Operations Manual

Federal Ministry of Health (FMOH), National Health Insurance Scheme (NHIS) and the National Primary Health Care Development Agency (NPHCDA)

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FOREWORD

The Basic Health Care Provision Fund is envisaged as one of the single most potent social security interventions in our journey towards the achievement of Universal Health Coverage. The sources of the Fund as advocated in Section 11 of the National Health Act are the Federal Government of Nigeria, International development and from other sources which includes the private sector and the states. The Fund will be used for the provision of a Basic Minimum Package of Health Care Service as defined by the Honourable Minister of Health to all Nigerians.

Hence, the primary purpose of this Fund is to ensure adequate and sustainable funding that will be efficiently and equitably used to provide quality health services and ensure financial risk protection in access to health services for all Nigerians, particularly the poor and most vulnerable.

The smooth operation of the BHCPF and the achievement of intended results will depend largely on the commitment of the different stakeholders, federal, states, development partners, health care facilities and the citizens.
This Operations Manual has been produced as a guide to implement the different gateways of the Basic Healthcare Provision Fund with the overarching aim of ensuring results, transparency and accountability.

The Operations Manual was produced through desk review of relevant documents, extensive consultation and collaboration; and consensus building among different stakeholders particularly the federal actors- National Health Insurance Scheme, National Primary Health Care Development Agency, Federal Ministry of Health, Federal Ministry of Budget and National Planning, Federal Ministry of Finance, State actors and development partners as well as Civil Society Organisations in Nigeria.

The Administrative, Governance and Fund Flow mechanism in the manual are well thought out to provide constant feedback and avenue for cross correction as we implement this Fund.

I commend the efforts of the National Steering Committee (NSC) for the BHCPF, the Secretariat supporting the NSC, National Primary Healthcare Development Agency, National Health Insurance Scheme, Civil Society organizations, colleagues from the media, the Private Sector, members of the academia and the Development Partners in producing this Operations Manual.

I enjoin all our implementers and partners to support the implementation of the Fund using the Operations Manual as a guide.

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ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CFFI	Counterpart Fiscal Funding Instrument
CPD	Continuous Professional Development
CRF	Consolidated Revenue Fund
CSOs	Civil Society Organisations
DFAAR	Decentralised Financing for Accountability and Results
DFF	Decentralized Facility Financing
FCT	Federal Capital Territory
FEC	Federal Executive Council
FMBNP	Federal Ministry of Budget and National Planning
FMOF	Federal Ministry of Finance
FMoH	Federal Ministry of Health
HMH	Honourable Minister of Health
HMSH	Honourable Minister of State for Health
IE	Impact Evaluation
IUCD	Intra-uterine Contraceptive Device
LGA	Local Government Area
LGAD	Local Government Administration
LGAT	Local Government Authority
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NBS	National Bureau of Statistics
NCH	National Council on Health
NEC	National Economic Council
NEMA	National Emergency Management Agency
NHA	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NSC	National Steering Committee
OAGF	Office of the Accountant General of the Federation
PCP	Primary Care Providers
PFMU	Project Finance Management Unit
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
RBF	Results Based Financing
SEC	State Executive Council
SHC	Secondary Health Care
SIMs	Scene Incident Managers
SPHCB/SPHCDA	State Primary Health Care Board (also called State Primary Healthcare Development Agency)
SSC	State Steering Committee
SSHIA/SSHIS	State Social Health Insurance Agency (also called State Social Health Insurance Scheme)

The Secretariat of the NSC	The Secretariat of the National Steering Committee
TSA	Treasury Single Account
UHC	Universal Health Coverage
WDC	Ward Development Committee

DEFINITIONS

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

Administrative Charge: amount set aside to run the operations of the NSC secretariat and the implementing entities.

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

Benefit: this means a benefit, offering, service or advantage of any kind derived from a Scheme.

Benefit Package: refers to all the services available to beneficiaries on enrolment into the BHCPF scheme and the rules, which govern their access to these services.

Catastrophic Spending (for each individual/household): occurs when hospitalisation spending for that person/household as a proportion of ability to pay (household consumption spending less combined survival income for all household members) exceeds a certain threshold.

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

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

Decentralised Financing for Accountability and Results (DFAAR): A two-way process of increasing facility level autonomy around decisions for expenditure, whilst demanding for increased accountability of service and financial management.

Electronic Medical Records: Digital version of a paper record that contains all of a patient's medical history with the health care provider including diagnosis, treatment and medical services rendered.

Enrolee: Also known as beneficiary refers to an eligible person who is enrolled in a health insurance scheme health plan or the eligible person's qualifying dependant.

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

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

Fiscal Space: The availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position. Usually, in creating fiscal space, additional resources can be made available for some form of meritorious government spending.

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

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

Global Payment: refers to bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, package pricing, or packaged pricing, defined as the reimbursement of health care providers (such as hospitals and physicians) "on the basis of expected costs for clinically-defined episodes of care."

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

Health Care Provider: these are any government or private health care facilities, hospital, maternity centre, community pharmacies and all other service providers, accredited for the provision of prescribed health services for insured persons and their dependents.

Independent Verification Agent (IVA): An entity whose function is to ensure that only verified outputs are reimbursed, through (a) certifying that the contractual outputs, as reported by the service provider, have been physically delivered and that pre-agreed standards of service have been achieved, and (b) validating the service provider's reimbursement request (performing cost reconciliation by multiplying the quantity of outputs achieved by their unit cost).

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

Medical Documents: These include all case notes, prescriptions, laboratory forms, excuse duty, death certificate and other documents used in the management of patients.

Medical Practitioner: A person with a medical related degree registerable with the Medical and Dental Council of Nigeria.

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

Per Diem: A method of reimbursing a health provider based on a fixed rate per day rather than on actual charges. It is usually uniform irrespective of degree of care.

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

Primary-Level Facility: Typically staffed by general practitioners and/or nurses with limited laboratory services for general but not for specialised pathological analysis; bed size ranging from 0-20 beds; often referred to as first level referral.

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

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

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

Rural areas in Nigeria: Are low density communities with less than 20,000 residents. A greater part of the population is involved in agriculture and forestry. The residents maintain traditional (close to nature) life styles and habits. There is a preponderance of open landscape or a scarcity of built-up areas and settlement that is dispersed. Typically, the inhabitants consider themselves as rural-dwellers and there may be a paucity of public infrastructure such as healthcare facilities and schools. Such determination shall be confirmed by the National Bureau of Statistics (NBS)

Secondary-Level Healthcare Facility: Highly differentiated by function with five to ten clinical specialities; bed size ranging from 20-100 beds; often referred to as Specialist Hospital.

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

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

Strategic Purchasing: This is the effective allocation of financial resources to providers to enhance health system performance. Specifically, it considers:

- Which interventions to be purchased in response to population needs and wishes, considering national health priorities and evidence on cost-effectiveness
- How they should be purchased, including contractual mechanisms and payment systems.
- From whom they ought to be purchased considering providers' relative levels of quality and efficiency.

Tertiary-Level Healthcare Facility: Highly specialised staff and technical equipment, (Cardiology, Intensive Care Unit ICU and specialised imaging units); clinical services are highly differentiated by function; might have teaching activities; bed size ranging from 100-800 beds; often referred to as Teaching or Tertiary level hospital.

Third Party Administrator: This is either a For-Profit or Not for Profit organisation with expertise and capability to administer all or a portion of insurance business processes. They are usually contracted to also administer services including enrolment, premium collection, claims administration and other administrative functions.

Total Expenditure on Health: The sum of public and private health expenditure that covers the provision of health services (preventive and curative), family planning services, nutrition activities and emergency aid designated for health.

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

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

Vulnerable: This refers to the following categories of people (a) pregnant women, (b) children under five (5) years (c) the elderly >85 years, (d) the disabled, (e) the poor (to be) and others falling within the group.

INTRODUCTION

Nigeria's commitment to Universal Health Coverage has been symbolised by the passage of the National Health Act of 2014, which in section 11 mandates the establishment of a Basic Healthcare Provision Fund (BHCPF) to support the effective delivery of Primary Healthcare services, provision of a Basic Minimum Package of Health Services (BMPHS) and Emergency Medical Treatment to all Nigerians.

The National Health Act prescribes that the Basic Healthcare Provision Fund would be funded through:

1. Federal Government annual grant of not less than one percent of its Consolidated Revenue Fund
2. Grants by international donor partners and
3. Funds from other sources

Lately activities and documentations have ensued to ensure that sections of the Act related to the execution of the BHCPF are operationalized. This Operations Manual has been jointly designed and developed by the Federal Ministry of Health and her parastatals, the National Primary Health Care Development Agency (NPHCDA), National Health Insurance Scheme (NHIS), States and Development Partners. It is expected that the manual will drive an effective implementation of the BHCPF, support improved performance and outputs, while reducing miscommunication and non-compliance by stakeholders.

The Operations Manual is the authoritative guidebook of how the BHCPF will be administered on a day to day basis. It documents activities necessary to complete tasks in accordance with harmonized guidelines of the BHCPF and the National Health Act. Designated activities are pragmatic and take into consideration familiar structures and processes.

It enumerates all stakeholders involved in the operationalization of the fund, their dependencies, expected inputs and outputs alongside timelines for their activities. It also provides guidance for the roles of stakeholders, mechanism for monitoring and compliance as well as penalties/sanctions for non-compliance with the Operations Manual.

In preparing the Operations Manual the following documents were consulted:

1. National health Act, 2014
2. Implementation manual for Implementing the Primary Health Care governance in Nigeria (PHCUOR)
3. National Health Insurance Scheme (NHIS) operational guidelines
4. Operations Manuals and project implementation manuals from other health schemes in Nigeria and other parts of the world

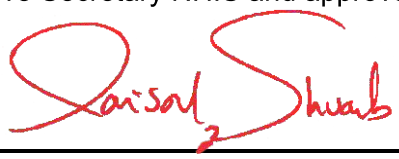
The Operations Manual underscores and assures the focus of the BHCPF on current health priorities: Reproductive, Maternal, Child, Adolescent Health plus Nutrition, Non-Communicable Diseases Screening and Emergency Services (Road Traffic Injuries i.e. RTIs).

The Operations Manual ensures that governance, administration, fund management, operations and monitoring and evaluation requirements are clear, consistent and in line with best practices that assure the transparency, credibility and effectiveness of the fund. The manual employs innovative processes that utilizes existing infrastructure, practices, resources and initiatives rather than developing exclusive processes or initiatives, which will result in duplication of roles and resources with attendant underutilization and inefficiencies.

The development of this Operations Manual involved extensive consultation and involvement of stakeholders from the public, developmental/civil society and private sector across the federal, state and facility levels.

The National Steering Committee welcomes continuous feedback from all stakeholders to ensure the success of the BHCPF. Such feedback may result in the issuance of supplements, appendices or errata to this manual.

The Operations Manual will be a living document, which will be updated in the light of fiscal developments, implementation successes, new technologies and constraints in implementation. At each instance, for the finalised version of the Operations Manual for the implementation of the BHCPF to be considered a policy document, it shall be endorsed by the Executive Director NPHCDA, Executive Secretary NHIS and approved by the Honourable Minister of Health.



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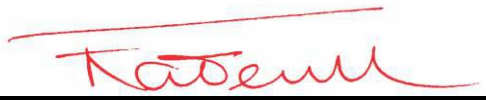

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Honourable Minister of Health

1 GOVERNANCE AND ADMINISTRATION OF THE FUND

Section 11 of the National Health Act established the Basic Healthcare Provision Fund as the vehicle for providing a basic minimum package of health services for all Nigerians as defined by the Honourable Minister of Health.

To ensure the achievement of the goals and objectives of the fund, a governance and administration mechanism shall be established at the national / federal, states and facility level.

There are three hierarchies of governance for the BHCPF.

1. National/Federal:
   a. The National Council on Health
   b. The National Steering Committee

2. State:
   a. State Steering Committees

3. Facility:
   a. Local Government Health Authorities
   b. Ward Development Committees

There are three hierarchies of administration for the BHCPF

1. Federal:
   a. NHIS (NHIS gateway)
   b. NPHCDA (NPHCDA gateway)
   c. FMOH (EMT gateway)

2. State:
   a. SPHCDA
   b. SSHIA

3. Facility:
   a. PHCs
   b. SHCs
   c. Emergency medical treatment service providers

Figure 1: Hierarchy of Governance and Administration

HIERARCHIES OF GOVERNANCE	HIERARCHIES OF ADMINISTRATION
NATIONAL /FEDERAL a. The National Council on Health b. The National Steering Committee	**FEDERAL** a. NHIS (NHIS Gateway) b. NPHCDA (NPHCDA Gateway) c. FMoH (EMT Gateway)
STATE a. State Steering Committees	**STATE** a. State Primary Healthcare Development Agency b. State Social Health Insurance Agency
FACILITY a. Local Government Health Authorities b. Ward Development Committees	**FACILITY** a. Primary Healthcare Centres b. Secondary Healthcare Centres c. Emergency Medical Treatment Service Providers

1.1 Roles and Responsibilities of Stakeholders

1.1.1 National Council on Health (NCH)

1.1.1.1 The National Council on Health (NCH), as established by National Health Act 2014 (Sections 4), is the highest policy making body in Nigeria on matters relating to health and it has oversight responsibility for the BHCPF.

1.1.1.2 Specifically, among other responsibilities the NCH shall:

i. Have responsibility for the protection, promotion, improvement and maintenance of the health of the citizens of Nigeria and the formulation of enabling policies and prescription of measures necessary to achieve national health goals and priorities.
ii. Ensure the delivery of basic healthcare services to the people of Nigeria and prioritize other healthcare services that may be provided within available resources.
iii. Facilitate and promote the provision of health services for the management, prevention and control of communicable and non-communicable diseases.
iv. Perform such other duties as may be assigned to it by the Minister for Health.

1.1.2 The National Steering Committee (NSC)

1.1.2.1 The NSC shall meet at least quarterly and provide cross-functional leadership, strategic operational direction, oversight, ensure programme visibility and serve as an advocacy group for increased resource mobilization. Other functions shall include:

i. Function as a national strategic group promoting true collaboration in the development and implementation of the BHCPF and be fully transparent in its decision-making.
ii. Coordinate the operations of the different stakeholders to ensure alignment with the overall objectives of the BHCPF.
iii. Review and approve annual work plans and budgets of Federal and State implementing entities and the Secretariat of the NSC.
iv. Review updates on funds flow, performance management and verification of results as collated by the Secretariat of the NSC.

v. Evaluate programme report presented by the implementing agencies (NPHCDA, NHIS and EMT (FMoH and NCDC)).
vi. Have the responsibility to ensure compliance of all participating agencies and entities with the Operations Manual.
vii. Review performance of the implementing entities based on a clear set of agreed upon Key Performance Indicators (KPIs) across the programme.
viii. Review quality improvement performance of enlisted facilities arising from the programme's quality monitoring system.
ix. Review reports from system of complaints and redress mechanism and provide necessary directives and guidance for resolutions.
x. Proactively identify programme risks.
xi. Ensure that monies are disbursed, managed, and accounted for in a transparent and accountable manner and in accordance with this Operations Manual.
xii. Review patient satisfaction based on feedback obtained through the fund's grievance and redress mechanism.
xiii. Advocate and ensure the provision of the required resources for planning and delivery of the programme. Notably, the NSC shall ensure that health and the BHCPF becomes a recurring agenda at the meetings of the National Economic Council (NEC) to ensure the mobilization of required national, sub-national and private resources.
xiv. Monitor programme progress against approved plans and guidelines.
xv. Facilitate implementation of financial audits by appointing independent external auditors.
xvi. Appoint independent verification agents following due procurement processes.
xvii. Review and ensure the reports to be made to the NCH, NEC and other stakeholders are robust and technically sound.
xviii. Resolve disputes or issues arising from implementation of the BHCPF.

1.1.2.2 The National Steering Committee (NSC) of the BHCPF shall consists of:

1. The Minister for Health as Chairman
2. Minister of State for Health as Alternate Chair
3. Permanent Secretary Federal Ministry of Health (FMOH) as Vice Chair and in the absence of either the Minister of Health or the Minister of State for Health shall assume Chair of the NSC
4. Permanent Secretary of the Ministry of Finance
5. Permanent Secretary of the Ministry of Budget and National Planning
6. Executive Secretary NHIS
7. Executive Director NPHCDA
8. Chair of the Committee of State Commissioners of Health
9. One Representative/Chairperson of SPHCB Executive Secretaries
10. One Representative/Chairperson SSHIA Executive Secretary
11. One (1) Representative each of development partners contributing to the fund
12. One (1) Representative of healthcare focused civil society organizations (CSOs) selected by CSOs.
13. One (1) independent member[1]
14. The Head of the Secretariat of the NSC shall be a non-voting member and shall serve as secretary of the NSC

[1] An independent member refers to one who does not have any other material pecuniary relationship or transactions with the committee, its promoters, the stakeholders or its affiliates, which in judgment of the committee may affect independence of decisions of the member. Such an independent member will be appointed by Minister of Health.

15. Representatives of the contributing partners / private sector organizations contributing to the fund

1.1.3 The Secretariat of the NSC

The National Steering Committee shall be served by a secretariat domiciled in the FMoH and headed by a Director of the FMoH. The secretariat shall be supported by a team drawn from the FMoH and the implementing agencies. Each implementing agency would deploy two members of staff to the Secretariat of the NSC.

The administrative costs of carrying out its functions shall be based on a budget and work plan presented and approved by the NSC.

1.1.3.1 The Secretariat of the NSC acting on instructions of the National Steering Committee shall carry out the following responsibilities:

i. Preparation of collated reports from the Gateways which will include:
   a. Programmatic - which shall be categorized into two (2) sections (i) technical presentations made to relevant stakeholders during technical sessions of the NCH (ii) policy briefs that synthesize insights from programme implementation, enumerates policy options and recommendations.
   b. Financial – which will provide information on funds flow to each gateway, State and service delivery points. The report will also contain the total amount available to the gateways at the time of reporting.

ii. Secretariat Functions
   a. Serve as The Secretariat of the NSC and ensure communication of the mandate of the NSC in a manner that facilitates the alignment of stakeholders and their activities with the Fund's strategic goals and objectives
   b. Organize the joint routine review of the BHCPF Operations Manual at pre-determined intervals with the NHIS, NPHCDA, FMOH and other stakeholder's sequel to the approval of the NSC.

iii. M&E
   a. Collate the reports from quarterly randomised surveys by assigned independent verification agents (IVAs); the Independent Verification Agent shall preferably be third party Government or Academic Institution and reports collated will be presented to NSC and other stakeholders

iv. Planning and Budgeting
   a. Collate, and present to the NSC the implementation plans from implementing agencies.
   b. Organise review meetings bi-annually or as directed by the NSC.

v. Communication, Advocacy and Grievance redress mechanism
   a. Collate and review high level advocacy materials from the gateways for the NSC
   b. Facilitate the harmonization of communications and advocacy messaging and brand elements amongst the Gateways and present same to the NSC.

1.1.4 National Health Insurance Scheme (NHIS)

1.1.4.1 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 percent of the BHCPF).

1.1.4.2 The NHIS shall be responsible for:

i. Provision of the Basic Minimum Package of Health Services (BMPHS) to all Nigerians/eligible target groups of Nigerians, through accredited public and private primary and secondary health care facilities.
ii. Provision of technical support to the SSHIAs;
iii. Establishment of the regulations covering accreditation and quality improvement (in collaboration with NPHCDA). At programme commencement, all public PHCs will receive provisional accreditation from the NHIS to enable them to qualify for payments.
iv. The NHIS reserves the right to withdraw this provisional status if facilities do not meet the NHIS accreditation standards one year after.
v. Enrolment of beneficiaries shall be carried out by SSHIAs and validated by NHIS
vi. Contracting of accredited healthcare providers for the provision of services under the NHIS gateway
vii. Consolidate the financial and service utilization report for review and onward submission to NSC
viii. Timely remittance of funds to SSHIA
ix. Carry out implementation monitoring, quality assurance and outcome evaluation under NHIS gateway to ensure that the programme is delivered according to plan and achieves desired goals and objectives

1.1.4.3 The combined Administrative Costs to the NHIS and the SSHIAs for carrying out these roles and functions have been capped at and shall not exceed two percent (2%) of the BHCPF

1.1.4.4 However, start-up implementation expenses may exceed this designated cap subject to approval of appropriate work plans and associated budgets by the NSC.

1.1.5 National Primary Health Care Development Agency (NPHCDA)

1.1.5.1 NPHCDA shall strengthen the operations of PHCs through the "NPHCDA Gateway," forty-five percent (45%) of the BHCPF

1.1.5.2 The NPHCDA gateway shall provide funding through the SPHCDAs to eligible public Primary Health Care facilities as operational budgets for running of the PHC including:

i. Provision of essential drugs and consumables and transportation for retrieval of vaccines;
ii. Provision and maintenance of facilities, equipment and medical transport vehicles;
iii. Community outreaches
iv. Development of human resources. Up to five percent (5%) of the NPHCDA fund may be utilised based on States' stated priorities, to support community based human resources; – Nurses/Midwives, CHEWS or CHIPS. However, Community Based Human Resource Intervention (CHIPS) shall be given priority in all states. Five percent (5%) shall be allotted for training institutions upon approval by the NSC.

1.1.5.3 The NPHCDA shall be responsible for:

i. Development of regulations and standards for PHC facilities (in collaboration with SPHCDAs).
ii. Evaluation of quality improvement in primary using a stepwise quality

improvement tool with quantifiable outcome measures.
iii. Provision of technical support to the SPHCDAs
iv. Building Capacity across board for implementation of the NPHCDA Gateway
v. Conducting implementation research to generate evidence for improvement in implementation of the NPHCDA Gateway and PHC
vi. Working with the SPHCB to determine the baseline at 'on-boarding' of states on to the BHCPF in collaboration with other stakeholders.
vii. Conducting annual quality improvement surveys for PHC
viii. Conducting supportive supervision, monitoring and evaluation of the NPHCDA gateway at all levels.
ix. Publish a 'Handbook' for the NPHCDA Gateway to further guide OIC of Health Facilities and LGHA Staff on Gateway operational actions.
x. Timely payment to the SPHCDAs
xi. Other functions delegated by the NSC
xii. Where necessary, up to ten percent 10% of the BHCPF funds can be utilised for the procurement of bundled vaccines where there are gaps in financial resource requirements upon approval by the NSC

1.1.5.4 The Administrative Costs to NPHCDA, State Primary Health Care Development Agencies (SPHCDAs), SSC and LGHA for carrying out these roles and functions shall be based on budget and work plans as approved by the NSC

1.1.6 Emergency Medical Treatment Gateway

1.1.6.1 The provision of emergency medical services shall be funded through the "EMT Gateway" 5 percent (5%) of the BHCPF

1.1.6.2 This will be divided between the Department of Hospital Services (2.5%) and the Nigeria Centre for Disease Control (2.5%)

1.1.6.3 The NCDC shall utilise the funds to improve Nigeria's emergency preparedness response. This shall include but not limited to reference labs, delivery of relevant strategies and objectives necessary to achieve stated aims

1.1.6.4 The DHS shall ensure the provision of basic Emergency Medical Treatment (EMT), by eligible Ambulance Services and designated Emergency Care facilities

1.1.6.5 Emergency Medical Treatment (EMT) covers a spectrum of activities including:
i. Pre-Hospital Care &Transport
ii. Initial Evaluation
iii. Resuscitation and
iv. In-Hospital Care - In this context, Emergency Medical Treatment (EMT) will apply to, surgical and non- surgical emergencies related to road traffic accidents.

1.1.6.6 The DHS shall be responsible for:
i. Accreditation of Ambulance Service Providers nationwide, which may include the Federal Road Safety Corps (FRSC), State Ambulance Services, National Emergency Management Agency (NEMA), Private Sector Ambulance Service Providers and Voluntary Sector Ambulance Service Providers
ii. Developing a strategic purchasing and payment system (upon approval by the NSC) for Emergency Initial Evaluation, Diagnosis & Resuscitation and any required basic In-
iii. Hospital Care at accredited Healthcare Facilities
iv. Provision of technical support to the accredited parties
v. Timely payment of the EMT service providers
vi. Other functions delegated by the Minister of Health

1.1.6.7 The combined Administrative Costs, consisting of payments to DHS for carrying out its roles and functions in overseeing the DHS, has been capped at and shall not exceed half percent (0.5%) of the BHCPF however start up implementation expenses may exceed this designated cap subject to approval of appropriate work plans and associated budgets by the NSC.

1.1.7 The State Steering Committee

The commissioner shall be responsible for the establishment of the State Steering Committee (SSC). The SSC is charged with the responsibility of stewardship for the BHCPF at the State level.

1.1.7.1 The SCS shall meet at least quarterly and provide cross-functional leadership, strategic operational direction, ensure programme visibility and serve as an advocacy group for the BHCPF within the State for increased fiscal space.

1.1.7.2 Other functions shall include:

i. Function as the state strategic group promoting collaboration in the development and implementation of the BHCPF and be fully transparent in its decision making
ii. Review and approval of annual work plans and budgets of the state implementing agencies (SSHIA and SPHCDA) before escalation to the Federal implementing agencies (NHIS AND NPHCDA respectively)
iii. Review updates on funds flow, performance management and verification of results provided by the state implementing agencies (SSHIA and SPHCDA) and/or other delegated persons/entities.
iv. Review quality improvement performance of enlisted facilities arising from the BHCPF's quality monitoring system
v. Review patient satisfaction based on feedback obtained through the grievance redress mechanism.
vi. Evaluate programme report presented by the state implementing agencies (SSHIA and SPHCDA).
vii. Advocate and ensure the provision of the required resources for planning and delivery of the programme. Notably, the team shall ensure that health and the BHCPF becomes a recurring agenda at the meetings of the State Economic Council (SEC) to ensure the mobilization of required sub-national and private resources.
viii. Monitor programme progress against approved plans and guidelines
ix. Facilitate implementation of financial audits by auditors appointed by the Auditor-General of the State.
x. Review and ensure the reports to be made to the SCH, SEC and other sub-national stakeholders are robust and technically sound
xi. Resolve issues outside the authority or control of the SSHIA & SPHCDA, such as priority setting, decision-making and resource commitments that cross-organisational boundaries and require agreement from other stakeholders.

1.1.7.3 Composition of The State Steering Committee

The State Steering Committee shall be a standing committee composed of the following persons:

i. The State Commissioner for Health
ii. The Permanent Secretary in the Ministry of Health
iii. The State Accountant General
iv. Permanent Secretary of the Ministry of budget and planning
v. Permanent Secretary of the Ministry of Finance
vi. The Executive Director or equivalent of the SPHCDA
vii. The Executive Secretary or equivalent of the SSHIA
viii. The NHIS State Coordinator
ix. The NPHCDA State Coordinator
x. The Director of Planning, Research and Statistics in the SMoH who shall serve

as the Secretary of the Committee.

xi. Representatives of the contributing partners / private sector organizations contributing to the fund

xii. Representatives of CSOs at the state level

1.1.7.4 Tenure

Each member of the State Steering Committee shall hold office on such terms and conditions as may be specified in their letters of appointment to their primary positions.

