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IMPLEMENTATION COMPLETION AND RESULTS REPORT

TF-A7938

ON A

GRANT

IN THE AMOUNT OF US$20 MILLION

FROM THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

THROUGH THE

GLOBAL FINANCING FACILITY FOR WOMEN AND CHILDREN

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR THE

BASIC HEALTHCARE PROVISION FUND PROJECT (HUWE PROJECT; P163969)

May 20, 2022

Health, Nutrition & Population Global Practice
West and Central Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective {April 8, 2022})

Currency Unit =	Nigerian Naira (N)
N403.712 =	US$1

FISCAL YEAR
July 1 – June 30

Regional Vice President:	Ousmane Diagana
Country Director:	Shubham Chaudhuri
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ABBREVIATIONS AND ACRONYMS

ASA	Advisory Services and Analytics
BHCPF	Basic HealthCare Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
CAS	Country Assistance Strategy
CBN	Central Bank of Nigeria
CMU	Country Management Unit
COVID	Corona Virus
CRF	Consolidated Revenue Fund
DFF	Decentralized Facility Financing
DPT	Diphtheria, Pertussis, and Tetanus
EIM	Enhanced Independent Monitoring
EMT	Emergency Medical Treatment
FCDO	Foreign, Commonwealth, and Development Office
FCT	Federal Capital Territory
FFS	Fee-for-Service
FGoN	Federal Government of Nigeria
FM	Financial Management
FMOH	Federal Ministry of Health
FPFMD	Federal Project Financial Management Division
FY	Fiscal year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoN	Government of Nigeria
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
HFMC	Health Facility Management Committee
ICR	Implementation, Completion, and Results Report
ICT	Information and Communications Technology
IFC	International Finance Corporation
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
LGA	Local Government Area
LMIC	Low- and middle-income country
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Neonatal, and Child Health
MOC	Ministerial Oversight Committee
MPA	Multi-Phased Approach
NCH	National Council on Health
NDHS	National Demographic and Health Survey
NEC	National Economic Council
NERGP	National Economic Recovery and Growth Plan

NGO	Nongovernmental organization
NHAct	National Health Act
NHIS	National Social Health Insurance Scheme/Agency
NHSDP	National Health Strategic Development Plan
NPHCDA	National Primary HealthCare Development Agency
NPoPC	National Population Commission
NSC	National Steering Committee
NSHIP	Nigeria State Health Investment Project
NSR	National Social Register
OAGF	Office of Accountant General of the Federation
OAuGF	Office of the Auditor General of the Federation
OG	Operations Guidelines
OM	Operations' Manual
OOPE	Out-of-Pocket Expenditure
PAD	Project Appraisal Document
PCU	Project Coordinating Unit
PDO	Project Development Objective
PFM	Public Financial Management
PforR	Program for Results
PHC	Primary HealthCare/Facility
PHCUOR	Primary HealthCare Under One Roof
PHF	Primary Health Facility
PIU	Project Implementation Unit
PMU	Project Management Unit
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
RMNCAH+N	Reproductive, Maternal, Neonatal, Child, and Adolescent Health + Nutrition
SDG	Sustainable Development Goal
SHF	Secondary Health Facility
SMART	Standardized Monitoring and Assessment of Reliefs and Transitions
SMOH	State Ministry of Health
SOC	State Oversight Committee
SOE	Statement of Expenditure
SPHCDA	State Primary HealthCare Development Agency
SSC	State Steering Committee
SSHIA	State Social Health Insurance Agency
TSA	Treasury Single Account
UBEC	Universal Basic Education Commission
UHC	Universal Health Coverage
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	United States Dollar
WBG	World Bank Group
WDC	Ward Development Committee
WHO	World Health Organization

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DATA SHEET

BASIC INFORMATION

Product Information

Project ID	Project Name
P163969	BASIC HEALTHCARE PROVISION FUND PROJECT (HUWE PROJECT)
Country	**Financing Instrument**
Nigeria	Investment Project Financing
Original EA Category	**Revised EA Category**
Partial Assessment (B)	Partial Assessment (B)

Organizations

Borrower	Implementing Agency
Federal Ministry of Finance	Federal Ministry of Health

Project Development Objective (PDO)

Original PDO

The project development objective (PDO) is to establish the accreditation, verification and payment mechanisms for the operationalization of the Basic Health Care Provision Fund in the participating states.

