NCDC

NIGERIA CENTRE FOR DISEASE CONTROL

A Report on the Implementation of 'Basic Health Care Provision Fund' for Public Health Emergencies

BY NIGERIA CENTRE FOR DISEASE CONTROL

A Report on the Implementation of 'Basic Health Care Provision Fund' for Public Health Emergencies by Nigeria Centre for Disease Control

Published July 2020

The 2018 implementation guidelines of the Basic Health Care Provision Fund provided for the utilisation of 50% of the '5%' of the fund earmarked for 'Medical Emergencies' for the preparation and response to 'public health emergencies.' This recognised the unique requirements for responding to outbreaks of infectious diseases distinct from the requirements for clinical emergencies.

The BHCPF provided a once in a lifetime opportunity to provide stable, substantial and sustainable funding for health security.

This provision is excluded from the draft 2020 implementation guidelines of the BHCPF.

Contents

About NCDC

The Nigeria Centre for Disease Control (NCDC) is Nigeria's national public health institute with the mandate to protect Nigerians from the impact of communicable diseases of public health significance, amongst other responsibilities. It does this through evidence-based prevention, integrated disease surveillance and response activities, using a One Health approach, guided by research and led by a skilled workforce.

NCDC's operations and activities are guided by five key goals to:

- Accurately measure the burden of infectious diseases in Nigeria
- Ensure Nigeria is able to meet its international obligations as a member of the World Health Assembly
- Develop a Public Health laboratory service network to support the detection and prevention of, and response to critical infectious diseases
- Reduce the adverse impact of predictable and unpredicted public health emergencies
- Create an efficiently managed and evidence-based organisation with a clear focus of health promotion and disease prevention.

NCDC currently operates through five directorates: Surveillance and Epidemiology, Public Health Laboratory Services, Health Emergency Preparedness and Response, Prevention Programmes and Knowledge Management, Finance and Accounts and Administration and Human Resources.

Executive Summary

In 2014, the National Health Act was signed into law. Through this Act, the Government of Nigeria committed to provide at least 1% of its consolidated revenue fund to the Basic Health Care Provision Fund (BHCPF).

In 2018, the Government of Nigeria launched the Basic Health Care Provision Fund (BHCPF). Of these funds, the Nigeria Centre for Disease Control was allocated 2.5%, specifically for public health emergency preparedness and response in the 2018 implementation guidelines. Other implementing agencies for the BHCPF were the National Health Insurance Scheme (50%), National Primary Healthcare Development Agency (45%) and the Department of Hospital Services (2.5%).

The 2018 annual budget of the BHCPF was N55.9bn. Of this, N13.78bn was approved and made available for Quarter 1 of 2018 to the implementing agencies. The total amount released to the Nigeria Centre for Disease Control (NCDC) for Q1 implementation was N361.59m. This has been the only release to NCDC to date.

As part of its mandate to lead health emergency preparedness and response in Nigeria, NCDC developed a three-pronged approach for the BHCPF:

- Emergency Outbreak Response Funding, Stockpiling and Capacity Development
- Emergency Outbreak Response Infrastructure
- Emergency Outbreak Response Detection Systems

This report describes NCDC's implementation of the BHCPF including the establishment of State Public Health Emergency Operations Centres, deployment of SORMAS for digital case-based surveillance, training of health care workers, strengthening of the national public health laboratory network and establishment of an Indigent Patient Treatment Support for Lassa fever cases.

Despite the successful implementation of the fund and the continued risk of infectious disease outbreaks in Nigeria, the draft 2020 guidelines of the BHCPF proposes to defund the public health emergencies component.

CHAPTER 1

Overview of the Basic Health Care Provision Fund

Nigeria's commitment to Universal Health Coverage (UHC) is symbolised by the passage of the National Health Act of 2014. Section 11 of the Act established the Basic Health Care Provision Fund (BHCPF), as a vehicle for supporting the effective delivery of primary healthcare services, provision of a Basic Minimum Package of Health Services (BMPHS) and Emergency Medical Treatment for all Nigerians. The BHCPF is funded through the Federal Government annual revenue (at least 1% of the Consolidated Revenue Fund), and grants by international donor and funds from other sources.

In November 2018, the Federal Ministry of Health, in collaboration with its parastatals (National Health Insurance Scheme (NHIS), National Primary Health Care Development Agency (NPHCDA), the Nigeria Centre for Disease Control (NCDC), partners and other key stakeholders developed a BHCPF Operations Manual. This was launched on the 8th of January 2019 by His Excellency, the President of the Federal Republic of Nigeria.

The BHCPF Operations Manual was developed to serve as the authoritative guidebook for the deployment of funds. The manual describes how the BHCPF will be administered and enumerates all stakeholders involved in the operationalisation of the fund, their dependencies, expected inputs and outputs and timelines of activities. It also sets out guidance on the role of stakeholders, governance, administration, fund management, operations and mechanism for monitoring and compliance.

The 2018 BHCPF Operations Manual set out three main gateways for the provision of services as outlined below:

- **National Health Insurance Scheme (NHIS)** – The Provision of the Basic Minimum Package of Healthcare services (BMPHS) shall be through the process of strategic purchasing, funded through the 'NHIS Gateway' (50% of the BHCPF)
- **National Primary Health Care Development Agency (NPHCDA)** – NPHCDA shall strengthen the operations of the Primary Health Centres through the 'NPHCDA Gateway', (45% of the BHCPF).
- **Emergency Medical Treatment (EMT)** – The provision of emergency medical services shall be funded through the 'EMS gateway', 5% of the BHCPF. The 2018 implementation

guidelines divided the EMT funds between the Department of Hospital Services (DHS) (2.5%) and the **Nigeria Centre for Disease Control (2.5%)**.