1.1.8 State Ministries of Health

1.1.8.1 State Ministries of Health (SMoH) shall provide leadership at the State level and ensure successful implementation of the initiative in each State.

1.1.8.2 The Commissioner of Health will ensure there is a fully functional State Primary Healthcare Development Agency (SPHCDA) for administration of the NPHCDA gateway in the state.

1.1.8.3 The Commissioner of Health will ensure there is a fully functional State Social Health Insurance Agency (SSHIA) for administration of the NHIS gateway in the State.

1.1.8.4 State shall allocate at least 25% matching grant as prescribed in the National Health Act (2014) and deposited in the state BHCPF TSA CBN domiciled account

1.1.8.5 The Commissioner of Health shall ensure that the State shall make annual budgetary provisions and releases for the BHCPF, which shall be pooled in the State BHCPF TSA account at the CBN. Such budgetary provisions will support:

i. Provision of at least one PHC in each political ward

ii. The process of ensuring that the selected PHCs meet the required standards for service provision as determined by the National Standards for Primary Healthcare set by NPHCDA/NHIS.

iii. Expansion of the BMPHS to other population sub-groups

iv. Operational expenses of Primary Healthcare Centres and provision of human resources especially midwives

1.1.8.6 The SMoH would be responsible for supervision and evaluation of quality improvement in empaneled secondary health facilities.

1.1.8.7 Each participating State Government (and the FCT), shall sign a Global Programme Agreement with the Honourable Minister of Health on behalf of the NSC and implementing agencies: NHIS and NPHCDA to govern its participation in the initiative, including estimated amounts allocated for disbursement, reporting obligations, Service-Level Agreements (SLAs) and reporting requirements. In addition, the Federal implementing agencies will each sign subsidiary MOUs with corresponding State implementing agencies i.e. NHIS with SSHIAs and the NPHCDA with SPHCDAs. All states shall ensure the repositioning of their PHCUOR within six (6) months of commencement of BHCPF.

1.1.9 State Primary Health Care Development Agencies (SPHCDAs)

1.1.9.1 It shall be a pre-condition for accreditation of primary healthcare facilities in all States, who wish to benefit from the NPHCDA gateway, that their State Government has established (or is in the process of establishing) a State Primary Health Care Development Agency (SPHCDA).

1.1.9.2 State Primary Health Care Development Agencies (SPHCDAs) shall provide state level capacity and oversight for implementation of the NPHCDA gateway with support from the NPHCDA.

1.1.9.3 The SPHCDAs shall ensure there is at least one (1) participating PHC facility in every Ward to be enlisted into the NPHCDA gateway with public PHCs eligible for receiving operational budget support via the NPHCDA gateway as "Decentralised Facility Financing (DFF)" disbursed through the SPHCDAs.

1.1.9.4 In line with the payment process of DFF, funded through the NPHCDA Gateway 45 percent (45%) of the BHCPF, all funds received on this account by the SPHCDAs shall be transferred electronically to PHC facilities within a period of not more than seven (7) days after the funds have been received.

1.1.9.5 Both the NPHCDA and SPHCDAs shall have oversight roles over accredited primary healthcare facilities.

1.1.9.6 SPHCDAs with support from the NPHCDA and in collaboration with NAFDAC (federal and state) would accredit manufacturers, local distributors and local manufacturers including the central drug store from which PHCs may procure drugs directly. Such accreditation shall ensure that supplied drugs are genuine and from verifiable manufacturers whose products are NAFDAC certified. The SPHCDAs shall negotiate prices with the drug vendors and shall ensure that no PHC procures drugs at rates higher than the negotiated rates and from unaccredited vendors.

1.1.9.7 SPHCDAs shall ensure all accredited healthcare facilities open and maintain bank accounts with commercial banks that are part of the Nigeria bankers' clearing house system to enable electronic receipt of funds from the SPHCDAs. The accounts will have as signatories, the Officers in Charge at the Facility Level and the Chairmen of the Ward Health Committees.

1.1.10 State Social Health Insurance Agency

1.1.10.1 In the States, the NHIS gateway will be implemented through State Social Health Insurance Agencies

1.1.10.2 States shall set up their SSHIAs in line with guidelines and support from the NHIS .

1.1.10.3 The functions and roles assigned to the SSHIA include:

i. Management of the benefit package (BMPHS) in line with the BHCPF Operations Manual
ii. Accredit and empanel primary and secondary health care facilities using simple and inclusive criteria.
iii. Contracting of Healthcare Providers
iv. Enrolment and registration of beneficiaries
v. Provider Management, including continuous quality assurance, case management and call-centre operation to facilitate improved provider and patient experience
vi. Claims collation and processing
vii. Financial management in line with the BHCPF Operations Manual
viii. Provider payment
ix. Liaison with other BHCPF stakeholders

x. Other functions designated by the NHIS

1.1.11 Local Government Administration

1.1.11.1 The SPHCDA and SSHIA shall work closely with the Local Government Administrations and Local Government Health Authorities to achieve the objectives of the BHCPF.

1.1.11.2 The Local Government Health Authorities (where applicable) shall continue to provide supportive supervision of PHCs in the LG. In states where the PHC-under-one-roof (PHCUOR) concept has been fully implemented, it is expected that the staff of the LGA Health authorities shall be integrated into the SPHCDA and provide the required PHC supervisory functions.

1.1.11.3 The supportive supervision shall ensure that:

i. PHCs are staffed, equipped and functioning appropriately in line with the accreditation and service delivery requirements of the BHCPF outlined in this Operations Manual.
ii. Beneficiaries have seamless access to the set of services defined as the BMPHS and at no additional cost.
iii. Funds from the NPHCDA gateway through the SPHCDA are utilized judiciously and transparently to supplement the operational budget of the PHC to continuously improve quality of care and service.
iv. Funds realized from the NHIS gateway through the SSHIA are utilized judiciously and transparently to continually improve service delivery.

1.1.11.4 Drugs are procured from manufacturers, accredited pharmacies or distributi on channels and at negotiated prices.

i. Clinical and non-clinical (financial and non-financial) records are kept in line with the data recording and reporting of the BHCPF outlined in this manual. Including ensuring that NHMIS, utilization and/or claims forms are correctly filled and submitted on time.
ii. Provide direct technical support to the PHC for implementation of activities related to the BHCPF.

1.1.11.5 Quantified supervisory checklist (draft) is attached as Appendix 7

1.1.12 Ward Development Committee

1.1.12.1 The Ward is regarded as the unit of political representation. It enables citizen participation in the political economy through a councillor. The ward development committee exists at the community level to enable mobilization and governance of community resources. In line with NPHCDA's minimum standards for PHCs in Nigeria, Ward Development Committees are involved alongside health workers and LG PHC department officials for co-managing the PHCs at Ward level.

1.1.12.2 The WDC is composed of:

i. One representative from each Village Development Committees (VDC) in the ward
ii. An elected member of the committee who shall serve as the head of the committee (Chairperson)
iii. An elected member of the committee who shall serve as the secretary of the committee
iv. Ward head or Autonomous clan head who shall serve as the Patron, but where no such person exists, the most respectable ward head or any other person so elected may serve as Committee Patron
v. The Ward's Community Development Officer, if available
vi. Heads/officers-in-charge of public health facilities in the ward
vii. The committee where necessary can co-opt members of health-related

sectors such as Secondary School Principals and Primary School Headmasters, Agric-Extension Workers, PHCN/Water works staff, NGOs

1.1.12.3 At least forty percent (40%) of membership should be women with effective roles in the WDC

1.1.12.4 The Roles and Responsibilities of the WDC include:

i. Collaboration with the PHC facility leadership in identification of health and social needs of the ward and planning for them
ii. Prioritization of identified health needs in annual work plans
iii. Identification of local human and material resources to meet needs enumerated in the health facility annual work plan
iv. Forwarding all health/community development plans (village, facility and Wards levels) to the LGA and other relevant entities
v. Mobilizing and stimulating active involvement of prominent and other local people in the planning, implementation, and evaluation of projects
vi. Raising funds for community programme when necessary at village, facilities and Wards levels
vii. Providing feedback to the rest of the community on how funds raised are disbursed
viii. Liaising with government and other voluntary agencies in finding solution to health, social and other related problems in the Wards
ix. Supporting activities at the health facilities in the Wards
x. Providing necessary support to VHWs/TBAs
xi. Nomination of one member of the WDC other than the representative(s) from the facility to serve in the facility's Quality Improvement Committee

1.1.13 Primary Healthcare Centres (PHCs)

1.1.13.1 Primary Healthcare Centres (PHCs) shall be the first point of contact for patients who are seeking and receiving care from accredited providers under this initiative.

1.1.13.2 PHCs shall provide the essential preventive, curative and rehabilitative healthcare services offered in the BMPHS and serve as gatekeepers for the initiative.

1.1.13.3 Designated public PHC facilities, which meet the accreditation criteria set out by the NHIS/SSHIA shall be enlisted into the NHIS gateway to deliver the BMPHS and be reimbursed via the NHIS Gateway via “Global Payments (GP)” disbursed from the Fund through SSHIAs.

1.1.13.4 The designated public PHCs shall have functional bank accounts with signatories including the OIC and the Chairman of the WDC

1.1.13.5 Under the NPHCDA Gateway, public PHC facilities shall receive quarterly, and in advance direct electronic fund transfers from the SPHCDA as operational budgets.

1.1.13.6 Funds received by the public PHCs shall be used in strengthening health service delivery. Facilities shall use funds for improving commodity availability, ensuring facility functionality and generating demand through community outreaches in line with their quality improvement plans.

1.1.13.7 Participating public PHC facilities shall be required to produce and submit Income and Expenditure Statements for monies received from the Fund, to the SPHCDA through the LGHA at the end of each quarter and end of the financial year.

1.1.13.8 Private facilities may be contracted by the SSHIA to complement the activities of the public PHCs, these private PHCs shall not receive operating budgetary support from the SPHCDA however they shall be qualified to participate and be reimbursed retrospectively for service delivery under the NHIS gateway.

1.1.13.9 Participating public and private PHCs are required to be have signage indicating that they provide the BMPHS (maternal care, child health, malaria treatment, hypertension and diabetes screening, and immunization services etc.) at no cost to beneficiaries.

1.1.13.10 Participating public and private PHCs shall have a minimum of 2 committees with verifiable evidence of functioning viz-a-viz meetings, staff awareness and demonstrable outputs. These committees are:

i. Facility management committee comprising of the officer-in-charge (as chairperson) and the unit heads/heads of departments
ii. Quality improvement committee comprising of the officer-in-charge (as chairperson), one nurse/CHEW, one member of the WDC, one Pharmacy personnel, one laboratory personnel, and one non-medical worker from the facility.

1.1.14 Secondary Health Care (SHC) Facilities

1.1.14.1 Public and private Secondary Health Care (SHC) facilities shall provide specialist services to patients on referral from the participating public and private PHCs.

1.1.14.2 Accreditation of SHC facilities shall be specialty specific and focused on specialist capability for the management of:

i. Emergency Obstetric interventions - Assisted deliveries and elective/emergency caesarean interventions
ii. Chorioamnionitis
iii. Intra-uterine Growth Retardation
iv. Gestational Diabetes
v. Hypertension in Pregnancy

vi. Multiple Gestation
vii. Placenta Praevia
viii. Pre-eclampsia and Eclampsia
ix. Referral Neonatal and Childhood conditions

1.1.14.3 Patients can only access SHC specialists through a written referral from their PHC provider.

1.1.14.4 SHC facilities, which meet the accreditation criteria set out by the BHCPF shall only receive funding through the NHIS Gateway as “Global Payments (GP)” disbursed directly through the SSHIAs.

1.1.14.5 SHC facilities shall be paid retrospectively following claims submission and processing.

1.1.15 Emergency Medical Service Providers (DHS and NCDC)

1.1.15.1 The NCDC shall set up an emergency operations fund to support disease outbreaks around the country

1.1.15.2 The NCDC shall set up public health emergency operations centres and reference laboratory across Nigeria.

1.1.15.3 NCDC shall ensure that public health emergency response is digitized and provide on a quarterly basis to the NSC, every programmatic and financial performance data

1.1.15.4 Ambulance Service Providers shall provide, as a standard of care, "Scene Incident Managers (SIMs)" who shall secure the scene, coordinate the Emergency Response, all communications and transport at and from the RTI scene to designated emergency medical treatment facilities

1.1.15.5 Both private-sector and public-sector ambulance service and healthcare providers shall be eligible to apply for accreditation and participate in the EMT gateway

1.1.15.6 To be eligible to receive payment in this initiative, each ambulance service provider or healthcare provider must be contracted.

1.1.15.7 Each ambulance service provider or healthcare provider shall meet the minimum criteria of quality standards before it can be accredited. A quantitative quality supervisory checklist will be administered to all enrolled facilities and service providers to monitor and ensure a consistent level of quality.

1.1.15.8 Healthcare Providers shall not refuse treatment to any RTI patient under the initiative or charge user fees, either as a "Top-Up" or as "Co-Payment"

1.1.15.9 Emergency Care Providers shall maintain high standards of medical record keeping and submit both clinical and administrative data to the NSC.

1.1.15.10 Ambulance Service Providers shall develop and maintain robust communications and referral systems for the management of emergency patients, so there is direct access between Ambulance Service Provider and neighbouring Emergency Care facilities with the capacity to manage any such cases.

1.1.15.11 Any patient determined to require emergency care, must be promptly transported and arrive at the Emergency Care centre within half an hour (30 minutes) of the decision being made.

1.1.15.12 Selection and continued participation in the initiative is contingent on the ambulance service and healthcare providers maintaining adequate quality standards of care.

1.1.15.13 Designated healthcare professionals must remain in good professional standing with their registration bodies, including meeting Continuous Professional Development (CPD) requirements.

1.1.15.14 To ensure management of expectations service and fund utilization under the EMT gateway shall be publicly disclosed.

1.1.16 Civil Society Organisations (CSOs)

1.1.16.1 Civil Society Organisations (CSOs) with a proven history of involvement in health sector monitoring and development will be encouraged to:

i. Actively monitor the disbursements from the BHCPF and ensure robust financial prudence, transparency and accountability.
ii. Follow up annual independent audit and assessment report findings.

1.2 Execution of Global BHCPF Programme Memorandum of Understanding with States

1.2.1.1 Each participating State Government (and the FCT), through the office of its Governor/Minister of the FCT will sign a global BHCPF programme agreement with the NSC represented by Honourable Minister of Health. The Executive Secretaries of the NHIS and NPHCDA, and their state counterparts in the SSHIA and SPHCDA as well as the heads of DHS and NCDC will also co-execute the MOU with the respective national agencies.

1.2.1.2 The BHCPF programme agreement shall set out details of involvement, expected benefits as well as obligations of the State, financial reporting obligations, Service-Level Agreements (SLAs) and reporting requirements, especially of health metrics and indicators.

1.2.1.3 A copy of the BHCPF global programme agreement (draft) has been attached as Appendix 1.

1.3 Relationship between Stakeholders

1.3.1 Liaison and Relationship between the NSC, DHS (FMOH), NCDC (FMOH), NHIS and NPHCDA

1.3.1.1 The NSC shall work in conjunction with the DHS, NCDC NHIS and the NPHCDA to realize stated outcomes of the BHCPF.

1.3.1.2 The meetings of the National Steering Committee will provide a forum for the leaderships of the DHS, NCDC, NHIS, NPHCDA and the NSC to relate and achieve alignment on key fund objectives, work plans and outcomes.

1.3.1.3 The NSC will provide oversight on funds disbursed to the NHIS sub-account at the CBN. In addition, the NHIS will provide to the NSC quarterly financial and monthly programmatic data/reports relevant to the programme

1.3.1.4 The NSC will provide oversight on funds disbursed to the NPHCDA sub-account at the CBN. In addition, the NPHCDA will provide to The NSC quarterly financial and monthly programmatic data/reports relevant to the programme

1.3.1.5 The NSC will provide oversight on funds disbursed to the EMT sub-account at the CBN. In addition, the DHS and NCDC will provide to The NSC quarterly financial and monthly programmatic data/reports relevant to the programme

1.3.1.6 Upon appointment of the External Auditors by the NSC, The Secretariat of the NSC, DHS (FMOH), NCDC, NPHCDA & NHIS will cooperate with the appointed auditor to provide access to relevant data pertaining to fund use

1.3.2 Liaison and Relationship between NSC, and State Governance and Administrative Entities (SSC, SPHCDAs, SSHIA)

1.3.2.1 The relationship between NSC and the State governance and administrative entities will be initiated by the execution of a global BHCPF agreement with the State.

1.3.2.2 The NSC may relate with the SSC directly

1.3.2.3 The NSC will relate with the State implementing agencies through the NHIS and NPHCDA.

1.3.2.4 Administration, Disbursements, Fund Management and Monitoring and Evaluation of the NHIS gateway at the State level will be the responsibility of the SSHIA.

1.3.2.5 Administration, Disbursements, Fund Management and Monitoring and Evaluation of the NPHCDA gateway at the State level will be the responsibility of the SPHCDA.

1.3.2.6 Both the SSHIA and the SPHCDA will cooperate with the appointed external auditor to provide access to relevant data pertaining to fund use

1.3.3 Liaison and Relationship between the NHIS and State Governance and Administrative Agencies (SSC and SSHIA)

1.3.3.1 The NHIS shall work in conjunction with the State governance and administrative entities to realize stated outcomes pertaining to the Fund.

1.3.3.2 The relationship between the NHIS and the State governance and administrative entities will be initiated by the execution of a global BHCPF agreement.

1.3.3.3 The NHIS State coordinator shall be a member of the SSC.

1.3.3.4 Administration, Disbursements, Fund Management and Monitoring and Evaluation of the NHIS gateway at the State level will be the responsibility of the SSHIA with technical support from the NHIS

1.3.3.5 The SSHIA shall routinely furnish the NHIS with designated financial and programmatic data/reports.

1.3.4 Liaison and Relationship between the NPHCDA and State governance and administrative agencies (SSC and SPHCDA)

1.3.4.1 The NPHCDA shall work in conjunction with the State governance and administrative entities to realize stated outcomes pertaining to the Fund.

1.3.4.2 The relationship between the NPHCDA and the State governance and administrative entities will be initiated by the execution of a programme MOU.

1.3.4.3 Administration, Disbursements, Fund Management and Monitoring and Evaluation of the NPHCDA gateway at the State level will be the responsibility of the SPHCDA with technical support from the NPHCDA.

1.3.4.4 The SPHCDA shall routinely furnish the NPHCDA with designated financial and programmatic data/reports.

1.4 BHCPF Advocacy

1.4.1 Objectives of BHCPF Advocacy

To ensure the seamless take-off and sustainable operation of the BHCPF, the National Steering Committee shall prioritize advocacy activities. The objectives of advocacy for the BHCPF shall include:

i. Mobilization of broad based national and sub-national support for the BHCPF
ii. Sustainable resource mobilization for expansion and delivery of the

programme
iii. Show case the transparent disbursement of designated funds
iv. Facilitate release of counterpart funding by States
v. Demonstrate output and outcomes achievements/performance of the BHCPF
vi. Other objectives designated by the NSC or SSC

1.4.2 Target groups for federal advocacy activities

Shall include:

i. The Federal Executive Council
ii. The National Economic Council
iii. The Economic Management Team
iv. The Federal Ministry of Finance
v. The Federal Ministry of Budget and Planning
vi. The Federal Legislature - particularly the committees on health of both the senate and house of representatives
vii. Developmental Partners and Civil Society Organisations
viii. The media and the public

1.4.3 Target groups for state advocacy activities

Similarly, the State SSC and designated State Agencies (SSHIA and SPHCDA) shall prioritize advocacy to:

i. The State executive council
ii. The State economic council
iii. The State ministry of finance
iv. The State ministry of budget and planning
v. The State legislature - particularly the committee on health of the state house of assembly
vi. Developmental partners
vii. Traditional and religious leaders
viii. The media and the public

1.4.4 Advocacy tools

The NSC in collaboration with implementing stakeholder national and sub-national agencies shall employ the following tools for advocacy:

i. Courtesy visits and parleys with federal and state government executives, legislature and the media
ii. Routine release of policy briefs and targeted materials to the relevant stakeholders. FEC, NEC, EMT, FMOF, FMOBP and the legislative arm of government.
iii. Public Seminars
iv. Town hall meetings
v. Social media publication of activities and performance
vi. Annual reports
vii. Periodic infographic updates; and other initiatives and activities approve by the NSC
viii. Other initiatives and activities approved by the National Steering Committee

1.4.5 Documentation and Approval of Advocacy Initiatives

Advocacy initiatives and events shall be documented in the annual programme work plan presented to the NSC for input and approval.

1.5 Social and Environmental Safeguards

1.5.1 Social Safeguards

1.5.1.1 The BHCPF is structured to improve quality and accountability at different levels of the health system: services of agreed quality are only paid for after the claims are verified on the NHIS gateway while funds on the NPHCDA gateway are only transferred contingent on achieving specified disbursement and utilization criteria. The funds thus made available are earmarked for improvements in the quality and delivery of health services. Furthermore, to improve on quality and accountability of the system, the BHCPF aims to do the following;

i. Enhance community participation by reactivating facility/ward development committees with clearly defined roles in facility planning & budgeting and monitoring processes, including collaborating with PHC facility leadership to make decisions on prioritizing health interventions resources
ii. Increase transparency in health sector resource allocation/budgeting and expenditures by disclosing such information in a citizens' charter and information board displayed at each facility and at the LGA level. In addition, a poster stating that services offered under the BHCPF are free of charge will be displayed at each participating PHC.
iii. Enhance social accountability through community validation of facility performance, feedback and grievance redress systems and
iv. Increase awareness and access to information by implementing a targeted multi-media strategy to disseminate information to communities on availability and cost of services at their health facility, thereby generating greater demand for services available at public facilities.

1.5.1.2 The responsibility for ensuring that these social safeguards are met will lie with the Health Facility/Ward Development Committees. These committees will need significant capacity building to effectively take up the functions. The SPHDCA would utilize TA funds to provide training and capacity building to enable the committees to perform effectively.

1.5.1.3 Maintaining a Pro-Poor Focus: The Project will maintain a pro-poor focus by:

i. Geographically targeting interventions to rural LGAs within States with higher poverty rates
ii. Targeting groups most vulnerable to preventable mortality and morbidity, such as women and children; and
iii. Increasing the availability of basic primary health services free of cost, thereby increasing access to such services to the poorest.

1.5.2 Environmental Safeguards

1.5.2.1 The BHCPF will not involve any major civil works. Potential adverse environmental and social impacts are expected to be minor, site specific and relatively easy to mitigate. The project activities would generate healthcare wastes including sharps. The management of the waste generated will be guided by the National Healthcare Waste Management Policy. The policy stipulates that waste generated by both public and private medical institutions in Nigeria must be safely handled and disposed of and provides guidelines for medical waste management activities at medical institutions.

1.5.2.2 Specifically, the BHCPF will;

i. Apply the necessary environmental safeguard requirements at primary care facility level;
ii. Leverage the BHCPF modality, especially the NPHCDA gateway, to provide incentives for conforming to good Health Care Waste Management (HCWM) practices and penalties for non-compliance; and
iii. Draw upon the HCWM plan of the Nigeria State Health Investment Project to develop a HCWM plan that will provide guidance on processes that will ensure the protection of healthcare workers, wastes handlers, and the community from hazardous healthcare wastes and to maximize project compliance with environmental regulations.

1.5.2.3 The BHCPF will achieve the above objectives by incentivizing all levels of the health system to support the achievement of environmental safeguards by

i. Quantifiable Supervisory Checklists will assess and report waste management as part of quality measures on the NPHCDA gateway. Furthermore, health facilities will be provided with guidelines for waste management depending on level of care
ii. The BHCPF will promote safe sanitation practices
iii. Part of the funds received by the facilities will be utilized for rehabilitation and maintenance such as painting, fixing leaks, repairing and fixing roofing, covering verandas and waiting areas, fixing plumbing and electricity.
iv. The SPHCDA will vet more substantial activities funded by the BHCPF that participating facilities intend to carry out. Such activities will be contained in annual work plans that will be cascaded upwards through the NPHCDA and the NSC for approval.

1.5.2.4 The primary responsibility for HCWM at the state level will rest with the SPHCDA and the SMOH.

1.5.2.5 At the LGA level, the LGA through its PHC Department will be responsible for administering quantitative supervisory checklists in health facilities.

1.5.2.6 The Ward/Health Facility Committees will be actively engaged in supervising HCWM. Each facility will designate a staff to be responsible and accountable for HCWM.

1.5.3 Accountability and Responsibility for Social and Environmental Impacts and Mitigation

1.5.3.1 The NSC is accountable for anticipating, identifying and mitigating potential social and environmental impacts that may result from the BHCPF's implementation.

1.5.3.2 The NSC shall coordinate social and environmental impacts and mitigation.

1.5.3.3 The NSC shall ensure that potential social and environmental impacts and mitigation are highlighted in annual work plans submitted to the NSC for approval

1.5.3.4 The Secretariat of the NSC shall ensure that actual social and environmental impacts and mitigation are enumerated in programme reports presented to the NSC.

1.5.3.5 At the Federal Level, the responsibility for anticipating, identifying and mitigating potential social and environmental impacts across all programme States and sites will be carried out by the National Steering Committee

1.5.3.6 At the State level, the responsibility for anticipating, identifying and mitigating potential social and environmental impacts across all programme States and sites will be carried out by the State Steering Committee.

1.5.3.7 Appendix 9 enumerates potential environmental and social impacts and mitigation measures in a tabular format

1.6 Anti-corruption and Transparency

1.6.1 The Anti-Corruption and Transparency Unit (ACTU):

The Federal Ministry of Health, NHIS and NPHCDA have Anti-Corruption and Transparency Units (ATCU) duly empowered as per Independent Corrupt Practices Commission (ICPC)[2] guidelines, and compliant with instructions from the Head of Service Office (Circular No. OHCSF/MSO/192/94 of 02/10/01). The ACTUs had previously conducted various corruption risk assessment and at the level of Federal health facilities (funded by UNDP), the FMoH ACTU has done an assessment, which helped it figure out how to address risks identified and strengthen the anti-corruption system within the Ministry.

1.6.2 The ACTU and Implementation of the BHCPF

The Anti-Corruption and Transparency Units (ACTU) of the various implementing Agencies and the Federal Ministry of Health would be operationalized to fully exercise its mandates in the implementation of the BHCPF. The ACTU will be empowered to effectively address fraud and corruption complaints coming to it. This Operations Manual details out how complaints will be handled, institutionalized and mainstreamed down to the level of the frontline service providers (namely Primary Health Centres) following a defined protocol (ensuring easy access, tracking of treatment of complaints, and reporting on outcome).

1.6.3 Annual ACTU Action Plan and Reporting of Activities

The annual action plan of the ACTUs and annual report of activities will be submitted to the ICPC. Sanctions in the BHCPF will be tough. This operation manual (OM) specifies strict sanctions for facilities that submit false claims. Sanctions will also be applied to supervisors in the SPHCDA who fail to prevent fraudulent claims by public facilities.

[2] Established in 2000 by the corrupt Practices Act, the ICPC has both a repressive and preventive role in anti-corruption practices. Legal provisions ensure the independence and probity of the Commission. For the past three years, the ICPC has refocused on the prevention of corruption in three areas of service delivery: health, education and water supply.