FINANCING

	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Financing			
TF-A7938	20,000,000	20,000,000	11,500,000
Total	**20,000,000**	**20,000,000**	**11,500,000**
Non-World Bank Financing			
Total	**0**	**0**	**0**
Total Project Cost	**20,000,000**	**20,000,000**	**11,500,000**

KEY DATES

Approval	Effectiveness	MTR Review	Original Closing	Actual Closing
13-Aug-2018	17-Jan-2019		30-Jun-2021	30-Jun-2021

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Amount Disbursed (US$M)	Key Revisions

KEY RATINGS

Outcome	Bank Performance	M&E Quality
Satisfactory	Satisfactory	Substantial

RATINGS OF PROJECT PERFORMANCE IN ISRs

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	17-Dec-2018	Satisfactory	Satisfactory	0
02	12-Jun-2019	Satisfactory	Satisfactory	1.50
03	05-May-2020	Satisfactory	Moderately Satisfactory	11.50
04	02-Mar-2021	Unsatisfactory	Unsatisfactory	11.50
05	29-Jun-2021	Moderately Satisfactory	Moderately Satisfactory	11.50

SECTORS AND THEMES

Sectors

Major Sector/Sector	(%)
Health	**100**
Public Administration - Health	15
Health	85

Themes

Major Theme/ Theme (Level 2)/ Theme (Level 3)	(%)
Human Development and Gender	**100**
Health Systems and Policies	100
Health System Strengthening	55
Health Service Delivery	85
Health Finance	100
Child Health	44

ADM STAFF

Role	At Approval	At ICR
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I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Context

1. **At the time of appraisal, Nigeria had just emerged from its deepest recession in 25 years, and there was a recognition of the need to diversify the economy.** With a dependency on oil, Nigeria was accustomed to a repeated oil-price driven boom-bust cycle.[1] In the period leading up to appraisal (2010 to 2017), Nigeria's general government revenue averaged 10.6 percent of GDP, among the lowest in the world.[2] Even with improvements to the macro-fiscal space over the medium term, substantial financing was directed to debt servicing and other priorities, including the conflict in the north. Forty percent of Nigeria's population was poor in 2018,[3] with higher poverty rates in rural (52.1 percent) than urban areas (18 percent). Poverty rates were higher for women given that only about 5.6 percent of women (compared to 18.3 percent of men) had completed post-secondary education.[4]

2. **Nigeria's future success relied on the Government's ability to transform non-renewable (often volatile) natural capital into productive wealth by investing more in human capital.** In this context, the Federal Government of Nigeria (FGoN) launched the National Economic Recovery and Growth Plan (NERGP) 2017–20 to set the country on a path of sustained, inclusive growth. In addition to plans to restore macroeconomic stability, diversify the economy, and improve the efficiency of public and private spending, the plan focused on "investing in our people" as one of three broad strategic objectives to achieve inclusive growth, noting the improved accessibility, affordability, and quality of health care in Nigeria as a FGoN priority.[5] Pressure for the Government to deliver on this agenda of investing in its people increased when the World Bank released the first Human Capital Index ranking in 2018, which ranked Nigeria 152 out of 157 countries. In response, the Nigerian National Economic Council (NEC) formed the Human Capital working group – chaired by the Vice President and with representation from government agencies at national and state level; private sector; nongovernmental organizations (NGOs); and development partners - with an agenda to drive implementation of health and education interventions.[1]

Sector and Institutional Context

3. **At the time of appraisal, health outcomes in Nigeria were among the poorest globally.** Marked inequality negatively affected the poorest citizens, women, and children. Infant and under-five mortality rates (70 and 120 per 1,000 live births, respectively[6]) had plateaued since 2013, and inequalities were high: the under-five mortality rate was twice as high in rural areas as urban areas and three times higher among the poorest quintile than the wealthiest quintile.[4] The total fertility rate was high and had remained largely the same over 25 years, leading to missed opportunities to benefit from a demographic transition. When combined with early marriage, this represented a notable risk factor for maternal mortality. Nigeria was also the single largest contributor—in absolute terms—to the annual number of maternal deaths worldwide. Furthermore, the nutritional status of

[1] World Bank. 2018. *Nigerian Biannual Economic Update, Investing in Human Capital for Nigeria's Future*. Washington, DC.
[2] IMF, World Economic Outlook 2018
[3] Federal Republic of Nigeria, National Bureau of Statistics (NBS). *2019 Poverty and Inequality in Nigeria*.
[4] Federal Republic of Nigeria, National Bureau of Statistics, 2018 Nigeria – Multiple Indicator Cluster Survey/National Immunization Coverage Survey 2016-17, Pg 55, Fifth Round (MICS) and NICs.
[5] Federal Republic of Nigeria, Ministry of Budget and National Planning. 2017. *Economic recovery and growth plan, 2017-2020*.
[6] FGoN. Second National Strategic Health Development Plan 2018-2022, Ensuring healthy lives and promoting the wellbeing of Nigerian populace at all ages.