Sections 1.1.15.1 to 1.1.15.3 of the guidelines set out three main responsibilities of NCDC:

- The NCDC shall set up an Emergency Operations Fund to support disease outbreaks around the country
- The NCDC shall set up public Health Emergency Operations Centres (PHEOCs) and reference laboratories across Nigeria
- NCDC shall ensure that the public health emergency response is digitalised and provides programmatic and financial performance data, on a quarterly basis to the National Steering Committee (NSC).

Figure 1 illustrates the implementation structure for the BHCPF, based on the 2018 BHCPF Operations Manual. This implementation structure splits the 5% allocation for emergencies into **medical emergencies** and **public health emergencies.**

The Nigeria Centre for Disease Control was established in 2011. The NCDC Act was signed into law in November 2018, giving the agency the legal mandate to lead the prevention, preparedness for, detection and response to infectious disease outbreaks. Section 14 (2) of the NCDC Establishment Act states, "There shall be credited to the NCDC Fund, 2.5% of the 5% Basic Health Care Provision Fund established under section 11(1) of the National Health Act".

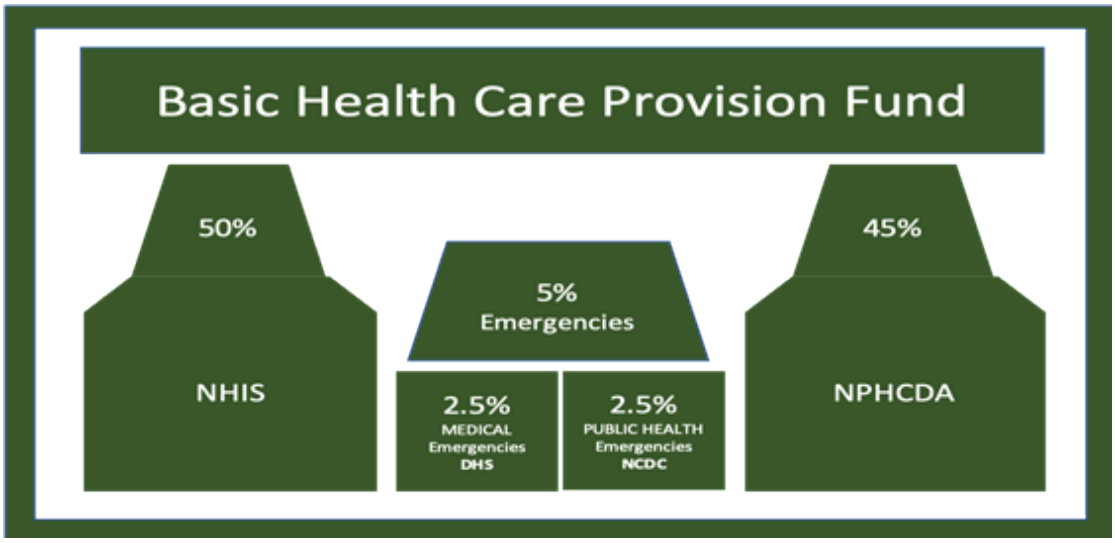


Figure 1: Allocation of BHCPF (based on BHCPF Manual 2018)

1.1 Nigeria's Health Security and the Basic Health Care Provision Fund

Over the last five years, Nigeria has experienced annual and often concurrent outbreaks of infectious diseases. This includes outbreaks of Lassa fever, yellow fever, monkeypox, cholera and new serotypes of existing pathogens like Neisseria meningitidis serogroup C. In 2017, Nigeria recorded its first case of monkeypox 39 years after the last case was reported in the country. Similarly, the first yellow fever case in 21 years was reported in Nigeria in 2017. Since then, monkeypox and yellow fever cases have been reported nearly every week in the last three years.

The priority epidemic-prone diseases have caused significant recent or ongoing epidemics in Nigeria, straining the public health sector and causing significant economic and social costs. An analysis of the data on disease outbreaks showed that in 2017, four major disease outbreaks resulted in over 40,000 cases and around 1,000 deaths in Nigeria.

In addition to the social and community impacts caused by the deaths of children and adults in the labour force, outbreaks can have powerful direct impacts on households, firms, and the government. Disease outbreaks can also have significant adverse indirect impact on economic and political stability as it can lead to panic, disrupt the social and economic structure and impede development in affected communities. As was seen during the West African Ebola outbreak in 2014 and with the current COVID-19 pandemic, reactions by other countries includes curtailing or restricting travel from countries where the outbreak is occurring.

NCDC clearly understands the magnitude of the problem and has been effective in its response to outbreaks that have occurred in the recent years. This is largely due to the improved strategy, organisational structure and increased leveraging

of technology, such as a digital case-based surveillance system. This enables the NCDC to quickly identify early warning signs of disease outbreak and to respond accordingly.

Notwithstanding this improved performance, the NCDC is still very limited in its ability to effectively execute its mandate due to resource constraints. This situation has been evident in the early stages of disease outbreaks, including the COVID-19 outbreak. In light of this, the need for sustainable funding is self-evident as the ability of NCDC to effectively utilise the funds provided has been proven over time.

Investing in preparedness and response efforts can therefore strengthen the Nigerian public health sector's ability to prevent, prepare for and respond to priority disease and consequently reduce epidemic spread, frequency, and overall impact.

The 2018 BHCPF Operations Manual provided an opportunity to strengthen the health security architecture in Nigeria. Prior to this, NCDC has depended largely on support from international partners in the implementation of its mandate. The BHCPF provides a sustainable mechanism for country ownership of health security. If well operationalised, the BHCPF provides a unique opportunity to improve and sustain Nigeria's capacity to prevent, detect and respond to public health emergencies through the NCDC.