2 FINANCIAL MANAGEMENT ANDDISBURSEMENT

Fund management and disbursement refers to processes across all gateways associated with fund accumulation, pooling and disbursement of funds for purchased services and designated operational and strategic initiatives.

2.1 Contributions into the Fund

2.1.1 Expected contributions into the Fund:

Expected contributions into the fund shall be as follows:

2.1.1.1 Annual grant from the Federal Government of Nigeria amounting to not less than one percent (1%) of its Consolidated Revenue Fund;

2.1.1.2 Grants from donors, international partners and others who wish to either donate or contribute into the Fund;

i. Donor contributions to the fund will be disbursed in accordance with the Health Act and this BHCPF Operations Manual

2.1.2 Appropriation of BHCPF Funding

2.1.2.1 The Federal Government's statutory contribution shall be in accordance with the appropriation cycle of the Federal Government of Nigeria (FGN)

2.1.2.2 The FG contribution shall be not less than one percent (1%) of the projected FG's CRF for each fiscal year

2.1.2.3 Donor contributions to the BHCPF shall be included in the BHCPF Consolidated Revenue Fund Account at the CBN as additional contributions to the BHCPF.

2.1.2.4 All other funds shall be included in the BHCPF account at the CBN as additional contributions to the BHCPF.

2.1.2.5 Appropriated funds will similarly be credited into BHCPF Consolidated Revenue Fund Account which shall be part of the Treasury Single Account (TSA) of the Federal Government. This account will comprise of two (2) components: (i) A receiving US Dollar denominated and Naira Account from which all contributions are paid into (ii) A Naira clearing account, from which drawdowns into the sub-accounts are withdrawn.

2.1.3 Designated Accounts for NHPCDA, EMT and NHIS Gateways

2.1.3.1 The “NHIS Gateway”, is the pathway by which fifty percent (50%) of the BHCPF will be disbursed. The second pathway through which forty-five percent (45%) of the Fund will be disbursed is known as the “NPHCDA Gateway”. The third is the “EMT Gateway”, which is the pathway by which five percent (5%) of the BHCPF will be disbursed for Emergency Medical Treatment.

2.1.3.2 The NHIS, NPHCDA and EMT Gateways should each maintain a TSA BHCPF Account that are held at the CBN.

2.1.3.3 Disbursements from the Fund shall be made from the designated BHCPF Consolidated Revenue Fund Account as direct credits into the TSA sub accounts of the NHIS, NPHCDA and EMT at the CBN.

2.1.3.4 Each SPHCDA and SSHIA shall set up a designated account for the BHCPF at the CBN, with the approval of the State Controller General. The accounts shall be linked to State’s TSA.

2.1.3.5 PHCs are required to have operational accounts with Commercial banks that are part of the clearing house system. The PHCs are not required to set up distinct accounts for the BHCPF only.

2.1.3.6 All State Counterpart funds shall be deposited in the SPHCDA or the SSHIA BHCPF sub-accounts, as designated.

2.1.4 Disbursement from the BHCPF Account into NPHCDA, NHIS and EMT Sub-Accounts

2.1.4.1 Following approval of Gateway plans by the NSC, disbursements shall be made in the form of direct credits from the BHCPF Consolidate Revenue Fund Account to the NPHCDA, NHIS and EMT Gateway accounts at the CBN on a quarterly basis. The Gateways would similarly ensure downward flow of resources to the beneficiaries as outlined in the manual.

2.1.4.2 Subsequent transfers to the NHIS, NPHCDA and EMT Gateways shall be made on a quarterly basis contingent on the following:

i. Submission of the quarterly financial report;
ii. Submission of the quarterly interim financial projection;
iii. Compliance with service delivery data reporting requirements; and
iv. Resolution of all outstanding external audit, or ad-hoc financial review finding.

2.1.5 Disbursement of Funds from Federal Implementation Agencies (NHIS and NPHCDA) to State Implementation Agencies (SSHIA and SPHCDA)

2.1.5.1 The NPHCDA and NHIS upon receipt of their allocation from the BHPCF shall transfer the funds within ten (10) working days to SPHCDA and SSHIA sub-accounts held by the State Project Financial Management Unit (PFMU) or the State Accountant General’s office subject to compliance with the provisions in the global agreements

2.1.6 Signatories to BHCPF, NPHCDA and NHIS CBN Accounts

2.1.6.1 The approving authority for the BHCPF Consolidated Revenue Fund Account shall be the National Steering Committee while the signatories will be the Permanent Secretary of the FMoH and a project Accountant seconded by the AGF

2.1.6.2 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 currently exist for NPHCDA consolidated fund-related transactions

2.1.6.3 The approving authority for the NHIS account shall be the Executive Secretary of the agency, while the signatories for the NHIS account shall be the same signatories as currently exist for NHIS consolidated fund-related transaction

2.1.6.4 The signatories for the EMT account shall be the same signatories as currently exist for FMOH and NCDC consolidated fund-related transactions

2.1.6.5 Banking Mandate submitted to the CBN, governing the operation, disbursement and monitoring of the account, shall be in line with above and with the approval of the National Steering Committee.

2.1.7 Domiciliation of BHCPF Funds by the State Agencies and the PHCs

2.1.7.1 State agency funds (SPHCDA and SSHIA) transferred through either of the NPHCDA or NHIS gateways must be domiciled and operated as sub-accounts of the BHCPF Naira Treasury Single Account held at the CBN.

2.1.7.2 The signatories to the SPHCDA account must be the ES or equivalent of the SPHCDA and the Head or Deputy Head of the State Project Financial Management Unit (PFMU) or the State Accountant General. The PFMU or the State Accountant General shall maintain segregated accounts for the SPHCDA gateway funds. This account shall be part of the TSA.

2.1.7.3 The signatories to the SSHIA account must be the ES or equivalent of the SSHIA and the Head or Deputy Head of the State Project Financial Management Unit (PFMU) or the State Accountant General. The PFMU or the State Accountant General shall maintain segregated accounts for the SSHIA gateway funds. This account shall be part of the TSA.

2.1.7.4 Funds transferred by the State Agencies to the PHCs must be domiciled in commercial banks.

2.1.7.5 The signatories to PHC accounts must be the Officer in charge and ward development committee chairperson

Figure 2: Operational Funds Flow Schematic **(Operational Funds)**

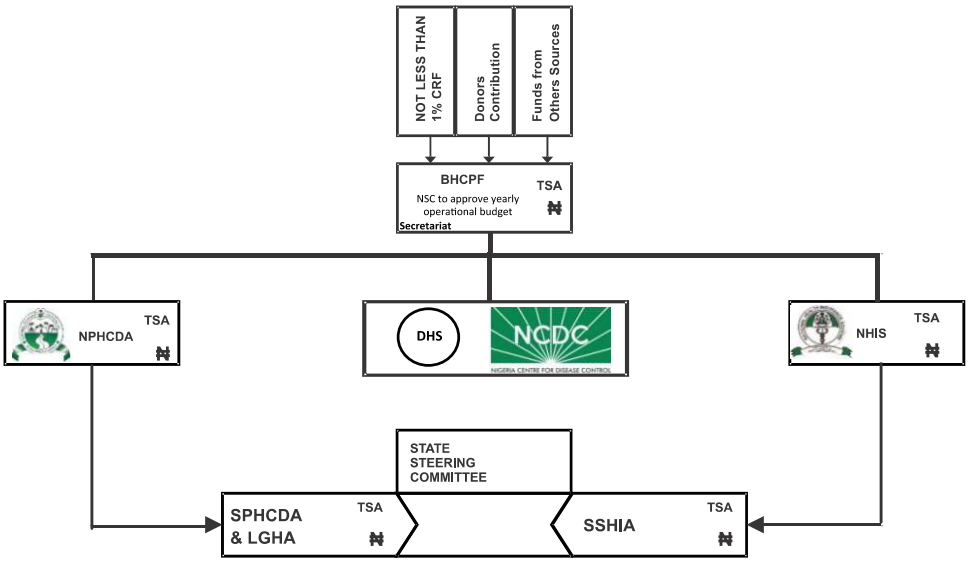
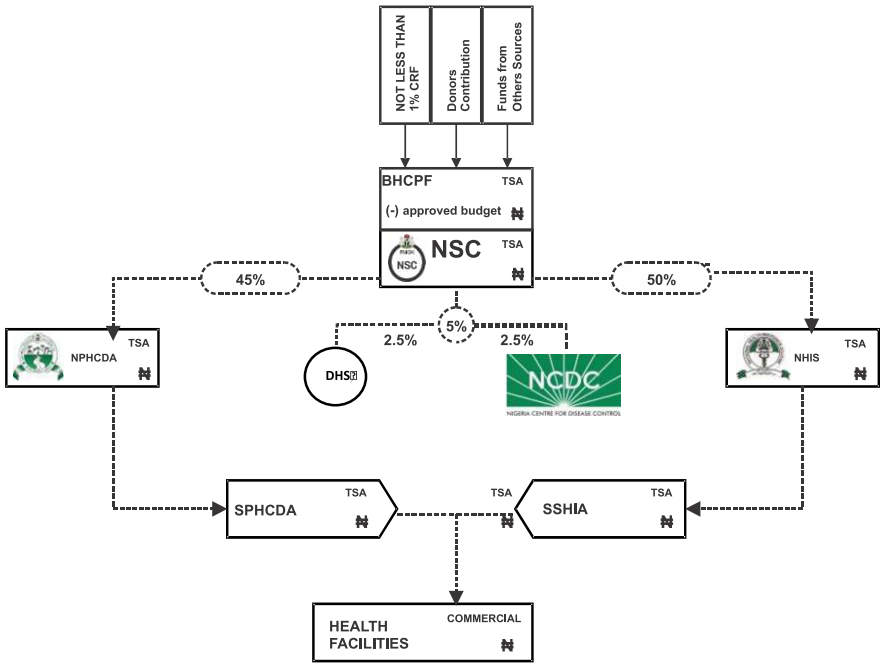


Figure 3: Programme Funds Flow Schematic **(Programme Fund)**



2.1.8 NHIS Payment Model

2.1.8.1 Contracted healthcare providers who have rendered services shall be paid through the Global Payments Mechanism, which is a retrospective cased based payment.

2.1.8.2 Monthly payments will be made through the SSHIAs to healthcare providers on behalf of the NHIS, based on the quantity of services rendered to presenting patients.

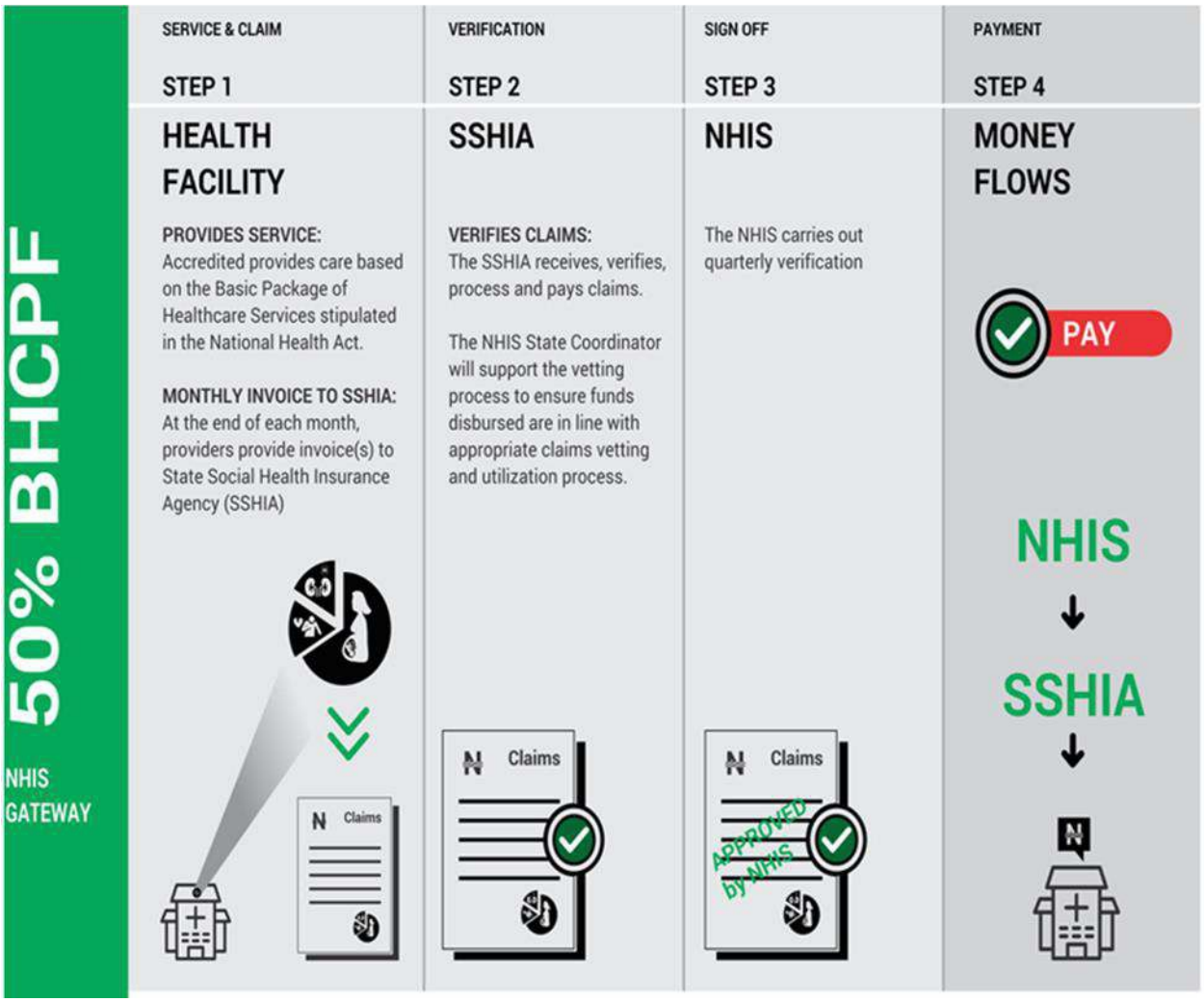
2.1.8.3 The provider payment model is a retrospective, claim-based process outlined in Figure 4.

2.1.8.4 Within 30 days of the end of each month, providers must present claims invoice(s) for services rendered in the prior month to the SSHIA for verification and claims reimbursement. The NHIS State officer will support the vetting process to ensure funds disbursed are in line with appropriate claims vetting and utilization process.

2.1.8.5 Upon review of the claims for payment from PHCs, the SSHIA shall furnish the payment voucher to the State Project Financial Management Unit (PFMU) for payment of the relevant HCPs.

2.1.8.6 Claims made shall be reimbursed within 45days of submission of such claims

Figure 4: Payment Model for the reimbursement of providers under the NHIS Gateway



2.1.9 NPHCDA Payment Model

2.1.9.1 The regular funding cycle would be quarterly to the SPHCDA accounts held by the State PFMU with the following incentivised schedule:

i. **Quarter One:** Allocated funds-released on meeting commencement criteria
ii. **Quarter Two:** Allocated funds-released on receipt of up to date financial data
iii. **Quarter Three:** Allocated funds released on receipt of up to date financial data and programmatic data at the end of quarter one
iv. **Quarter Four:** Allocated funds released on receipt of up to date financial and programmatic data at the end of quarter two

2.1.9.2 The Quarter Four disbursement shall be contingent on receipt by the NSC from the NPHCDA /SPHCDA the validated proof of utilisation status of initial grants to PHCs.

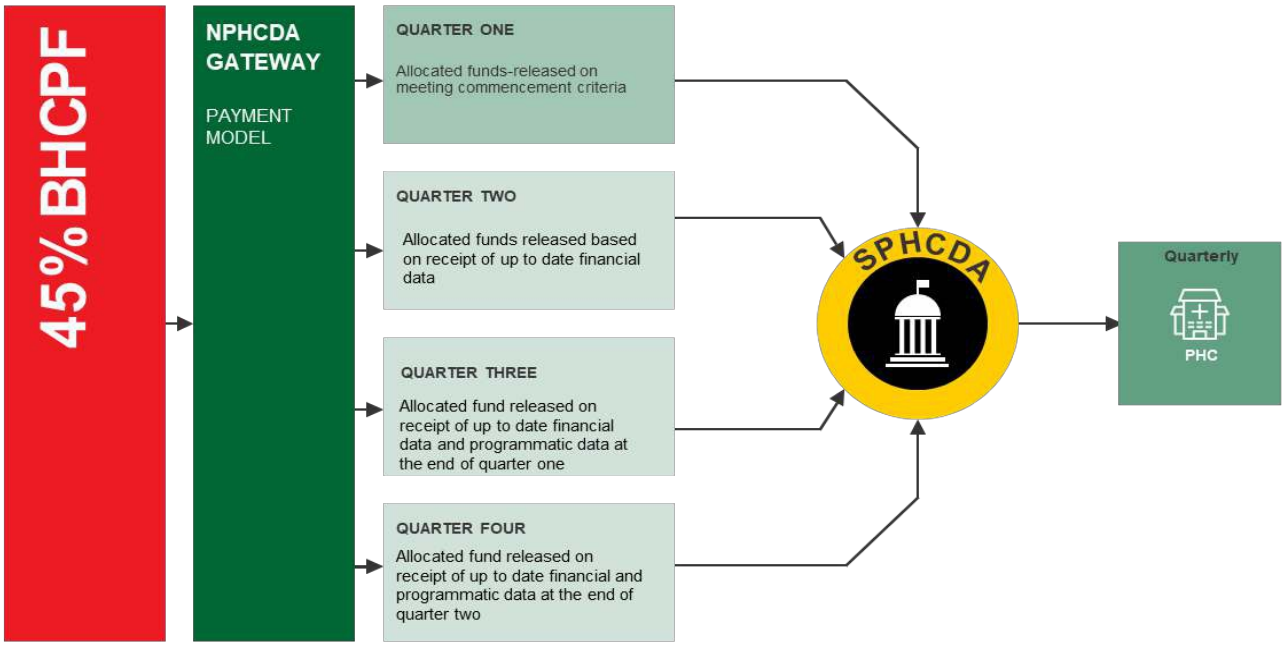
2.1.9.3 States that do not meet the requirements for disbursement in any given year shall be deemed to have forfeited the allocation.

2.1.9.4 The provider payment model is prospective, bulk grant process outlined in Figure 8.

2.1.9.5 Upon review and validation of support for funds transfer by PHCs, the SPHCDA shall furnish the PFMU with the requisite documentation to the State PFMU and request the PFMU to transfer into the bank accounts of each eligible, empaneled PHC facility, sums as prospective, grants, for operational expenses, within seven 7 days of receipt of funds from the NPHCDA BHCPF CBN TSA sub-account. The PFMU shall make the transfer after verifying the adequacy of the supporting documents.

2.1.9.6 Payments to the public PHCs will be quarterly

Figure 5: Payment Model for the funding of providers under the NPHCDA Gateway



2.1.10 EMT Payment Model

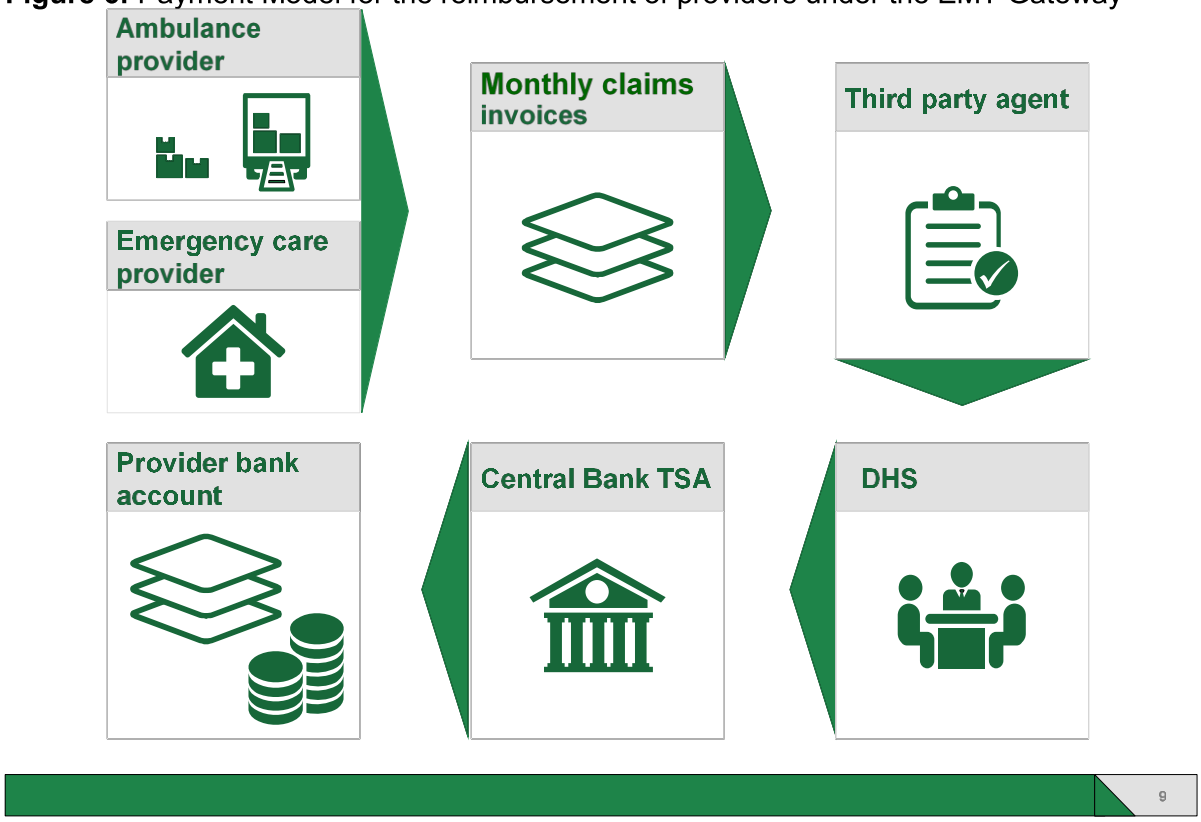
2.1.10.1 Contracted healthcare providers who have rendered services shall be paid through the Global Payments Mechanism, which is a modified "Fee-for-Service process.

2.1.10.2 The provider payment model is a retrospective, claims-based process

2.1.10.3 Monthly payments may be made to contracted healthcare providers by the DHS, based on the services provided to presenting RTI patients.

2.1.10.4 At the end of each month, providers present claims invoice(s) for services rendered to the TPAs who process/verify the claims. The TPAs then pass valid claims/invoice(s) and payment vouchers to the DHS for payment. The DHS shall review the voucher and initiate payments directly into the account of designated healthcare providers, for services rendered

Figure 6: Payment Model for the reimbursement of providers under the EMT Gateway



Use of funds

The Fund shall be utilised primarily for three purposes to:

2.1.10.5 Pay for the provision of the Basic Minimum Package of Health Services (BMPHS) via the NHIS gateway

2.1.10.6 Fund the operational expenses of Primary Healthcare Centres (PHCs) across Nigeria via the NPHCDA gateway

2.1.10.7 Provide basic Emergency Medical Treatment, initially focused on Road Traffic Injuries (RTIs) arising from "accident hotspots" across Nigeria and public health emergencies via the EMT gateway

2.1.10.8 Consideration for administrative, audit and monitoring and evaluation for EMT will be catered for subject to approval by NSC

2.1.11 Eligible use of Gateway Funds by Public Healthcare Providers

2.1.11.1 The eligible use of gateway funds by public PHCs and SHCs shall be primarily for:

i. Rectification of infrastructure, equipment and staffing deficits highlighted in accreditation or quality assessment reports.
ii. Continuous quality improvement
iii. Operations of the medical facility
iv. Demand generation activities

2.1.11.2 It is intended to provide flexibility for public PHCs to spend the funds received under the gateways. At the same time, in order to achieve effective and efficient use, it is important to be clear on what items funds under the BHPCF cannot be spent on. These include:

i. Payments in cash or kind to the employed government staff of the health facility
ii. Payments to any officials of the WDC, LGA, state, or federal governments.
iii. Air conditioning equipment.

2.1.11.3 Private sector providers under the NHIS gateway are not restricted in their use of funds however they are strongly encouraged to utilize funding received for continuous quality improvement and operations of their facilities. Stock outs and service disruptions will not be accepted.

2.1.11.4 Counterpart funds provided by States shall be spent on the same eligible expenses at public PHCs and SHCs as a matter of priority.

2.1.12 Fund Access by States and Healthcare Providers

2.1.12.1 The disbursement of monies from the Fund is designed to be simple and transparent.

2.1.12.2 Access to the Fund will be open to all States and FCT of the Federation contingent on:

i. Execution of a global BHCPF agreement with NSC
ii. Setting up of SPHCDA or equivalent
iii. Setting up of SSHIA agency or equivalent.
iv. Annual budgetary provisions and releases for operational expenses of Primary Healthcare Centres (PHC) to satisfy the requirement for counterpart funding outlined in Section11 (5) of the National Health Act 2014. Such releases shall be paid into the State's BHCPF account at the CBN.

2.1.12.3 To improve access and quality of care in rural areas, during the first five (5) years of operation of the NHIS Gateway, sole preference shall be given to healthcare providers situated in Rural Areas[3]. Throughout this initial period, zero funding would be available for healthcare providers in urban areas. For the providers in rural areas as defined by the National Population Commission (NPopC), significant assistance for accreditation would be provided so that at least "one healthcare facility per ward" is able to participate in this initiative.

2.1.12.4 Access to the Fund by care providers would be open to all (public-sector and private-sector) providers, in all States (and FCT) of the Federation contingent on:

i. Selection and contracting of one public PHC per ward to participate in the NPHCDA gateway by SPHCDAs
ii. Contracting of public and private PHCs and SHCs to participate in the NHIS gateway by the SSHIAs
iii. Contracting of Emergency medical treatment providers to participate in the EMT gateway by the DHS.

[3]Rural areas in Nigeria are low density communities with less than 20,000 residents. A greater part of the population are involved in agriculture and forestry. The residents maintain traditional (close to nature) life styles and habits. There is a preponderance of open landscape or a scarcity of built-up areas and settlement that is dispersed. Typically, the inhabitants consider themselves as rural-dwellers and there may be a paucity of public infrastructure such as healthcare facilities and schools. Designation of an area as rural shall be confirmed by the National Bureau of Statistics (NBS).

2.1.13 Counterpart Funding

2.1.13.1 Each State shall for a period of at least the first five (5) years of BHCPF implementation in the State, make annual budgetary provisions and releases for operational expenses in Primary Healthcare Centres (PHC). Such releases shall be paid into the State's BHCPF account at the CBN. After which, State are expected to take full ownership of providing facility operational budgets.

2.1.13.2 State shall allocate at least twenty-five percent (25%) matching grant as prescribed in the National Health Act (2014) and deposited in the state BHCPF TSA CBN domiciled account

2.1.13.3 This budgetary provision shall be reflected in the annual SPHCDA budget as PHC overhead costs.

2.1.13.4 The NSC shall monitor the actual release of the funds provided in the Appropriated Budgets of State Governments and FCT.

