centre, for coordinated responses.
- Support the operationalisation of the MEAL framework at the subnational level using the global 7-1-7 metrics.
- Develop and submit a report detailing the response activities funded by the PHEORF to the PIU upon the completion of the response by the IM/HERO-M.

7.4.2. NCDC Subnational Department

The Subnational Department of the NCDC reviews State workplans before they are presented to the Director General for funding approval.

In addition, the department will support in the following areas:

- Operationalisation of the NCDC BHCPF at the subnational level.
- Capacity Building and Technical Support at the subnational level.
- Support the PIU in developing and implementing the Monitoring, Evaluation, Accountability, and Learning (MEAL) framework.
- Stakeholder Engagement and Communication at the subnational level
- Advocate for one health approaches at the subnational level.

7.4.3. State Epidemiologist

- The State Epidemiologist (SE) will lead the development and implementation of activities related to PHEOC operations, outbreak investigations, and responses within the state.
- The State Epidemiologist, under the guidance of the Director, Public Health (DPH), will develop workplans tailored to the state's evidence-based needs. The work plan will be approved by the Commissioner of Health before submission to the NCDC.
- The State Epidemiologist will be responsible for reporting progress to the State Oversight Committee (SOC) and NCDC.

7.4.4. State Disease Notification Surveillance Officer (DNSO)

a. Ensure that surveillance activities are included in the state work plan as well as in respective LGAs.
b. Report findings of the initial investigation to the State Epidemiologist.
c. Assist LGAs in implementing the BHCPF State workplan as submitted to the NCDC

7.4.5. LG DSNO

The role of the LGA surveillance officer is to:

a. Investigate and verify possible outbreaks, collect diagnostic samples, advise on treatment/prevention protocols
b. Prepare and analyse weekly surveillance reports and submit promptly to higher authorities
c. Ensure that surveillance sites maintain surveillance reports, logbooks properly
d. Maintain a list of all reporting facilities/sites

e. Establish and maintain a database of all trained and registered health care workers, who can serve as surveillance focal persons at the reporting facilities, as well as other CBS FPs

f. Ensure an adequate supply of data collection and reporting tools at the surveillance reporting facilities

g. Ensure that the IDSR standard case definitions for all the priority diseases are understood and used by healthcare workers at the facility; provide on-the-spot training if needed

h. Monitor the performance indicators (such as timeliness and completeness) of the IDSR, as stipulated in the IDSR guideline

7.4.6. Community Informants/Civil Society Organisations (CSO)

a. Provide support to the NCDC gateway towards operationalisation at the national and subnational levels.

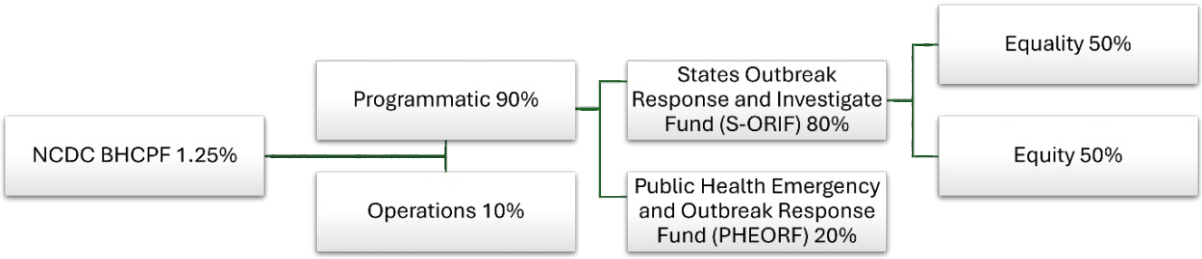
7.5. Financial Management

The NCDC maintains a BHCPF TSA at the Central Bank of Nigeria (CBN) with appropriate signatories for BHCPF Operations and Programmes. The BHCPF MOC shall allocate and disburse quarterly funds to the NCDC Gateway. Each quarterly (and overall annual) disbursement from the BHCPF TSA shall comprise of two components-

a. Operations - ten per cent (10%)
b. Programmatic allocation – ninety per cent (90%).

States are expected to meet the eligibility criteria as stated below before the DG's approval for the disbursement of funds to the state TSA account. The NCDC BHCPF PIU finance officer will ensure that funds are disbursed to States within ten (10) days of the DG NCDC's approval for disbursement after meeting the eligibility criteria (excluding CBN processes).

The finance officer (PIU) shall prepare and submit quarterly financial reports, quarterly interim financial projections, compliance with service delivery data requirements and resolution of outstanding external audit, or ad-hoc financial review findings.



7.5.1. Eligibility for S-OIRF Disbursement

The State PHEOCs will be eligible to access the BHCPF-NCDC Gateway Funds when they have:

a. A dedicated State NCDC BHCPF TSA.
b. Three (3) assigned signatories to the State NCDC BHCPF TSA nominated by the State Accountant General that meet the eligibility criteria.
c. An annual State PHEOC workplan with activities/interventions aligned with NCDC's BHCPF gateway budget allocated themes.
d. Reviewed state submissions by the PIU in collaboration with the subnational department and approval by DG, NCDC.
e. Future disbursements will be contingent on the State's quarterly retirement of previously disbursed funds. If a State fails to retire funds, NCDC will step in to operationalise the state workplans and provide support to resolve the retirement issues.

7.5.2. Financial Management at the Subnational Level

At the subnational level, states will receive 80% of the programmatic funds allocated through the NCDC Gateway. The distribution to each state will be determined using the following criteria:

- **50% based on equality** (equal distribution across all states)
- **50% based on evidence from the national seasonal disease calendar** (reflecting the state's disease burden and outbreak risk)

States are required to allocate 20% of the disbursed funds towards the Subnational Public Health Event/Outbreak Response Fund (S-PHEORF). This fund serves as a dedicated financial pool to support timely and effective responses to public health emergencies as well as to achieve deliverables of the 7-1-7 matrix. The State Commissioner of Health or delegate is responsible for activating the S-

PHEORF, with formal notification provided to the Nigeria Centre for Disease Control and Prevention (NCDC) upon activation.

Unutilized or inactivated funds under the S-PHEORF will be retained by the state as a reserve pool for future public health events, ensuring continuous preparedness and readiness.

7.5.3. Operations Fund

A total of **15% of the disbursed funds** to each state shall be reserved as an **Operations Fund**, split equally between the state and local government levels as follows:

- **7.5% for State-level operations**
- **7.5% for Local Government Areas (LGAs),** to be disbursed by the state to the respective LGAs

States are expected to maintain oversight functions (including auditing and keeping programmatic and financial reports from each LGAs) over local government activities related to the use of the Operations Fund. The NCDC may also conduct periodic spot checks at both state and LGA level to assess and verify reports of fund utilization and ensure accountability.

The **NCDC may also conduct periodic spot checks** at both state and LGA levels to verify fund utilisation and promote transparency and accountability.

7.5.4. Reporting Requirements

States are required to submit **quarterly programmatic and financial reports**, including statements of account, to the NCDC physically and via email at: 📧 **ncdc.bhcpf@ncdc.gov.ng**

7.6. Reporting

The NCDC PIU will share reports with the MOC. Quarterly and annual programmatic and financial reports on the NCDC Gateway shall be prepared by the State PHEOCs (led by State Epidemiologists) who have received disbursement. This report shall be collated by the SSD which will be forwarded to the PIU.

7.7. Fraud

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

Audit Spot Checks: NCDC team will perform audit spot checks in the states as well as monitoring and evaluation which will be documented and reported to the DG NCDC and MOC.

Whistle-Blowing and Reporting Mechanism: NCDC is committed to transparency, accountability, and integrity in the implementation of the Basic Health Care Provision Fund (BHCPF) Gateway. To uphold these values, all stakeholders and members of the public are encouraged to report any suspected fraud, financial mismanagement, misuse of funds, or unethical conduct related to BHCPF activities.

If you observe or suspect any form of malpractice, please report confidentially via:
ncdc.bhcpf@ncdc.gov, **wpo@ncdc.gov.ng**, **ncdcactu@ncdc.gov.ng**.

Your report will be treated with the highest level of confidentiality and in accordance with NCDC's whistle-blower protection policy. Your voice matters in promoting accountability and ensuring that resources are used effectively to strengthen Nigeria's health system.

NCDC Anti-corruption and Transparency Unit (ACTU): The approval and the directive to set up Anti-corruption and Transparency Unit (ACTU) in all MDAs was given during a Federal Executive Council (FEC) meeting as contained in the rules 4 and 5 of the standing order 2023.

7.8. Monitoring Evaluation Accountability and Learning (MEAL) Framework

The Monitoring, Evaluation, Accountability, and Learning (MEAL) framework below mandates timely reporting from responsible persons at national and subnational levels, with periodic field monitoring, supervision, and rapid assessments.

7.8.1. Objectives of the MEAL Framework

The objectives of MEAL for the NCDC gateway are to ensure effective implementation, enhance public health emergency response, demonstrate impact,

enhance accountability, foster learning, and enable evidence-based decision-making for improved outcomes and sustainable disease surveillance at the national and subnational levels.

a. To track fund releases and disbursements.
b. To ensure transparency and accountability to stakeholders, including beneficiaries, donors, and partners.
c. To facilitate a culture of continuous learning and improvement. MEAL processes encourage reflection, analysis, and knowledge sharing to generate lessons learned and best practices.

7.8.2. M&E Indicators

Key M&E Indicators

Indicator	Target	Frequency	Data Source	Responsibility
Goal 1: Track the timely and efficient disbursement of funds and deployment of resources to ensure rapid response to public health emergencies (PHEs)				
1.1 Percentage of States with timely disbursement of funds within 10 days of DG approval	100%	Quarterly	Financial reports from TSA and PIU	NCDC PIU Finance Officer
1.2 Proportion of alerts where PHEORF was deployed within 48 hours of public health alert	100%	Per Event	Incident Reports, PHEOC reports	NCDC PIU
Goal 2: Ensure rapid and coordinated response actions at the national and subnational levels to minimize public health risks (7-1-7 matrix)				
2.1 Proportion of National RRTs deployed within 7 days of PHE alert	100%	Per Event	National PHEOC reports	NCDC HERO-M
2.2 Proportion of State PHEOCs activated within 24 hours of PHE alert	80%	Per Event	State-level activation logs	State PHEOC Coordinators
Goal 3: Strengthen surveillance systems for early detection and timely response to public health emergencies				
3.1 Proportion of public health alerts reported within 24 hours	100%	Per Event	State PHEOC report	State Disease Notification Officers

Indicator	Target	Frequency	Data Source	Responsibility
3.2 Proportion of S-PHEORF activations within 24 hours of alert	80%	Per Event	State-level financial reports	State PHEOC Coordinators

7.8.3. Structure of the MEAL Framework

TSA Accounts and Funding: All States will operate a TSA account for NCDC Gateway. States will be expected to submit financial reports regularly.