With Nigeria's rapid population growth, increasing movement of people, security challenges and challenging socio-economic circumstances in the rural areas, outbreaks of new and re-emerging pathogens diseases are likely to continue.

1.2 The Current Implementation Structure of the NCDC '2.5% Emergency Fund' of the BHCPF

The 2018 annual budget of the BHCPF was N55.9bn. Of this, N13.78bn

was approved and made available for quarter 1 of 2018 to the implementing agencies. The total amount released to the Nigeria Centre for Disease Control for Q1 implementation was N361.59m. This has been the only release to NCDC to date.

Following the disbursement of funds through the Basic Health Care Provision Fund (BHCPF) to NCDC, a strategic approach was defined:

- Strategy 1: To build prevention, detection and response architecture for public health preparedness and response.
- Strategy 2: To sustain the outputs from Strategy 1 for public health preparedness and response.

The strategy for the first three years of implementing the '2.5% PUBLIC HEALTH EMERGENCY FUND' of the BHCPF was built on three main pillars:

- Emergency Outbreak Response Funding, Stockpiling and Capacity Development
- Emergency Outbreak Response Infrastructure
- Emergency Outbreak Response Detection Systems

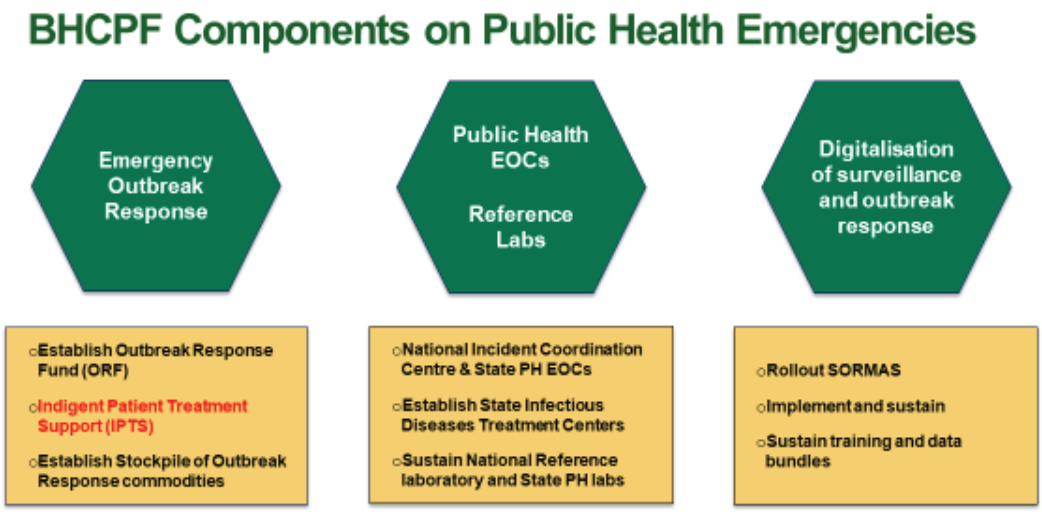


Figure 2: NCDC-EMT BHCPF components on public health emergencies

The Emergency Outbreak Response pillar had four major components as described below:

A. **Outbreak Response Fund (ORF):** This fund was established to ensure prompt access to funding for early deployment of Rapid Response Teams (RRTs) for outbreak investigations and response.

B. **Indigent Patient Treatment Support (IPTS)**: This fund was established to support the management of patients with viral haemorrhagic fever (VHFs) specifically Lassa fever across treatment centres in the country. The fund was established as an intervention to ensure early treatment, prevent further spread of the disease and reduce deaths from Lassa fever.

C. **Training in Priority Disease Management:** Training of healthcare workers in the management of priority public health diseases.

D. **Stockpile of Outbreak Response Commodities**: Establish stockpile of outbreak response commodities and distribution of emergency medical commodities across the country.

The Emergency Outbreak Response Infrastructure had three major components:

A. **National Incident Coordination Centre and State Public Health Emergency Operations Centres (PHEOCs):** To set up PHEOCs in states across the country. In addition, to train state teams in coordinating public health emergencies.

B. **Infectious Disease Treatment Centres:** Given the increasing burden of VHFs such as Lassa fever in many states in Nigeria, this component sought to establish an infectious disease treatment centre in each state in Nigeria. This is expected to be within an existing tertiary hospital in a state.

C. **Sustain National Reference Laboratory and State Public Health Laboratories:** To provide relevant support and training to public health laboratories across the country. This will rapidly reduce the turnaround time between detection and response.

The Digitalisation of Surveillance and outbreak response pillar had one component:

A. **Deployment of Surveillance Outbreak Response Management and Alert System (SORMAS):** To deploy a digital, open-source, tool called Surveillance Outbreak Response Management and Alert System (SORMAS) for early reporting of public health emergencies in all states

The BHCPF operational manual also stipulated the set-up of a project implementation unit at NCDC, for the day-to day running of the NCDC component of the BHCPF public health emergencies gateway. NCDC also opened a TSA BHCPF Account held at the Central Bank of Nigeria (CBN) with the appropriate designated signatories, in line with the guidelines set out in the BHCPF operational manual and financial management documents for the programme.

CHAPTER 2

Implementation of Public Health Emergencies Component of BHCPF

This section outlines the implementation of activities and successful outcomes.

TOTAL 2018 BUDGET FOR BHCPF	AMOUNT APPROVED FOR Q1	AMOUNT RELEASED TO NCDC
N55.90bn	**N13.775bn**	Programme: **N327,156,250**
		Operations: **N34,437,500**
		Total: **N361,593,750**

2.1 Emergency Outbreak Response Funding, Stockpiling and Capacity Development

A. Establish Outbreak Response Fund (ORF)

In 2019, Nigeria experienced a large outbreak of Lassa fever. This outbreak saw a significant decline in the case fatality ratio (CFR), when compared to previous years. One reason for this was the early deployment of Rapid Response Teams (RRTs). National RRTs were deployed to support states in developing their response strategies. In addition, this fund was used to support early coordination meetings of the multi-sectoral COVID-19 Preparedness Group. This group was responsible for the monitoring of trends, development of guidelines and coordination of training activities, prior to the first case of COVID-19 in Nigeria.