2.1.13.5 Actual funds released shall be pooled with the federal funds provided through the BHPCF and subject to quarterly reporting and annual audit requirements of the BHPCF

2.1.13.6 State Governments and the FCT, at the beginning of each year or as soon as is practically possible, shall send electronic copies and hardcopies of their budget to the NPHCDA and NHIS which would in turn collate and present same to the NSC highlighting the budgetary provisions for operational expenses of PHCs.

2.1.13.7 Sunset Clause: After the initial period of three years, a fresh set of Guidelines shall be drawn up outlining the terms for the provision of counterpart funding by States, FCT and Local Governments.

2.1.14 Administrative Expenses

2.1.14.1 This shall be based on budgets and workplan as approved by the NSC

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

2.1.14.3 In the start-up phase, certain capital investments such as developing a grievance address mechanism, an IT system for reporting on service delivery and claims processing and a n external audit function shall be required for all the implementing entities. Such investments are distinct from the operational costs of the BHPCF.

2.1.14.4 All administration expenses, including disbursement, monitoring, audit and data collection costs to be incurred by The Secretariat of the NSC, NHIS, NPHCDA, DHS, SSHIA, SPHCDA and LGHA shall be paid for through the delineation of an annual operational allowance. This annual allowance shall be based on work plans and with exception of the first 2 years not exceed an annual maximum limit of five percent (5%) of the funds accruing to The Fund. This sum shall be set aside for this purpose. The amount set as administrative expenses may increase subject to approval by the NSC.

2.1.14.5 The allocation of funds to entities facilitating the implementation of the programme shall be as follows:

Priority	5% BHCPF (3rd year onwards)	Use of funds description
	0.5%	External Financial Audit & Verification of Service delivery and outputs. The Independent Verification Agent shall preferably be third party Government or Academic Institution.
		The secretariat of the NSC Operational cost
		IT backbone
		Feedback mechanism
Balance to be shared among NHIS/NPHCDA/EMT (4.5%)	2%	NHIS operational costs SSHIA operational costs
	2%	NPHCDA operational costs SPHCDA operational costs
	0.5%	EMT operational cost

Table 1: Allocation of BHCPF Operating Cost

2.1.15 Roll-Over of Excess Funds

2.1.15.1 At the end of each financial year, where an annual surplus arises in the Fund because of under utilisation, poor uptake or any other development and having settled all outstanding claims and cash-calls, any such surplus funds shall be rolled-over to be ploughed back into the next years' Fund.

2.1.15.2 Accumulation of a significant surplus shall be discouraged, as projected surplus shall be applied to improved coverage within participating states.

2.1.15.3 States who do not meet the requirements for funds disbursement in any given year have no recourse to retrieving the funds retrospectively.

2.1.16 Financial Records

All recipients of BHCF shall maintain proper books of accounts that show the amount of funds received and how the funds were spent using cash basis of accounting.

2.1.16.1 The Secretariat of the NSC shall:

i. Prepare a budget estimate for the NSC at the beginning of each year that shows the projections for the sources and uses of funds for the BHCPF in collaboration with the implementing agencies. The NSC shall approve this budget.
ii. Reconcile its operating cost funds quarterly
iii. Prepare quarterly interim Financial Statement on sources and uses of funds for the BHCPF for all Gateways 30 days after the end of the fiscal quarter. This report shall be an aggregation of the reports from the NPHCDA, NHIS and EMT gateways. This report shall also include the operating cost of The Secretariat of the NSC.
iv. At the end of fiscal year, The Secretariat of the NSC shall prepare consolidated annual financial statements for the BHCPF with accompanying notes. The report shall be submitted to the NSC within 90 days of the end of the fiscal year.
v. Prepare variance analysis reports whenever indicated
vi. The Secretariat of the NSC shall prepare an overview of the status of The Fund annually and submit to the NSC. The report shall be discussed by the NSC and published at the website of the FMoH before 30th June of the following year

2.1.16.2 <u>The NHIS shall prepare:</u>

i. Quarterly Interim and Annual Statement of sources and uses of funds
ii. Reconcile operating cost funds received and Bank accounts quarterly within 30 days and 45 days of the fiscal quarter and fiscal year, respectively.

2.1.16.3 <u>The NPHCDA shall prepare:</u>

i. Quarterly Interim and Annual Statement of sources and uses of funds
ii. Reconcile operating cost funds received and Bank accounts quarterly within 30 days and 45 days of the fiscal quarter and fiscal year, respectively.

2.1.16.4 <u>SPHCDA AND SSHIAs financial reporting</u>

i. Quarterly Interim and annual Statement of sources and uses of funds for gateways shall be prepared by the State Project Financial Management Unit (PFMU)
ii. The PFMU shall also reconcile operating cost funds received and Bank Accounts quarterly within 30 days and 45 days of the fiscal quarter and fiscal year, respectively.
iii. The financial statements prepared shall include counterpart funds provided by each state as their contribution to the BHPCF.

2.1.16.5 <u>Public PHCs and SHCs shall prepare:</u>

i. Statement of funds received and uses of funds for each gateway within 30days of the end of each fiscal quarter.
ii. Reconcile operating cost funds received and Bank accounts within 15 days after the end of each quarter.

2.1.17 Signatories to BHCPF Accounts

Signatories to the various BHCPF accounts shall be as follows:

Entity	Approvals	Signatories	Alternate (Substitute) Signatories
BHCPF Consolidated Revenue Fund Account	National Steering Committee (NSC)	Permanent Secretary FMoH and Accountant	Not applicable
The Secretariat of The NSC Operations/Administrative account	Not applicable	The Secretary of the NSC & Programme Accountant	Not applicable
NPHCDA gateway	ED NPHCDA	Existing NPHCDA signatory authority	Existing NPHCDA signatory authority
NHIS gateway	ES NHIS	Existing NHIS signatory authority	Existing NHIS signatory authority
EMT gateway	Permanent Secretary for DHS gateway and DG NCDC for NCDC gateway	Existing signatories in the FMoH & NCDC	Existing signatories in the FMoH & NCDC
SPHCDA		Executive Secretary SPHCDA	State PFMU Head or Deputy
SSHIA		Executive Secretary SSHIA	State PFMU Head or Deputy
Public PHCs		Ward Health Committee Chairman and Officer-in-charge	Ward Health Committee Treasurer and Officer-in-charge
Private PHC		Relevant authority in the private facility	Relevant authority in the private facility

Table 2: Signatories to the various BHCPF Accounts

2.1.18 Risk Management

Risk management is important to ensuring that implementing entities achieve National Health Act and BHCPF goals and objectives by continuously complying with the provisions of the National Health Act, and the Operations Manual.

2.1.18.1 Verification of Fund Utilisation

i. At the State level, the SSHIAs shall conduct periodic random ex-ante and ex-post verification at the provider level to ascertain the service usage and quantity. On a sample basis, beneficiaries shall be interviewed to verify that care given was appropriate, up to the expected standards and was associated with quality outcomes. Documentation of services provided shall also be conducted under the NHIS gateway and of inputs acquired under the NPHCDA gateway shall be retained at the provider level and subject to verification by both gateways.
ii. Similarly, the SPHCDAs shall conduct ex-post verification of operational funds usage by public PHCs.

2.1.18.2 External Audit

i. The Secretariat of the NSC shall prepare and review proposals for the financial audit functions and pass recommendations to the Honourable Minister who appoints the external auditor who shall audit the BHCPF

annually.

ii. The external auditor may be rotated every three years.

iii. The terms of the reference of the auditor shall at the minimum include:

a. Verification of funds receipt and utilization by each level of the BHCPF administration

b. Compliance with funds management requirements designated in this Operations Manual

c. Other terms as specified by the Minister of Health and/or the NCH.

iv. The audit report shall be published at the FMoH website and submitted to the Senate Public Accounts Committee as part of the overall audit of the health sector.

v. Ex-post independent verification of utilisation and quantity of services shall be conducted on a sample basis at the facility level by the external auditor every six months using random samples and customer surveys, both from a central call centre and home visits. A report shall be prepared at the end of each exercise and submitted to the National Steering Committee.

vi. The ex-post service usage and quantity verification shall be included in the terms of reference of the external auditor. Preference will be given to local universities of repute.

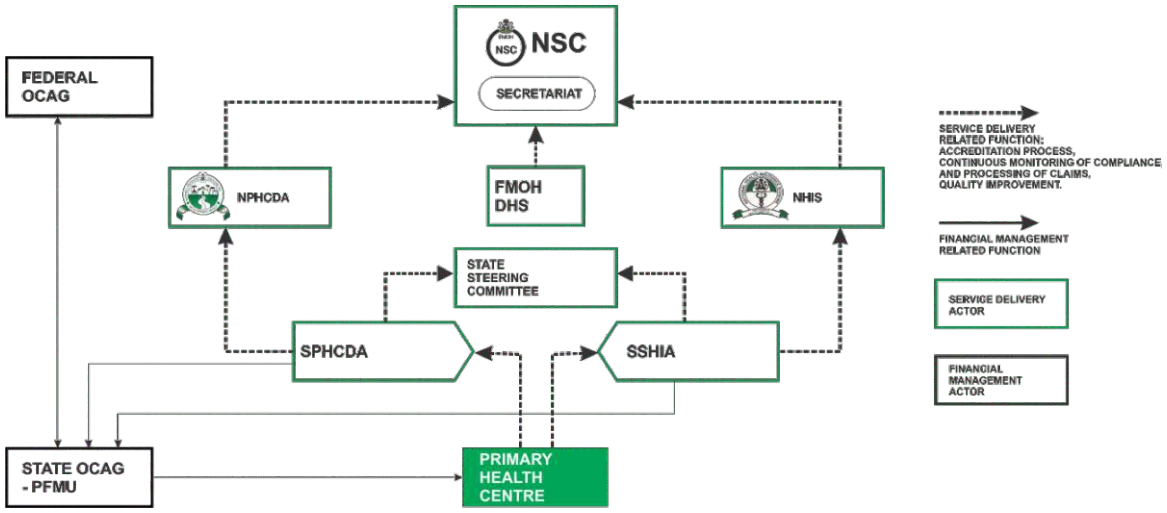
vii. All implementing entities shall provide official written response to all external audit queries or findings affecting them within 20 working days of receipt of such queries. The response shall be forwarded to the NSC and copied to the office of the Federal Minister of Health

2.1.19 Accountability Framework

2.1.19.1 Implementation of the BHPCF will use country systems and the development of requisite capacities where needed. The roles, responsibilities and reporting arrangements are designed to ensure maximum transparency and accountability for the use of funds.

2.1.19.2 The NSC shall report to the National Council on Health (NCH) through presentation of annual reports on the performance of BHPCF.

Figure 7: Accountability Framework



2.1.19.3 The NSC shall be responsible for the coordination of the fund.

2.1.19.4 Financial and service delivery reports shall be submitted by the NPHCDA, NHIS and EMT gateways.

2.1.19.5 Through the accreditation process, continuous monitoring of compliance, and processing of claims, the NPHCDA, NHIS, DHS, SPHCDA and SSHIA shall hold contracted healthcare providers accountable for the quality and quantity of services delivery.

2.1.19.6 At the state level, the State Steering Committee (SSC) shall provide oversight over the activities of SHPHCDA and SSHIA. Matters arising out of the implementation of the BHCPF at the state level, including the counterpart contribution shall be discussed at SSC. Serious implementation issues shall be escalated to the NHIS and NPHCDA and also discussed at the NSC for resolution. Also, State Project Financial Management Units (PMFU), who are staff of the Controller and Accountant General's office (OCAG) shall be responsible for managing the disbursement of funds to healthcare providers through the REMITA system. After reviewing support for transfer of funds for the NPHCDA gateway, and the validation of claims for NHIS gateways, the SPHCDA, SSHIA shall submit their support for the transfer request to the PFMU for review and disbursement. The PMFU shall reject the transfer request if sufficient documentation and justification is not provided.

2.1.19.7 Given that counterpart funds from States will be pooled with the BHPCF at the State level, the State Auditor General may conduct a review or audit of the use of funds by SPHCDAs and SSHIAs.

3 GATEWAY OPERATIONS

The fund shall be operated through 3 complementary programmes described as gateways. These gateways are:

i. The National Primary Health Care Development Agency (NPHCDA) gateway
ii. The National Health Insurance Scheme (NHIS) gateway
iii. The Emergency Medical Treatment (EMT) gateway. The operations of these gateways are described below:

3.1 The NPHCDA gateway:

The NPHCDA Gateway shall provide funding to strengthen the delivery of Primary Care across the country by supplementing the operational budgets of designated public Primary Healthcare Centres (PHCs). Operational Expenses, including funds required for improvement of facility, basic repairs, procurement of basic supplies, vaccine retrieval from the cold chain store, community outreaches and health promotion activities which have traditionally been underfunded, will be supplemented with funding from the NPHCDA gateway to improve/assure the effectiveness and functionality of designated public PHCs.

3.1.1 Operation of the NPHCDA Gateway

3.1.1.1 The SPHCDA shall seek the opinion of the ward development committees to select 1 public PHC per ward to be designated as the beneficiary public PHC for the NPHCDA gateway.

3.1.1.2 The SPHCDA shall encourage active community participation in the PHC facility operations.

3.1.1.3 The PHC and community, through the Ward Development Committee, shall have autonomy over the utilisation of payments from the Fund; to be used as designated for the improvement of facility-based services, outreach services and other eligible expenditure.

3.1.1.4 The PHCs will be expected to use the funds for demand generating activities, community outreaches, health promotion and prevention activities, basic repairs, procurement of basic commodities and vaccine retrieval from the cold chain store.

3.1.1.5 The PHC shall not remit funding received to the State or LGA.

3.1.1.6 Healthcare providers shall maintain high standards of medical record keeping and promptly submit both clinical and administrative data to the SPHCDA.

3.1.1.7 Selection and continued participation in the initiative is contingent on the healthcare provider maintaining adequate quality standards of care and compliance with the clinical and financial reporting requirements.

3.1.1.8 Healthcare professionals employed by the PHCs must remain in good professional standing with their registration bodies, including meeting Continuous Professional Development (CPD) requirements.

3.1.1.9 All the designated NPHCDA gateway PHCs shall be enlisted to provide services through the NHIS gateway.

3.1.2 PHC Contracting for the NPHCDA gateway

The Public PHCs will be contracted by execution of the single global BHCPF agreement with the State or FCT executives.

3.1.3 Conditions for continued participation of PHCs under the NPHCDA gateway

i. Annual facility licensure by SMoH or other prescribed State entity
ii. Continued compliance with conditions for initial accreditation or as updated by the BHCPF (for the NHIS gateway)
iii. Health Care Provider must have made all data/reporting returns due to the LG HMIS and SPHCDA
iv. Possess valid current licenses of personnel and registration with regulatory

bodies.

v. Evidence of internal quality management system and demonstrable incremental quality improvement
vi. Compliance with this BHCPF Operations Manual
vii. Other criteria as may be announced by the NPHCDA

3.1.3.1 Health Care Providers who do not meet the requirements after the initial criteria as set out in 3.2.9. shall be informed formally by way of a documented communication.

i. Such providers will be given 3 months to make amends.
ii. Subsequently, a re-assessment will be done to determine their qualification.

3.1.3.2 Health Care Providers who fail to qualify following the repeat assessment will be delisted fromthe NPHCDA gateway

i. Such providers will be informed formally by way of a documented communication and publication on the SPHCDA website.
ii. An alternate public PHC within the ward will be contracted and enlisted into the NPHCDA gateway by the SPHCDA

3.1.4 Provider Payment Model

Will be implemented as described under section 2.1.9 of this document

3.2 The NHIS gateway:

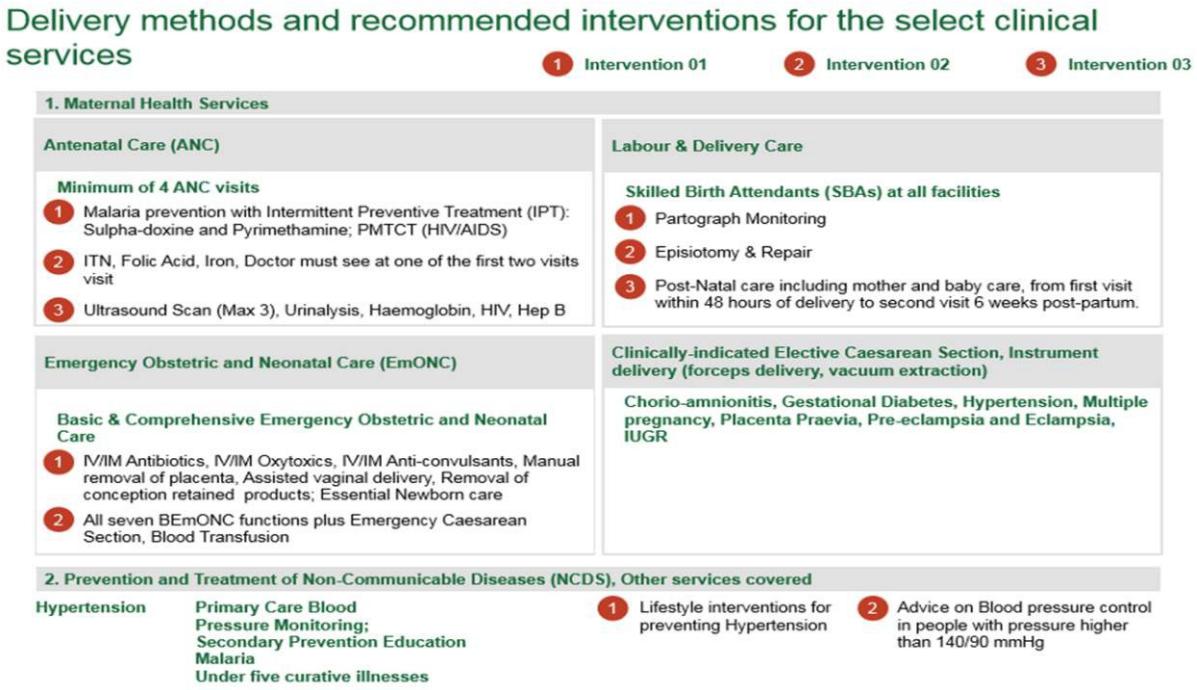
The Basic Minimum Package of Health Services shall be provided to beneficiaries through the NHIS gateway from designated/accredited public and private primary and secondary healthcare providers.

3.2.1 The Benefit Package: The BMPHS

The Basic Minimum Package of Health Services (BMPHS) for Nigeria (2016) consists broadly of nine (9) interventions;

i. Four (4) Maternal Health interventions for pregnant women (ANC, Labour and Delivery, Emergency, Obstetric and Neonatal Care and caesarean section),
ii. Two (2) children focused interventions for under-5s (curative care and immunization).
iii. Urinalysis screening test and a Cardiovascular Disease screening check (blood pressure check)
iv. Treatment of malaria for all Nigerians

Figure 8: Defined Benefit Package for BHCPF Programme



The following tables (Tables 3 – 8) highlight the contents and interventions in some Basic Minimum Package of Health Services (BMPHS) for Nigeria 2016 (excluding Emergency Medical Treatment)

3.2.1.1 BMPHS Ante-natal Care (ANC) interventions

Intervention	Comments
ANC Visits	4 visits
Tetanus toxoid	2 tetanus toxoid immunizations
Syphilis screening and treatment	Rapid plasma reagent test and treatment of seropositive cases with Penicillin
Hypertensive disease case management	Includes hypertension without proteinuria
Management of Pre-eclampsia (Magnesium Sulphate)	Includes mild to severe pre-eclampsia
Anaemia Treatment	Anaemia treatment
Deworming (Pregnant women)	Hook worm treatment with anthelminthic
Ante-natal corticosteroids	Steroids with suspected preterm labour
Antibiotics for SPROM	Oral antibiotics
IPT (Pregnant women)	Intermittent presumptive treatment
Case management of malaria in Pregnant women	Diagnosis and treatment with Artesunate-based Combination Therapy
PMTCT	HIV testing and counselling for all pregnant women ART for mother and new born Infant feeding counselling

Daily iron and folic acid supplementation in Pregnant women	Supplementation for pregnant women
Haemoglobin screening and urinalysis	
Hepatitis B	Vaccination
Ultrasound	2 times in Pregnancy

Table 3: ANC Interventions

3.2.1.2 BMPHS Labour and Delivery Care and Emergency Obstetric and Neonatal Care (EmONC) interventions

Intervention	**Comments**
Induction of labour (beyond 41 weeks)	Induction of labour to prevent births at or beyond 41 completed Weeks
Labour and Delivery Management/Essential care for all women and immediate essential new born care (Facility based deliveries)	Monitoring of labour progress (partograph), detection of complication, infection control (clean delivery), immediate drying and skin-to-skin contact, breast feeding initiation
Active management of 3rdstage of labour (AMTSL)	Controlled cord traction, oxytocics, fundal massage
Pre-referral management of labour complications	Stabilization of women in labour to lower level health facilities with complications that require referral to a hospital
Obstructed Labour	Assisted vaginal delivery (10% of obstructed cases) and C-section (90%)
Magnesium Sulphate management of Eclampsia	Management of severe eclampsia
New-born resuscitation (clinic based deliveries)	Detection of breathing problems and resuscitation of new born when required
New-born - treatment of local infections	Conjunctivitis, infection of the umbilical stump and other local infections
Kangaroo mother care	For premature new-borns
Post-natal preventive care	Postnatal preventive care including 2 home visits
Mastitis	Treatment of mastitis
Post-Partum Haemorrhage	Treatment for post-partum haemorrhage
Maternal sepsis management	Treatment of sepsis within 42 days of delivery
New-born Sepsis - injectable antibiotics	Administration of intramuscular antibiotics for neonatal sepsis, meningitis or pneumonia
New-born Sepsis - Full supportive Care	Hospital based management of sick new born as an inpatient with supportive care

Table 4: Labour and Delivery Care and EmONC Interventions

3.2.1.3 BMPHS children under-5 interventions

Intervention	**Comments**
Vitamin A supplementation for treatment of xerophthalmia	Therapeutic doses of Vitamin A for treatment of xerophthalmia including night blindness, Bitot's spots, corneal xerosis, corneal ulceration and keratomalacia
Management of mild and moderate diarrhoea with ORT	ORS
Zinc for diarrheal treatment	Oral zinc
Antibiotics for dysentery	

Treatment of severe diarrhoea (children)	Treatment with IV Fluids
Pneumonia treatment (children)	
Treatment of severe malaria (children)	Diagnosis and treatment with Artesunate-based Combination Therapy
Vitamin A for measles treatment (children)	Non-complicated measles with Vitamin A therapy
Treatment of severe measles	At referral level
Prevention and Management of Acute Malnutrition	At the facility level to include Growth Monitoring, Micro-Nutrient Powders, BCC for IYCF

Table 5: Under-5 Interventions

3.2.1.4 BMPHS Childhood vaccine interventions

Intervention	Comments
Measles (2 doses)	2 doses
Haemophilus influenzae type b (3 doses)	3 doses
DPT (3 doses)	3 doses
Pneumococcal (3 doses)	3 doses
Polio (3 doses)	3 doses
BCG (1 dose)	1 dose
Yellow Fever	
Hepatitis B	

Table 6: Childhood Vaccines Interventions

3.2.1.5 BMPHS Malaria treatment and Non-Communicable Disease (NCD) screening and prevention

Intervention	Comments
Malaria Treatment (population over 5)	Diagnosis and treatment with Artesunate-based combination drugs (ACTs)
Screening for risk of Cardiovascular Disease and Diabetes	Blood glucose, Cholesterol, Urine analysis and counselling

Table 7: Malaria and NCD Interventions

3.2.1.6 BMPHS Family Planning interventions

Intervention	Comments
Pills	Combination (Estrogen + Progestagen) or only Progestagen
Condoms	Male (95%) and Female (5%) 120 per year
Injectables	
IUCD	Copper-T 380-A IUD (10 years)
Implants	

Table 8: Family Planning Interventions

3.2.2 Exclusions from the BMPHS

1. Treatment and procedures for conditions or diagnosis not listed under the benefit package
2. Treatment and procedures not designated for a target group e.g. vaccinations for adults
3. Occupational/industrial injuries to the extent covered under the Workmen Compensation Act.
4. Injuries resulting from:
   i. Natural disasters, e.g. earthquakes, landslides.
   ii. Conflicts, social unrest, riots, wars.

5. Injuries arising from extreme sports, e.g. car racing, horse racing, polo, mountaineering, boxing, wrestling, etc.
6. Epidemics overwhelming the primary healthcare centre
7. Drug abuse/addiction
8. Domiciliary visit
9. Surgical procedures
10. Optical care
11. Dental care
12. Treatment of congenital malformations
13. Prematurity
14. Treatment of infertility including Artificial insemination, including IVF and ICSI
15. Post mortem examination and embalming

3.2.3 Review of benefit package/The Basic Minimum Package of Health Services

3.2.3.1 In the first five (5) years of implementation priority will be given to enhancing population coverage rather than benefit package expansion however subsequently, the BMPHS shall be systematically reviewed periodically (every 3 years).

3.2.3.2 States who opt to expand the benefit package shall do so via top-ups. The top-ups must be actuarially costed and adequately funded with funds in a pool maintained at the SSHIA but separate from the BHCPF.

3.2.4 Approach to costing and determination of the BMPHS

3.2.4.1 The economic costing of the BMPHS was implemented to inform the design and implementation of the BHCPF by estimating costing scenarios of the BMPHS for different coverage and unit cost levels, both nationally and at the level of the participating states.

3.2.4.2 The objectives of the BMPHS costing were to:

i. Inform the design and implementation of the BHCPF by estimating the full economic cost of the basic benefits package at the facility level through sensitivity analysis for changes in coverage and input costs; national and participating states projections; comparison of costs/revenues
ii. Provide a view of the long-term investments required to guarantee access to primary care as Nigeria moves to expand coverage and improve quality.
iii. Provide a view of the short-term investments required for implementing the BMPHS by providing quantitative input into discussions about marginal cost and payments and also inform resource allocation for the programme.

3.2.4.3 The economic costing methodology was based on the approach defined in the WHO One Health Tool (OHT) and was achieved by:

i. Step 1. Bottom-up costing of recurrent cost by estimating input requirements based on standards of practice for individual interventions contained in the BMPHS
ii. Step 2. The estimated unit cost was then multiplied across the population in need to estimate population-level total cost

3.2.5 Beneficiaries

3.2.5.1 All Nigerians shall be eligible for the BMPHS however in the initial five (5) years of implementation priority will be given to the rural poor.

3.2.5.2 The BMPHS has been further designed to target children below the age of 5 and pregnant women. Other Nigerians in the priority rural poor communities shall only benefit from malaria treatment and screening services for diabetes and hypertension.

3.2.6 Rights and Privileges of Beneficiaries

The target Beneficiaries have a right to:

i. Be treated with respect, dignity, and privacy.
ii. Receive information about the BMPHS, its benefits, policies, and participating providers.
iii. Access care at no additional cost for covered services from participating public or private providers after proper identification at the care facility without any discrimination or prejudice
iv. Receive complete course of treatment and generic medications for covered services
v. Change their primary care provider/Receive services from any designated PHC
vi. Voice complaints and grievances about the health plan or care provided, and to receive a timely response
vii. Participate in decision-making regarding their health care through the village and ward development committees.
viii. Confidential treatment of their medical information
ix. Access to their medical record in accordance with the National Health Act.