7.8.4. Reporting for the MEAL framework

Reporting for the MEAL framework shall emanate from routine reports from States, including financial and supervisory reports. All reports (programme and financial) shall be compiled at least quarterly, and other required reports for the NCDC BHCPF Gateway as indicated in relevant sections of this guideline. These reports shall clearly highlight aspects of the framework and work plan, also stating successes, commendations, good practice, gaps identified and proposed solutions, as well as sanctions invoked as necessary based on the accountability framework and NCDC Gateway Guidelines. State PHEOCs and NCDC may be required to provide additional reports to the SOC and MOC, respectively.

7.9. Sanctions

Sanctions shall not contravene the public service rules and regulations, public financial regulations, and the national Procurement Act. For any involvement of private sector entities in NCDC Gateway, extant federal laws shall apply as relevant for financial matters.

7.10. Grievance Redress System

All BHCPF-related issues should be reported to NCDC through NCDC.BHCPF@NCDC.GOV.NG. NCDC will establish Standard Operating Procedures (SOPs) to address various types of grievances, including those related to service delivery, financial management, and procurement. Each grievance will be directed to the appropriate focal point (e.g., financial, procurement, services). NCDC will ensure the timely resolution of grievances and outline clear escalation steps if issues remain unresolved.

8. MONITORING AND EVALUATION OF THE BASIC HEALTH CARE PROVISION FUND

A comprehensive Monitoring and Evaluation (M&E) system within the BHCPF is crucial to ensure health care delivery is not only efficient but also effective and equitable. It will also help achieve the following:

- Guarantee health interventions are targeted towards reducing morbidity and mortality among pregnant women and young children.
- Furnish stakeholders with accurate and timely data that will support evidence-based decision-making and policy formulation that can lead to significant improvements in maternal and child health, as well as attaining Universal Health Coverage (UHC).
- Provide a framework for continuous quality improvement, allowing for the identification of gaps in service delivery and the implementation of strategies to address them.

Implementation of Monitoring and Evaluation (M & E) of the Basic Health Care Provision Fund (BHCPF) involves multiple stakeholders, their interdependencies, processes, and performance across the four gateways; National Health Insurance Authority (NHIA) Gateway, the National Primary Health Care Development Agency (NPHCDA) Gateway, the National Emergency Medical Treatment Committee (NEMTC) Gateway and Nigeria Centre for Disease Control (NCDC) Gateway each playing their relevant roles in collecting and reporting data. The implementation progress will be regularly monitored by the gateways and MOC Secretariat and will be reported during the quarterly MOC meetings.

8.1. General Objective

To systematically monitor and evaluate the implementation, performance and outcomes of the BHCPF to ensure transparency, accountability and continuous improvement in the delivery of essential health services.

8.1.1. Specific Objectives

a. Establish a systematic process for collecting, analysing and using information to track progress
b. Ensure the resources allocated for the BHCPF are used efficiently and effectively.
c. Ensure accountability and transparency in the utilisation of BHCPF resources
d. Track achievement of key health outcomes and outputs.

e. Facilitate evidence-based decision-making for improved health service delivery

8.2. Scope of the BHCPF Monitoring and Evaluation

a. Implementation progress will be measured systematically by continuous review of Key performance indicators collected at baseline and throughout the implementation period.

b. For each gateway, the M&E will span across

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

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

   iii. Outcomes: how has the intervention influenced the health and socioeconomic wellbeing of the Nigerian population?

8.2.1. Approach

The M&E structure shall ensure a robust mechanism for continuous information collection and analysis to track progress of BHCPF activities, including financial disbursement and funds flow, verification of routinely reported service delivery data and beneficiary feedback.

8.2.2. Independent Monitoring and Verification Agency

As stipulated in the BHCPF Guideline, at the instance of the MOC, an Independent Monitoring and Verification Agency (IMVA) may be contracted to conduct end-to-end financial and programmatic verification of the BHCPF in select states across the six geopolitical zones. This includes verification of financial disbursements of the BHCPF, counter verification of financial records, verification of utilization of BHCPF for specific health interventions, validating data reported by the health facilities against actual service delivery, validating data accuracy and completeness, verification of implementation of fiduciary risks remediation plans, etc. their findings will be used to validate the reports submitted by the states and LGAs.

The IMVA shall report all findings of their verification to the MOC Secretariat for the BHCPF, upon which informed decisions shall be made at the MOC meetings.

8.2.3. Indicators

Periodic M & E will be conducted to assess inputs, processes, outcomes, and impact indicators, based on the Health Sector Strategic Blueprint and the indicators tracked by the 4 (four) gateways. Specific key performance indicators (KPIs) (see section 8.10 below) shall be routinely used to track performance.

8.2.4. Data Sources

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

a. Statements of Accounts
b. Financial reports
c. NHMIS – DHIS2
d. National and State Health Accounts
e. M & E reports from the Gateways
f. National surveys, such as the Multiple Indicator Cluster Survey (MICS), the National Demographic and Health Survey (NDHS), the National Health Facility Survey, etc.

8.2.5. Program Monitoring

a. Monitoring of BHCPF implementation is crucial for ensuring the effective and efficient use of resources to improve healthcare service delivery. Regular monitoring allows for timely identification of issues, enabling corrective actions and adjustments to strategies to enhance program outcomes.

b. The monitoring of the BHCPF will involve multilevel participation from Federal, State and Local government health authorities. This will ensure that there are collaborative efforts to monitor, report and verify the use of the funds and quality of services provided at the PHCs

c. Joint monitoring and spot check visits will be conducted to monitor BHCPF implementation, functionality of management structures at the state, LGA, and facility levels, review as well as functionality of PHCs programmatic and financial records, including community engagement and ownership. This process shall involve systematic administration of checklists to assess implementation, appropriate disbursement of funds, verify quality improvement and facility performance scores and reports from states.

8.2.5.1. Federal Level

To provide oversight and policy direction for the BHCPF implementation. Ensure timely disbursement of funds, supervise the performance of key health indicators and monitor compliance with national guideline.

Responsibility

I. Quarterly field supervision, monitoring, verification and mentoring visits to select states and LGHA.
II. Review of state quarterly M&E reports and provision of feedback
III. Ensure development of action plans for issues identified and monitor its implementation
IV. Conflict resolution

8.2.5.2. State level

Coordinate the M&E activities within the state and provide technical support to LGA. Ensure data is collected, validated, and reported accurately within the stipulated time. Supervise PHCs to ensure compliance with the national guideline.

Responsibility

I. Quarterly review of reports from LGAs.
II. Quarterly monitoring, supervision and mentoring of PHCs in collaboration with LGHA teams.
III. Ensure development of action plans for issues identified and monitor its implementation
IV. Conflict resolution

8.2.5.3. Local Government Level

To conduct routine monitoring and mentoring visits of PHC activities and ensure that services provided align with the BHCPF guideline. Collect and report data on key indicators.

Responsibility

I. Monthly facility supervision and mentoring visits
II. Facilitate community engagement sessions to assess the impact of BHCPF on service delivery.
III. Ensure development of action plans for issues identified and monitor its implementation
IV. Conflict resolution

8.2.6. Data Collection and Management

Within the specified periods, all gateways are expected to collect data using various data collection platforms, including DHIS2, and appropriate tools to evaluate program performance across the various levels, i.e., State, LGHA, and PHCs.

Data collection will follow the DHIS2 system and other HMIS tools. Data will be collected at the facility level by the healthcare providers and reported to the LGA, which will further validate and transmit on the National Health Information System (NHMIS). The state M&E team will review the completeness and quality of the data.

8.2.6.1. Data Collection Tools

I. Data collection will include the standardised registers and monthly summary forms.
II. Across the various levels, data shall be collected using gateway-specific tools and designed platforms.

8.2.6.2. Data Quality Assurance

Routine data quality assessment (DQA) will be conducted at all levels to ensure the accuracy and completeness of the reported data.

8.2.7. Evaluating Results from Health Investments

a. The evaluation of the results of BHCPF shall involve a systematic assessment of program effectiveness to achieve its objectives and improve health outcomes. This includes analysing data on Key Performance Indicators (KPIs), Quality of Care (QoC), health outcomes and comparing them against the baseline measurements and targets.

b. Data analysis shall be used to evaluate the BHCPF's performance and effectiveness, while standard checklists shall be used to assess the progress made by the state, local governments, and health facilities. Results from the data analysis will be made available to all state and local governments and PHCs to plan and improve on previous performance scores.

8.2.8. Research

Implementation research will be conducted to measure the fidelity of the revised BHCPF guideline, identify innovations and implementation strategies deployed by the states, and provide recommendations for improvement. Gateways are

encouraged to conduct operational research for evidence synthesis to enhance the effectiveness and efficiency of the BHCPF.

Findings and data from the studies shall be made available to the MOC for advocacy and public dissemination.

8.3. Parameters for the Monitoring and Evaluation Framework

Outlined below is a global parameter for the monitoring and evaluation framework, taking into consideration past programme reports and the likely investment required to achieve the identified indicators.

Investment Domain	Objective	Indicators
Essential drugs, vaccines & consumables	Ensure adequate and timely availability of essential drugs, vaccines, and consumables in all health facilities.	Stock Level Maintenance: Maintain an assigned critical minimum of stock levels for all essential drugs and vaccines across all health facilities each quarter, Reduction in Stock-Outs: Reduce the incidence of stock-outs per quarter by December 2028
Maintenance of facilities, laboratory, equipment & transport	Improve the operational state of facilities, equipment, and transport to ensure uninterrupted health service delivery.	Facility Renovation: Complete renovation of health facilities requiring maintenance by Dec 2027. Equipment Functionality: Ensure laboratory equipment is fully functional and calibrated quarterly. Transport Availability: Increase the availability of
Human Resources Development	Build capacity and improve the competency of	Number of capacity building interventions implemented. Number of healthcare workers

	the healthcare workers to enhance service delivery	that benefited from capacity building, Competency Improvement: Achieve an improvement in healthcare worker competency scores as assessed through post-training evaluations by Dec 2028.
Governance and Stewardship	Strengthening governance structures for sustainability of the health system at state & federal levels	Policy Implementation: Ensure 80% compliance with newly developed guidelines across all levels by Dec 2028 Technical Assistance Utilization: Provide and utilize technical assistance in the states requiring support by December 2028.
Health Financing and Financial Management Systems	Establish sustainable health financing mechanisms and improve financial management to ensure efficient use of resources.	Health Insurance Coverage: Increase the number of vulnerable people covered by health insurance against the target population by December 2028. Out-of-Pocket Expenditure Reduction: Reduce out-of- pocket (OOP) expenditure on health annually
ICT, Health Information Management, and Innovations	Enhance the management of health data through improved ICT infrastructure and innovative technologies	ICT Infrastructure Improvement: Upgrade ICT infrastructure in health facilities by Dec 2028.