B. Indigent Patient Treatment Support (IPTS)

A major challenge in the response to Lassa fever outbreaks, is the inability of patients to pay for hospital treatment and care. The National Health Insurance Scheme (NHIS) does not include infectious disease care, leaving the burden of payment with patients- most of whom are poor and unable to afford to pay their medical bills. Following increasing reports of patients refusing to seek care due to inability to pay, NCDC initiated an Indigent Patient Treatment Support Scheme (IPTS) with the BHCPF. Lassa fever patients do not only pose a risk to themselves when they do not seek care, but also to the public given the infectious nature of the virus.

A framework and design for establishing and implementing the IPTS scheme was established. This was done through multi-stakeholder engagement, including engagement with Lassa fever patients. The health facilities engaged were; Bingham University Teaching Hospital (BUTH) Jos, Plateau State; Irrua Specialist Teaching Hospital (ISTH), Irrua, Edo State; Federal Medical Centre (FMC) Jalingo, Taraba State and Abubakar Tafawa Balewa University Teaching Hospital (ATBUTH) Bauchi, Bauchi State. These states were selected based on their high burden of Lassa fever.

A pilot scheme was planned for one year with only Lassa fever patients. The IPTS had the potential to expand to other epidemic prone diseases.

Unfortunately, the IPTS scheme has not kicked off due to scarcity of funds and the proposed discontinuation of funding to support the public health emergency / NCDC component of the Emergency Medical Treatment gateway.