3.2.7 Enrolment

3.2.7.1 Cost-effective efforts will be put in place to identify beneficiaries and manage utilization.

3.2.7.2 The BMPHS has been structured as a low-cost universal health scheme hence no extraordinary enrolment registration will be required. However, the BMPHS will piggy-back on existing formal and informal identification mechanisms in addition to limited registration on enrolment.

3.2.7.3 Registration shall be facility based and implemented at or prior to the first/inaugural utilization by target beneficiaries in BHCPF registers.

3.2.7.4 Each beneficiary shall be enrolled and issued a pre-printed scheme ID card personalized with details of the beneficiary's preferred primary care provider and personal identifiers (not limited to those listed below)

3.2.7.5 Identifiers must include:

i. Name
ii. Functional phone number and/or phone linked digital health wallets
iii. A unique BHCPF identity number
iv. National identity number (NIN) where available
v. Head of household/spouse identifiers (Name, NIN, phone number or digital health wallet)
vi. Name of village
vii. Other identifiers as may be prescribed by The NSC and NHIS

3.2.8 Organization of Healthcare Providers

3.2.8.1 Primary Care Providers (PCP) which are the entry point for accessing care under the NHIS gateway. These providers provide essential preventive, curative and rehabilitative healthcare services and serve as gatekeepers to the NHIS gateway. These shall consist of the publicly owned NPHCDA designated PHCs in the wards, other public PHCs and privately owned PHCs.

3.2.8.2 Secondary Care Providers (SCP), which provide specialist/specialized services to beneficiaries referred from the PCPs. Primary Care Providers initiate the referrals and shall maintain responsibility for arranging the referrals. SHC providers shall consist of public general hospitals and equivalents and privately-owned hospitals, which are equipped to offer designated specialist services under the BMPHS.

3.2.9 PHC Accreditation

3.2.9.1 Health facility accreditation refers to the detailed process of review that healthcare facilities participate in, to demonstrate that they meet predetermined criteria and standards established by the NPHCDA. All public PHCs will undergo a quality improvement plan using a stepwise accreditation plan that enables facilities improving quality of service delivery.

3.2.9.2 All public PHCs expected to benefit from this programme will also receive provisional accreditation from the NHIS to enable them qualify for the NHIS gateway. This accreditation will be reviewed one year after the provisional accreditation has been issued. It is expected that the quality improvement plan under the NPCHDA gateway would enable facilities improve and meet the NHIS minimum accreditation criteria.

3.2.9.3 One of the objectives of the BHCPF is to improve access and utilisation of basic maternal health services with a special emphasis on the poor who are more represented in rural areas. Given the need to reach the rural and poor communities, this Operations Manual therefore sets out minimal accreditation standards. This is a deliberate pro-poor choice of the BHCPF.

3.2.9.4 Any rural provider including the NPHCDA gateway designated public PHCs and other PHCs and SHCs that wish to participate in the initiative shall be accredited by the NPHCDA as an entry requirement.

3.2.9.5 The accreditation process for PHCs (see Appendix 4 for sample Process Form) will be simple. It shall consist of electronic data capture (where possible), availability of required staff and clinical functionality rather than just physical assets.

3.2.9.6 The limited criteria for the ‘kick-off’ of Accreditation of Rural Primary Healthcare Centres are as enumerated in table below

3.2.9.7 In addition, the primary healthcare centres must meet applicable state registration/licensing requirements. Such registration would be a prerequisite to accreditation for participation in the BHCPF.

3.2.9.8 Health Care Providers who do not meet the accreditation requirements shall be informed formally by documented communication.

3.2.9.9 Such providers will be given 3 months to make amends.

3.2.9.10 Following which a re-assessment will be done to determine their qualification.

3.2.9.11 Each accreditation shall be limited to three (3) years. Nonetheless, within this period, provider accreditation may be suspended or withdrawn based on beneficiary feedback, complaints and provider performance.

3.2.9.12 SPHCDA officials may make spot/unscheduled checks to verify that personnel, equipment and infrastructure requirements are maintained at the designated standards post accreditation.

3.2.9.13 To ensure incremental quality improvement, each participating PHC will be required to design and implement an annual quality improvement plan. Continued participation in the BHCPF shall require that participating PHCs demonstrate incremental quality improvement.

3.2.9.14 Accreditation requirements may be reviewed annually by the NPHCDA to promote incremental quality improvement.

INITIAL CRITERIA FOR SELECTION OF PHCs TO BENEFIT FROM BHCPF

A.	**CORE SERVICES**
1	**Reproductive Maternal New-born and Child Health**
	Reproductive Health Family Planning
	Maternal Health Antenatal and Postnatal Care Intermittent Treatment of Preventive Malaria HIV Testing Services (HTS) Immunization (Td) Labour and Delivery
	Neonatal Care Umbilical cord care with Chlorhexidine
	Child Health Immunization Growth Monitoring Integrated Management of Childhood Illness
2	**Control of other Communicable diseases:**
	Malaria
	Intermittent Preventive Treatment for Malaria (IPT) Case management of simple, non-complicated malaria
3	**NUTRITION**
	Preconception: Nutrition education Early initiation of breastfeeding including consumption of colostrum Promotion of Exclusive breastfeeding
4	**Treatment of Minor Ailment and Injuries**
B.	**ENABLERS**
	Health Education and community Mobilization Formation and Reactivation of WDCs PHC Facility based health education (talks and demonstration were possible
	PHC Information System Forms for data submission

Table 9: Core Services and Enablers

B. PHC EQUIPMENT

EQUIPMENT ITEM	Number
Thermometer	1
Weighing scale	1
Paediatric weighing scale	1
Suction machine or Manual Suction Set (disposable)	1
Artery forceps	2
Episiotomy scissors	1
Bed pan	1
Foetal stethoscope	1
Forceps jar	1
Length measure	1
Stainless galipot	1
Scalpel blade	
Stethoscope	1
Drip stand	1
Delivery couch	1
Plastic bowl with cover	1
Mackintosh sheet	1
Nail scrubbing brush	1
Gloves disposable pack	1
Tongue depressor	
Cord clamps	
Tape measure	1
Vaginal speculum	1
Plastic waterproof apron	1
Disposable gloves	2
5ml syringes	
Protective goggle	
Waterproof of hair covering / cap	
Protective Foot Covering	
Placenta Dish / Receiver	2

EQUIPMENT ITEM	Number
Catheter – Self Retaining	
Mucus Extractor	
Sphygmomanometer	1
Flash Light (Rechargeable)	1
Episiotomy Scissors	1
Korckers Forceps	1
Cord Scissors	1
Sharps Scissors	1
Sterile Cord Clamp	
Needle Holder	1
Dissecting Forceps	1
Bracelets	
Sponge Holding Forceps	1
Baby Ambu Mask / Face Mask	1
Rectangular Bowl for Instruments	2
Partograph	
Angle Poise Lamp	1
Table	1
Benches	2
Beds for admission and observation	3
Stool specimen bottles	
Urine specimen bottles	
Urine dipstick	
RDT (kit and/or evidence of knowledge of its use)	
Suture needles	
Weighing scale (adult)	1
Stitch removal/suture	1
Direct drive solar refrigerator	1

Table 10: Equipment Items

C. PHC ESSENTIAL DRUGS

Evidence of recent access to and dispensing of essential drugs.

D. HUMAN RESOURCE FOR PHC

At least 5 Skilled Health Workers of which two (2) MUST be Midwives.

E. INFRASTRUCTURE

Space in the Facility for:

a. Screening
b. Health Talk
c. Consulting
d. Treatment
e. Effective Drug Storage
f. Antenatal Care Clinic
g. Delivery
h. Observation

3.2.10 SHC Accreditation

3.2.10.1 SHCs will be subject to assessment to demonstrate that they meet predetermined quality and patient safety criteria and standards established by the NPHCDA that qualifies the healthcare facilities to be admitted as SHC providers. The NHIS will also accredit SHCs to determine their suitability to effectively deliver the BMPHS.

3.2.10.2 Such requirements shall consist of general and specialty specific personnel, infrastructure, equipment and process requirements for providing secondary care for childhood ailments and assisted deliveries and emergency and elective Caesarean Sections.

3.2.10.3 Such assessment shall apply to all public and private SHC providers desirous of administering the BMPHS under the NHIS gateway.

3.2.10.4 Healthcare providers may have concurrent PHC and SHC specialty accreditation if they meet both accreditation requirements.

3.2.11 Healthcare Provider Rights and Responsibilities

3.2.11.1 Both public and private sector (rural) healthcare providers shall be eligible to apply for accreditation by the SPHCDA and participate in the NHIS gateway.

3.2.11.2 To be eligible to participate in the NHIS gateway initiative, each healthcare provider must be accredited by both the SPHCDA & SSHIA.

3.2.11.3 Each facility shall meet the minimum criteria of quality standards before it can be accredited. A quantitative quality supervisory checklist (developed by the NPHCDA) will be administered to all enrolled facilities to monitor and ensure a consistent level of quality.

3.2.11.4 Healthcare providers shall not refuse treatment to any patient under the initiative or charge user fees of any sort, either as a “Top-Up” or as “Co-Payment”

3.2.11.5 The provider will be obliged to display a large poster (template attached as Appendix 6) in front of its building publicizing: (i) that it provides free care for all pregnant women and children; (ii) will provide free malaria treatment and blood pressure and diabetes screening tests for all citizens; and (iii) the telephone number and web address of the redress mechanism established by scheme.

3.2.11.6 Pre-selected public and private sector providers shall be paid retrospectively a bundled fee (global payment) for providing designated services at no cost to the target population.

3.2.11.7 Healthcare providers shall maintain high standards of medical record keeping and submit both clinical and administrative data to the SSHIA (for onward transmission to the NHIS and the NSC) as and when due. The providers will allow auditors and IVAs designated by NSC access to their records whenever required;

3.2.11.8 Healthcare providers shall develop and maintain a referral system for the management of emergency or complicated patients, so there is direct access between primary care provider and neighbouring secondary health facilities with the capacity to manage such cases.

3.2.11.9 Any patient determined to require emergency care, must be promptly referred and arrive at the secondary centre within one hour (60 minutes) of the decision being made.

3.2.11.10 Selection and continued participation in the initiative is contingent on the healthcare provider continually improving its quality of care and complying with BHCPF requirements.

3.2.12 Contracting

Under the NHIS gateway, accredited PHC/SHC providers will sign contracts with the SSHIA.

Electronic contracts alongside electronic signatures or pre-printed signatures of the authorized representative(s) of SSHIA may be employed. Such contract will specify:

3.2.12.1 Roles and Responsibilities of the Healthcare Facility (PHC or SHC)

i. Maintain accreditation requirements continually
ii. Enrolment and registration of beneficiaries
iii. Provide BMPHS services to beneficiaries
iv. Comply with the BHCPF Operations Manual and standard treatment guidelines
v. Ensure beneficiaries' satisfaction with the facility and services provided
vi. Provide data returns on utilization of services and other reports to the LG HMIS units and the SSHIA by the 15th of each successive month at the latest
vii. Report any complaints to the SSHIA and/or the NHIS
viii. Limit delivery of services to accreditation status as PHC or SHC
ix. Carry out routine community outreaches and health education of beneficiaries
x. Institutionalization of internal quality management systems
xi. Other responsibilities to ensure the viability of the Programme as may be determined by NHIS from time to time.

3.2.12.2 Roles and Responsibilities of SSHIA

i. Mobilization of individuals and families
ii. Continuous sensitization of beneficiaries
iii. Provide tools required for enrolment and registration of beneficiaries
iv. Contracting of Healthcare Facilities
v. Effect timely payments to Health Care Providers
vi. Ensure effective processing of claims (Primary and Secondary Services)
vii. Carry out continuous quality assurance of healthcare services
viii. Ensure timely approval of referrals and undertake necessary follow up to complete referrals
ix. Effect necessary data returns to the NHIS in line with the Operations Manual
x. Comply with other provisions as spelt out in the Operations Manual
xi. Education of beneficiaries and providers about the SSHIA
xii. Institutionalization of quality management systems
xiii. Other responsibilities to ensure the viability of the Programme as may be determined by the NSC from time to time

3.2.12.3 Addendum

i. Addenda to Health Care Provider contracts will be by way of an update incorporating additions or deletions or additional stakeholders.
ii. All addenda will require execution by the authorized representatives of the SSHIA and the healthcare provider.
iii. Such addenda may be administered in hard copy or by electronic means

3.2.13 Conditions for Renewal of Accreditation

3.2.13.1 Accreditation of every Health Care Provider shall be renewable every three (3) years.

3.2.13.2 Notification for renewal shall be provided by the SSHIA or her assigned agents.

3.2.13.3 Some of the criteria for renewal shall include:

i. Annual facility licensure by SMoH or other prescribed State entity
ii. Continued compliance with conditions for initial accreditation or as updated by NPHCDA
iii. Health Care Provider must have made all returns due to the LG M&E and the SSHIA
iv. Possess valid current licenses of personnel and registration with regulatory bodies.
v. Evidence of internal quality management system and incremental quality improvement.

vi. Compliance with this BHCPF Operations Manual
vii. Other criteria as may be announced by NHIS

3.2.13.4 Health Care Providers who do not meet the renewal requirements shall be informed formally by way of a formal communication.

i. Such providers will be given three (3) months to make amends.
ii. Following which a re-assessment will be done to determine their qualification or non-qualification

3.2.13.5 Health Care Providers who fail to qualify following the repeat assessment will be delisted from the NHIS gateway

i. Such providers will be informed via formal communication and publication on the SSHIA website.
ii. Beneficiaries with such providers will be assigned to the nearest accredited Primary Health Care Provider.
iii. Beneficiaries have the choice to be transferred initially or subsequently to providers of their choice within their ward.

3.2.14 Provider Exit from the NHIS Gateway/Relocation/ Change of Name

3.2.14.1 Provider Exit

A health care facility wishing to exit from the operation of the NHIS gateway shall:

i. Have the concurrence of its ward development committee if publicly owned
ii. Give three (3) months written notice to their SSHIA.
iii. Inform its beneficiaries by publication on its publicly viewable notice board and other means such as town criers, bulk SMS etc.
iv. Accord NHIS gateway beneficiaries the necessary rights and privileges due to them as beneficiaries of the NHIS gateway within the three (3) month period of this notice.

3.2.14.2 Provider Relocation

Any healthcare facility wishing to relocate to a new site and still operate under the NHIS gateway must:

i. Give a three (3) months written notice to their SSHIA of its intention.
ii. Apply for inspection and approval of the new premises by the SSHIA.
iii. Inform its beneficiaries by publication on its publicly viewable notice board and other means such as town criers, bulk SMS etc.
iv. The facility shall accord NHIS gateway beneficiaries the necessary rights and privileges due to them as beneficiaries of the NHIS gateway within the 3-month period of this notice and thereafter.

3.2.14.3 Change of Name/Ownership

Any health care facility wishing to change name/ownership and still operate under NHIS gateway must:

i. Give a three (3) months written notice to their SSHIA of its intention.
ii. If its trade name i.e. public name is affected, the facility must publish its change of name in at least one (1) newspaper with significant circulation in the state/local government.
iii. Inform its beneficiaries by publication on its publicly viewable notice board and other means such as town criers, bulk SMS etc.
iv. Notify the SSHIA formally attaching evidence of newspaper publication where applicable and CAC approval if the business name is registered with the CAC.

3.2.15 Beneficiary Access to Care

3.2.15.1 All beneficiaries are to access PHC services from the PHCs in their ward

3.2.15.2 The beneficiaries should be registered with one PHC in their wards as their Primary Care Provider. This registration must be completed before or during the first encounter i.e. presentation to the PHC for healthcare services,

3.2.15.3 All access to care shall commence from the PHCs in their wards except for covered medical, obstetrics and surgical emergencies.

3.2.16 Beneficiary Identification and Eligibility Verification

3.2.16.1 Identification of beneficiaries at the provider locations is essential to prevent benefit leakage or overutilization.

i. Validate identity using formal means such as prior PHC registration, national/community/employment identity cards, phone numbers, biometrics, SMS short code or other prescribed means provided or supported by the SSHIA OR
ii. Validate using informal means such as confirmation by ward residents or facility health officials
iii. Other means as may be prescribed, provided or supported by the SSHIA

3.2.16.2 Ensure beneficiary is eligible to access care as one of the target group beneficiaries

i. Age 5 and below – eligible until 6th birthday for designated benefits
ii. Pregnant woman – eligible from first trimester to 6 weeks post-natal for designated benefits
iii. All population – eligible for malaria treatment and hypertension and diabetes screening

3.2.17 Providing Care to Eligible Beneficiaries

3.2.17.1 The beneficiaries are expected at their PHC only when they have a health concern, need medical attention or a covered screening.

3.2.17.2 It is very important that the beneficiaries:

i. Receive access to care and medical services timely and in a courteous and caring manner.
ii. Consult with medical personnel in their assigned PCP in line with prescribed standard treatment guidelines published or approved by the NHIS.
iii. Are informed about the treatment options including drugs, necessary diagnostic tests, and access to needed specialist care by referral.
iv. Are treated with respect, dignity and privacy, as well as confidential treatment of their medical information.
v. Are referred to appropriate SHC providers in a timely manner when indicated and in line with this Operations Manual.
vi. Are treated at no cost as healthcare providers shall not solicit, collect nor charge any fee from a beneficiary in addition to the fees payable by the SSHIA.
vii. Are treated according to designated or approved standard treatment guidelines

3.2.18 Treatment of Persons Not Registered with the Provider/Resident in the Ward

It is important to take note that persons who may not be resident in the ward are eligible to receive care if they meet target group eligibility criteria above. Such non-resident eligible beneficiaries may be attended to:

3.2.18.1 For emergency care - immediate healthcare services offered to cater for life-threatening conditions or conditions, which may result in significant deterioration of their quality of life if not treated. Beneficiaries on a visit to another part of town requiring emergency care should be catered for similarly. The beneficiaries must present with a formal identity card or can be identified informally by the healthcare officials, community members or relatives. Claims should be sent to SSHIA including the unique identifier of the non-resident beneficiary, and medical report, for reimbursement for the service.

3.2.18.2 When referred by a PHC to another PHC/SHC in another ward

3.2.19 Provider Access Standards

Access standards are service delivery benchmarks all providers are encouraged to conform to in order to ensure prompt and timely delivery of healthcare services to all beneficiaries. This applies to PHC and SHC providers.

	Service	**Standards**
1	**Minimum Provider Operating Hours**	
A	Primary Care Services	24 hours daily access (for PHCs in rural areas)*
B	Specialist Obstetric Services	24 hours daily (for SHCs)
C	Routine Specialist Clinics***	Min. once a week (for SHCs)
D	Emergency services**	24 hours provision*
2	**Internal Waiting Time**	< 60 minutes

* PCPs in rural underserved areas will at the minimum offer access to BMPHS benefits for 24 hours daily. For facilities that operate for less than 24 hours, designated medical staff should be on call and available within 30 minutes to attend to emergency cases that present after opening

hours.
**Emergency care – care required for an unexpected condition, illness or injury which necessitates the immediate care and attention of a qualified healthcare worker, and which, if not treated immediately, would jeopardize or impair the health of the Beneficiary or may lead to death or reduced quality of life.
***Routine care – care scheduled for the treatment of non-urgent and non-emergency conditions. Urgent care – care required for a sudden illness or condition that necessitates medical care right away but is not life threatening.

3.2.20 Referrals

All non-emergency access to care shall be via PCP. Cases beyond the competence or capacity of the primary care provider, complicated cases, high risk cases, emergency cases, cases out of primary care scope and other cases that require specialist attention are to be referred in line with the following laid down guidelines from the Primary to Secondary levels:

i. A patient may be referred from a Primary to a Secondary/Tertiary Service Facility due to need for specialized investigations, for medical/ surgical reasons or other services – diagnostic, physiotherapy etc.
ii. Referral can be within the same facility with primary and secondary accreditation or from one provider to another provider.
iii. Rarely a referral may arise from one PHC to another PHC if services are not available at the referring PHC or it is expedient for to save life.
iv. Following stabilization and treatment the referred Beneficiary is expected to be referred back to his primary care provider with a medical report and follow up treatment instructions and/or protocol.

3.2.20.1 Basic Principles of Referral

i. There must be a clinical basis for referral - Cases beyond the competence or capacity of the primary care provider, complicated cases, high risk cases, emergency cases, cases out of primary care scope and other cases that require specialist attention.
ii. Patient must be resuscitated and stabilized
iii. Primary care physicians are obliged to refer promptly to the next level of care.
iv. A referral line (target SHC) must be confirmed.
v. A referral letter must accompany every case.
vi. Personal and medical details must be contained in the referral letter.
vii. All investigations carried out at a lower level must be transferred to the referral centre.
viii. The outcome of a referral should be satisfactorily and properly documented by the SHC.
ix. Referred cases must be sent back by the SHC/specialist after completion of treatment to the referring PHC facility, with a medical report and instructions for follow-up management.

3.2.20.2 Information Required for Referral

i. Patient's name, gender, age and address
ii. Referring Health Care Provider's name and referring unit (department/clinic), if applicable
iii. Referring healthcare facility's SSHIA code
iv. Patient's hospital number
v. Patient's unique identifier (To Be Determined)
vi. Referral date
vii. Clinical findings/investigations and results
viii. Treatment administered before referral
ix. Provisional diagnosis
x. Reasons for referral
xi. Referral code obtained from the SSHIA

xii. Referring personnel's name and signature

3.2.20.3 Claims Management for PHC and SHC services

i. Provider collates and submits claims using claims form in hard copy or electronic form in the format approved by NHIS and the NSC
   a. NHIS and the NSC may provide an online portal, which synchronizes with providers' EMRs ensuring seamless exchange of claims data and other required data.
   b. NHIS and the NSC may provide mobile data transfer wallets/portals or applications which enable mobile data submission
   c. NHIS and the NSC will make available appropriate APIs (Application Programme Interface) that allows seamless exchange of encounter, claims and other data) between providers' EMRs and SSHIA's databases.
ii. Provider ensures that all fields are filled particularly:
   a. Beneficiary name, age, phone number, address,
   b. Name of doctor/care provider
   c. Name of the hospital providing the service
   d. The date of service
   e. The diagnosis, investigation and therapy codes as applicable
   f. The charges for the service. Charges should be in line with the valid BHCPF reimbursement schedule
iii. Provider sends filled claims forms physically or electronically to their SSHIA within 30 days following the month in which the claims were incurred.
iv. SSHIA will process claims within 30 days of receipt for all beneficiaries provided that the following conditions are met:
   a. SSHIA receives the claim within 30 days from the last day of the month of the encounter.
   b. Claims are submitted using the SSHIA pre-numbered claims booklets given to all participating providers or the SSHIA electronic data management format or system
   c. All the necessary fields in the form or are appropriately completed, with all the required elements:
v. Payment for claims cleared will be made to the healthcare providers by the SPFMU.
vi. Reimbursement of claims will be paid based on the BMPHS benefits and contracted tariff.
vii. Enquiries regarding the status of providers' claims by the providers can be made by:
   a. Calling the SSHIA contact centres
   b. Web Based Provider Portal
   c. Mobile Provider Application
   d. SMS claims status short code
   e. Other channels as determined by the NHIS and the NSC
viii. Claims submitted by providers will be denied under the following circumstances:
   a. Claims submitted on a format other than the authorized Claims forms or electronic data format/Channel
   b. Data fields not filled completely or incorrectly filled
   c. Claims submitted more than 90 days from the date of service
   d. Duplicate claims submitted
   e. Claims for encounters not reported in the monthly utilization report
   f. Claim that is fraudulent
   g. All claims that do not follow the guidelines listed under section 3.2.20.3 (Submission of Claims).
ix. Provider dissatisfied with claims denial or processing outcome may appeal to the ES of the SSHIA and the NHIS.

3.2.21 Safeguards to prevent over and under-utilization:

Shall rely on

i. Beneficiary access of primary care through PHC in ward
ii. Beneficiary registration with PHC in ward
iii. Provider compliance with beneficiary identification
iv. Provider compliance with beneficiary benefit validation
v. Provider compliance with NHIS BHCPF treatment guidelines
vi. Provider compliance with NHIS BHCPF medicines list
vii. Provider compliance with NHIS BHCPF tariff and claims submission
viii. SSHIA claims processing
ix. IVA monitoring and evaluation

3.3 The EMT gateway:

The EMT Gateway shall provide funding to ensure all Nigerians are able to receive the Emergency Medical Treatment (EMT) component of the BHCPF at no cost. The EMT component of the BHCPF shall consist of three (3) modules:

3.3.1 Components of the EMT gateway

3.3.1.1 Scene (Emergency Pre-Hospital) Care: Tier One First Responder, Tier Two Basic Pre-Hospital Trauma Care, Tier Three Advanced Prehospital Trauma Care, Care Documentation. Ambulance Service Providers shall provide, as a standard of care, “Scene Incident Managers (SIMs)” who shall secure the scene, coordinate the Emergency Response, all communications and transport from the RTI scene.

3.3.1.2 Transfer (Transportation & Communication): Field Triage, Ground Transportation, Air Medical Transport, “Universal” Telephone Number

3.3.1.3 Facility (Initial Evaluation, Diagnosis & Resuscitation and In-Hospital Care): Reception-Registration, Screening, Triage, Handover; Emergency Unit Care-Initial Assessment & Resuscitation, Monitoring and Revaluation, Detailed Assessment, Diagnostic Studies, Additional Therapeutics; Inpatient Care-Early Operative Care, Early Critical Care

3.3.2 EMT Providers

3.3.2.1 Both private and public healthcare providers shall be eligible to apply for accreditation and participation in the initiative

3.3.2.2 To be eligible and receive payment in this initiative, each healthcare provider must be accredited by the NPHCDA and registered by the DHS as designated EMT service providers of any of the three (3) modules indicated above

3.3.2.3 Each provider shall meet the minimum criteria of quality standards before it can be accredited. A quantitative quality supervisory checklist will be administered to all enrolled providers to monitor and ensure a consistent level of quality.

3.3.2.4 Designated EMT providers shall not refuse treatment to any patient under the initiative or charge user fees, either as a “Top-Up” or as “Co-Payment”

3.3.2.5 Designated EMT providers shall maintain high standards of medical record keeping and submit both clinical and administrative data (to TPAs appointed by the DHS) as and when due.

3.3.2.6 Ambulance Service Providers shall develop and maintain a robust communications and referral system for the management of emergency patients, so there is direct access between Ambulance Service Provider and neighbouring Emergency Care facilities with the capacity to manage any such cases.

3.3.2.7 Any patient determined to require emergency care, must be promptly transported and arrive at the Emergency Care centre within **half an hour (30 minutes)** of the decision being made.

3.3.2.8 Selection and continued participation in the EMT gateway are contingent on the EMT service provider maintaining adequate quality standards of care and complying with BHCPF requirements.

3.3.2.9 Designated EMT Providers must remain in good professional standing with their registration bodies, including meeting Continuous Professional Development (CPD) requirements.