Nigeria's children had worsened in the decade before project appraisal, and Nigeria had overtaken India with the largest number of unimmunized children in the world. Coverage among the poor was particularly low, with only 10 percent of the poorest children immunized (Penta3), compared to 28 percent in Chad and 52 percent in Niger.[4]

4. **A key factor contributing to Nigeria's poor health outcomes was low spending on health and inefficiency in the use of funds.** Nigeria had one of the lowest levels of government health spending per capita in the world, at just US$11 per capita. While approximately 72 percent of the country's disease burden could be prevented or treated at the PHC or community level, most health spending was allocated to secondary and tertiary care facilities, leaving PHC facilities dysfunctional or nonfunctional. As a result, out-of-pocket spending on health accounted for 76 percent of health spending in 2018, leading to impoverishment or causing individuals to forego necessary care. The country was also facing an impending transition from development assistance given its lower-middle income status.[7]

5. **The way the health system was organized did little to incentivize performance.** The health system mirrored the complex and fragmented institutional arrangements for public service delivery in Nigeria. According to the 1999 Constitution, Local Governments were tasked with the provision of primary health care (PHC) services. However, in practice, Federal, State and Local Governments all play roles in the financing and delivery of services.[8] Oversight was provided by State governments, while the Federal Ministry of Health (FMOH) and its parastatal organization, the National Primary Health Care Development Agency (NPHCDA), were responsible for policy making, planning, coordination, and regulation. At the subnational level, limited funding, and a desire to focus on immediate needs such as building roads took priority over long-term investments in PHC. Providers often received salary payments with a two-to-three-month delay and those payments did little to incentivize provider performance (health care worker absenteeism in Nigerian PHCs was 27% and the average number of patients seen per day was 2.6).[9] Only a third of publicly owned PHC facilities (PHCs) received any form of operational funding, leaving such PHCs with few basic amenities, equipment, and drugs. Three fourths of PHCs reported charging user fees for drugs, delivery services and antenatal care – all services that were intended to be 'free'.[9] The private sector, which accounted for 60% of PHC services, was poorly coordinated with the public sector.[10] Complementing this 'supply-side' model of care was the National Health Insurance Scheme (NHIS), which was set up in 2005 to expand health insurance in the country. However, it covered only 4.2 percent of the population (mainly civil servants), and remained voluntary, with no mechanism to cover the poor.[11],[7]

6. **The Federal Ministry of Health launched an ambitious plan that would transform the PHC system.** Fortunately, the National Health Act (NHAct) had been passed four years earlier but had not been implemented. Following a decade of planning and advocacy, the Act provided the legal framework for a Basic Minimum Package of Health Services (BMPHS) for all Nigerians and the organization and management of the health system. The Basic Health Care Provision Fund (BHCPF) was the financing mechanism for the NHAct and required the FGoN to channel at least one percent of its Consolidated Revenue Fund (CRF) to finance PHC at the subnational level to fund a basic package of the most cost-effective services. But the transformation would not be easy. Implementation of the BHCPF could have big risks, as it would change the status quo regarding the control of funds and accountability across multiple levels of the Nigerian governance and political system. The health

[7] Hafez, 2018. Nigeria Health Financing System Assessment. Discussion Paper, April 2018, World Bank Group.
[8] The term 'government' or 'GoN' is used in this document when referring to multiple levels of government given that the BHCPF is a shared responsibility; otherwise, the level of government is specified, e.g., federal, state, local
[9] Federal Ministry of Health Nigeria, 2016. National Health Facility Survey.
[10] World Bank. 2019. Nigeria Systematic Country Diagnostic. Washington, DC: World Bank.
[11] World Bank, 2018-19. World Development Indicators. Washington, DC: The World Bank