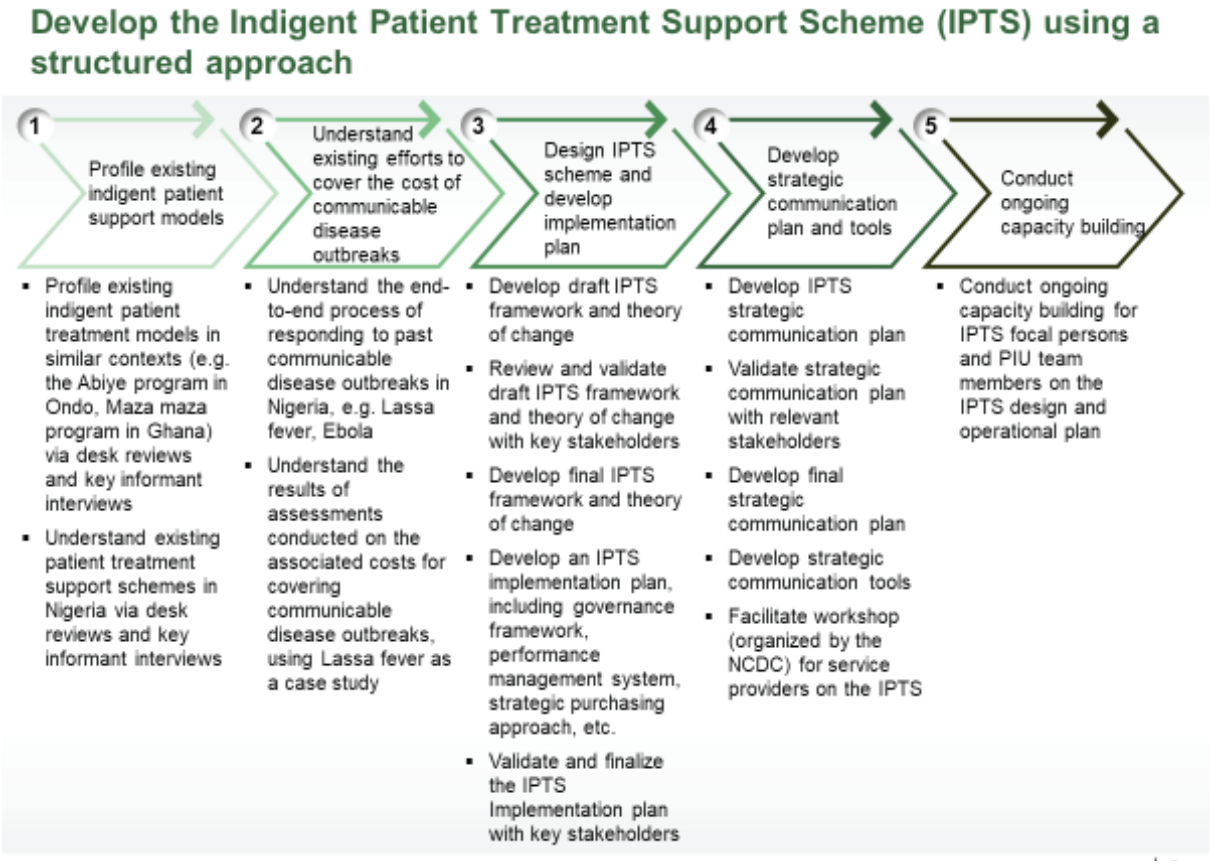


Figure 3 – IPTS scheme development

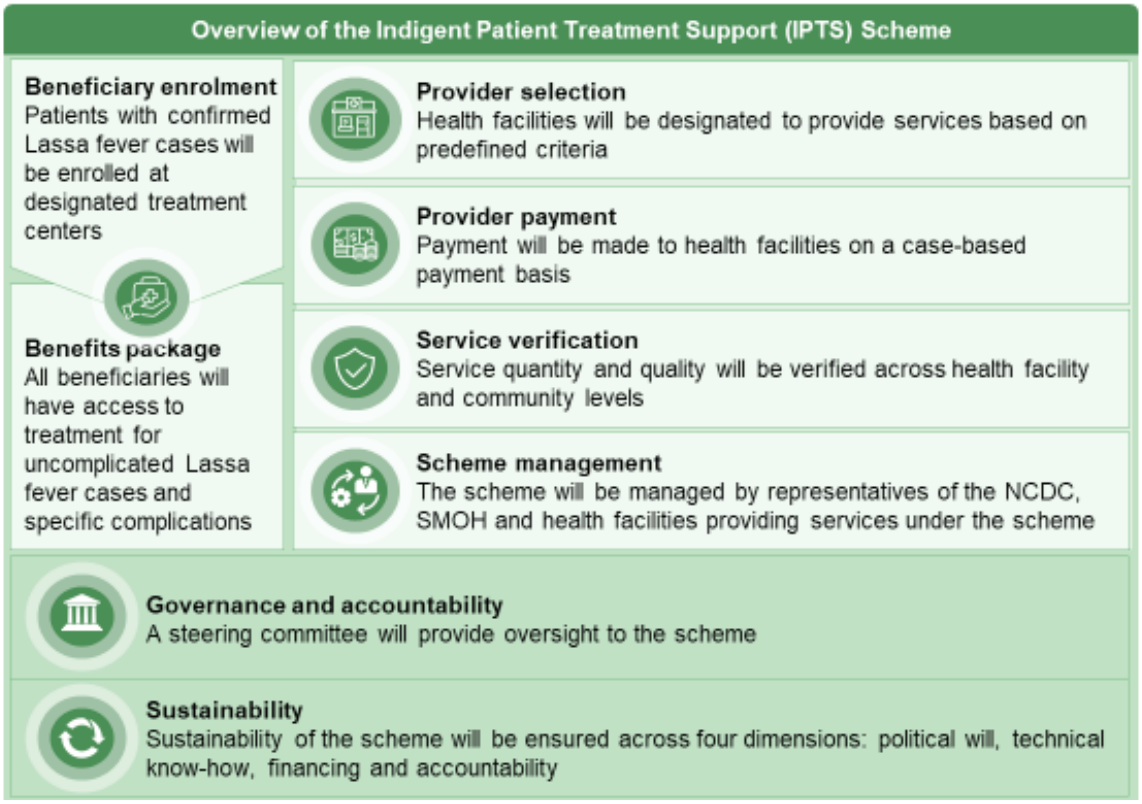


Figure 4: Components of the IPTS scheme

C. Training in Priority Disease Management

In 2017, Nigeria experienced a large Cerebrospinal Meningitis (CSM) outbreak. A major challenge was the low rate of collection of samples due to the limited number of trained health workers. The BHCPF was used in the training of healthcare workers on lumbar puncture and CSM case management in the affected states with a high burden of cases. A total of 138 health workers were trained in both states on CSM case management, sample and data management. The training resulted in an increased cerebrospinal fluid (CSF) collection rate and improved knowledge among clinicians on the reporting of priority notifiable diseases through Integrated Disease Surveillance and Response (IDSR).

D. Stockpile of Outbreak Response Commodities

Two response vehicles were procured to support outbreak investigation and response activities. In addition, laptops, printers and photocopiers were procured

to support the development of national guidelines for all priority diseases in Nigeria. These are available via *ncdc.gov.ng/guidelines*. As funds become available, NCDC will establish a national stockpile of outbreak response commodities and distribute emergency medical commodities across the country.

2.2 Public Health Emergency Operation Centre, Treatment Centres and Public Health Laboratories

A. Establishment of Infectious Disease Treatment Centres

Following the absence of standard treatment centres for infectious diseases in many states in Nigeria, NCDC planned to renovate and equip an infectious disease treatment centre in every state in Nigeria. This was proposed to be within an existing tertiary hospital in each state. Ten treatment centres were assessed to ascertain the current situation and potential for expansion to deal with the increasing number of patients diagnosed with Lassa fever and other highly contagious infections. The Treatment Centre at Bingham University Teaching Hospital (BUTH), Jos was expanded, renovated and equipped with facilities for male, female and paediatrics.

The treatment centre at BUTH is currently used to manage COVID-19 cases in Plateau state. Other planned treatment centres are on hold, due to limited funds for continuity.

B. Establishment of State Public Health Emergency Operations Centre

The NCDC-EMT BHCPF gateway established a Public Health Emergency Operations Centre (PHEOC) in five states: Osun, Delta, Gombe, Kwara, and Abia. This involved advocacy visits to these states, high level discussions with senior health managers about the project, renovation and equipping of State PHEOC. This was followed by training of a multi-sectoral team in each state PHEOC and a simulation exercise.

These PHEOCs are currently serving as coordination hubs for the states' response to COVID-19.

Kwara PHEOC before renovation

Kwara PHEOC after renovation

Gombe PHEOC

C. National Reference Laboratory and State Public Health Laboratories

The NCDC is responsible for the coordination of the network of public health laboratories in Nigeria. A major target through the BHCPF, was the establishment of State public health laboratories in all states. The importance of this has become more obvious, following the COVID-19 outbreak. An assessment was carried out across states and a plan developed for the establishment of State public health laboratories. In addition, coordination meetings were held to develop and validate standard operating procedures for the network of laboratories existing at the time.

Prior to the confirmation of the first COVID-19 case in Nigeria, five laboratories in the existing Lassa fever laboratory network were activated and trained. These five laboratories served as the foundation for the COVID-19 laboratory network in Nigeria.