3.3.3 Operation of the EMT Gateway

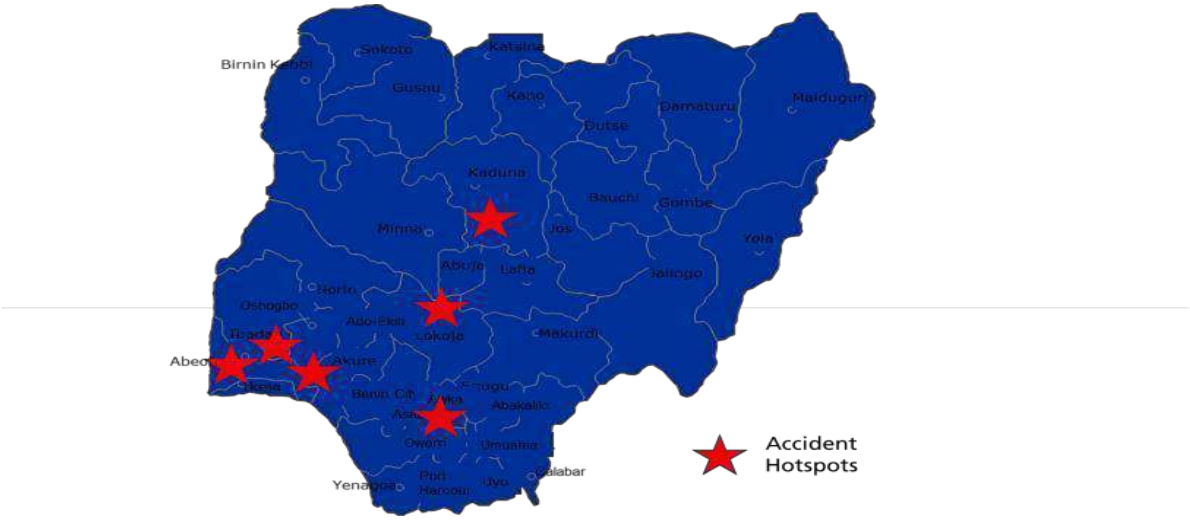
3.3.3.1 In the first three (3) years of its operation, the EMT Gateway shall be implemented as an INTERVENTION programme, with a view to addressing the excess mortality surrounding fatal Road Traffic Injuries (RTIs) in Nigeria

3.3.3.2 To significantly reduce mortality during the first three (3) years of operation of the Fund, six (6) most dangerous routes in Nigeria, designated "Accident Hotspots" (Table 4) will be targeted with deployment of maximum resources

3.3.3.3 During this initial period, a Universal Emergency Number that would be valid throughout the catchment areas, available by telephone (landline or mobile), easy to remember and dial (i.e., limited to 3 or 4 digits) and would be toll free would be commissioned by the Secretariat of the NSC.

3.3.3.4 Emergency Care Providers near (30 km radius) to each of these "Accident Hotspots" will be identified and incentivized to significantly upgrade and improve their capacity and capability and offered maximum assistance for accreditation to participate in this initiative.

3.3.3.5 Sunset Clause: After this initial period of three years, a fresh set of Guidelines shall be drawn up outlining the terms for the operation of the EMT Gateway especially on the eligibility of other providers (urban and rural) to be accredited into and join the initiative. Annual implementation findings shall be used to improve program delivery as approved by the NSC.



	ROUTE	NO OF RTI FATALITIES (2015)
1	Abuja-Lokoja	293
2	Lagos-Ibadan	154
3	Doka-Kaduna	94
4	Onitsha-Awka	74
5	Lagos-Ore	57
*6	Abeokuta-Lagos	51

Table 11: Top Six routes for road traffic injuries fatalities in Nigeria (2015)
Source: Federal Road Safety Commission Annual Report 2015

3.3.4 Commissioning of EMT Services

3.3.4.1 Day-to day operational aspects of the EMT Gateway shall be carried out by EMT Providers and Facilities who shall either be for-profit or not-for-profit organisations; contracted to carry out defined functions and roles on behalf of the DHS and FMoH.

3.3.4.2 The DHS shall commission (Strategic Purchasing) accredited Ambulance Service Providers nationwide, including the Federal Road Safety Corps (FRSC), State Ambulance Services, National Emergency Management Agency (NEMA), Private Sector Ambulance Service Providers and Voluntary Sector Ambulance Service Providers.

3.3.4.3 The DHS shall commission nationwide (Strategic Purchasing) accredited Healthcare Providers with capacity and personnel for Emergency Initial Evaluation, Diagnosis & Resuscitation and any required basic In-Hospital Care including the Federal Tertiary Centres, State Tertiary Centres, Private Sector Tertiary and Emergency Care Providers and Voluntary Sector Tertiary and Emergency Care Providers

3.3.4.4 The DHS shall commission nationwide (Strategic Purchasing) Healthcare Providers who shall be engaged provisionally for three (3) years in the first instance.

3.3.4.5 At the expiration of the initial three (3) year contract, the contract maybe renewed provided there is a favourable assessment of medical performance of the designated EMT provider and compliance with BHCPF requirements.

3.3.5 EMT Provider Contracting for the EMT Gateway

Under the EMT gateway, designated EMT providers will be contracted by the DHS. Electronic contracts alongside electronic signatures or pre-printed signatures of the authorized representative of DHS may be employed. Such contract will specify:

3.3.5.1 Roles and Responsibilities of the EMT providers include:

i. Provide EMT services as designated
ii. Comply with the BHCPF Operations Manual and standard treatment guidelines
iii. Ensure beneficiaries' satisfaction with EMT services and facilities
iv. Provide data returns on service utilization promptly
v. Institutionalization of internal quality management systems
vi. Other responsibilities to ensure the viability of the Programme as may be determined by the DHS and the NSC from time to time.

3.3.5.2 Roles and Responsibilities of the DHS

i. Set guidelines and standards for the Programme
ii. Effect timely release of payments to the EMT providers
iii. Carry out continuous quality assurance to ensure qualitative healthcare services and Programme management
iv. Technical Support to the EMT providers
v. Advocacy, Sensitization and mobilization.
vi. Other activities required to ensure the viability of the Programme as may be determined by NCH from time to time

3.3.5.3 Addendum

Addenda to the EMT contracts will be by way of an update incorporating additions or deletions or additional stakeholders.

i. All addenda will require execution by the authorized representatives of DHS and the EMT provider.
ii. Such addenda may be administered in hard copy or by electronic means

3.3.6 Conditions for Renewal of EMT provider contract

3.3.6.1 EMT provider contracts shall be renewable every three (3) years.

3.3.6.2 Criteria for renewal shall include:

i. Annual facility licensure by MOH or other prescribed State entity
ii. Continued compliance with conditions for initial accreditation or as updated by the DHS
iii. EMT Provider must have made all data returns due to the DHS
iv. Possess valid current licenses of personnel and registration with regulatory bodies.
v. Evidence of internal quality management system and demonstrable incremental quality improvement.
vi. Compliance with this BHCPF Operations Manual
vii. Other criteria as may be announced by the DHS

3.3.6.3 EMT Providers who do not meet the renewal requirements shall be informed by formal documentation.

i. Such providers will be given 3 months to make amends.
ii. Following which a re-assessment will be done to determine their qualifications.

3.3.6.4 EMT Providers who fail to qualify following the repeat assessment will be delisted from the EMT gateway

i. Such providers will be informed via formal communication.
ii. Alternate EMT providers will be contracted and enlisted into the EMT gateway

3.3.7 Provider Payment Model

3.3.7.1 Shall be implemented as described under section 2.1.10 of this document

4 MONITORING AND EVALUATION OF THE BHCPF

4.1 Monitoring and evaluation of the BHCPF:

M&E for the BHCPF shall span all stakeholders, their interdependencies, processes and performance across the 3 gateways: NPHCDA Gateway, NHIS Gateway and the EMT gateway

4.2 Scope of the BHCPFM&E

For each gateway, M&E shall span:

i. Processes: How compliant are Federal, State and facility entities with the BHCPF's governance, administrative, financial and operational/service delivery processes?
ii. Outputs: What has been the utilization of designated services by target groups?
iii. Outcomes: What are the health and socio-economic impacts of these interventions?

4.3 Objectives of the BHCPF M&E

To test the feasibility and effectiveness of the BHCPF model so that decisions can be made quickly about financing, implementation arrangements, and expansion of the BHCPF. In the slightly longer term a more robust "impact evaluation" on population level coverage, quality of care, and possibly health outcomes would be conducted to determine the impact of the BHCPF.

4.4 Approach

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

4.5 Indicators

4.5.1 Process Measures

i. Funds were transferred electronically in the correct amount and in a timely fashion only to those providers/facilities who were supposed to receive BHCPF funds;
ii. BHCPF funds received by public health facilities were used appropriately;
iii. Verification that services paid for under the NHIS gateway actually provided;
iv. Actual cost of services to patients; and
v. Patient satisfaction.

4.5.2 Output Measures

These consist of coverage and quality measures which will be disaggregated by income quintile to assess the BHCPF's impact on equity. The proportion of services provided in the private and public sectors will also be disaggregated. These measures consist of:

vi. Antenatal care coverage;
vii. Skilled birth attendance;
viii. Post-natal care coverage;
ix. Modern Contraceptive Prevalence Rate (CPR);
x. Penta3 immunization coverage;
xi. Common childhood illnesses treated; and
xii. Quality of care as measured by a series of indicators measured through the National Health Facility Survey.

4.5.3 Impact Measures:

4.5.3.1 It may be worthwhile to track or record baseline measures for:

i. The neonatal mortality rate and stillbirth rate
ii. Maternal mortality rate and
iii. Financial risk protection.

4.6 Data Sources:

Various sources of data would be employed to implement the M&E for the BHCPF start-up, including:

i. Audit of Fund Holders and Public Facilities will be carried out to determine whether the proper amounts have been paid to the right providers'/health facilities on a timely basis, with proper documentation, and that funds have been used appropriately.

ii. Health Facility /Provider Verification Visits will be carried out by a third party at baseline and on a regular basis thereafter to a sample of public and private sector health facilities. Building on the experience with performance-based financing (PBF) in Nigeria, the verification visits will include: (a) comparison of DHIS-2 monthly reports or BHCPF invoices with information in the registers or patient records in the facility; (b) quick assessments of infrastructure, equipment, drug availability, and other aspects of quality; (c) adherence to the regulations and conditions of the BHCPF; (d) documentation of changes (e.g.; photographs, reports); etc.

   Household Verification Visits (and phone calls) will be conducted randomly semi-annually in a way like what is done under PBF. A sample of patients identified from registers or records will be visited in their houses (or called by telephone) to establish: (a) whether they exist; (b) whether they received the stipulated services on the stipulated date; (c) whether they were happy with the services they received; and (d) how much they paid for the services. This service audit will be conducted randomly semi-annually.

iii. The 2016-17 Multiple Indicator Cluster Survey (MICS) carried out by NBS with support from UNICEF. This large, nation-wide, household survey provides a sample of nearly 1,000 households per state and collects data on impact and output measures as well as important co-variates (income, education, etc.)

iv. Customized Household Survey 2018 will be carried out in BHCPF start-up states and would be modelled on the MICS but would use a shorter recall period (1 year) and probably a larger sample size. It will also include questions on health expenditures and patient satisfaction not included in the MICS.

v. National Health Facility Survey (NHFS) will be conducted annually as part of data strengthening under the BHCPF programme.

4.7 Mechanisms for Process and Output monitoring of the BHCPF

4.7.1 Process and Output Monitoring of the NPHCDA Gateway

Monitoring of disbursements shall take place as follows:

4.7.1.1 Ex-Ante Verification of NPHCDA gateway

4.7.1.1.1 Guiding Principles of ex-ante verification

i. Shall take place prior to the initial disbursement of funds to State Primary Healthcare Development Agencies.
ii. Shall provide satisfactory evidence to the NSC that all participating States have made a budgetary provision for PHC in their annual budget/appropriation for the disbursement year and such provisions have been released into the State's BHCPF account at the CBN.
iii. Shall take place for hundred percent (100%) of participating States.

4.7.1.1.2 Ex-Ante Verification Mechanism

i. States through the Commissioner of Health shall submit to The NSC through the NPHCDA, no later than 30th March of each year, State budgets for health that evidences appropriation projections for Primary Healthcare
ii. Budgets shall also be publicly disclosed on the website of either the State Government, its Ministry of Health or State Primary Healthcare Development Agency, within 1 week of passage by the legislature
iii. States are required to provide evidence that PHC budget provisions are released and that provisions for operational budget support of the PHCs are paid into the State's BHCPF account at the CBN.
iv. States shall be required to submit quarterly reports of utilization data for key indicators, including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits and immunization

4.7.1.2 Ex-Post Verification of NPHCDA Disbursements:

4.7.1.2.1 Guiding Principles of Ex-Post Verification

i. Shall provide satisfactory evidence to the NSC appointed IVA that:
   a. All participating States have disbursed hundred percent (100%) of funds received to 100% of participating facilities;
   b. Facilities have been given the autonomy to run individual bank accounts, book-keeping and accounting;
   c. Facilities have been given the autonomy to expend resources based on facility/community health needs as determined by the facility management and in accordance with the guidelines set out in the Memorandum of Understanding.
   d. The funds have been utilized to improve the infrastructure and operational capabilities of the facilities to provide quality healthcare services
ii. Shall take place in least ten to fifteen (10 -15%) of facilities in each participating state;
iii. Shall be completed no later than end of the 3rd quarter or 30th of September of the disbursement year;
iv. Completion of verification shall trigger the disbursement of the next tranche of funds due to the participating States from the Fund; and
v. Non-payment of facilities shall result in withholding of the next tranche of funds as outlined earlier.

4.7.1.2.2 Ex-post Verification Mechanism

ii. The NSC appointed IVA which preferable shall be a third-party Government Organisation or Academic Institution shall use the sampling frame of all participating facilities to randomly select at least fifteen percent (15%) of facilities as targets for the verification exercise

iii. At State level, the IVA shall use the designated verification checklists to assess the following:
   a. Statement of accounts to ascertain the date of receipt of funds from the Fund (Federal Level).
   b. Payment vouchers for evidence of disbursement of funds to facilities no later than one
   month following the SPHCDA's receipt of the first tranche of funds from Federal level.
   c. Quarterly reports of utilization data for key indicators including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits and immunization.

iv. At facility level the IVA shall:
   a. Establish from facility bank statements a triangulation, that amounts

due to health facilities from SPHCDA were received as due no later than one month following the SPHCDA's receipt of the first tranche of funds from Federal level.

v. Establish from facility's income and expense statements that health facilities have expended resources in accordance with pre-defined guidelines as outlined above and as agreed in the Memorandum of Understanding signed with the State. Verification reports shall be collated for the State, by The IVA and be completed no later than the end of the third quarter of the disbursement year

vi. The NSC shall review and approve or withhold funds due to States, based on the submissions, no later than two (2) weeks following the end of the third quarter of the disbursement year

vii. States defaulting on the disbursement or reporting requirements shall be subject to penalties as outlined in section six (6) of this document.

4.7.2 Process and output Monitoring of the NHIS Gateway

4.7.2.1 Provider Accreditation

4.7.2.1.1 Guiding Principles

Provider accreditation under these Guidelines shall:

i. Take place prior to enlistment of primary and secondary healthcare providers into the NHIS gateway; and
ii. Entail assessment of the providers by the NHIS/SSHIA using a range of basic minimum criteria (described in Appendix 2) to determine capability of the providers to safely deliver BMPHS services and provision of satisfactory evidence to the NSC on the suitability of providers to participate in the programme:

4.7.2.1.2 Provider Accreditation Mechanism

i. Detailed overview of accreditation process available in section 3 of this Operations Manual
ii. Detailed overview of re-accreditation requirements is available in section 3 of this Operations Manual.

4.7.2.2 Ex-Post Verification of Utilization at Provider Level

4.7.2.2.1 Guiding Principles

i. Ex-post verification of utilization at provider level shall:
   a. Take place to provide satisfactory validation to the NSC, that the quantum of services reported by health facilities have been performed.
   b. Take place in least ten to fifteen (10-15%) of facilities in each participating state.
   c. Be completed by the IVA no later than one month following a bi-annual review.

4.7.2.2.2 Mechanism for Ex-Post Verification of Utilization at Provider Level

i. Participating health facilities shall report services rendered routinely on provided claims forms or on a real-time/near real-time basis using the designated mobile/electronic application:
   a. At primary health care level: a service rendered shall be defined as the continuum of four or more antenatal visits, delivery attended by skilled personal and a post-natal visit within 48 hours of delivery, treatment of under 5 childhood illnesses, treatment of malaria and screening for non-communicable diseases specified in this manual.
   b. At secondary level: Assisted deliveries, Caesarean Sections and admission services following referral from an eligible primary healthcare facility
   c. Data shall contain complete bio-data of beneficiaries, including name,

telephone number, address and relative's contact details

ii. The IVA shall randomly select, from a sampling frame of all eligible facilities, a sample of up to fifteen percent (15%) of health facilities for verification. Risk profiled health facilities will be prioritized.
iii. The verification team shall make phone calls to trace back beneficiaries, verify the service they assessed from the health facility and elicit their perception on the quality of care for nolessthan1% of beneficiaries. The verification team shall trace back beneficiaries in person, at community level, via household visits for no less than 25% of the selected sample of beneficiaries.
iv. The report of verification shall be completed no later than one month following a bi-annual review
v. The NSC shall approve disbursements due to SSHIAs no later than one month following the end of the quarter
vi. Disbursements shall be withheld for services not verifiable. In addition, a high degree of discordance (greater than fifteen percent (15%)) between services reported and services verified will attract a penalty as outlined in Section 6 of this Operations Manual.

4.7.2.3 Ex-Post Verification of Disbursements

4.7.2.3.1 Guiding Principles

i. Shall take place to provide satisfactory validation to The Secretariat of the NSC that SSHIAs have, in a timely manner, disbursed payments due to providers for the services rendered in the previous quarter.
ii. Shall take place for least twenty-five percent (25%) of healthcare facilities randomly selected across participating States.
iii. Shall be completed no later than one month following the end of each quarter.
iv. Completion of verification shall trigger disbursements of administrative fees due to SSHIAs.

4.7.2.3.2 Mechanism for Ex-Post Verification of Disbursements

i. The NSC shall randomly select twenty-five percent (25%) of healthcare facilities randomly selected across participating States as targets for the verification exercise.
ii. IVA shall assess the records of SSHIAs to ascertain that disbursements have been made as and when due to providers. Accordingly, they shall review the following:
    a. Statement of accounts to ascertain the outflow of funds from the SSHIA to the provider.
    b. Payment vouchers as supporting evidence of disbursement of funds to facilities.
iii. At provider level verification teams shall assess the following:
    a. Establish from facility bank statements, a triangulation that amounts due to providers were received as due, no later eight weeks following the end of the quarter.
    b. Verification reports shall be completed no later than one month following the end of the quarter.
iv. The NSC shall, in the instance of defaulted payments by the SSHIA, apply the penalties as described in Section 6.

4.7.2.4 Assessment of Quality of Care at Provider Level

4.7.2.4.1 Guiding Principles

i. Shall take place at least semi-annually for a selected proportion of enlisted providers to provide substantive evidence to The Secretariat of the NSC that the quality of care offered by providers is satisfactory
ii. Shall assess quality domains including but not limited to general and financial management, Essential Drugs Management, Outpatient services, Antenatal

services, Prenatal and Postnatal Care and Skilled Birth Attendance

iii. Shall take place at two levels:
   a. At PHC Provider level conducted by the Local Government Primary Healthcare Authority
   b. At Secondary Care Provider level conducted by the Hospitals Management Board
   c. The SSHIA may assess quality at public and private PHC and SHC providers

iv. Shall not be linked to disbursements or provider payments. However, shall attract a penalty as outlined if quality standards are found to be below the minimum standard criteria

4.7.2.4.2 Mechanism for Assessment of Quality of Care at PHC provider level

i. The Local Government Primary Healthcare Authority (LGA PHCA) shall take a sample of up to twenty-five percent (25%) of enlisted PHC providers every quarter
ii. The LGA PHCA shall visit the sampled PHC to assess the quality of care by administering The NSC designated quality checklist. LGA PHCA shall provide feedback to providers on improvements required at the point of administration
iii. The quality assessment reports and scores shall be collated by the SSHIA and submitted to The NSC no later than one month following the end of the quarter
iv. Any providers found to have sub-standard quality scores shall be penalized.

4.7.2.4.3 Mechanism for Assessment of Quality of Care at Secondary Care provider level

i. The HMB shall take a sample of up to twenty-five percent (25%) of enlisted secondary care providers every quarter
ii. The HMB shall visit the sampled secondary facilities to assess the quality of care using The NSC designated quality checklist. HMB shall provide feedback to providers on improvements required at the point of administration
iii. The quality assessment reports and scores shall be collated by the SSHIA and submitted to The NSC no later than one month following the end of the quarter
iv. Any providers found to have sub-standard quality scores shall be penalized.

4.7.3 Process and output Monitoring of the EMT Gateway

4.7.3.1 Provider Accreditation

4.7.3.1.1 Guiding Principles

Provider accreditation under these Guidelines shall:

i. Take place prior to enlistment of EMT providers into the EMT gateway; and
ii. Assess the providers using a range of criteria (described in section 3 of this Operations Manual) to determine capability of the providers to safely deliver EMT services and provide satisfactory evidence to DHS of their suitability to participate in the programme:

4.7.3.1.2 Provider Accreditation Mechanism

i. Detailed overview of accreditation process available in section 3 of this Operations Manual.
ii. Detailed overview of re-accreditation requirements is available in section 3 of this Operations Manual.

4.7.3.2 Ex-Post Verification of Utilization at Provider Level

4.7.3.2.1 Guiding Principles

i. Ex-post verification of utilization at provider level shall:
   a. Take place to provide satisfactory validation to the NSC, that the quantum of services reported by the EMT healthcare providers had been rendered.
   b. Take place in least ten to fifteen percent (10-15%) of facilities in 100% of participating locations

c. Be completed no later than one month following the end of each quarter.

ii. Completion of verification shall trigger the disbursement of funds to the DHS who shall in turn, disburse the amounts due to health facilities no later than four (4) weeks following the end of the quarter.

4.7.3.2.2 Mechanism for Ex-Post Verification of Utilization at Provider Level

i. Participating health facilities shall report services rendered routinely in appropriate forms and/or on a real-time/near real-time basis using the designated mobile/electronic application
ii. The NSC shall randomly select, from a sampling frame of all eligible facilities, a sample of up to fifteen percent (15%) of health facilities for verification
iii. The IVA shall make phone calls to trace back beneficiaries, verify the service they assessed from the health facility and elicit their perception on the quality of care for no less than one percent (1%) of beneficiaries. The verification team shall trace back beneficiaries in person, at community level, via household visits for no less than twenty-five percent (25%) of the selected sample of beneficiaries.
iv. The report of verification shall be completed no later than one month following the end of the quarter
v. The NSC shall approve disbursements due to the EMT care providers no later than one month following the end of the quarter
vi. Disbursements shall be withheld for unverifiable services not. In addition, a high degree of discordance (greater than fifteen (15%)) between services reported and services verified will attract a penalty as outlined in Section 6 of this Operations Manual.

4.7.3.3 Ex-Post Verification of Disbursements

4.7.3.3.1 Guiding Principles

i. Shall take place to provide satisfactory validation to The NSC that the DHS has, in a timely manner, disbursed payments due to providers for the services rendered in the previous quarter.
ii. Shall take place for least 25% of EMT care providers.
iii. Shall be completed no later than one month following the end of each quarter, commencing from the 2nd quarter of the disbursement year.
iv. Completion of verification shall trigger disbursements of administrative fees due to the DHS.

4.7.3.4 Assessment of Quality of Care at Provider Level

4.7.3.4.1 Guiding Principles

i. Shall take place at least once a quarter for a selected proportion of enlisted EMT care providers to provide substantive evidence to the NSC that the quality of care offered by providers is satisfactory
ii. Shall assess quality domains including but not limited to general and financial management, essential drugs management, emergency transportation and emergency medical and surgical services
iii. Shall not be linked to disbursements or provider payments. However, shall attract a penalty as outlined earlier for the provider if quality standards are found to be below the minimum standard criteria.

4.7.3.4.2 Mechanism for Assessment of Quality of Care at Provider Level

i. The IVA shall take a sample of up to twenty-five (25%) of enlisted EMT providers every quarter
ii. The IVA shall visit the sampled EMT to assess the quality of care by administering the NSC designated quality checklist. The IVA shall provide feedback to providers on improvements required at the point of administration
iii. The quality assessment reports and scores shall be completed no later than one (1) month following the end of the quarter
iv. Any providers found to have sub-standard quality scores shall be penalized.

4.7.4 Process and Output Monitoring of The Secretariat of the NSC

4.7.4.1 Guiding Principles and Mechanism

4.7.4.1.1 The Honourable Minister of Health may designate additional assessment of the performance of The Secretariat of the NSC as follows:

i. Service audits are commissioned and mobilized in order to review actual service use
ii. Statement of accounts shall provide evidence that the disbursements due to the SPHCDA through the NPHCDA Gateway have been duly implemented promptly each quarter
iii. Payments due to SSHIA and providers through the NHIS Gateway are implemented no later than 4 weeks following the end of each quarter
iv. Utilization and quality data generated from NHIS Gateway providers is analysed and publicly disseminated every quarter with feedback to SSHIA for performance management and quality improvement
v. Mid-term report submitted no later than the end of the first month of the third quarter of every year and annual report and audit submitted no later than the end of the first month of the second quarter of the subsequent year

4.7.4.1.2 The assessment team shall provide a performance assessment report to the Honourable Minister on the performance of The Secretariat of the NSC the end of the first month of the second quarter or end of the first month of the third quarter of the disbursement year.