8.4. Key Performance Indicators for BHCPF

The BHCPF performance indicators to be tracked have 4 levels. Result-oriented indicators will be tracked and managed by the MOC secretariat, while others will be tracked at the gateway level. See the table below with the indicators.

S N	Indicator	Data Frequency	Data Source	Responsible
National Level: To be Tracked at Ministerial Oversight Committee				
1	BHCPF allocation from FAAC	Annual	Annual Budget, FMoF, FMBEP	MOC
2	Percentage of annual BHCPF budget released	Quarterly	Annual Budget, FMoF, FMBEP	MOC
3	Proportion of States that provided annual 25% counterpart funding for BHCPF	Annual	States budgets	MOC
4	Proportion of BHCPF facilities that have an average quality assessment score of 80%	Quarterly	Programmatic reports	NPHCDA/ NHIA
5	Number of vulnerable populations enrolled into insurance through the BHCPF	Biannual	NHIA programmatic report	NHIA/ SHIAs
6	Antenatal Care Coverage 4	Quarterly	DHIS2, programmatic report	NPHCDA/ SPHC DA
7	Facility-based deliveries	Quarterly	DHIS2, programmatic report	NPHCDA/ SPHCDAs
8	Number of health insurance enrollee	Quarterly	NHIA programmatic report	NHIA/ SSHIAs

9	Number of people covered under BHCPF NHIA gateway	Quarterly	NHIA Gateway Reports	NHIA/SSHIAs
10	Number of emergency encounters handled	Quarterly	EMT Gateway Reports	NEMT/SEMT
11	Number of wards with operational Rural Emergency Services and Maternal Transportation (RESMAT) for deliveries and obstetrics emergencies	Quarterly	EMT Gateway Reports	NEMT
12	Out-of-pocket expenditure on health	Annual	National Health Account	FMoH (DHPRS) & NBS
NHIA Gateway: To be Tracked by NHIA				
1	Total number of Primary Health Care Facilities (PHFs) enlisted into the BHCPF	Quarterly	programmatic report	NHIA/SSHIAs
2	Proportion of Private HCFs enlisted into the BHCPF	Quarterly	programmatic report	NHIA/SSHIAs
3	Number of beneficiaries enrolled under BHCPF	Quarterly	Programmatic report	NHIA/SSHIAs
4	Number of Secondary Health Care Facilities (SHCFs) per state enlisted into the BHCPF	Quarterly	Programmatic report	NHIA/SSHIAs
5	Percentage of enrollees that utilized the Basic Minimum Package of Health Services (BMPHS) at primary care level	Quarterly	Programmatic report	NHIA/SSHIAs
6	Number of enrollees that have encounter with the BHCPF PHCFs.	Quarterly	Programmatic report	NHIA/SSHIAs
7	Percentage annual change in utilization of BMPHS by	Quarterly	DHIS, Programmatic	NHIA/SSHIAs

	enrolled populations		reports	
8	Proportion of states that enlist at least one PHCF per ward for BHCPF	Quarterly	Programmatic reports	NHIA/ SSHIAs
NPHCDA Gateway: To be Tracked by NPHCDA				
1	Proportion of SPHCBs receiving quarterly disbursement from NPHCDA	Quarterly	Programmatic report	NPHCDA, SPHCDAs or SOCs
2	Proportion of BHCPF PHCs that received DFF disbursement from SPHCB	Quarterly	Programmatic report	NPHCDA/ SPHC DA or SPHCB
3	Proportion of BHCPF PHCs with active WDCs	Quarterly	DHIS; State programmatic reports	SPHCDA or SPHCB
4	Proportion of BHCPF PHCs with minimum quality assessment (QA) score of 80%	Quarterly	Programmatic reports	SPHCDA or SPHCB
5	Proportion of the population accessing PHC services	Quarterly	DHIS	SPHCD or SPHCB
6	Number of BHCPF PHCs that meet PHC standards (level 2)	Quarterly	Programmatic reports	NPHCDA
7	Proportion of children that received Penta 3 vaccines	Quarterly	DHIS	NPHCDA
EMT Gateway: To be tracked by NEMTC				
1	Proportion of states with functional and accredited emergency call centers	Annually	EMT Gateway Reports	NEMTC, SEMTC
2	Number of pregnant women who received delivery voucher during ANC booking	Quarterly	Programmatic reports	NEMTC/ SEMTC

3	Number of children under 5 years transported.	Annually	EMT Gateway Reports	NEMTC, SEMTC
4	Number of pregnant women transported.	Quarterly	Programmatic report	NEMTC, SEMTC
5	Number of other emergencies transported to the HFs.	Quarterly	Programmatic report	NEMTC, SEMTC
NCDC Gateway				
1	Number of recorded cases of public health concern per state	Biannual	Programmatic report	NCDC/ State PHEOCs, SOCs
2	Number of states with incidence of disease(s) of public health concern	Biannual	Programmatic report	NCDC/ State PHEOCs, SOCs
Indicators for Community Engagement, Communication and Knowledge Management				
1	Number of BHCPF campaigns conducted	Annually	Programmatic report	Gateways, MOC Secretariat
2	Total engagement across all BHCPF platforms	Quarterly	Programmatic report	MOC Secretariat
3	Number of training workshops held on BHCPF	Quarterly	Programmatic report	SPHCDA, SOC Secretariat

Independent Monitoring and Verification

To ensure transparency, quality assurance, timely reporting, risk mitigation, and accountability, the MOC may direct the engagement of a third-party monitoring firm/s that will systematically monitor the BHCPF implementation, assess progress, and provide independent and objective perspective on the BHCPF implementation, ensuring trust and transparency among all stakeholders, including the federal and state governments, the implementing agencies, the donors, and the beneficiaries. This will offer concrete methods for accountability

and learning that will ensure that the BHCPF projects stay on track and meet the predetermined goals and objectives. The firm will have the ability to access and operate in hard-to-reach and insecure areas, where the BHCPF implementation may face the most challenges or risks and produce regular and comprehensive reports highlighting the achievements, challenges, best practices, and recommendations for improvement.

The overall objective is to provide independent biannual or annual verification of BHCPF implementation in Nigeria, covering all four gateways and the states participating in the BHCPF.

a. **Specific objectives**
   i. To verify the compliance of the BHCPF implementation with the operational guidelines and the obligations of the implementing agencies and the SPHCBs/SSHIA
   ii. To assess the quality and effectiveness of the BHCPF services and interventions, including the BMPHS, operational cost, human resource for health, emergency ambulance services, and states set up for surveillance and readiness to tackle and manage epidemics.
   iii. To measure the progress and performance of the BHCPF implementation against the agreed outputs and outcomes, using the key performance indicators and targets
   iv. To identify the strengths, weaknesses, opportunities, and threats of the BHCPF implementation, and provide actionable recommendations for improvement.
   v. To document and disseminate the findings, lessons learned, and best practices of the BHCPF implementation, and facilitate feedback and learning among the stakeholders.

b. **The Verification agency shall undertake the following functions**
   i. **Financial Oversight:**
      - Undertake financial records counter verification.
      - Ensuring compliance with financial guidelines and regulations.
   ii. **Performance Monitoring:**
      - Assess the performance of the implementing facilities, PHEOCs and EMTS.
      - Verify the utilisation of BHCPF funds for specific health interventions.

iii. **Stakeholder Engagement:**

- Engage relevant stakeholders, including health workers, community representatives, government officials, PFMOs and DPs.
- Solicit feedback on issues raised.

8.5. Reporting

Reporting on BHCPF is essential for maintaining a cohesive and transparent health system, including 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, SHIA, SEMTC, LGHA, and PHC and dispatched upwards through the gateways on a regular basis for national collation.

8.6. 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 program success. The table in 8.6.4 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 gateways, for routine implementation.

8.6.1. Objective of the Accountability Framework

The core objectives of the accountability framework are:

a. To ensure compliance with the BHCPF Guideline, and

b. To ensure that eligible health facilities benefitting from the program are funded in a timely, transparent, and accountable manner, which ensures incremental quality improvement and effective service delivery.

8.6.2. Reporting for Accountability Framework

a. Reporting for the framework shall emanate from regular administration of the tool by the MOC Secretariat in collaboration with the CSOs and through the review of 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.

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

8.6.3. 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 sanctions 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 NHIA and EMT gateways, extant federal and state laws shall apply as relevant for financial matters.

8.6.4. Accountability Framework

Federal Level

S/N	Level	Indicators	Description/Comment	Rating (1=on track, 2=slightly off track, 3=severely off track)	Data Frequency	MoV/Source of Data	Respondent
GOVERNANCE							
1	Federal	Percentage of states that have developed remediation plans to address issues flagged during the annual audit	Annual external audits are conducted by the OAGF, facilitated by the MOC secretariat. States are expected to progress towards resolving issues flagged during the annual audit's exercises through the implementation of the remediation plans developed.		Annually	BHCPF Audit Reports	MOC
2	Federal	Quarterly meeting of the MOC in the preceding quarter	The MOC meets quarterly to ensure synergy and coordination of different stakeholders and implementation of involved in planning BHCPF		Quarterly	Meeting report	MOC
FUNDING							

3	Federal	Percentage of CRF allocated to BHCPF by the National Assembly	At least 1% CRF is stipulated in the NHAct to be released for implementation of the BHCPF.		Annually	TSA, State/federal annual budget	Chairmen of the Health Committees of National Assembly
4	Federal	Percentage of the allocated BHCPF disbursed in the preceding fiscal year	At least 1% of the CRF should be released and disbursed. There is need to ascertain if the % or more was fully disbursed in the previous year		Annually	MoF	FMoF/ MOC
PROGRAMME MANAGEMENT							
5	Federal	Percentage of SPHCDA that submitted quarterly programmatic & financial reports to NPHCDA	Submission of programmatic and financial reports (before the 2nd week of the succeeding month) by SPHCB to NPHCDA is a prerequisite to earn funding for subsequent quarter. The retirements are submitted by SPHCBs expected to be to NPHCDA by the 4th week of the preceding quarter		Quarterly	Reports	NPHCDA/SPHCDA
6	Federal	Percentage of SSHIAs that submitted quarterly programmatic & financial reports to NHIA	Submission of programmatic and financial reports by SSHIAs to NHIA is a prerequisite to earn funding for subsequent quarter.		Quarterly	Reports	NHIA/SSHIAs
7	Federal	Percentage of PHEOCs that submitted quarterly programmatic & financial reports to NCDC	Submission of programmatic and financial reports by PHEOCSs to NCDC is a prerequisite to earn funding for subsequent quarter.		Quarterly	Reports	NCDC/ PHEOCs
8	Federal	Percentage of SEMTCs that submitted quarterly programmatic & financial reports to NEMTC	Submission of programmatic and financial reports by SEMTCs to NEMTC is a prerequisite to earn funding for subsequent quarter.		Quarterly	Reports	NEMTC/SEMTCs