2.3 Digitalisation of Surveillance and Outbreak Response

Surveillance Outbreak Response Management and Alert System (SORMAS) was deployed in three states, to improve surveillance of priority infection diseases. This system is built to harmonise digital surveillance and ensure early reporting of public health emergencies in Nigeria. SORMAS was deployed in Anambra, Cross Rivers and Kebbi States using the BHCPF. The deployment involved advocacy to states to introduce the concept and increase ownership of the tool, procurement of hardware, instalment of software and training of all state and local government Disease Surveillance and Notification Officers (DSNOs), assistant DSNOs, focal persons in the state laboratory and treatment centres.

State Surveillance Implementation Officers (SSIOs) were recruited to provide support to the State Epidemiologist in each supported state, and the national SORMAS team have carried out state supervisory and mentoring visits.

The states with SORMAS at the beginning of the COVID-19 outbreak, were better prepared in collecting, collating and analysing data as well as contact tracing.

CHAPTER 3

Project Implementation Unit Operations

The Project Implementation Unit (PIU) played a critical role in ensuring the smooth operations of the project. Critically, this included the creation of transparent financial and accountability systems.

Three project staff were recruited to the NCDC-BHCPF PIU; finance assistant, programme officer and driver. The PIU coordinated the day-to-day management and oversight of the implementation of the programme and workplan. Office equipment such as laptops, printer, photocopier, stationaries were procured to support the administration of the programme.

A complaints management system (grievance redress mechanism) was developed as required by the BHCPF manual. This involved hiring a consultant to support the process, setting up an CMS steering committee to oversee the development and implementation of the CMS, developing and printing CMS information leaflet.

The NCDC-EMT gateway Programme's monitoring and evaluation framework, manual and monitoring tools were developed. Consultants were hired to support the development of these, with oversight of the Programme Coordinator.

The PIU staff and other NCDC staff attended project management and finance operation courses. The programme coordinator ensured the staff were well-trained on important project management skills.

Despite the limited availability of funds, NCDC carried out communication campaigns to ensure Nigerians are aware of the Government's commitment to health security through the NCDC- EMT Basic Health Care Provision Fund programme. This was done at the state and national level through social media, radio and TV programmes.

CHAPTER 4

Conclusion

The funding of public health emergency preparedness and response through the BHCPF provides an opportunity to strengthen health security at national and state level. Of particular importance is the critical role that these established Public Health Emergency Operation Centres, SORMAS, trained health workers, laboratory networks and other structures are playing in the response to COVID-19 in Nigeria. There is clear evidence that effective response to public health emergencies requires management processes and structures that support the following:

- Confident and competent decision making and operational execution
- Reliable and rapid processing of data and information into action plans
- Rapid deployment of resources (human, medicines, medical consumables and resources)
- Effective human and financial resource and accountability

The BHCPF provides a sustainable opportunity for Nigeria to take increased ownership of its health security and to be better prepared for public health emergencies.

Despite the evidence of successful implementation of the NCDC-led EMT BHCPF programme and clear need for investments in national and global health security, it is very concerning that defunding support to the NCDC-EMT is being proposed in the 2020 BHCPF Operations guideline. The establishment of the Indigent Patient Treatment Support Funds has the potential to serve as a gamechanger and reduce the death from infectious disease outbreaks in Nigeria. This is now on hold, in the absence of funds for its implementation.

Unlike the 2018 guidelines which specifically recognised the need to fund the response to emerging infectious diseases threats, the proposed 2020 BHCPF guidelines does not make any provision for the funding of preparedness and response for public health emergencies. The view of NCDC is that this increases the risk of Nigerians to the threat of emerging infectious diseases, now and in the future.

In addition to the contravening of the NCDC Act, the timing of the proposal to defund health emergencies from the BHCPF could not be at a worse time as Nigeria's health, social and economic systems face unprecedented pressure from the effects of the COVID-19 pandemic. In addition to the COVID-19 outbreak, Nigeria continues to record cases of Lassa fever, cholera, measles, yellow fever, monkeypox, meningitis nearly every week. Without the resources and other improvements expected from the BHCPF, Nigeria's health security is left exposed and dangerously unprepared for any future outbreak or pandemics.

Universal Health Coverage and health security are two sides of the same coin- none should be left for the other. Defunding public health emergency threatens Nigeria's health security in the short and long term.

CHAPTER 5

Recommendation

- NCDC's considered recommendation is for the re-introduction of the 2.5% allocation for public health emergencies to the 2020 BHCPF implementation guidelines in order to secure the health security of future generations of Nigerians.
- NCDC recommends that investing 50% of the 5% of the BHCPF (i.e. 2.5% of the fund) on preparedness against the threat of infectious diseases will save Nigerian lives, protect the Nigerian economy and ensure the sustainabity of current investments in our health security architecture.
- NCDC's interpretration is that this would be in line with Nigeria's National Health Act of 2014 and the Nigeria Centre for Disease Control Act of 2018.

CHAPTER 6

Annexe

6.1 Financials

AMOUNT RECEIVED: N361,593,750.00	
A. **EMERGENCY OUTBREAK RESPONSE PILLAR**	
I. Vehicles for outbreak response	
Purchase and fueling of vehicles for outbreak response	N43,424,976.19
Sub-Total	**N43,424,976.19**
II. Deployment of teams to states	
Travel to 21 states at various project implementation points for assessment, audit, planning meetings, advocacy meetings and related activities	N15,557,259.17
Sub-Total	**N15,557,259.17**
III. Development of Indigent Patient Treatment Support (IPTS) funds	
Consultancy services to develop a framework and system for implementing the Indigent Patient Treatment Support	N13,028,462.20
Multi-stakeholder engagement in treatment centres/ tertiary hospitals in Edo, Ondo, Bauchi, Plateau, Taraba and Ebonyi States	N3,594,440
Sub-Total	**N16,622,902.20**
IV. Outbreak preparedness/response training	
Training of medical doctors, disease surveillance officers and other health workers on case and sample management for optimum cerebrospinal meningitis management in Cross River and Sokoto States	N11,543,150
Capacity building and mentoring exercise for PHEOCs in Kwara, Gombe, Delta, Abia and Osun States	N22,882,860
Training on financial management and expenditure control for NCDC'S BHCPF PIU	N500,000
Sub-Total	**N34,926,010.00**