4.8 Summary of approach to monitoring and evaluation

A. NPHCDA GATEWAY				
ACTIVITY BY THIRD PARTY	**FIRST PHASE**		**SECOND PHASE**	
	START-UP STATES	"CONTROL" STATES	START-UP STATES	"CONTROL" STATES
1. **Audit** to look at timeliness, amount, and proper documentation of payments to facilities, as well as use of funds.	Baseline & after 6 months	Baseline & after 6 months, limited to public funds	At 12 and 18 months from the start of the start-up phase.	At 12 and 18 months from the start of the start- up phase.
2. Assessment of **quality of care** & physical inputs (take photographs) including record review.	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months
3. **Quantity verification**, assessment of registers vs. DHIS reports – sampled HFs	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months
4. **Quantity verification, registers vs. household** assessment (also look at patient satisfaction, user fees, - sampled HF's and sampled households	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months

B. NHIS GATEWAY				
ACTIVITY BY THIRD PARTY	**PHASE 1**		**PHASE 2**	
	PRIVATE SECTOR	PUBLIC SECTOR	PRIVATE SECTOR	PUBLIC SECTOR
1. **Audit** to look at timeliness, amount, and proper documentation of payments to facilities.	Baseline & after months	Baseline & after 6 months, limited public funds	At 12 and 18 months from th start of the start-up phase.	At 12 and 18 months from th start of the start- up phase.
2. Assessment of **quality of care** & meeting **accreditation criteria** including record review sampled HFs	Baseline & every months	Baseline & every months	Every 6 Months	Every 6 months
3. **Quantity verification**, assessment of registers/ records vs. invoices – sampled HFs	Baseline & every months	Baseline & every months	Every 6 Months	Every 6 months
4. **Quantity verification**, **registers/records vs. household** assessment (also look at patient sampled HF's and sampled households	Baseline & every months	Baseline & every months	Every 6 Months	Every 6 months

C. EMT Gateway				
ACTIVITY BY THIRD PARTY	**PHASE 1**		**PHASE 2**	
	START-UP ROUTES	"CONTROL" ROUTES	START-UP ROUTES	"CONTROL" ROUTES
1. **Audit** to look at timeliness, amount, and proper documentation of payments to facilities.	Baseline & after 6 months	Baseline & after 6 months, limited to public funds	At 12 and 18 months from the start of the start-up phase.	At 12 and 18 months from the start of the start- up phase.
2. Assessment of **quality of care** & meeting **accreditation criteria** including record review sampled HFs	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months
3. **Quantity verification**, assessment of registers/ records vs. invoices – sampled HFs	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months
4. **Quantity verification**, **registers/records vs. household assessme**nt (also look at patient satisfaction, user fees, sampled HF's and sampled households	Baseline & every 3 months	Baseline & every 3 months	Every 6 Months	Every 6 months

D. OVERALL IMPACT					
		Baseline		End line	
		START-UP STATES	"CONTROL" STATES	START-UP STATES	"CONTROL" STATES
1.	Health Facility Survey	NHFS 2016	NHFS 2016	NHFS 2018	NHFS 2018
2.	Household survey	MICS 2016	MICS 2016	Special survey	Special survey

5 USE OF TECHNOLOGY

5.1 Use of technology for BHCPF governance and administration

Each of the governance and administrative entities will be equipped with appropriate technology to implement seamless communication, exchange of information and data analysis for effective decision making.

A web-based database in which all data and transaction entries are consolidated will form the back-bone of the BHCPF system. This database will be linked to others via APIs and data entry forms. Cloud based, mobile and open source technologies will be utilized to ensure sustainability and interoperability with other applications.

5.2 Use of technology for BHCPF fund management

All BHCPF transactions will be enabled via the Remita platform to ensure transparency and accountability. Cash transactions will not be tolerated or encouraged. This includes transactions between:

i. The Secretariat of the NSC and NHIS, NPHCDA and the DHS
ii. NHIS and SSHIA
iii. NPHCDA and SPHCDA
iv. SSHIA and healthcare providers
v. SPHCDA and PHCs
vi. DHS and designated EMT service providers

Transactions between the PHCs/SHCs and their vendors will also be required to be via the banking system for transactions outside their monthly imprest.

5.3 Use of technology for BHCPF operations

At commencement, priority shall be given to ensuring that the SSHIAs have the capability to:

i. Create a database of registered enrollees and
ii. Collate and process claims electronically

The PHCs and SHCs shall have in the shortest possible period, automate the process of:

i. Enrolment
ii. Medical record keeping
iii. Referral management
iv. Claims submission

This shall take into consideration infrastructure constraints such as power and inadequate user capabilities prevalent in the rural areas. Also, opportunities to leverage existing systems such as health data management systems, GIFMIS will be explored to minimize cost from starting a new system.

5.4 Use of technology for BHCPF monitoring and evaluation

Automation of the BHCPF operations and data reporting will allow for seamless monitoring and evaluation of the BHCPF processes in real time and on an adhoc basis.

6 PENALTIES FOR NON-COMPLIANCE

Monitoring and evaluation/verification reports will trigger penalties due to non-compliance with processes or performance standards. These penalties are highlighted below:

6.1 Penalties

Where established via a verification report, penalties shall be applied for the following infractions:

6.1.1 Non-payments to health facilities by SPHCDA for NPHCDA gateway

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

6.1.1.2 This may be intentional, due to unforeseen limitations at State level, poor records at State or facility level or administrative errors.

6.1.1.3 Penalties applied will be dependent on the proportion of facilities that did not receive funds from the SPHCDA as per the verification report.

6.1.1.4 Subsequent infraction or non-payment to over twenty-five percent (25%) of facilities will lead to suspension of the State's SPHCDA. The NSC may choose to implement direct payments to health facilities in the affected state through the NPHCDA.

6.1.1.5 A ten percent (10%) margin of error is allowed to account for administrative errors and other events beyond the control of the SPHCDA.

6.1.2 Non-payments to providers by SSHIA for NHIS gateway

6.1.2.1 Verification team establishes that payments have not been made by SSHIA to providers in a timely manner. This includes part payments of funds due to facilities or payments only to a proportion of enlisted providers.

6.1.2.2 This may be intentional, due to unforeseen limitations of SSHIA payment systems, absence of records, poorly kept records or administrative errors.

6.1.2.3 Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of SSHIA administrative fees in the first infraction.

6.1.2.4 Subsequent infraction or non-payment to over 25% of facilities will lead to suspension of State's SSHIA. The NSC may choose to implement direct payments to health facilities in the affected state through the NHIS.

6.1.2.5 A10%marginof error is allowed to account for administrative errors and other events beyond the control of the SSHIA.

6.1.3 Non-payments to providers by TPAs for EMT gateway

6.1.3.1 Verification team establishes that payments have not been made by TPA to providers in a timely manner. This includes part payments of funds due to facilities or payments only to a proportion of enlisted providers.

6.1.3.2 This may be intentional, due to unforeseen limitations of TPA payment systems, absence of records, poorly kept records or administrative errors.

6.1.3.3 Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of TPA administrative fees in the first infraction.

6.1.3.4 Subsequent infraction or non-payment to over 25% of facilities will lead to suspension of the DHS. A repeat infraction for greater than 25% will result in termination of the DHS from implementing the EMT gateway. The NSC may choose to implement direct payments to EMT providers.

6.1.3.5 A10%marginof error is allowed to account for administrative errors and other events beyond the control of the SPHCDA.

6.1.4 Services rendered by healthcare or emergency medical treatment providers unverifiable

6.1.4.1 Verification team establishes that not all services rendered as reported by providers are traceable. This may be due to poor patient registration records, change in patient contact details (phone number, address), intentional false reporting by provider in the form of 'ghost patients' or claiming more services than the patient assessed or verifier error.

6.1.4.2 Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of payment due to providers on the first infraction. Subsequent infractions will lead to withholding 50% of fees and thereafter suspension of the provider.

6.1.4.3 A discordance of greater than 15% will results in transfer of the OIC out the affected facility and SPHCDA/SSHIA network and withholding of commensurate amounts from payments due to the culpable provider in the first instance. In the second instance, the provider will be suspended from the scheme while in the third instance, the provider will lose their accreditation and be terminated from the BHCPF scheme. The State implementing agencies will be required to refund leakages or financial receipts arising from over-invoicing from their respective gateways.

6.1.4.4 A10%marginof error is allowed to account for administrative errors and other events beyond the control of the provider.

6.1.5 Sub-standard quality of care by healthcare or emergency medical treatment providers

6.1.5.1 Verification team establishes that not all services rendered are in line with the BHCPF treatment guidelines.

6.1.5.2 Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of payment due to providers on the first infraction. Subsequent infractions will lead to withholding 50% of fees and thereafter suspension of the provider.

6.1.5.3 Adiscordanceofgreaterthan25%willresultsinwithholding payments due to providers impart on the first office. On the second offence, providers will be suspended from the scheme and lose their accreditation on the third offence.

6.1.5.4 A10%marginof error is allowed to account for administrative errors and other events beyond the control of the provider.

6.2 Compliance and Sanction powers available to the NSC

The NSC, shall ensure full implementation and compliance with the BHCPF Operations Manual through:

i. Circulation of the BHCPF guidelines and Operations Manual to all stakeholders
ii. Training stakeholders (at initiation and routinely) on the BHCPF guidelines and Operations Manual
iii. Issuing written advisory notes and reminders on behalf of the NSC to non-complying States and implementing agencies.
iv. Suspending/Deferring payments to non-complying States until such requirements are met.

PENALTIES FOR INFRACTIONS ON ACTIVITIES RELATED TO DISBURSEMENT OF THE FUND			
	Administering Agent/Recipient	Degree of discordance	Penalties
1.NPHCDA GATEWAY	A. State Primary Healthcare Development Agencies	i. Verification reveals that between 10% - 25% of facilities did not receive funds due to them	1st Default: Withdrawal of 10 percent of state funds pro-rated for the degree of discordance 2nd Default: State is suspended for release of 2nd tranche of funds or 1st tranche of funds in the subsequent disbursement year
		ii. Verification reveals that greater than 25% of facilities did not receive funds due to them	1st Default: State is suspended for release of 2nd tranche of funds or 1st tranche in the subsequent disbursement year
2.NHIS GATEWAY	A. Third Party Administrators	i. Verification reveals that between 10% - 25% of facilities did not receive funds due to them	1st Default: Withdrawal of 10 percent of administrative funds due to SSHIA, pro-rated for the degree of discordance 2nd Default: SSHIA is suspended for release of administrative fees due for the next quarter
		ii. Verification reveals that greater than 25% of facilities did not receive funds due to them	1st Default: SSHIA is suspended for release of administrative fees due for the next quarter 2nd Default SSHIA contract is suspended

PENALTIES FOR INFRACTIONS ON ACTIVITIES RELATED TO DISBURSEMENT OF THE FUND			
	B. Providers: Quantum of Services Rendered	i. Verification reveals that between 10% - 25% of reported services rendered to beneficiaries could not be verified	1st Default: Withdrawal of 10 percent (10%) of payments due to provider in the next quarter, pro-rated for the degree of discordance 2nd Default: 50% of fees due to the provider are withdrawn in the next quarter 3rd Default Provider is suspended and ineligible to receive payments for the next quarter
		ii. Verification reveals that greater than 25% of reported services rendered to beneficiaries could not be verified	1st Default: 50% of fees due to the provider are withdrawn in the next quarter 2nd Default Provider is suspended and ineligible to receive payments for the next quarter 3rd Default Provider accreditation withdrawn
	C. Providers: Quality of Services Rendered	i. Quality assessment reveals a quality score of less than 50% for less than 25% of the sampled facilities	1st Default Warning letter to provider 2nd Default Suspension of provider 3rd Default Withdrawal of accreditation of providers
		ii. Quality assessment reveals a quality score of less than 50% at greater than 25% of the provider facility	1st Default Warning letter to providers 2nd Default Suspension providers 3rd Default Withdrawal of accreditation of providers and termination of TPA

PENALTIES FOR INFRACTIONS ON ACTIVITIES RELATED TO DISBURSEMENT OF THE FUND			
3.EMT GATEWAY	A. Third Party Administrators	i. Verification reveals that between 10% - 25% of facilities did not receive funds due to them	1st Default: Withdrawal of 10 percent of administrative funds due to TPA, pro-rated for the degree of discordance 2nd Default: TPA is suspended for release of administrative fees due for the next quarter
		ii. Verification reveals that greater than 25% of facilities did not receive funds due to them	1st Default: TPA is suspended for release of administrative fees due for the next quarter 2nd Default TPA contract terminated
	B. Providers: Quantum of Services Rendered	i. Verification reveals that between 10% - 25% of reported services rendered to beneficiaries could not be verified	1st Default: Withdrawal of 10 percent of payments due to provider in the next quarter, pro-rated for the degree of discordance 2nd Default: 50%offeesduetotheprovider are withdrawn in the next quarter 3rd Default Provider is suspended and ineligible to receive payments for the next quarter
		ii. Verification reveals that greater than 25% of reported services rendered could not be verified	1st Default: 50%offeesduetotheprovider are withdrawn in the next quarter 2nd Default Provider is suspended and ineligible to receive payments for the next quarter 3rd Default Provider accreditation withdrawn
	C. Providers: Quality of Services Rendered	i. Quality assessment reveals a quality score of less than 50% for less than 25% of the sampled facilities	1st Default Warning letter to provider 2nd Default Suspension of provider 3rd Default Withdrawal of accreditation of provider

PENALTIES FOR INFRACTIONS ON ACTIVITIES RELATED TO DISBURSEMENT OF THE FUND			
		ii. Quality assessment reveals a quality score of less than 50% at greater than 25% of the provider facility	1st Default Warning letter to providers 2nd Default Suspension providers 3rd Default Withdrawal of accreditation of providers

Table 12: Penalties for Infractions on Activities Related to Disbursement of the Fund

7 APPENDICES

7.1 Appendix 1 – BHCPF Global Programme Agreement (Draft)

7.2 Appendix 2 – Subsidiary Agreement – NHIS AND SSHIA

7.3 Appendix 3 – Subsidiary Agreement – NPHCDA AND SPHCDA

7.4 Appendix 4 – PHC Accreditation criteria checklist and form (Draft)

General

Item	Value
• Population in the catchment area	
• How often does the facility open (hours per day & days per week)	
• Data based or self-reported utilization rates for following services (underline "Data-based" or "Self-reported")	
o Antenatal Visits	
o Normal Delivery	
o Post-natal Visits	

I. Human Resources

Item	Value
• Number of nurses/midwives	
• Number of CHEWS & JCHEWS	
• Number of other staffs	
• Any temporary workers? (mode of employment and pay)	
• Accommodation for a resident staff	

II. Equipment/Amenities and Infrastructure

Item	Yes/No
• Thermometer	
• Weighing scale	
• Paediatric weighing scale	
• Suction machine or Manual Suction Set (disposable)	
• Artery forceps	
• Episiotomy scissors	
• Bed pan	
• Foetal stethoscope	
• Forceps jar	
• Length measure	
• Stainless galipot	

• Scalpel blade	
• Stethoscope	
• Drip stand	
• Delivery couch	
• Plastic bowl with cover	
• Mackintosh sheet	
• Nail scrubbing brush	
• Gloves disposable pack	
• Tongue depressor	
• Cord clamps	
• Tape measure	
• Vaginal speculum	
• Plastic waterproof apron	
• Disposable gloves	
• 5ml syringes	
• Protective goggle	
• Waterproof of hair covering / cap	
• Protective Foot Covering	
• Placenta Dish / Receiver	
• Catheter – Self Retaining	
• Mucus Extractor	
• Sphygmomanometer	
• Flash Light (Rechargeable)	
• Episiotomy Scissors	
• Korckers Forceps	
• Cord Scissors	
• Sharps Scissors	
• Sterile Cord Clamp	
• Needle Holder	
• Dissecting Forceps	
• Bracelets	

• Sponge Holding Forceps	
• Baby Ambu Mask / Face Mask	
• Rectangular Bowl for Instruments	
• Partograph	
• Angle Poise Lamp	
• Table	
• Benches	
• Beds for admission and observation	
• Stool specimen bottles	
• Urine specimen bottles	
• Urine dipstick	
• RDT (kit and/or evidence of knowledge of its use)	
• Suture needles	
• Weighing scale (adult)	
• Stitch removal/suture	
• Direct drive solar refrigerator	

III. Availability of Services and Drugs/ supply chain/vaccine availability and storage

Item	Yes/No/Value
• Where are commodities obtained from (DRF vs open market)	
• If open market, seek clarity on process informing procurement and mark up on prices	
• Assess the drug store for labelling, stock availability	
• Malaria Prevention (Sulphadoxine and Pyrimethamine)	
• Capacities for prevention of mother-to-child transmission of HIV/AIDS	
• Insecticide Treated Nets(ITN)	
• Folic Acid	
• Iron	
• Urinalysis tests	
• Haemoglobin screening tests	
• Childhood Vaccines (storage facility and functionality)	
• Oral rehydration therapy(ORT)	
• Artemisinin-based combination therapies (ABCT)	
• Amoxicillin	
• Magnesium sulphate	
• Oxytocin OR Ergometrin OR Misoprostol	
• Supply chain guidelines in place	
• Contingency stocks available	
• Data based or self-reported stock-out rates (highlight which)	

IV. Financial Management Capacities (planning, budgeting and execution)

Item	Yes/No/Value
• Bank account	
• Capacity to generate and submit income and expenditure statements	
• Operational expenses (cash) by source and frequency	
• User fee charges displayed (confirm any exemptions)	
• Data based or self-reported proportion of operational costs vs. direct ones	
• Designated accountant and/or financial manager (underline which)	
• Are work plans prepared (confirm mode of preparation, those involved and frequency. Also ask to see workplan prepared	

V. Health Management Information Systems (HMIS)

Item	Yes/No
• Beneficiary Registration Forms (capturing patient biometric data, including contact information)	
• Patient record forms (patient height, weight, temperature, blood pressure and etc.)	
• Patient referral forms	
• Standardized statistical and/or budgetary codes	
• Standardized HMIS systems (paper based, computer-based or electronic – underline which)	
• Designated administrative/data management staff	
• Experience with generating and submitting claims	

VI. Governance Structures

Item	Short Description
• Role of Office in Charge	
• Role of Ward Development Committee (if any)	

• Role of Community	
• Role of Civil society (if any)	

XI. Additional Comments

7.5 Appendix 5 – SPHCDA And PHC Agreement (Draft)

(SPHCDA AND PRIMARY HEALTH CARE FACILITY REGARDING THE BASIC HEALTHCARE PROVISION FUND)

DISCUSSION DRAFT

1. **Nature of the Contract:** This contract governs the relationship between the State Primary Health Care Development Agency (SPHCDA) of_____State and_____primary health centre (the facility) in regard to the Basic Health Care Provision Fund (BHCPF). This contract may only be amended with the agreement of The Secretariat of the NSC and the NPHCDA. The facility agrees to abide by the conditions of this contract. Should the facility, its staff, the Ward Development Committee (WDC), or community members have compliments or complaints, they will be able to register them online at [URL for grievance redress website] or by text on [phone number for grievance redress organization]. These compliments or complaints will be handled by an independent organization not associated with the NPHCDA, SPHCDA, NHIS, SHIS, TPA, or the FMOH. It is expected that they will receive a response within_____(two) weeks.

2. **Objectives of the BHCPF:** The intention of the FMOH and the SPHCDA is to use the BHCPF to increase the quantity of services provided in this facility as well as the quality of care. The BHCPF is predicated on an explicit focus on the poor because they often lack access to services and suffer the poorest health outcomes.

3. **Posting of Results:** The facility will maintain and keep up to date a series of graphs in full public view related to its performance on the following indicators: (i) ANC1 and ANC4; (ii) antenatal care patients receiving HIV counselling and testing; (iii) skilled birth attendance; (iv) postnatal care 1; (v) Penta3 and Measles child immunization coverage; (vi) number of new and continuing users of family planning; and (vii) outpatient visits by children under 5. The graphs will be in of a form as in Annex 1.

4. **Enlistment under the NHIS Gateway:** Public PHC facilities, which meet the accreditation criteria set out by the NHIS/SSHIA will be enlisted into the NHIS gateway to deliver BMPHS. They will be reimbursed under the BHCPF for the free care they provide set out below. The facility will maintain the accreditation criteria so long as it is receiving funds under the NHIS Gateway.

5. **Sanctions and Penalties:** Failure of the facility to abide by the conditions set out in this contract will result in a warning followed by suspension of the facility from the BHCPF. In addition, submission of false information or unwarranted claims (e.g. invoices containing wrong information) may also result in criminal prosecution under Nigerian criminal law.

6. **Records:** The facility will maintain proper records of all patient interactions in the appropriate registers. It will, to the extent possible, record the phone numbers of patients or their parents. Not less than 20% of patients will have working phone numbers associated with their record. Under the NHIS Gateway, the facility may NOT claim payment for services which are not properly recorded.

7. **Free Services:** The facility may also NOT claim payment under the NHIS Gateway regarding services for which they have received any payment (no matter how small, nor for any reason) from, or on behalf of, the patient.

8. **Access to the Facility and to Records:** The facility and all its staff shall cooperate fully with the staff of the SPHCDA and THE SECRETARIAT OF THE NSC (or their designees, including independent verification agents) and provide unhindered access to the facility and its records.

9. **Sign Board:** The facility will put up and maintain at least one sign in a prominent place that describes the benefits that patients can obtain for free. The sign will be at least 50 cm. wide by 70 cm. tall and will be in English and another appropriate language. A font size of at least 24 will be used for the lettering. The sign board will contain the following language:

"Welcome to_____Primary Health Centre! The Federal Government of Nigeria is supporting this facility through the Basic Health Care Provision Fund. This means that the services listed below are absolutely **FREE** in this facility. You should **NOT** pay any money to anyone in this facility for these services or for any drugs, supplies, diagnostic tests, or any other charges associated with these services.

Should you, or anyone you know, have compliments or complaints about this facility, you can register them online at [URL for grievance redress website] or by text on [phone number for grievance redress organization]. These compliments or complaints are handled by an independent organization not associated with the Federal, State or Local Governments. It is expected that you will hear back within a maximum of

_____(two) weeks to any complaint or compliment. You may also discuss any issues with your Ward Development Committee or the Officer-in-Charge (OIC) of this facility.

The services provided **FREE** of charge in this facility are:

(i) Antenatal care
(ii) Skilled birth attendance
(iii) Postnatal care
(iv) Family planning services
(v) Immunization of children and mothers
(vi) Blood pressure and diabetes screening

Other services may be added at future dates. You are welcome."

10. **Staff Training and Responsibility of the OIC**: The OIC of the facility is responsible for training all the staff working in the facility on the content of this contract. The OIC is also ultimately responsible for the behaviour of his/her staff and will appropriately discipline those who do not comply with this contract. The OIC may enlist the help of the SPHCDA in ensuring staff compliance with this contract.

11. **Financial Management:** The facility will maintain proper financial records as per separate guidance provided by the BHCPF. The facility is required to produce and submit Income and Expenditure Statements for monies received from the BHCPF, to the SPHCDA at the end of each financial year.

12. **Bank Account:** The facility shall maintain a bank account in a commercial bank. The signatories of the account will include, at least, the OIC of the facility and the Chairman of the Ward Development Committee (WDC) or his/her designee.

13. **No Transfer of Funds to Government or Government Officials:** The facility will not transfer funds to any other part of the government (SPHCDA or hospital management board) not to any government official without express written consent from the Secretary of the THE SECRETARIAT OF THE NSC. Any effort by government officials to received funds intended for the facility should be reported (anonymously if so desired) to the grievance redress organization described above.

14. **Submission of Reports and Invoices:** Under the NHIS Gateway, the facility shall submit reports to the State Health Insurance Scheme (SHIS) within 30 days of the end of each calendar quarter. Failure to submit an invoice within the appropriate time will result in a penalty of up to 1% of the invoiced amount per calendar day that the invoice is late.

15. **Timeliness of Payments of Claims under NHIS Gateway and Receipt of Funds under the NPHCDA Gateway:** The SHIS will make payments to the facility within 30 calendar days of receipt of the invoice except in the case that it discovers anomalies or has not received satisfactory responses to formal (written) concerns that it sends to the Facility. Under the NPHCDA Gateway, the facility will receive electronic transfer of funds monthly.

16. **Use of Funds Received Under the NPHCDA Gateway**: The facility will use the funds it receives under the NPHCDA Gateway exclusively and directly for improving the quantity and quality of services in the facility, especially those provided for free under the NHIS Gateway. The facility management committee will enjoy autonomy in the use of the funds but is accountable for the use of the funds to improve the quantity and quality of services. Improper use of the BHCPF funds (including over-payment for goods or services) under the NPHCDA Gateway will be dealt with as described above under

penalties and sanctions.

17. **Positive List:** The facility is encouraged to use funds received under the NPHCDA Gateway to procure the following items or expenditures. However, this does NOT mean that the facility can only pay for items on this list or that it must use the funds for the items on this list:

(i) Retrieval of vaccines from the central cold stores
(ii) Outreach or mobile activities in the community
(iii) Family planning commodities
(iv) Drugs and commodities for reproductive health services
(v) Drugs and commodities for treatment of children under 5
(vi) Repairs and maintenance of the health facility
(vii) Proper disposal of medical waste

18. **Negative List:** The following is a list of specific items that the NPHCDA Gateway funds may NOT be used for. Just because something does not appear on this list does NOT mean that it is an acceptable use of BHCP Funds. The principles guiding the use of NPHCDA Gateway funds, described above, still apply:

(i) Payments in cash or kind to the government staff of the health facility
(ii) Payments to any officials of the WDC, LGA, state, or federal governments.
(iii) Air conditioning equipment.

19. **Drug and Commodities Procurement:** The facility shall use its NPHCDA Gateway resources to procure drugs, supplies, and equipment only from the list of wholesale pharmacies provided by the SPHCDA. All drugs must be generics and NAFDAC approved.

20. **Use of Funds Received Under the NHIS Gateway:** The facility will use funds received under the NHIS Gateway in the same way as for the NPHCDA Gateway with the exception that it may use up to ____ percent for payments, in cash or kind, to health staff.

21. **Keeping a Signed Copy of this Contract:** The OIC of the facility shall maintain a signed copy of this contract in the health facility at all times.

Signed this_____day of_____, 201 at _____

X _____

Representative of the SPHCDA

X _____

Officer-in Charge

7.6 Appendix 6 – Healthcare Provider Poster

The facility will put up and maintain at least one sign in a prominent place that describes the benefits that patients can obtain for free. The sign will be at least 50 cm. wide by 70 cm. tall and will be in English and another appropriate language. A font size of at least 24 will be used for the lettering. The sign board will contain the following language:

"Welcome to_____Primary Health Centre! The Federal Government of Nigeria is supporting this facility through the Basic Health Care Provision Fund. This means that the services listed below are absolutely **FREE** in this facility. You should **NOT** pay any money to anyone in this facility for these services or for any drugs, supplies, diagnostic tests, or any other charges associated with these services.

Should you, or anyone you know, have compliments or complaints about this facility, you can register them online at [URL for grievance redress website] or by text on [phone number for grievance redress organization]. These compliments or complaints are handled by an independent organization not associated with the Federal, State or Local Governments. It is expected that you will hear back within a maximum of

_____(two) weeks to any complaint or compliment. You may also discuss any issues with your Ward Development Committee or the Officer-in-Charge (OIC) of this facility.

The services provided **FREE** of charge in this facility are:

(i) Antenatal care
(ii) Skilled birth attendance
(iii) Postnatal care
(iv) Family planning services
(v) Immunization of children and mothers
(vi) Blood pressure and diabetes screening

Other services may be added at future dates. You are welcome."

7.7 Appendix 7 – Quantified Supervisory Checklist – (Draft)

Objective: provide an overview of health services delivery in primary health centres and health centres in Nigeria.

Frequency: Monthly supervisory visits are recommended in each primary health facility.

By: LGA, SPHCDA, and NPHCDA supervisory staff. (Self-assessment by health facility staff is encouraged so they can improve their score).

Calculations: A calculator or calculator function on a cell phone is helpful in calculating scores. If a register is not filled in or not available at the time of the supervisory visit then the score for that item would be 0.