9	Federal	Proportion of verification visit conducted by the NPHCDA/NHIA for QoC and QA	Jointly conduct the NPHCDA and NHIA quarterly verification visits to the states to ascertain disbursement of DFF, data and invoices as well as for Quality Assurance		Quarterly	Reports	NPHCDA/NHIA
10	Federal	Number of monitoring spot checks visits conducted to BHCPF implementing facilities by the MOC	The MOC as part of its coordinating role should conduct monitoring visits to the facilities of the gateways, on such visits, documentation of findings and feedback should be done		Quarterly	Proof of monitoring visits	MOC

State Level

S/N	Level	Indicators	Description/Comment	Rating (1=on track, 2=slightly off track, 3=severely off track)	Data Frequency	MoV/Source of Data	Respondent
GOVERNANCE							
1	State	Percentage of LGHA that submitsthe annual workplan and budget before the current fiscal year	Each LGHA has the responsibility to submit an annual operational work plan & budget to the MOC. This should be done before implementation of next year begins.		Annually	Submitted annual workplan & budgets	SOC
2	State	Development of a remediation plan to address issues flagged during the annual audit	Annual external audits are conducted by the MOC secretariat in collaboration with OAGF. States are expected to progress towards resolving issues flagged during the annual audit's exercises through the implementation of the remediation plan developed		Annually	BHCPF Audit Reports	MOC

3	State	Conduct of quarterly meeting of the SOC in the preceding quarter	The SOC meets quarterly to ensure synergy and coordination of different stakeholders involved in planning and implementation of BHCPF in the State		Quarterly	Agenda, minutes/ action points	SOC
4	State	Proportion of PHCs whose business plans were approved by the SPHCDA in the preceding quarter	All PHCs are required to develop and submit a business plan informed by the annual quality improvement plan which focuses on enhancing user experience. The business plan is developed by the PHCs in consultation with the WDC and with technical support from the LGHA which is to be approved by the SPHCDA or SPHCB via the LGHA		Quarterly	Approved business plan	SPHCDA
FUNDING							
5	State	Percentage of counterpart funds budgeted/allocated for BHCPF in the state	Measure of State Government commitment to implementation of the BHCPF. The state governments are expected to pay 25% counterpart fund to the SOC TSA for BHCPF. Allocation is the first step of commitment to the counterpart fund for BHCPF in each state.		Annually	MoF	SMoH/SHoA
6	State	Proportion of counterpart funds released (cash-backed) to SOCs TSA for BHCPF	Measure of State Government commitment to implementation of the BHCPF. Release of the counterpart fund for BHCPF in each state is proxy for measuring availability of funding at the accredited BHCF facilities for implementation		Annually	MoF	SMoH/ Min. of Finance
7	State	Percentage of health facilities that received capitations (timely) not later than 5 days before the commencement of the next month	Receipt of funding by health facilities is a pre-requisite for service provision and quality improvement. PHCs are to receive funds not later than 5 days before the commencement of the next month		Quarterly	State health Insurance agency	SSHIA

8	State	Percentage of PHCs receiving quarterly DFF allocation from SPHCB	The Direct Facility Financing (DFF) is direct investment in BHCPF facilities through the NPHCDA gateway, in collaboration with support PHC facilities SPHCDAs or SPHCBs to improve structural quality i.e. infrastructure, medical equipment, drugs, consumables and human resource.		Quarterly	Facility Statement of Account	SPHCDA
PROGRAMME MANAGEMENT							
9	State	Percentage of State level gateways that submit annual budget and workplans to the SOCs	Timely submissions of annual workplans and quality improvement plans (before 2nd week of January) have a domino (cascade) effect on the timeliness of implementation of planned activities		Annually	Workplan & budget by reviewed by SOC	SOC
10	State	Proportion of PHCs that score at least 80% in their quality scores (good and excellent)	To ascertain quality improvement in the PHCs, the SPHCBs conduct a quarterly quality assessment visit to the PHCs using a predeveloped tool and quality scores which are as follows; 0-49% - Poor, 50-59% - Fair, 60-79% - Good, >80& Excellent)		Quarterly	Assessment reports	SPHCDA
SERVICE DELIVERY							
11	State	Percentage of BHCPF implementing PHCs offering 24 hours services	The offering of 24-hour services in PHCs is critical in attaining the first 48 hours of care in emergency medical service.		Quarterly	Supervision reports	SOC, ISS/ SPHCDA
12	State	Percentage of BHCPF Enrollees who accessed care at least once in the health facilities in the preceding quarter	This explains utilization of health services by enrollees. Source of data: (i) SPHCDA/SSHIS (ii) ISS		Quarterly	State Audit Reports	SOC, ISS/ SPHCDA

LGA Level

S/N	Level	Indicators	Description/Comment	Rating (1=on track, 2=slightly off track, 3=severely off track)	Data Frequency	MoV/Source of Data	Respondent
GOVERNANCE							
1	LGA	Percentage Local Government Advisory Committee (LGAC) available and meeting quarterly	The LGAC meets regularly to ensure synergy and coordination of different stakeholders involved in planning and implementation of BHCPF at the LGA level		Quarterly	Agenda, minutes /action points	SOC
FUNDING							
2	LGA	Percentage of PHCs submitting complete retirement documents to SPHCBs	At the end of each quarter, PHCs are expected to complete the provided formats for retirement of expenditure for that quarter, prior to receipt of additional funding. The PHCs are required to submit them to SPHCDA/SPHCDB through the LGHA		Quarterly	Completed Expenditure Analysis Sheets	LGHA/SP HCDA
PROGRAMME MANAGEMENT							
3	LGA	Proportion of planned supervisory visits conducted by LGA in the last quarter	The LGHA is expected to conduct supervisory visits to the PHCs every quarter. The LGHA conducts routine supportive supervision and monitoring of PHCs in the LGA and ensures that: i. PHCs are staffed, equipped and functional ii. Community members have access to the BMPHS iii. BHCPF funds received by the PHC facilities from the SPHCDA are utilized judiciously and transparently to supplement the		Quarterly	Visitors book at the PHC, Supervision reports	LGHA

			operational budget of the PHC for improvement in quality of care.				
SERVICE DELIVERY							
4	LGA	Percentage of BHCPF implementing PHCs offering 24 hours services	The offering of 24-hour services in PHCs is critical in attaining the first 48 hours of care in emergency medical service.		Quarterly	Supervision reports	SOC, ISS/ SPHCDA
5	LGA	Percentage of BHCPF enrollees who accessed care at least once in the health facilities in the preceding quarter	This explains utilization of health services by enrollees. Source of data: (i) SPHCDA/SSHIS (ii) ISS		Quarterly	State Audit Reports	SOC, ISS/ SPHCDA
6	LGA	Proportion of facilities that has at least 2 Nurses/Midwives on government payroll	This determines the sufficiency of required health workers on government payroll in the facility with a focus on nurses/midwives		Quarterly	Facility Duty roaster	LGHA/ SP HCDA
7	LGA	Proportion of BHCPF facilities with assigned BHCPF mentors	Trained LGHA staff are assigned to PHC facilities as mentors. They supervise, support plan development, periodically check fund management and are responsible for timely transmission of plans and expenditure statements		Quarterly	List of BHCP mentors and assigned facilities	LGHA
CLIENT SATISFACTION/COMMUNITY							
8	Community	Percentage of BHCPF enrollees that are satisfied with services received.	Client satisfaction will be measured through an exit survey where BHCPF enrollees will be asked Yes or No questions on satisfaction after consultations, client satisfaction will be asked about the following: i. Health workers responsiveness ii. Waiting time iii. Receipt of prescribed		Biannually	Exit survey report	WDC, SPHCDA

			drugs iv. Amount of money spent out of pocket, and v. Availability of skilled health workers Any respondent that answers Yes to at least three of the five questions is classified as satisfied				
9	Community	Percentage of WDC members that perceived BHCPF as effective in their supported facilities	Perception of BHCPF effectiveness among the WDCs will be measured by eliciting the perception of effectiveness of BHCPF among the WDCs in the following areas: i. Availability of services 24 hours ii. Right people (intended beneficiaries) benefit from BHCPF iii. Increased utilization of services in the facility iv. Reduction in out-of-pocket expenditure, and v. Needed drugs are always available Any respondent that answers yes to at least three of the five questions perceives BHCPF as effective		Biannually	Survey report	WDC, SPHCDA

8.6.5. 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.

9. COMMUNITY ENGAGEMENT, COMMUNICATION AND KNOWLEDGE MANAGEMENT

9.1. Introduction

The success of the BHCPF hinges significantly on effective communication and robust citizen engagement. This chapter outlines strategies and mechanisms aimed at bolstering public awareness, promoting transparency, and cultivating trust in the BHCPF program. Additionally, it outlines approaches for engaging stakeholders and implementing targeted initiatives to boost healthcare service utilisation.

Community-based services and communication are pivotal for ensuring effective healthcare delivery and nurturing trust and engagement among community members. The overarching objectives in developing these Community Engagement, Communication, and Knowledge Management guidelines for the BHCPF implementation are to:

a. Create public awareness on the BHCPF implementation using modern solutions and traditional methods to enhance KMC at all levels.
b. Develop and promote branding for the BHCPF.
c. Institutionalise and strengthen the KMC system in the BHCPF implementation.
d. Promote learning within the BHCPF implementation to generate evidence for improved decision-making.

This chapter outlines guidelines encompassing the community engagement strategy, communication plan, and knowledge management approach for the BHCPF and is to serve as a guide for implementation by the MOC Secretariat, implementing gateway Partners and CSOs. It emphasises targeted initiatives to increase service utilisation within the community, aiming for effective healthcare delivery through engagement, transparency, and sustainability. The following framework offers a structured approach to achieving these objectives.

9.2. Communication and Citizens Engagement

Communication and citizens' engagement are critical components for the success of any health program, including the Basic Health Care Provision Fund (BHCPF). These processes aim to inform, involve, and empower community members and stakeholders to actively participate in and support health initiatives. Effective communication ensures that accurate and timely information is disseminated,

while citizens' engagement fosters trust, transparency, and a sense of ownership among community members.