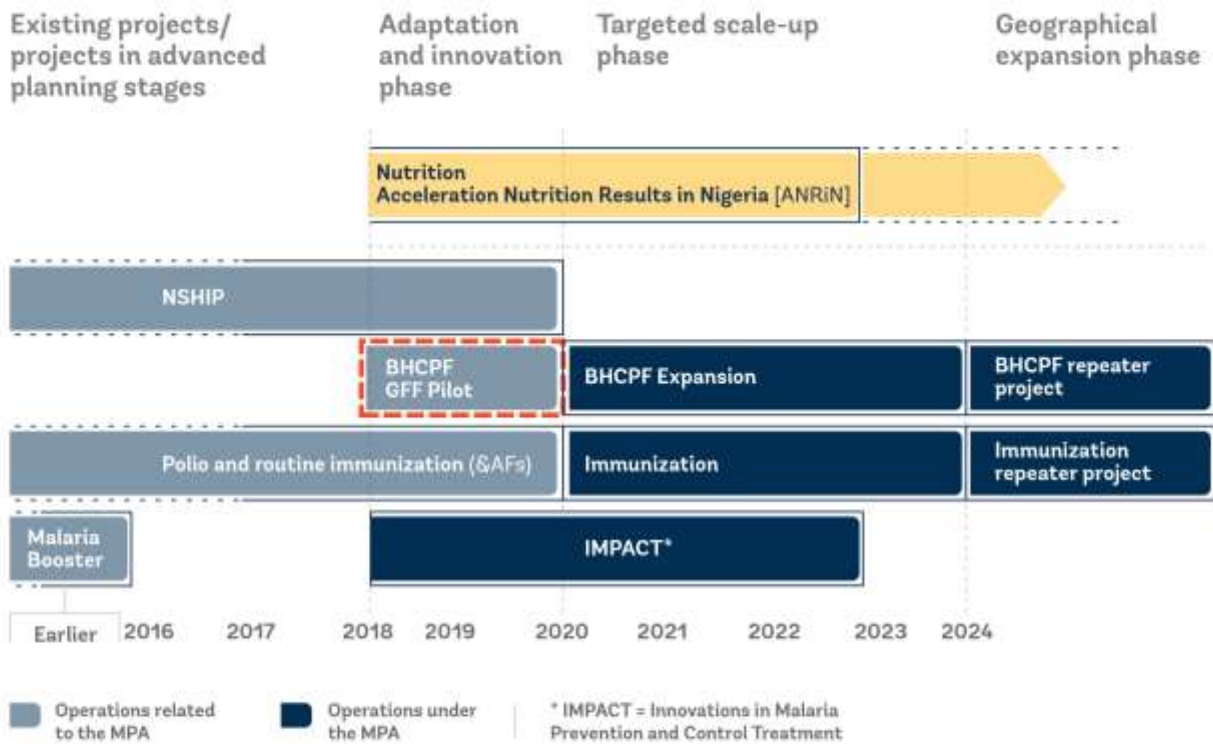
sector, known for its poor performance, would also need to build credibility with the Ministry of Finance by designing a fund that would increase transparency and accountability, and demonstrate that the health sector was capable of producing results.[12] The FGoN therefore launched a three-pronged plan to: a) develop an operational manual (OM) that spelled out how the BHCPF would be operationalized, with financial accountability and transparency at its core; b) gain international backing for a pilot project that would serve as a proof-of-concept and would develop the systems needed for nationwide roll-out; and c) use advocacy to build a coalition to support the implementation of the BHCPF among senior government leaders, civil society, the general public and donors. It was expected that the national implementation of the BHCPF would lead to a fundamental shift in the financing and delivery of PHC services in decentralized settings.