Name of Supervisor:					
Affiliation:					
Name of Health Facility:					
Location of health facility:					
Type of health facility: PHC/HEALTH CENTRE/Other:					
Name of In-Charge:					
SUPERVISION VISIT	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Date of Supervision (day/month/year)					
Signature/initials of In-charge					
Signature/initials of Supervisor					
A. INFRASTRUCTURE	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
1. CLEANLINESS: Health Facility is clean (Score: 1 if no litter, no cobwebs, & floor is swept. Otherwise = 0)					
2. HAND WASHING: Health Facility has water to wash hands, soap and clean towel (Score: 1 if all three present. Otherwise = 0)					
3. HAND SANITIZER: Available on desk in consulting room (Yes=1/ No=0)					
4. MEDICAL WASTE MANAGEMENT: Score 1 if facility has waste disposal system (secured and covered pit or incinerator) that are in use. Otherwise =0					
5. SHARPS CONTAINER: all sharps in safety box which is readily available (Yes=1/ No=0)					
6. COMMUNICATIONS: Score 1 if facility has working mobile phone and the number is prominently displayed outside the facility Otherwise = 0					
7. LATRINE: Score 1 if facility has a clean, covered and working latrine. Otherwise = 0					

8. LIGHT: Score 1 if facility has a working source of light (if even just a working torch), Otherwise = 0					
9. WAITING AREA: Waiting room has benches or chairs for seating and is protected against sun and rain (Yes=1/ No=0)					
10. CONSULTATION ROOM: Confidentiality in the consultation room is assured (Score 1 If patient can be examined and counseled in a room with curtains or painted windows or room divider if room is shared, or doors that close; Otherwise 0)					
TOTAL INFRASTRUCTURE (out of possible 10)					
A. INFRASTRUCTURE PERCENTAGE SCORE (Total X 10)					

B. BASIC EQUIPMENT	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
11. Facility has a working examination table (Yes=1/No=0)					
12. Facility has a working thermometer (Yes=1/ No=0)					
13. Facility has a working stethoscope (Yes=1/ No=0)					
14. Facility has a working weight scale for children (or MUAC) (Yes=1/ No=0)					
15. Facility has a working Blood Pressure cuff (Yes=1/ No=0)					
16. Facility has latex gloves (Yes=1/ No=0)					
17. Facility has needles and syringes (Yes=1/No=0)					
18. Facility has a working vaccine carrier (Yes=1/No=0)					
19. Facility has a partogram (Yes=1/No=0)					
20. Facility has a sterile cord cutter (Yes=1/No=0)					
21. Facility has a fetoscope (Yes=1/No=0)					
22.Facility has a working delivery bed (Yes=1/No=0)					
23. Facility has rapid diagnostic tests (RDT) for malaria (Yes=1/No=0)					
24. Facility has rapid tests for HIV (Yes=1/No=0)					
TOTAL EQUIPMENT (Out of possible 14)					
B. EQUIPMENT PERCENTAGE SCORE (Total /14 x 100)					

C. HUMAN RESOURCES/HMIS/ MANAGEMENT	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
25. **PRESENCE OF STAFF:** Proportion of staff on roster present at the beginning of the visit (e.g. if 6 of 12 staff are present = 6/12 = 0.50)					
26. **PRESENCE OF FEMALE CLINICAL STAFF:** Score 1 point if at least one trained female staff is present who can carry out antenatal care and family planning counselling. Otherwise = 0					
27. **DHIS2 MONTHLY REPORTS:** Score **1** points if the counterfoil for the monthly report for the last completed month is available in the facility. Otherwise = 0					
28. **HEALTH FACILITY REGISTER:** Score 1 points if health facility register is present and up-to-date. Otherwise=0					
29. **CHILD HEALTH CARD:** Facility has child health card (Yes=1/					

No=0)					
30. **ANC Card:** Facility has mothers' antenatal card (Yes=1/ No=0)					
31. **DRUG PRICE LIST**: Legible price list for drugs clearly displayed for patients to see (Yes=1/ No=0)					
32. **UP TO DATE FINANCIAL RECORDS**: Cash receipts from drug sales are available, up to date & specify client's name, amount received and date (Yes to all= 1; No = 0)					
33. **BANK DEPOSIT SLIPS**: Deposit slips for most recently completed month available, up to date and are in concordance with billing records (Yes to all=1; No=0)					
34.**EXPENDITURE RECORDS**: Evidence for expenditures available specifying name of purchaser, amount spent and reason for expenditure (Yes to all=1; No=0)					
TOTAL HUMAN RESOURCES/HMIS/ MANAGEMENT (Out of possible 10)					
C. PERCENTAGE HUMAN RESOURCES/HMIS/ MANAGEMENT SCORE (Total x10)					

D. ESSENTIAL DRUGS (Check they are not Expired)	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
35. Facility has ACT1 in stock at time of visit (Yes=1/No=0)					
36. Facility has ACT4 (Yes=1/No=0)					
37. Facility has SP for IPT (Yes=1/No=0)					
38. Facility has amoxicillin suspension in stock (Yes=1/No=0)					
39. Facility has ORS in stock (Yes=1/No=0)					
40. Facility has paracetamol suspension (Yes=1/No=0)					
41. Facility has injectable ampicillin in stock (Yes=1/No=0)					
42. Facility has iron sulphate now (Yes=1/No=0)					
43. Facility has ampicilin tablets (Yes=1/No=0)					
44. Facility has folic acid tablets in stock (Yes=1/No=0)					
45. Facility has paracetemol tablets (Yes=1/No=0)					
46. Facility has magnesium sulphate in stock (Yes=1/No=0)					
47. Pharmacy is clean (Yes=1/No=0)					
48. Drugs are easy to find and on shelves (Yes=1/No=0)					
49. Pharmacy is accessible during visit (Yes=1/No=0)					
50. Bin cards: Choose 4 essential drugs at random and score 1 point each if there is a stock card available that is up to date. Maximum=4					
51. Pharmacy has inventory of drug stock from last completed month. (Yes=1/No=0)					
TOTAL ESSENTIAL DRUGS (Out of possible 20)					
D. ESSENTIAL DRUGS PERCENTAGE SCORE (Total x 5)					

E. Out Patient Service Provision	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of patients in last completed month in register X 12					
b. Catchment area population (Use EPI data)					
52. Outpatient service use: Calculate: (a/b)X100					
E. OUTPATIENT SERVICE PROVISION SCORE:					

F. Immunization Service Provision	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of children less than 1 year who received DPT1 in the last completed month in monthly report X 12					
b. Catchment area population X 0.04					
53. DPT1 coverage: Calculate: (a/b) X 100					
a. Number of children less than 1 year who received DPT3 in the last completed month in monthly report X 12					
b. Catchment area population X 0.04					
54. DPT3 coverage: Calculate: (a/b) X 100					
55. Cumulative EPI graph**:** Score 25 points if facility has cumulative EPI graph that is correctly filled in and up to date for the last completed month. Otherwise = 0.					
56.Register/ report agreement**:** Score 25 if the number of children below 12 months of age immunized with DPT1 exactly matches the number in the monthly report. Otherwise = 0.					
IMMUNIZATION TOTAL (Out of possible 250)					
F. IMMUNIZATION PERCENTAGE SCORE (Total / 25) X 10					

G. Prenatal and Postnatal Care Provision	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of mothers in facility register who received their **first prenatal** care visit during the last completed month X 12					
b. Catchment area population X 0.04					
57. Prenatal care coverage: Calculate: (a/b) X 100					
58. Quality of prenatal care**:** Choose 5 women at random from prenatal register who were registered in the last month and score 2 points each if the following are recorded: 1) age; 2) weight; 3) gestational age; 4) expected date of delivery. Maximum = 40 points					
a. Number of mothers in register with a **postnatal** visit within 6 weeks of delivery during the last completed month X 12					
b. Catchment area population X 0.04					
59.**Postnatal** care coverage: Calculate: (a/b) X 100					

60. REGISTER/REPORT AGREEMENT: Score 10 if the number of mothers registered for first prenatal visit exactly matches the number in the monthly report. Otherwise = 0.					
PRENATAL AND POSTNATAL TOTAL (Out of possible 250): **Calculate 57+58+59+60**					
G. PRENATAL AND POSTNATAL SCORE (Total /25 *10)					

H. Skilled Birth Attendance	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of mothers in register who gave birth at this facility during the last completed month X 12					
b. Catchment area population X 0.04					
61. Sub-total skilled birth attendance coverage: Calculate: (a/b) X 100					
H. SKILLED BIRTH PERCENTAGE SCORE					

I. Family Planning Service Provision	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of new and continuing users of modern family planning user during the last completed month in the FP register					
b. Catchment area population X 0.2					
62. CPR: calculate (a/b) X 100					
63.Quality of FP**:** Choose 2 women at random from family planning register from 3 months ago and score 10 points for each if they have had a follow- up visit since then. Maximum = 20 points					
64.Facility has condoms in stock (Yes=10/ No=0)					
65. Facility has oral contraceptives now (Yes=10/ No=0)					
66.Facility has injectable contraceptive now (Yes=10/ No=0)					
67.**REGISTER/REPORT AGREEMENT:** Score 10 points if the number of new and continuing users of family planning in the register for the last completed month exactly matches the number in the monthly report. Otherwise = 0.					
I. FAMILY PLANNING TOTAL PERCENTAGE SCORE: Calculate: (62+63+64+65+66+67)					

J. HIV Care	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
a. Number of pregnant women registered in the last month who were screened for HIV					
b. Total number of pregnant women registered for 1st prenatal visit					
68. PMTCT Screen Sub-total: Calculate: (a/b) X 100					

J. HIV PERCENTAGE SCORE: TOTAL = 68					

TOTAL SCORES:

WRITE DOWN THE SHADED TOTAL FOR EACH OF THE FOLLOWING

Service	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Date					
A. Infrastructure					
B. Basic Equipment					
C. Human Resources / HMIS					
D. Essential Drugs					
E. Outpatient Services					
F. Immunization Services					
G. Prenatal and Postnatal Care					
H. Skilled Birth Attendance					
I. Family Planning					
J. HIV					
TOTAL (Out of possible 1,000)					
TOTAL SCORE (Total/10)					

FACILITY #	SUPERVISORS COMMENTS/SUGGESTIONS
Visit 1	
Visit 2	
Visit 3	
Visit 4	
Visit 5	

7.8 Appendix 8 – Scheme Stakeholder Engagement Mechanism

The scheme stakeholder engagement mechanism shall include:

i. Complains management system
ii. Customer satisfaction surveys
iii. Town hall meetings

7.8.1 Objectives of the BHCPF Scheme Engagement Mechanism

i. Provide a structured and consistent approach to stakeholder engagement
ii. Promote customer satisfaction by enabling complaints or grievances to be rectified quickly and efficiently;
iii. Identify areas, practices, procedures and services for improvement;
iv. Prevent complaints from unnecessary escalation that may result to adverse publicity; and

7.8.2 Complaint Management

All BHCPF governance and administration agents at the Federal, State and Facility levels are required to be customer-focused and responsive to complaints and other feedback. BHCPF governance and administration agents at the Federal, State and Facility levels and beneficiaries have the right to complain and express dissatisfaction, either verbally or in writing, about a decision, action or service provided (or not provided) by BHCPF designated administration agents. To ensure good customer service, all scheme administration agents are expected to have effective Complaint Management System (CMS) in place to address' complaints from different stakeholder groups, with the overall commitment of ensuring stakeholder satisfaction and achievement of BHCPF goals and objectives.

7.8.2.1 Characteristics of the BHCPF CMS

The CMS implemented by BHCPF administration agents shall possess the following characteristics:

i. Provide a simple and clear process for complaints handling
ii. Fair and timely complaint outcomes and information to help improve service delivery
iii. Have well-trained human resource based on recognized standards, principles and best practices
iv. A good problem identification, tracking, resolution and reporting system
v. A robust service quality indicators and review process to continuously improve the effectiveness of the CMS.

7.8.2.2 Recommended Tools

Scheme administrators may explore one or more of the following tools for complaints handling and reporting.

i. Paper Registers
ii. Web Based Platform and Mobile Application
iii. Email messaging platform
iv. Toll-free call centre
v. Short – code SMS messaging application

7.8.2.3 Periodic Reviews of the CMS

The CMS set up by The NSC and Scheme administrators shall be subject to bi-annual and annual reviews. The Scheme administrators shall implement the bi-annual reviews as part of their internal review process and report to The NSC, while the annual reviews will be conducted by external assessors appointed by The NSC. The appointed assessors shall complete the assessment and submit a final report within 30 working days after the reporting period under review. The periodic reviews of the CMS should ascertain, but not limited to the followings:

i. Main types and sources of complaints
ii. Knowledge and understanding of the complaints management process

iii. The system put in place for recording, tracking, resolving and reporting complaints
iv. The authority and training staff have to manage and resolve complaints
v. Confirm if the data generated from the system are used to rectify systemic and recurring problems
vi. Ascertain management involvement in reviewing and monitoring the effectiveness of the CMS
vii. Ascertain the level of management and staff committed to effective complaints management
viii. Understanding the organization's complaints culture and whether complaints are viewed negatively or positively.

7.8.3 Customer Satisfaction Surveys

Customer satisfaction surveys can identify scheme performance gaps and promote development of effective action plans for continuous quality improvement of the BHCPF. It also provides an opportunity for benchmarking as it relates to adherence to service quality domains covering the scope of activities carried out by the Scheme administrators. To this end, The Secretariat of the NSC shall work closely with Scheme administrators, Research Organizations, Development Partners and other Stakeholders, to conduct customer satisfaction surveys of beneficiaries and healthcare providers. Feedback and Reporting of customer satisfaction surveys

The Federal and State administration agencies shall put in place systems:

i. To ensure that survey data are continuously shared (real-time or periodic update) with The Secretariat of the NSC for collation and reporting.;
ii. Publish performance scores (real-time or periodic update) on their websites;
iii. A feedback process to engage stakeholders based on the outcomes of the surveys and to agree timelines for addressing areas identified for improvement;
iv. Ensure that the Scheme administrators communicate progress based on the timelines agreed during the feedback process; and
v. If the NSC considers it necessary, it shall conduct unannounced supervision visits to confirm the progress made so far.

7.8.4 Town Hall Meetings (Enrollee Forums)

Scheme administrators at the Federal, State and Facility levels shall conduct periodic town hall meetings. The underlying objective of these meetings is to engage the key community structures (Traditional Organizations, Religious Groups, and Trade Associations) in each beneficiary LGA in the State to raise awareness, solicit feedback and address issues between the community and the BHCPF scheme administrators.

7.9 Appendix 9 – Potential Environmental and Social Impacts and Mitigation Measure

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
7.7.1. FLORA AND FAUNA	Rehabilitation works could possibly involve the removal of vegetation cover in a bid to create work areas. This loss of plant cover could lead to a loss of fauna habitats and exposure of the top soil. Depending on the topography of the area, the removal of the vegetation cover and the subsequent exposure of the top soil could start the process of erosion The removal of top soil could reduce the number of certain organisms. This will alter the food chain in that habitat and eventually create an imbalance in the immediate ecosystem depending on the scale of vegetation removed.	The Contractor should minimize the work site to the minimum possible size in an attempt to minimize the destruction on flora were found and thus prevent of ecological damages. Removal of vegetation should be reduced to the barest minimum
7.7.2. SOIL	Soil can be contaminated from the spilling of petrol being used by generator sets and vehicles. It can also get contaminated if there is improper waste management. When waste is stored for a long time, leachates may form and this could in turn percolate into the soil beneath thereby contaminating it. The topography of the sites plays a significant role in the process of erosion. When vegetation is removed and the top soil is exposed, the sun tends to dry up the moisture in the soil and water and wind acting under the force of gravity will push soils downhill. The steeper the slope the faster the rate of erosion in most cases	Civil works should be done during the dry seasons and NOT during heavy raining season During civil works, all earth removed should be stored for use during foundation laying so as to reduce the amount of loose soil laying around

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
7.7.3. AIR	Air pollution may arise from the indiscriminate open air burning of woods, plastics and other wastes generated during and from the rehabilitation works. Air pollution could also occur from using diesel powered generator sets and vehicles with poor or high emission rates. All these activities would negatively affect air quality.	Burning of wastes at site should be avoided to reduce air pollution. Waste should be evacuated at least once a week All waste should be directed to an approved dumpsite.
7.7.4. WATER	Accidental spillage of fuel, lubricants and other chemicals may run-off onto surface waters and eventually into streams. This can lead to surface water contamination and eutrophication in extreme cases. Also, infiltration of wastes such as unfinished chemicals and paints can find their way into surface water drainages causing contamination. And lastly, leachate produced at onsite dump sites could also flow into surface waters and contamination could occur	Proper containment of water being used for rehabilitation works Tanks and storage facilities should be placed on impermeable surfaces

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
	▪ Fuel, diesel and other lubricants leakages from storage tanks, light machinery and vehicles can infiltrate/percolate into the soil and find their way into the ground water causing groundwater contamination. The human effect of this is more pronounced if the source of water supply to the health facility is a borehole drilled in or around the site. Also wastes such as unfinished chemicals and paints can percolate into the ground causing groundwater contamination	
7.7.5. PUBLIC HEALTH HAZARDS	Waste generated on site if not managed properly could accumulate, produce foul smells, and attract insects and rodents which inevitably would have health implications on the general public. Also, the release of carbon into the atmosphere can cause illnesses such as asthma to those residing around the health facility. If water is left to gather in areas without being drained, it could turn into a breeding habitat for insects particularly mosquitoes and this could pose increase mosquitoes and subsequently malaria becomes a health hazard.	Stagnant water on the construction site should be avoided through proper maintenance of the site and through the removal of water from trenches especially after rainfall. Waste should be stored inside containers Select an exhaust system with lowest noise emission rates

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
7.7.6. PUBLIC SAFETY	▪ Easy access to site areas could pose hazards to the public. ▪ Construction items such as nails, broken wood can be harmful to the public ▪ Equipment such as blocks, paint buckets, roofing items could fall down injuring passers-by	Prohibition of access to the work site by any person having no work permits. Areas occupied by operational, mechanical and electrical machinery and equipment should be marked as 'restricted' Proposed site should be clearly marked and cordoned off any access by the public
OCCUPATIONAL HEALTH UPATIONAL SAFETY	▪ Handling and use of dangerous substances and wastes and inhaling fumes will expose the workers to occupational health risks. ▪ Construction works such as excavations, working with heavy equipment working in confined spaces, working under noisy conditions, working on and along the traffic roads, heavy lifting will expose the workers to occupational safety risks	Vertical & perimeter debris netting should be used Civil work should be avoided at night except where necessary. Workers should be equipped with appropriate Protective Personal Equipment (PPEs) There should be a first aid kit at all times on each site

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
COMMERCIAL ACTIVIES	The noise associated with construction equipment and possible blockages of roads would serve to deter commercial activities on a temporary basis. If the rehabilitation activities during the BHCPFP spread over a significant period of time. This without adequate planning, communication of activities and construction activities may cause traffic disruptions and congestion, resulting in temporary disturbance and interruption of commercial and social activities.	▪ PMU should ensure civil works progress on schedule by supervising contractors
7.7.9. SOCIAL ACTIVITIES	There could be increase in the demand for basic services due to temporary influx of workers. There is a potential for petty crime to increase in proposed sub project areas as influx of people increases Loud noise and vibrations will result from the use of equipment such as generators, vehicles, drilling machines (in the case of burrowing) etc. Such noise can easily exceed 90dBA.	Waste generated should be properly managed using approved dumpsites. A proper HCWMP should be in place and enforced

ENVIRONMENTAL PARAMETER	POTENTIAL IMPACTS	MITIGATION MEASURES
7.7.10. WASTE MANAGEMENT	Waste generated on site if not managed properly could accumulate and become unpleasant sights to the area. Waste dumped besides roads may intrude onto the roads causing vehicular hold ups and accidents. There is an expected increase in waste generated from both public and private health centres if not managed properly, could be harmful to the public and in extreme cases hazardous waste could lead to disease outbreak	Ensure proper handling, and disposal of wastes Waste must be stored temporarily in designated areas daily Waste should be evacuated weekly On site waste collection and storage points should be located in areas that can easily be accessed by waste collection trucks without hindrance to traffic on the main road. For HCW A well detailed HCWMP should be put in place and should be prepared in accordance with the National Healthcare Waste Management Policy National Healthcare Waste Management Guidelines (NHCWMG) National Healthcare Waste Management Plan (NHCWMP)

S/N	ENVIRONMENTAL PARAMETER	DESCRIPTIONS	MITIGATION MEASURES
1	**LOSS OF FLORA**	Rehabilitation works could possibly involve the removal of vegetation cover in a bid to create work areas. This loss of plant cover could lead to a loss of fauna habitats and exposure of the top soil. Depending on the topography of the area, the removal of the vegetation cover and the subsequent exposure of the top soil could start the process of erosion	▪ Ecological restoration through environmental engineering should be undertaken after any human intervention. This may include restoration of top soils and introduction of local plant species to restore the local ecology ▪ The Contractor should minimize the work site to the minimum possible size in an attempt to minimize the destruction on flora were found and thus prevent of ecological damages. ▪ Removal of vegetation should be reduced to the barest minimum
	LOSS OF FAUNA	The removal of top soil could reduce the number of certain organisms. This will alter the food chain in that habitat and eventually create an imbalance in the immediate ecosystem depending on the scale of vegetation removed.	
2	**SOIL CONTAMINATION**	Soil can be contaminated from the spilling of petrol being used by generator sets and vehicles. It can also get contaminated if there is improper waste management. When waste is stored for a long time, leachates may form and this could in turn percolate into the soil beneath thereby contaminating it.	▪ Civil works should be done during the dry seasons and NOT during heavy raining season ▪ During civil works, all earth removed should be stored for use during foundation laying so as to reduce the amount of loose soil laying around Soils excavated, lumped and gathered on-site should be covered by impermeable materials
	SOIL EROSION	The topography of the sites plays a significant role in the process of erosion. When vegetation is removed and the top soil is exposed, the sun tends to dry up the moisture in the soil and water and wind acting under the force of gravity will push soils downhill. The steeper the slope the faster the rate of erosion in most cases.	

S/N	ENVIRONMENTAL PARAMETER	DESCRIPTIONS	MITIGATION MEASURES
3	AIR POLLUTION AND QUALITY	Air pollution may arise from the indiscriminate open air burning of woods, plastics and other wastes generated during and from the rehabilitation works. Air pollution could also occur from using diesel powered generator sets and vehicles with poor or high emission rates. All these activities would negatively affect air quality.	▪ Burning of wastes at site should be avoided to reduce air pollution. ▪ Waste should be evacuated at least once a week ▪ All waste should be directed to an approved dumpsite.
4	SURFACE WATER CONTAMINATION	Accidental spillage of fuel, lubricants and other chemicals may run-off onto surface waters and eventually into streams. This can lead to surface water contamination and eutrophication in extreme cases. Also, infiltration of wastes such as unfinished chemicals and paints can find their way into surface water drainages causing contamination. And lastly, leachate produced at on site dump sites could also flow into surface waters and contamination could occur	Proper containment of water being used for rehabilitation works Tanks and storage facilities should be placed on impermeable surfaces
	GROUNDWATER CONTAMINATION	Fuel, diesel and other lubricants leakages from storage tanks, light machinery and vehicles can infiltrate/percolate into the soil and find their way into the ground water causing ground water contamination. The human effect of this is more pronounced if the source of water supply to the health facility is a borehole drilled in or around the site. Also wastes such as unfinished chemicals and paints can percolate into the ground causing groundwater contamination	

S/N	ENVIRONMENTAL PARAMETER	DESCRIPTIONS	MITIGATION MEASURES
5	**PUBLIC HEALTH HAZARDS**	▪ Waste generated on site if not managed properly could accumulate, produce foul smells, and attract insects and rodents which inevitably would have health implications on the general public. Also, the release of carbon into the atmosphere can cause illnesses such as asthma to those residing around the health facility.	▪Stagnant water on the construction site should be avoided through proper maintenance of the site and through the removal of water from trenches especially after rainfall. ▪Trenches dug out should be covered with impermeable materials ▪Waste generated on-sites should be evacuated at least once a week
		▪ If water is left to gather in areas without being drained, it could turn into a breeding habitat for insects particularly mosquitoes and this could pose increase mosquitoes and subsequently malaria becomes a health hazard.	▪Waste should be stored inside containers ▪Monitor the noise levels daily ▪Select an exhaust system with lowest noise emission rates ▪Ensure well maintained machinery to reduce emission levels
	PUBLIC SAFETY	▪ Easy access to site areas could pose hazards to the public. ▪ Construction items such as nails, broken wood can be harmful to the public ▪ Equipment such as blocks, paint buckets, roofing items could fall down injuring passers-by	▪Prohibition of access to the work site by any person having no work permits. ▪Areas occupied by operational, mechanical and electrical machinery and equipment should be marked as 'restricted' ▪Proposed site should be clearly marked and cordoned off any access by the public
6	**OCCUPATIONAL HEALTH**	▪ Handling and use of dangerous substances and wastes and inhaling fumes will expose the workers to occupational health risks.	▪ Vertical & perimeter debris netting should be used ▪ Civil work should be avoided at night except where necessary.

S/N	ENVIRONMENTAL PARAMETER	DESCRIPTIONS	MITIGATION MEASURES
	OCCUPATIONAL SAFETY	Construction works such as excavations, working with heavy equipment working in confined spaces, working under noisy conditions, working on and along the traffic roads, heavy lifting will expose the workers to occupational safety risks	▪ Workers should be equipped with appropriate Protective Personal Equipment (PPE) ▪ There should be a first aid kit at all times on each site ▪ Clear markings and signage should be used in all areas of the site
7	COMMERCIAL ACTIVIES	The noise associated with construction equipment and possible blockages of roads would serve to deter commercial activities on a temporary basis. If the rehabilitation activities during the BHCPFP spread over a significant period of time. This without adequate planning, communication of activities and construction activities may cause traffic disruptions and congestion, resulting in temporary disturbance and interruption of commercial and social activities.	▪ PMU should ensure civil works progress on schedule by supervising contractors
	SOCIAL ACTIVITIES	There could be increase in the demand for basic services due to temporary influx of workers. There is a potential for petty crime to increase in proposed sub project areas as influx of people increases Loud noise and vibrations will result from the use of equipment such as generators, vehicles, drilling machines (in the case of burrowing) etc. Such noise can easily exceed 90dBA.	▪ Well serviced equipment should be used at all times during construction ▪ There should be designated and approved areas for basic services such as canteens, restaurants and temporary car transport parks ▪ Temporary vigilante groups should be made operational

S/N	ENVIRONMENTAL PARAMETER	DESCRIPTIONS	MITIGATION MEASURES
8	**WASTE MANAGEMENT**	There is an expected increase in waste generated from both public and private health centres. If not managed properly, could be harmful to the public and in extreme cases hazardous waste could lead to disease outbreak Waste generated on site if not managed properly could accumulate and become unpleasant sights to the area. Waste dumped besides roads may intrude onto the roads causing vehicular hold ups and accidents.	▪ Ensure proper handling, and disposal of wastes ▪ Waste must be stored temporarily in designated areas daily ▪ Waste should be evacuated weekly ▪ On site waste collection and storage points should be located in areas that can easily be accessed by waste collection trucks without hindrance to traffic on the main road. For HCW ▪ A well detailed HCWMP should be put in place and should be prepared in accordance with the ○ National Healthcare Waste Management Policy ○ National Healthcare Waste Management Guidelines (NHCWMG) ○ National Healthcare Waste Management Plan (NHCWMP)