9.2.1. Objectives of Communication and Citizens' Engagement:

1. **Enhance Public Awareness about BHCPF and its Benefits:**
   By increasing understanding and knowledge of the BHCPF and its advantages to the community.
2. **Foster Transparency and Build Public Trust in the BHCPF Program:**
   By ensuring openness in the Fund's process and activities. to cultivate trust among the public.
3. **Ensure Timely and Accurate Dissemination of Information:**
   By providing stakeholders with up-to-date and precise information regarding BHCPF initiatives and developments.
4. **Engage Community to Actively Participate in and Support the BHCPF:**
   By encouraging involvement and backing from local leaders, health workers, community organisations, and other relevant stakeholders in the BHCPF's activities.
5. **Drive Targeted Demand Generation to Increase Utilisation of Healthcare Services:**
   Through the Implementation of strategies to boost the community's use of available health services, addressing specific needs and barriers to access.

9.2.2. Communication Channels

Effective communication is vital for the success of the BHCPF. This section outlines the various channels that shall be used to disseminate information, engage citizens, and ensure transparency. By leveraging both modern and traditional media, it shall foster awareness, trust, and active participation in the BHCPF.

9.2.3. Key Messages

This section contains key thematic areas that shall guide BHCPF communication efforts and the development of messages to promote, ensuring consistency and coherence. These thematic areas and messages should be aimed at enhancing awareness, promoting transparency, and garnering support for the BHCPF, ultimately improving healthcare access and quality for all citizens.

Mainstream Media: •Partner with major media outlets to broadcast regular updates and success stories about BHCPF. •Develop radio jingles, TV commercials, and newspaper articles to reach a broad audience.	**Social Media:** •Create and maintain active social media accounts to engage with the community. •Post regular updates, success stories, and educational content. •Utilize social media influencers to amplify key messages and reach wider audiences.	**Community Activities:** •Organize town hall meetings, community forums, and community plays to engage directly with community members. •Implement door-to-door campaigns to provide personalized health education and gather feedback.	**Print Materials:** •Distribute brochures, posters, and flyers in local languages to ensure wide reach. •Place banners in strategic locations within communities to increase visibility.
Digital Platforms: •Develop a user-friendly website and mobile app to provide comprehensive information about BHCPF. •Use SMS notifications to send reminders and updates to beneficiaries, ensuring timely communication.	**Branding:** •Ensure all healthcare facilities display BHCPF signage information on Basic Minimum Package of Health Services (BMPHS) to create a unified identity	**Community Signage:** •Install directional signs at strategic points within the community to guide patients to healthcare facilities, making it easier for them to find the services they need	**Infographics and Local Dialects:** •Develop infographics that simplify complex health information, making it easier to understand. •*Translate all materials into local dialects to enhance comprehension and engagement within diverse communities.*

Thematic Areas and sample messages:

1. **Understanding BHCPF and Its Benefits:**
   "BHCPF: Making healthcare affordable and accessible for you and your community."
   "Discover the benefits of the BHCPF for you and your community"
   "Your trust is our priority: Stay informed about BHCPF activities."
2. **Fostering Transparency and Building Public Trust:**
   "We are committed to transparency in the BHCPF."
   "Join us in building a transparent and trustworthy healthcare system through the BHCPF."
   "Your participation matters: Get involved with BHCPF to improve healthcare for all."
   "Support BHCPF and help us enhance healthcare services in your community."
3. **Timely and Accurate Dissemination of Information:**
   "Stay updated with the latest news and developments about the BHCPF."
   "Get accurate information about BHCPF right when you need it."
   "BHCPF updates: Keeping you informed every step of the way."
4. **Engaging Stakeholders for Active Participation and Support:**
   "Your participation matters: Get involved with the BHCPF."

"Support the BHCPF and help us enhance healthcare for all."

5. **Driving Targeted Demand Generation:**
   "Take advantage of the healthcare services available through the BHCPF."
   "Utilize BHCPF services for better health outcomes."
   "Increase your access to quality healthcare with the BHCPF."

9.3. Community Engagement

The community engagement for the BHCPF shall entail working collaboratively with community groups to increase demand, identify and address health-related issues. This requires involving community members in decision-making, planning, and implementing health initiatives to improve public health outcomes and ensure that services meet the community's needs.

9.3.1. Objectives of Community Engagement for BHCPF:

1. **Enhance Public Awareness:**
   Inform and Educate: Increase the community's knowledge about available healthcare services, preventive measures, and health programs.
   Clarify Misconceptions: Address and correct any misunderstandings or myths about healthcare practices and treatments.
2. **Foster Trust and Transparency:**
   Build Trust: Establish and maintain trust between healthcare providers and the community through consistent, honest, and open communication.
   Promote Transparency: Ensure that the community is well-informed about healthcare policies, processes, and decisions.
3. **Encourage Participation and Collaboration:**
   Active Involvement: Involve community members in the planning, implementation, and evaluation of healthcare initiatives.
   Empower Communities: Empower community members to take ownership of their health and participate actively in health-related activities.
4. **Improve Health Outcomes:**
   Promote Preventive Care: Encourage the adoption of healthy behaviours and preventive care practices to reduce the incidence of diseases.
   Increase Utilization: Boost the use of healthcare services through targeted demand generation strategies.
5. **Strengthen Feedback Mechanisms:**
   Gather Insights: Collect feedback from the community to understand their needs, preferences, and concerns.

Improve Services: Use community feedback to refine and enhance healthcare services and delivery.

6. **Enhance Accessibility and Inclusivity:**
   Reach Diverse Groups: Ensure that healthcare messages and services are accessible to all segments of the community, including marginalised and vulnerable populations.
   Cultural Sensitivity: Develop culturally appropriate communication strategies to engage diverse communities effectively.
7. **Build Sustainable Relationships:**
   Long-term Engagement: Foster long-term relationships with the community to support sustained health improvements.
   Continuous Improvement: Establish mechanisms for ongoing dialogue and engagement to continuously improve healthcare delivery.
8. **Mobilise Resources and Support:**
   Leverage Partnerships: Collaborate with local leaders, organisations, and stakeholders to mobilise resources and support for healthcare initiatives.
   Community Contributions: Encourage community contributions, such as volunteerism and local fundraising, to support health programs.
9. **Facilitate Behaviour Change:**
   Behaviour Change Communication (BCC): Develop and implement BCC campaigns to promote healthy behaviours and lifestyle changes.
   Positive Reinforcement: Use success stories and testimonials to motivate and reinforce positive health behaviours.

9.3.2. Key Components of Community Engagement for BHCPF

Public Awareness Use diverse communication channels (mainstream media, social media, print materials etc) to inform and educate the public about BHCPF and its benefits.	**Trust and Transparency** - Maintain open, honest communication to build trust between healthcare providers and the community. - Ensure transparency in healthcare policies, processes, and decisions.	**Participation and Collaboration** - Engage community members in the planning, implementation, and evaluation of healthcare initiatives. - Empower communities to take ownership of their health.	**Feedback Mechanisms** - Implement multiple feedback channels (suggestion boxes, hotlines, online platforms etc) to gather and address community input.
Behaviour Change Communication - Develop and implement campaigns to promote healthy behaviours and lifestyle changes. - Use success stories and testimonials to reinforce positive health behaviours.	**Accessibility and Inclusivity** - Ensure healthcare messages and services are accessible to all community segments, including marginalized and vulnerable populations. - Develop culturally appropriate communication strategies.	**Resource Mobilization** - Collaborate with local leaders, organizations, and stakeholders to mobilize resources for healthcare initiatives. - Encourage community contributions to support health programs	**Sustainable Relationships** - Foster long-term relationships with the community to support sustained health improvements. - Establish mechanisms for ongoing dialogue and continuous improvement.

9.3.3. Approach to Community Engagement for BHCPF

1. **Town Hall Meetings**
    a. *Frequency:* Monthly
    b. *Responsible Parties:* Ward Development Committees (WDCs), local influencers, Civil Society Organisations (CSOs).
    c. *Stakeholders:* Community beneficiaries and the general public.
    d. *Deliverables:* Community feedback, increased awareness, promotion of service utilisation.
    e. *Strategy:* Utilise town hall meetings to discuss healthcare issues, share information about BHCPF services, and gather feedback from community members.
2. **Community Forums**
    a. *Frequency:* Quarterly
    b. *Responsible Parties:* Local Government PHC Advisory Committee, WDCs, and CSOs.
    c. *Stakeholders:* Community leaders and the general public.
    d. *Deliverables:* Address community concerns, gather input for program improvements, and improve the quality of healthcare services.

e. *Strategy:* Host community forums to provide updates on BHCPF progress, and address community concerns, and encourage community involvement in health initiatives.

3. **Door-to-Door Campaigns**
    a. *Frequency:* Continuous
    b. *Responsible Parties:* Local Government health authority, Community health extension workers, and CSOs.
    c. *Stakeholders:* Households within the community.
    d. *Deliverables:* Personalised health education, increased service utilisation.
    e. *Strategy:* Conduct door-to-door campaigns to educate households about BHCPF services and the importance of utilising healthcare facilities.
4. **Community Feedback Mechanisms**
    a. *Feedback Channels:* Suggestion boxes, hotlines, online platforms
    b. *Responsible Parties:* Federal and State Ministry of Health, local health authorities, CSOs.
    c. *Stakeholders:* Community members.
    d. *Deliverables:* Gather and address community feedback, improve service delivery.
    e. *Strategy:* Implement various feedback channels to collect input from community members and address their concerns promptly.
5. **Peer Learning and Evidence-Based Approaches**
    a. *Peer Learning Sessions:* Regular sessions for sharing best practices among community members and health workers.
    b. *Evidence-Based Approaches:* Implement strategies based on data and proven outcomes.
    c. *Responsible Parties:* SOC, LGHA, NGOs, CSOs, PHCs
    d. *Deliverables:* Enhanced good community health practices, data-driven improvements.
    e. *Strategy:* Facilitate peer learning sessions to share successful strategies and evidence-based practice among health workers and community members.

9.4. Knowledge Management

Knowledge Management (KM) within the BHCPF guideline shall be the systematic process of capturing, distributing, and effectively using information and insights to improve healthcare service delivery and community engagement.

It aims to enhance decision-making, foster innovation, and facilitate continuous learning and improvement in the implementation of the BHCPF across the country.