V. Stockpile of outbreak response commodities	
Support to Irrua Specialist Teaching Hospital Lassa fever Treatment Centre	N367,200
Sub-Total	**N367,200**
B. EMERGENCY OUTBREAK RESPONSE INFRASTRUCTURE	
I. Construction/renovation of treatment/isolation centres	
Construction of Lassa fever treatment centre at Bingham University Teaching Hospital (BUTH), Plateau State	N36,714,208.50
Early stage development and design of Lassa fever treatment centres in Taraba, Bauchi and Nasarawa	N5,106,250
Sub-Total	**N41,826,459**
II. Establishment of state Public Health Emergency Operations Centres (PHEOCs)	
Establishment of PHEOCs in Abia, Kwara, Osun, Gombe, and Delta including renovation, provision of audio-visual equipment and training of State officers	N90,214,851.47
Sub-Total	**N90,214,851.47**
III. Laboratory strengthening activities	
Procurement of laboratory supplies at the National Reference Laboratory, development and printing of guidelines	N302,428.57
Repairs and maintenance of PCR machines at the National Reference Laboratory	2,157,369.29
Sub-Total	**N2,459,797.86**
C. DIGITALISATION OF SURVEILLANCE AND OUTBREAK RESPONSE	
I. Deployment of SORMAS	
Deployment of SORMAS for digital surveillance in Cross River, Anambra, Kebbi States including hardware, training and human resource support	N47,987,095
Sub-Total	**N47,987,095**

D. **OPERATIONS OF PROJECT IMPLEMENTATION UNIT**		
I. Purchase of office equipment and supplies		
Purchase of laptops, printers, modem, stationeries and other office supplies used at the National EOC and NCDC'S BHCPF Project Implementation		N25,700,980
	Sub-Total	**N25,700,980**
II. Human resource		
Payment of project staff recruited to the NCDC-BHCPF PIU		N2,431,039.20
State Surveillance Implementation Officers (SSIOs) to support surveillance strengthening in states		N2,645,000.00
	Sub-Total	**N5,076,039.20**
Tax		
	Tax	N19,528,743.32
	Sub-Total	**N19,528,743.32**
Ongoing commitments		**N17,901,436.59**
	Grand Total	**N361,593,750.00**

6.2 Projects

NCDC Project Team

Dr. Priscilla Ibekwe - *Programme Coordinator*

Mr. Ikechukwu Okogwu – *Project Accountant*

Kelechi Kalu – *Programme Officer*

Rufai Abullahi – *Programme Officer*

Hamsatu Adams – *Finance Assistant*

David Assy - *Procurement Specialist*

Lassa Fever Treatment Centre, Federal Medical Centre, Owo, Ondo State

Lassa Fever Treatment Centre. Irrua Specialist Teaching Hospital, Irrua, Edo State

Cross-section of meeting attendees at Abubakar Tafawa Balewa University Teaching Hospital, Bauchi State

Cross-section of meeting attendees at Federal Medical Centre Jalingo, Taraba State

Cross-section of meeting attendees at Irrua Specialist Teaching Hospital (ISTH), Edo State

NCDC team and Solina Consultant at the Lassa fever Treatment Centre, Irrua Specialist Teaching Hospital (ISTH), Edo State

Cross-section of meeting attendees at Bingham University Teaching Hospital Jos, Plateau State

Accredited treatment centres will be a paid a fixed rate for each case group treated

	Lassa fever case group	Code	Payment rate
1	Uncomplicated Lassa fever in adults and children	LCG-1	₦ 95,000
2	Uncomplicated Lassa fever in pregnant women (without child birth)	LCG-2	₦ 112,000
3	Uncomplicated Lassa fever in pregnant women (child birth with normal vaginal delivery)	LCG-3	₦ 137,000
4	Uncomplicated Lassa fever in pregnant women (child birth with caesarian section)	LCG-4	₦ 182,000
5	Lassa fever with acute kidney injury	LCG-5	₦ 233,000
6	Lassa fever with non-viable pregnancy	LCG-6	₦ 128,000
7	Lassa fever with anaemia / severe bleeding	LCG-7	₦ 138,000
8	Lassa fever with shock (septic or hypovolemic shock)	LCG-8	₦ 117,000
9	Lassa fever with encephalopathy	LCG-9	₦ 162,000
10	Lassa fever with acute respiratory failure	LCG-10	₦ 119,000

If a patient presents with symptoms that cut across two or more case groups, the health facility will be paid the rate for the higher case category