Rationale for World Bank Assistance and link to Country Partnership Framework

7. **The FGoN requested that the World Bank carry out a pilot project to catalyze the BHCPF reform, in the form of grant financing through the Global Financing Facility (GFF) for Every Woman and Every Child.** The Minister of Finance specifically noted that to set up the structures for an effective implementation of the BHCPF, a proof-of-concept would be needed to establish and operationalize the BHCPF model in three states: Abia, Niger and Osun.[13] The pilot project, funded by a relatively small grant ($US 20 million) was intended to catalyze a nationwide reform in the way primary health care is financed and delivered, as articulated in the National Health Strategic Development Plan (NHSDP II) (See Figure 1 and details in Annex 6-1). ***Phase 1*** would serve as the pilot from 2018–20 in the three states, focusing on Reproductive, Maternal, Neonatal, Child, and Adolescent Health + Nutrition (RMNCAH+N). ***Phase 2***, planned for 2019, would scale up the provision of the basic package (using the BPCHF financing arrangements) to Nigeria's remaining 33 states and FCT (Federal Capital Territory) based on lessons from Phase 1. ***Phase 3*** would expand the package of services beyond RMNCAH+N, with support from the World Bank-financed Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services Project (IMPACT), Phase I of the Improved Child Survival Program for Human Capital Multiphase Programmatic Approach (MPA) (P167156). Other World Bank-financed projects would continue to support the BHCPF in the future given that the reform was the FGoN's flagship reform that would require ongoing support. The BHCPF project, approved by the World Bank on August 13, 2018, was declared effective on January 17, 2019.

[12] Schreiber, Leon, 2019. Case Study: Making Good on a Promise: Boosting Primary Health Care Funding in Nigeria, 2015-2019. Princeton University
[13] FMOH. March 10th 2017, Memo to World Bank Nigeria Country Director: Request for the Use of the GFF Grant in Piloting the BHCPF.

Figure 1. The role of the BHCPF pilot project in broader WB support to the Government of Nigeria



8. **The FGON requested that the project fully align with its BHCPF Operational Manual (OM), which was still under development and would need to be finalized before the pilot began.** This alignment with the OM was important for ensuring that the systems built through the project would be used for national scale-up and that the project could establish the mechanisms needed for the roll-out of the reform, while also transitioning from donor to domestic financing. Furthermore, the Ministry of Finance was concerned that the BHCPF could suffer the same fate as the Universal Basic Education Commission (UBEC) fund[14] and thus wanted a proof of concept that would ensure the public funds invested in the BHCPF would lead to impactful primary health care services. The World Bank and other partners supported the design of the OM during the preparation of the BHCPF project, based on proven international practices. The OM, consistent with the NHAct, outlined a plan to transform PHC in three ways:

a) **More money:** The law requiring the FGON to channel at least 1 percent of its CRF to primary health care was expected to mobilize close to N60 billion (approximately US$150 million) annually, on top of what the health sector would receive through the regular budget process.[15] This funding would eventually be set up as a statutory transfer, channeling funds from federal to subnational level through an intergovernmental fiscal transfer. But before the Federal Government could operationalize this statutory payment, the pilot project would be funded with development financing (which is where this small grant from the GFF of US$ 20 million becomes relevant).
b) **Greater efficiency of financing ('smarter money'):** The funding would be used to 'buy' the delivery of a package of basic, high-impact, cost-effective services that would address more than 60 percent of the country's disease burden. The plan was to design a package that could be affordable for all Nigerians.

This package of services—the BMPHS—comprised 51 interventions addressing RMNCAH+N. It was also designed to employ proven, results-based, and decentralized approaches.

c) **Strengthening accountability and transparency:** The goal was to demonstrate that funds allocated to the health sector could be used to produce results, as this would be important for attracting additional resources for health. The design of the BHCPF would bring credibility to the health sector by improving transparency and accountability through a bold public financial reform that aligned with ongoing PFM reforms. The project would set up the system that would channel project funds (and eventually FGON funds) through the GoN's Treasury Single Accounts (TSA) at the Central Bank of Nigeria (CBN). However, using the CBN account posed risk for the GFF-financed project in the Nigerian context; the project would need to mitigate this risk by establishing strong fiduciary controls that were consistent with the controls used for other IDA financing and Trust Fund grants in Nigeria that maintained their own separate accounts and reporting mechanisms. The significance of these PFM reforms is discussed in the Efficacy Section.

9. **The design of the BHCPF OM, the pilot project and the nationwide reform that would follow was a '*strategic purchasing'* reform and is an important aspect of a country's move to universal health coverage.** Strategic purchasing is simply a shift towards making explicit decisions about *which services* to buy, *from whom* to buy, and *how to* buy in ways that will improve access, equity, efficiency, and quality of care.[16] This strategic purchasing reform was expected to transform the performance of the PHC system by: a) shifting away from paying for inputs (regardless of quality) to tying payment to specific criteria that was expected to enhance quality; b) leveling the playing field between private and public providers by contracting with both; c) establishing a system of accreditation to improve quality of care; d) designing a rigorous verification system that would ensure that providers were only paid when they met specific performance criteria (and that there were checks in place to ensure funds were used as reported); e) creating robust payment systems via electronic transfer to providers, reducing the chances of corruption; and f) covering the cost of services for the poor using public funds. This design addressed the main drivers of underperformance in the health system.