9.4.1. Objectives:

1. **Enhance Information Sharing:**
    - Ensure timely and accurate dissemination of information on BHCPF implementation to all stakeholders.
    - Promote the exchange of best practices and lessons learned across different implementing entities.
    - Participate in conferences to share lessons learnt and publish in Scientific Journals.
2. **Improve decision-making**
    - Provide healthcare providers and policymakers with reliable data and insights to inform decisions. Utilise data analytics to identify trends, gaps, and opportunities for improvement.
3. **Foster Continuous Learning:**
    - Create a culture of continuous learning and improvement among implementing entities, including healthcare workers and community members.
    - Support training and capacity-building initiatives based on current knowledge and emerging trends.
4. **Support Transparency and Accountability:**
    - Ensure that information related to BHCPF implementation is transparent and accessible to all stakeholders.
    - Enable citizens to track the progress and impact of healthcare initiatives.

9.4.2. Key Components of Knowledge Management:

Knowledge Capture: - Strategy: Develop processes for documenting best practices, lessons learned, and success stories from all levels of program implementation. -Responsible Parties: National and State Gateways, MOC, SOC, LGHA and PHCs -Deliverables: Comprehensive documentation of knowledge resources.	**Knowledge Organization:** - Strategy: Create a centralized knowledge repository that is easily accessible to all stakeholders. Use categorization and tagging to facilitate easy retrieval of information. - Responsible Parties: MOC - Deliverables: Centralized knowledge repository.	**Knowledge Sharing:** - Strategy: Implement regular knowledge sharing sessions, webinars, and workshops etc. - Responsible Parties: National and State Gateways, MOC, SOC, LGHA and PHCs - Deliverables: Regular knowledge sharing events.
Knowledge Utilization: - Strategy: Integrate knowledge into planning and decision-making processes. Use data and evidence from knowledge resources to inform strategies and improve program implementation. - Responsible Parties: National and State Gateways, MOC, SOC, LGHA and PHCs - Deliverables: Data-informed strategies and decisions.	**Continuous Learning:** - Strategy: Foster a culture of continuous learning by encouraging feedback, evaluations, and the adoption of innovative practices. Provide opportunities for professional development and training. - Responsible Parties: National and State Gateways, MOC, SOC, LGHA and PHCs -Deliverables: Professional development programs and a culture of innovation.	**Reporting and Evaluation:** - Strategy: Regularly evaluate the effectiveness of knowledge management activities. Report on the utilization and impact of knowledge resources. - Responsible Parties: National and State Gateways, MOC, SOC, LGHA and PHCs - Deliverables: Evaluation reports on knowledge management activities.

9.5. Stakeholder Engagement Strategy

The BHCPF implementing entities shall adopt the following strategy.

S/N	Activities	Timeline/ Frequency	Responsible Parties	Stakeholders	Deliverables
1	Town Hall Meetings	Monthly	WDC, Local Influencers	Community members and Beneficiaries	Community feedback, increased awareness, promotion of service utilization.
2	Media Press Release	Quarterly	MOC Secretariat	Media	Public awareness, transparency.
3	Stakeholder Coordination Meetings	Quarterly	MOC, SOC	Relevant Stakeholders.	Policy updates, performance reviews

4	Training/ Workshops	Continuous	All implementing entities, CSOs, Partners.	All implementing entities.	Improved implementation Enhanced skills.
5	Progress Update Meetings	Continuous	All Implementing entities	PHC Staff, LGA Health Authorities.	Implementation progress, strategy adjustments.
6	Feedback Collection	Continuous	All Implementing entities	PHC Staff, Community Members.	Data for improvement, community engagement.
7	Knowledge sharing Workshops	Continuous	All Implementing entities.	All implementing entities.	Shared best practices, collaborative learning.
8	Media Engagement	Bi-Annual	MOC, National Gateways, Media Partners	Journalists, Media Professionals.	Accurate reporting, positive coverage
9	Media Monitoring	Continuous	MOC, National Gateways, Media Partners.	Media Monitoring Agencies, CSOs.	Analysis of public perception, strategy adjustment.

9.6. Targets and Indicators for KMC Monitoring

By setting clear objectives, targets, and indicators, the BHCPF shall effectively monitor and evaluate the success of its communication and citizens' engagement plan. This structured approach ensures effective engagement with the community, increased trust in the healthcare system and continuous improvement, leading to better health outcomes.

SN	Indicator	Definition	Numerator	Denominator	Data Frequency	Data Source	Baseline	Target	Responsible
1	Number of BHCPF campaigns conducted	Total number of BHCPF campaigns conducted at both state and national levels across traditional media (such as TV and radio). The aim of these campaigns is to raise public awareness about the BHCPF and to increase the utilization of its services.	Number of campaigns conducted.	20 campaigns	Annually	Programmatic report	2	20 campaigns	Gateways, MOC Secretariat
2	Follower growth rate on BHCPF MOC Secretariat X.	Percentage increase in followers on the BHCPF X, IG, FB and LinkedIn social media handle over a specific period. It is calculated by dividing the number of new followers gained per quarter by the number of followers at the start of the quarter, then multiplying by 100.	Number of new BHCPF X followers during the reporting period	Number of BHCPF X followers at the start of the period	Quarterly	Programmatic report	473 Followers	Achieving a 10% increase in followers at the start of the period	MOC Secretariat
3	Follower growth rate on BHCPF MOC Secretariat IG.		Number of new BHCPF IG followers during the reporting period	Number of BHCPF IG followers at the start of the period	Quarterly	Programmatic report	46 Followers	Achieving a 10% increase in followers at the start of the period	MOC Secretariat

4	Follower growth rate on BHCPF MOC Secretariat FB.		Number of new BHCPF FB followers during the reporting period	Number BHCPF FB follov at the sta of the pe	Quarterly	Programmatic report	930 Followers	Achieving a 10% increase in followers at the start of the period	MOC Secretariat
5	Follower growth rate on BHCPF MOC Secretariat LinkedIn.		Number of new BHCPF LinkedIn followers during the reporting period	Number of BHCPF LinkedIn followers at the start	Quarterly	Programmatic report	107 Followers	Achieving a 10% increase in followers at the start of the period	MOC Secretariat
6	Total engagement across all BHCPF platforms.	Average engagement per post on BHCPF's social media handles, including likes, shares, comments, retweets, and other interactions	Total engagements (across all platforms).	Total number of posts across all platforms	Quarterly	Programmatic report	48 posts	150 engagements	MOC Secretariat
7	Number of BHCPF PHC facilities that held town hall meetings.	Number of BHCPF-supported PHC facilities conducting quarterly town hall meetings to encourage community involvement and feedback.	Number of town hall meetings conducted.	Total number of PHCs in a state	Quarterly	Programmatic report	??	Number of PHCs in a state	SOC Secretariat

8	Number of training workshops held on BHCPF.	Number of quarterly training workshops, including refresher courses, conducted for PHC staff across all states and the FCT. These workshops aim to ensure quality healthcare delivery by enhancing staff skills.	Number of training worksho ps conduct ed.		Quarter ly	Program matic report	??	1 per quarter per state	SPHCDA , SOC

9.7. Expectations of Stakeholders on Implementation of KMC

Effective healthcare delivery is a collaborative effort, requiring the involvement of various key stakeholders who contribute in different capacities to ensure a well-coordinated, transparent, and impactful system. Each of the listed groups will play a crucial role in advancing the goals of the BHCPF and contributing to the overall revitalization of Nigeria's healthcare sector.

Legislators and Regulators
- Allocate resources.
Capacity building
- Ensure oversight, coordination, and data sharing.

Implementing Gateways:
Organize, participate in Training and Workshops
Report on progress and Challenges
Provide Feedback

Local Health Authorities
Organize meetings
- Execute and report on engagement activities.
- Manage feedback mechanisms to address community concerns.

Community-Based Organizations, Civil Society Organizations and Non-Governmental Organizations
- Collaborate on planning and implementation.
- Build capacity and advocate for community needs.

Media Partners
- Provide coverage and support awareness campaigns.
- Foster transparency through accurate reporting.

Healthcare Providers
- Deliver high-quality services and maintain communication.
- Engage in continuous improvement efforts.

Donors and Development Partners
- Provide funding and technical assistance.
- Support monitoring and evaluation activities.

Private Sector
- Collaboration in Service Delivery and Supply Chain
- Participation in Awareness Campaigns
- Financial and Technical Support through CSR Initiatives

Participation in Consultations and Policy Discussions:
- Actively engage in consultations and discussions on healthcare policies
- Dissemination of Guidelines to Members
- Recognition of Contributions to the BHCPF

10. STANDARD GRIEVANCE REDRESS MECHANISM (GRM) FRAMEWORK

The Standard Grievance Redress Mechanism (GRM) in this Guideline is designed to provide a comprehensive and adaptable framework that can be implemented across all levels of government—federal, state, local—and within communities. This GRM shall enhance transparency, accountability, and trust in the delivery of the BHCPF. By establishing a uniform system for receiving, processing, and resolving complaints, this mechanism shall ensure that grievances are addressed efficiently and fairly, contributing to the continuous improvement of the BHCPF implementation.

10.1. Objectives of the Standard GRM:

a. **To Ensure Accessibility Across All Levels:**

Creating a user-friendly platform, accessible at each level (federal, state, local government, and community levels), to enable all citizens to submit grievances and complaints regardless of location or circumstances.

b. **To Promote Transparency:**

Maintaining open, transparent processes for handling and resolving grievances across all government tiers, ensuring that aggrieved parties can track the progress of their grievances.

c. **To Enhance Accountability:**

Holding government, implementing gateways, and service providers, accountable for any infractions in conduct made.

Holding government, implementing gateways, and service providers, accountable for addressing and resolving concerns at every level.

d. **To Improve Service Delivery:**

Leveraging feedback and lessons learned from grievances to identify systemic issues and make necessary improvements across the different levels of BHCPF implementation and at service delivery points.

e. **To Foster Trust Between Government and Citizens:**

Building and maintaining trust by demonstrating a commitment to addressing and resolving issues raised by citizens.

f. **To Foster Trust Between Government and Partners:**

Building and maintaining trust by demonstrating a commitment to improving BHCPF implementation through fostering accountability.

10.2. Key Components of the Standard GRM

10.2.1. Grievance Submission Channels

a. **Multiple Channels:** A variety of channels for submitting grievances shall be provided, including suggestion boxes at public offices, hotlines, online platforms, mobile apps, and in-person submissions at government offices, health facilities, and community centres. These channels must be available at federal, state, local government, and community levels.

b. **Accessibility:** These channels shall be accessible to all, including people with disabilities, the elderly, and those in remote or underserved areas. Translation services shall be provided where necessary to accommodate different languages widely spoken within each community.

10.2.2. Grievance Registration and Tracking

a. **Unified Registration System:** A standardized system across all levels of government for logging grievances shall be implemented, ensuring that each complaint is documented and assigned a unique tracking number for easy reference.

b. **Tracking Mechanism:** A digital tracking system shall be accessible at all levels to monitor the status and progress of each grievance from submission to resolution, with regular updates provided to the complainant.