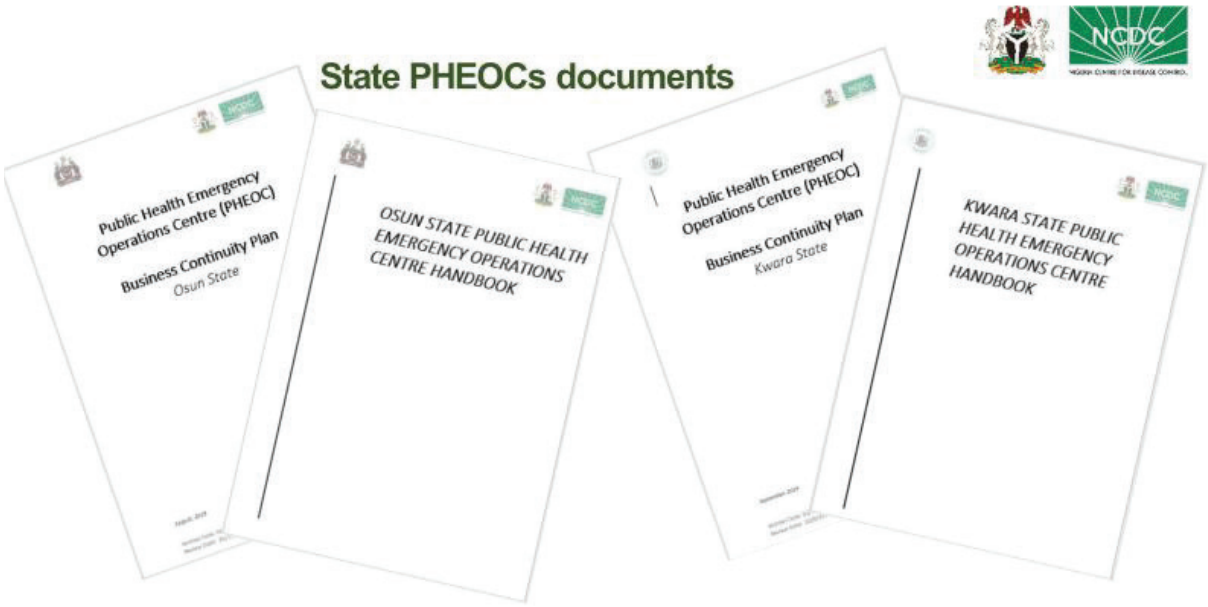
Source: Case management guidelines; FMC, Owo; ISTH Irrua; Team analysis | 23

Agenda for the IPTS stakeholder engagement meeting with the CMDs

Venue: Health facilities **Date: TBD | Total duration: 2 hours, 50 minutes**

Item	Discussion objective	Duration	Facilitator(s)
Welcome and introductions			
▪ Introduction		▪ 15 minutes	▪ All
▪ Welcome address		▪ 10 minutes	▪ The CMD
▪ Brief opening remark		▪ 10 minutes	▪ EMT Coordinator
Overview of the IPTS scheme			
▪ Background and rationale of the IPTS scheme ▪ Description of the scheme ▪ Q&A session	▪ To introduce and describe the IPTS scheme design and implementation plan	▪ 50 minutes	▪ Head, Lassa fever TWG / Lassa fever case management lead
Feedback on the scheme components			
▪ **Discussion to review key components of the scheme** – benefits package, beneficiary enrolment, provider selection and provider payment	▪ To discuss and agree on specific implementation modalities for key components of the scheme	▪ 50 minutes	▪ Case management lead, Lassa fever TWG
Roles of stakeholders in the scheme			
▪ Roles of all stakeholders in the scheme ▪ Discussion session	▪ To align on the roles of all stakeholders in the scheme	▪ 15 minutes	▪ EMT Coordinator
Closing			
▪ Recap of resolutions from the meeting ▪ Closing remarks	▪ To align on resolutions and next steps from the meeting	▪ 10 minutes	▪ Incident Manager, Lassa fever

SOURCE: Team analysis | 3



Treatment centres will be accredited before they are designated to provide services under the IPTS scheme

	1 Shortlisting of health facilities	2 Assessment of treatment centres	3 MOU signing and accreditation
Description	▪ Identify health providers. This can be done in two ways: – NCDC/State identifies potential health facilities and requests for an application letter and completed application form – Health facilities sends NCDC an application letter and completed application form to provide services under the scheme ▪ Review application and validate supporting documents based on minimum eligibility criteria	▪ Conduct physical assessment of health facilities that meet minimum eligibility criteria using assessment checklist (*see appendix*) ▪ Analyze and grade assessment results based on performance ▪ Validate results and make final decision ▪ Communicate the result of the assessment to health providers	▪ Develop Memorandum of Understanding (MOU) ▪ Sign MOU – (NCDC and health providers that passed the assessment stage) ▪ Issue accreditation certificate to health provider
Responsible	▪ IPTS accreditation team	▪ IPTS accreditation team	▪ NCDC legal unit ▪ NCDC Director General (MOU signing) ▪ Health facility Chief Medical Director (MOU signing)
Timeline[1]	▪ 1 week	▪ 3 weeks	▪ 2 weeks

One facility per state will be designated to provide Lassa fever treatment under the IPTS scheme

1. Accreditation is expected to be completed within 6-8 weeks
Source: Team analysis

| 12

Kwara PHEOC

- *Provision of a 10-day intensive basic orientation course on PHEOC management entails (first 5 days for training and the rest for mentoring)*
- *Cross section of PHEOC participants (surge and core staff)*
- *Training period was from 5th — 9th September 2019 with pre-test and post-test respectively*

Kebbi State DSNOs at the SORMAS training

Anambra State SORMAS deployment and training

Cross River State SORMAS deployment DSNOs, state officials and NCDC team

Infectious Disease Treatment Centre, Bingham University Teaching Hospital, Jos

Opening ceremony, DG NCDC and CMD

Staff Treatment Centre

Treatment Centre, Bingham University Teaching Hospital, Jos. Plateau State

National Reference Laboratory (NRL) Gaduwa PCR lab

A REPORT ON THE IMPLEMENTATION OF 'BASIC HEALTH CARE PROVISION FUND' FOR PUBLIC HEALTH EMERGENCIES

BY NIGERIA CENTRE FOR DISEASE CONTROL

NIGERIA CENTRE FOR DISEASE CONTROL

Plot 801 Ebitu Ukiwe Street, Jabi Abuja, Nigeria

0800 970 0010 (Toll-Free Call Number)

SMS 0809 955 5577 0708 711 0839

info@ncdc.gov.ng

@ncdcgov

ncdc.gov.ng