10.2.3. Grievance Handling and Resolution

a. **Dedicated GRM Teams:** Dedicated teams shall be established and trained at federal, state, local government, and community levels. These teams shall be responsible for reviewing and addressing grievances. The teams should include representatives from relevant government departments, community leaders, and civil society organizations.

b. **Timely Response:** Clear timelines shall be set for responding to and resolving grievances at each level, with protocols for escalation if a grievance is not resolved within the specified timeframe.

c. **Resolution Process:** A clear, step-by-step process for investigating and resolving grievances shall be established, including the involvement of independent mediators if necessary (see the section on standard operating

procedures below for each level). This process can be integrated with pre-existing GRMs where applicable but shall largely be consistent across all levels of government, and adaptable to specific local contexts.

10.2.4. Feedback and Communication

Regular Updates: Regular updates shall be provided to the aggrieved party on the status of their grievances through their preferred communication channels (e.g., SMS, email, phone calls, or in-person updates).

10.2.5. Confidentiality and Protection

a. **Confidentiality Assurance:** All grievances shall be handled with the utmost confidentiality, protecting the identity of aggrieved parties and ensuring that they are not subject to retaliation or discrimination.

b. **Secure Data Handling:** Robust data protection protocols shall be instituted at all levels to secure grievance-related information (e.g., passwords, and determining which personnel have access to data).

10.2.6. Monitoring and Evaluation

a. **Data Collection and Analysis:** Data collected on grievances at all government levels shall be used to identify trends, systemic issues, and areas needing reform/revisions. This data may also inform policy decisions to improve public service delivery.

b. **Regular Reporting:** Regular reports on grievance trends, resolutions, and actions taken to address underlying issues shall be developed and shared with the MOC, through the Secretariat for transparency and accountability.

10.2.7. Summary of Key Components

S/N	Key Component	Description
1	Grievance submission channels	Multiple Channels Accessible to all citizens
2	Grievance registration and tracking	Unified registration system Tracking mechanism
3	Grievance handling and resolution	Dedicated GRM teams Timely response Resolution process
4	Feedback and communication	Regular updates

5	Confidentiality and protection	Confidentiality assurance Secure data handling
6	Monitoring and Evaluation	Data collection and analysis Regular reporting

10.3. Standard Operating Procedures for the GRM

The following Standard Operating Procedures (SOPs) shall guide the implementation of the BHCPF GRM at various levels of government—federal, state, local—and within communities.

10.3.1. Standard Operating Procedures (SOPs) for the Federal Level GRM

a. **Establishment of a Federal GRM Unit:**
   i. A central GRM Unit shall be within the BHCPF MOC Secretariat and will be responsible for overseeing the GRM across the country.
   ii. A detailed BHCPF National GRM Procedure Manual shall be developed by the government with input from donors and partners, ensuring alignment with international best practices. This document shall be used at all levels.

b. **Grievance Submission and Registration:**
   i. Multiple grievance submission channels shall be set up and communicated to the public, including a national hotline, an online platform, and an address for written/in- person complaints.
   ii. A centralised digital grievance registration system that logs all complaints received through various channels shall be implemented, and a unique tracking number shall be assigned to each grievance for monitoring purposes.

c. **Grievance Handling and Resolution:**
   i. At every level, upon receipt, the GRM Unit shall review and classify grievances based on their nature and urgency.
   ii. Grievances shall be referred to the relevant federal departments/implementing entities for further investigation and resolution.

d. **Response Timeline:**
   The maximum timeline for resolving grievances at the federal level shall be 30-45 days. For unresolved cases, an extension may be requested from the MOC through the MOC Secretariat, while regular updates are provided to the complainant.

e. **Escalation Procedure:**
If a grievance is not resolved at the national gateways within the specified timeframe, it shall be escalated to the MOC through the MOC Secretariat.

f. **Monitoring and Reporting:**
The GRM Unit shall produce quarterly and annual reports on grievance trends, resolutions, and systemic issues that occur at all levels. These reports shall be shared with the MOC Secretariat and presented at quarterly MOC meetings. The GRM Unit shall also regularly monitor the status of grievances through the centralised system, ensuring timely resolution.

10.3.2. Standard Operating Procedures (SOPs) for the State Level GRM

a. **Establishment of State GRM Offices:**
   i. A GRM Officer/unit shall be identified/established within each SOC Secretariat to be responsible for managing the GRM process.
   ii. These state secretariats shall ensure close coordination with the Federal GRM Unit to align state-level processes with national guidelines and to report on state-level grievances.

b. **Grievance Submission and Registration:**
There shall be state-specific grievance submission channels, such as a state hotline, email, and physical submission points at state government offices and health facilities. These channels must be accessible to all residents, including those in rural areas.

c. **Grievance Logging, Handling and Resolution:**
   i. A centralized digital registration system shall be used to log grievances at the state level and all grievances shall be documented and assigned a tracking number.
   ii. Each submission shall be reviewed and assessed upon receipt to determine the appropriate action.
   iii. Submissions shall then be referred to relevant implementing entities or health facilities for resolution.

d. **Resolution Timeline:**
The maximum timeline for resolving grievances at the state level shall be 30-45 days, with provisions for extensions (approved by the SOCs) in unresolved cases.

e. **Escalation to Federal Level:**
If a grievance cannot be resolved at the state level, it shall be escalated to the Federal GRM Unit for further action.

f. **Monitoring and Reporting:**

The State GRM Office shall submit monthly reports to the Federal GRM Unit on grievances received and resolved, as well as any systemic issues identified at the state level. This office shall also monitor the status of grievances, ensuring that they are resolved within the set timeframe.

10.3.3. Standard Operating Procedures (SOPs) for the Local Government Level GRM

a. **Establishment of GRM LGHA Desks Officers:**
GRM Desks Officers shall be established within the LGHAs to be responsible for receiving and processing grievances at the Local Government Level.

b. **Grievance Submission and Registration:**
   i. Grievance submission channels shall be provided, including suggestion boxes at local government offices, community centres, and health facilities and digital mechanism. In-person submissions shall also be accepted at the LGHAs.
   ii. All submissions received shall be documented using the centralised digital registration system, and a tracking number shall be assigned for each one.

c. **Grievance Handling and Resolution:**
The LGHA GRM Desk Officer shall conduct an initial assessment of each grievance to determine the appropriate response within 30-45 days of submission. Minor grievances may be resolved directly at the community level.

d. **Escalation to State Level:**
Unresolved grievances shall be escalated to the state level.

e. **Monitoring and Reporting:**
Monthly reports shall be sent to the State GRM Office on local grievances, their resolutions, and any trends observed. The LGHA GRM Desk Officer shall monitor the progress of grievances to ensure timely resolution.

10.3.4. Standard Operating Procedures (SOPs) for the Community Level GRM

a. **Establishment of Community Grievance Redress Facilitator (CGRF):**
Each community shall be encouraged to select a CGRF from within the WDC.

b. **Grievance Submission and Registration:**
   i. Suggestion boxes at community centres, in-person submissions to CGRF, petitions at community meetings, hotlines, online platforms,

and in-person submissions at health facilities shall be means of submitting grievances. Community members, including those with disabilities and those in remote areas, should have access to at least one of these channels.

ii. All grievances shall be immediately documented either manually, by voice recording, or through the digital registration system.

c. **Grievance Handling and Resolution**

i. The WDC shall review each submission and seek to resolve them on a case-by-case basis where it can do so within the confines of Nigerian Law. This may be done through mediation, dialogue, or other community-based approaches.

ii. Simple grievances should be resolved within 14 days. If a grievance cannot be resolved within the community in 14 days, it shall be referred to the LGHA GRM Desk Officer for further action.

d. **Feedback Loop:**

Complainants shall be given updates on the status of their complaints (e.g. through SMS, online platforms or when they inquire in-person).

11.ANNEXES

Annex 1. Basic Minimum Package of Health Services

Primary level care and preventive medical services

Outpatient Care	• General consultation with prescribed drugs from accredited PHC facilities
Health Education	• Family planning education • Promotive and Preventive Health education for reduction of Maternal, Newborn, Child and Adolescent (RMNCAH) mortality and morbidity. • Dental health education • Health promotion for prevention of HIV/AIDS/Tuberculosis/Malaria • Immunization • Vitamin A supplementation • Promotion of essential nutrients for children and pregnant women • Promotion of personal, domestic and environmental hygiene including water sanitation • Breast self-examination • Counselling on the avoidance of self-medication, irrational drug use and substance Abuse
Maternal, Adolescent and reproductive health services	• Reproductive health counselling and services • Provision of modern methods of contraception (to enable method-mix approaches) such implants, copper and hormonal intrauterine devices (IUDs), oral contraceptives (combined and progestin-only), emergency oral contraceptives, injectables, female condoms, and male condoms • Antenatal care - Routine antenatal clinic - Routine drugs to cover duration of pregnancy, including MMS - Routine urine, blood tests and ultrasound • Referral services for complicated pregnancies

	• Spontaneous vaginal delivery by skilled attendant, (including repair of birth injuries and episiotomy) • Post-natal services, including post-partum family planning services • Maternal life-saving Essential and Emergency Drugs and Commodities e.g. (PPH Bundle, MgSO4, Misoprostol, Oxytocin, Carbetocin, Antibiotics etc. for Basic Emergency Obstetric Care (BEmOC) • Routine Immunization (Tetanus Toxoid) • Post natal preventive care (including 2 home visits) • Maternal Sepsis management • Gender Based Violence (GBV) prevention and response services
Newborn Care	• Postnatal newborn services - All eligible live births up to 6 weeks from date of birth (routine newborn care including cord care and eye care) • Newborn resuscitation • Kangaroo Mother Care • Cord Care with Chlorhexidine • Vitamin K injection • Newborn life-saving Essential and Emergency Drugs and Commodities e.g. (suction device and tubes, ambu bag, Chlorrhexidine gel, Erythromycin eye ointment, Antibiotics etc. for Basic Emergency Newborn Care)
Child Health Care	• Child Welfare Services • Child life-saving Essential and Emergency Drugs and Commodities such as antimalarials, Zn-ORS, amoxycillin DT, etc. • Growth monitoring • Routine immunization as defined by the NPHCDA • Vitamin A supplementation • Management of uncomplicated malnutrition • Treatment for Helminthiasis • Treatment of common childhood illnesses such as Uncomplicated malaria, Diarrhea with or without mild dehydration, Upper respiratory tract infections

	• Treatment of Schistosomiasis, • Uncomplicated pneumonia • Urinary Tract Infections (uncomplicated) • Simple otitis media, pharyngitis • Uncomplicated childhood exanthemas e.g., Chicken pox and measles • Treatment of mild to moderate anaemia with oral haematinics (not blood transfusion) • Simple skin diseases/infestations • Other viral illnesses such as mumps • Vomiting • Management of simple Neonatal infections (Neonatal sepsis, Neonatal tetanus)
HIV/AIDS	• HIV testing and counselling services • Medicine refills
Tuberculosis	• Treatment of drug-susceptible Pulmonary TB
Sexually Transmitted Infections	• Screening for STIs • Management of uncomplicated STIs
Primary Medical Care (Adult)	• Management of uncomplicated infections/infestations • Malaria • Respiratory tract infections • Urinary tract infections • Gastroenteritis • Primary ear, nose, and throat infections • Diarrheal diseases • Typhoid fevers • Schistosomiasis • Helminthiasis • Skin infections/infestations such as chicken pox and fungal diseases e.g. Tinea versicolor, Tinea capitis

	• Emergency management of bites and stings e.g. snakes, scorpions, bees, spiders etc. (Excluding serum) • Management mild to moderate anaemia with oral haematinics (not blood transfusion) • Screening for diabetes mellitus, hypertension, and other chronic non-communicable diseases like mental health • Treatment of simple arthritis and other minor musculoskeletal diseases • Routine management of sickle cell disease • Treatment of allergies • Treatment of stable diabetes mellitus and hypertension including routine medicine refills
Minor Surgical Care	• Incision & drainage • Suturing of lacerations • Minor burns • Simple abrasions and lacerations around the eye • Minor wound debridement • Circumcision of male infants • Evacuation of impacted faeces • Relief of urinary retention using urethral catheter
Primary Eye Care	• Basic examination and visual acuity • Treatment of minor eye ailments including: - Conjunctivitis - Parasitic and allergic ailments
Primary Mental Health Care	Diagnosis and Counselling for: • Mood Disorders • Sleep Disorders • Puerperal psychosis • Follow-up care for stable patients on mental health treatment
BEmONC (PHC)	• IV Fluid Replacement and Therapy • Uterotonics such as Oxytocin, PPH Bundle, misoprostol etc.

	• Parenteral Antibiotics • Parenteral Anticonvulsants - Loading dose of Magnesium Sulphate • Non-pneumatic anti-shock garments, Calibrated Drapes • Manual Vacuum Aspirator (MVA) • Vacuum Extractor • Ambulance Services with trained and equipped care providers • Newborn Resuscitation with bag and mask • Early and exclusive Breast Feeding • Parenteral antibiotics • Immediate kangaroo mother care for preterm and LBW infant mother care • Oxygen therapy with pulse oximetry for stabilization and transportation only)
Emergency Services	• Airway assessment and use of airway adjuncts (oropharyngeal airway) • Use of basic means of airway aspiration and clearance • Breathing assessment and use of simple equipment to aid and monitor breathing like Ambu-bag • Pulse oximetry • Respiratory Timer • Control of bleeding using compression dressing • Assessment of hemodynamic stability (general physical examination and assessment of vital signs) • Establishment of intravenous line • Fluid resuscitation • Basic cardiopulmonary resuscitation • Assessment and basic management of the unconscious patient • Suturing of small lacerations where no resuscitation is required • Immobilization of fractures and cervical spine using splints

	• Basic Management of Convulsion
Basic Laboratory Investigations	• Rapid Diagnostic Test/Blood Film for Malaria Parasite • Urinalysis • HB/PCV • Stool microscopy • Urine microscopy • Pregnancy Test • Blood Glucose Test • Sputum for AFB • Widal • Blood group • HBV/HCV screening • Urea Breath Test for H pylori
Annual medical checkup for disease prevention	• Examination and observation for administrative purposes Z02 - Full physical examination (General appearance, Temperature, BP check, Respiratory rate, Heart rate) - Investigations such may include stool microscopy, FBS, HbSAg, HCV screening, and RVS.

Secondary level care

	Condition	**ICD Code**
Secondary Level Consultation	Consultation with prescribed generic medications from accredited Secondary Health Care facility, as well as emergency care for such conditions	
	Emergencies occurring outside the usual residence or accredited healthcare provider	

Hospital admissions	Admission for maximum of 21 cumulative days per year for medical and surgical admission	
	Treatment and procedures that cannot be handled at the primary level but included in the BMPHS:	
Comprehensive Emergency Obstetric and Newborn Care (CEmONC)	All BEmONC services plus:	O42
	• Caesarean Section • Blood Transfusion • Thermal with radiant warmer or incubator • Continuous Positive Airway Pressure (CPAP) • Phototherapy • Assisted feeding with expressed breast milk with cup and spoon and tube feeding • IV Fluids	
	Instrumental Delivery, including forceps	
	- Management of preterm/pre-labour Rupture of Membrane (P/PROM)	
	- Detection and management of hypertensive diseases in pregnancy	O10.9, O13
	- Management of Ante-partum haemorrhage	O46.9
	- Management of postpartum haemorrhage	O72.0 - O72.2
	- Eclampsia	O15
	- Caesarean section	O82.9
	- Operative management for ectopic gestation	O00.1, O00.9

	- Management of intrauterine foetal death	P95
	- Management of puerperal sepsis - Management of Anaemia in Pregnancy	O85, O86.0, O86.1, O86.4, O86.8
	- Management of Obstetric fistula	
	Instrumental deliveries	O81
	High-risk deliveries – 1st deliveries, Beyond 4th deliveries, multiple deliveries, malpositioning/malpresentation and other complications	Z35, Z39, O32.0 -O32.8
	Post-abortion care	O03.3, O03.4, O03.8, O03.9
Child Health Care	Severe malnutrition	E40 - E43
	Treatment of Severe infections	
	Treatment of severe infestations	B88.9
	Severe malaria	B50.0, B50.8
	Diarrhoea disease with moderate to severe dehydration	R19.7, A09
	Upper Respiratory tract infections	J98.8 - J98.9
	Lower Respiratory tract infections including Severe pneumonia	J98.8 - J98.9
	Typhoid fevers	A01.0
	Septicaemia	A41.9
	Meningitis	G00.9
	Severe measles	B05.0 - B05.4, B05.8

	Urinary Tract Infections	N39.0
	Management of severe anaemia requiring blood transfusion	D64.9
	Management of childhood noncommunicable diseases	NA
Neonatal Conditions	Management of Small and Sick Newborns	P21.9
	Birth asphyxia	
	Prematurity	
	Management of neonatal infections – Neonatal sepsis, Neonatal tetanus	P36.9
	Neonatal jaundice	P59.9
	Management of children from diabetic mothers	P70.0
Management of communicable diseases and medical emergencies	Treatment of moderate to severe infections and infestations	
	Management of severe malaria	B50.0, B50.8
	Management of meningitis, septicaemia	G00.9, A41.9
	Management of complicated Respiratory Tract Infections	J98.8 - J98.9
	Management of complicated typhoid fever	A01.0
	Treatment of snake bites (inclusive of serum) Bites and stings from scorpions, bees, spiders, etc.	T63.9
Management of non-communicable diseases	Management of diabetes	E10.0-E10.3, E10.9, E11

	Management of hypertension	I10, I11, I15.9
	Treatment of severe musculoskeletal conditions	M79.0 -M79.2, M79.6
	Management of sickle cell disease	D57.0
	Treatment of cardiovascular conditions	150.0, I50.1, I50.9
	Treatment of renal diseases (such as nephritis, nephrotic syndrome)	N10 -N12
	Management of Urinary Tract Infections	N39.0
	Liver diseases (hepatitis, amoebic liver abscess)	K75.9, K77.0
	Management of severe anaemia	D64.9
HIV/AIDS	Management of newly diagnosed HIV/AIDS patients including initiation of first line treatment with ARVs	B20
	Treatment of opportunistic infections as defined in the HIV Treatment Protocol	B20
Gynaecological Intervention	Treatment of pelvic inflammatory disease	N73.9
	Management of uterine fibroids including myomectomy[1]	O34.1
	Hysterectomy[1]	O71.0, O71.1
Dental care	Dental Carries, Dental Check, Simple and surgical tooth extraction for medical reasons, Scaling and Polishing	K02

1 Subject to actuarial review

Eye Care	Eye problems, e.g., major trauma, pterygium, glaucoma, cataract extraction and other simple ophthalmological surgical procedures	H10, H25
	Removal of foreign bodies	T15
	Refraction, including the provision of spectacles not exceeding N10,000	H52
Ear, Nose & Throat	Antral wash-out	
	Foreign body removal from Ear, Nose and Throat	T16, T17
	Acute tonsillitis, tonsillectomy, Adenoidectomy	J03
	Nasal Polyp	J33
	Tracheostomy	
	Myringitis	65, H66
Common Surgical Interventions	Acute Appendicitis	K35
	Hernia repair	K40-K42
	Hydrocelectomy	N43
	Management of testicular torsion	N44
Others	Examination and observation for other reasons (alleged rape)	Z04.4
	Examination and observation for other reason (physical abuse)	Z04.7
Physiotherapy	Post-traumatic rehabilitation	

	Management of palsies within 15 days after initial treatment with a maximum of 5 sessions	
	Post-cerebrovascular accident therapy within 15 days with a maximum of 5 sessions	

Laboratory Investigations

Laboratory investigations	• Genotype
	• Urea/electrolyte/creatinine
	• Liver Function Test
	• Microscopy/culture/sensitivity – urine, blood, stool, sputum, wound, urethral, ear, eye, throat, aspirate, cerebrospinal fluid, endocervical swab, high vaginal swab, ascitic fluid and other body fluids
	• Occult blood in stool
	• Skin snip for microfilaria
	• Gram stain
	• GeneXpert
	• Blood groupings/Cross matching
	• Hepatitis B surface antibody screening
	• Confirmatory test for HIV
	• Full Blood Count
	• Erythrocyte Sedimentation Rate
	• PCR, IGRA (interferon-Gamma Release Assays
	• Platelets/ Reticulocyte count
	• Platelets concentration
	• Blood transfusion services for up to 3 pints of safe whole blood or blood products
	• Lipid profile test

	• Clotting profile • Direct and indirect Coombs test
Radiologic investigations	• X-ray of chest, abdomen, skull & extremities, dental X-rays • Abdominopelvic scan • Obstetric scan (maximum of 4)

Other conditions not included but undergoing review

Management of orthopaedic conditions.

12. LIST OF CONTRIBUTORS

The development of the *Revised Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund (BHCPF), 2025* was made possible through the leadership, technical guidance, and collaborative contributions of stakeholders across government, subnational structures, development partners, implementing partners, civil society, and the private sector.

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