10. **The FGoN's BHCPF national program was designed to channel funds through three 'gateways' as enshrined in the National Health Act; two of these gateways were the focus of the pilot.** The gateways were designed in the OM such that 50% of funds would flow through the National Health Insurance Scheme (NHIS) gateway, to public and private providers; 45% through the National Primary Health Care Development Agency (NPHCDA) gateway, directly to public providers; and 5% through the Emergency Medical Treatment (EMT) gateway (See Annex 6-2). The pilot project focused on two gateways because of their ability to directly influence PHC service delivery. The project sought to establish the accreditation, verification, and payment mechanisms at national, state, and local levels, before testing them (operationalization).

11. **The project's key expected outcome aligned with the World Bank's past (FY14–FY17) and current (FY21–FY25) Country Partnership Frameworks (CPF).** The current CPF outlines the improvement of PHC as its third core objective, under the investing in Human Capital pillar. The project's plan to prioritize a package of cost-effective services, with a focus on services for women and children and a mechanism that targeted the poor, aligned with the equity and inclusion agenda of the World Bank's corporate goals of reducing poverty and increasing shared prosperity. The project also planned to accredit one facility in every ward (10,000-20,000 people) through the

[14] There were concerns about funding services at the subnational level through a statutory transfer because the UBEC fund had not had any remarkable impact and several states were also unable to access or utilize the funds for various reasons. Thus, learning from this was factored into the design.
[15] The regular budget process is the allocation to Ministries, Departments and Agencies. The 1% of CRF is taken 'off the top', before this process.
[16] World Bank. 2005. Spending wisely: buying health services for the poor. IBRD.

'Reach Every Ward' strategy so that citizens in urban and rural areas have improved access; specific actions would also be taken to prioritize rural areas. This was important given that more than half (56.3 percent) of rural Nigerians fall into the two poorest wealth quintiles, compared with only 8 percent of urban dwellers.[17] Additionally, 83 percent of women who do not receive skilled birth attendance live in rural areas. However, by targeting public facilities in all areas, the project was designed as pro-poor as public PHCs are the main source of care for the poor.

12. **The project design was based on extensive evidence and documentation of lessons, globally and from Nigeria.** The project benefitted from a strong health financing ASA (Nigeria Health Financing Program: P162108) that worked alongside the BHCPF project to produce analytical work and review good practices of countries that had moved to Universal Health Coverage (UHC). Through this project, the World Bank had also been supporting the FGON with the design of the OM, which was based on good practices, including from the Nigeria National State Health Investment Project (NSHIP) (P120798), which spanned six years and focused on improving decentralized financing and management of PHC in three states (Adamawa, Nasarawa, and Ondo). NSHIP demonstrated results in Nigeria and a World Bank Impact Evaluation later revealed that decentralized financing and performance-based financing improved PHC performance. NSHIP provided several lessons, including the importance of timely payments for improving health care worker performance, the need for independent verification of invoices from facilities, and the importance of building a system that relies on independent and robust performance assessments. Thus, the BHCPF project was classified as a follow-on project from NSHIP and built on many of those recommendations to further strengthen accountability; the support from the pilot was also designed to feed into the World Bank supported MPA, as shown in Figure 1, which would support the BHCPF expansion phase. The project also drew lessons from the UBEC program, which did not have an official evaluation but for which considerable anecdotal evidence was available regarding the factors leading to poor implementation at the state level.

Theory of Change (Results Chain)

13. **The diagram in Figure 2 outlines the Theory of Change (TOC) for the project.** It reflects the wording of the PDO in the Grant Agreement and PAD. This ICR uses it in place of Figure 4.1 of the PAD, as it aims to clarify the activities that were conducted as part of 'establishing' the BHCPF. It also shows how those activities were expected to lead to outputs (which are largely measured through the intermediate results), the operationalization of the BHCPF, and the project's influence on long-term outcomes. The TOC also corrects an error,[18] and clarifies technical terminology.

14. **The implementation of the BHCPF project (and the broader government program that would follow) was designed to transform the financing, governance, and service delivery of primary health care in Nigeria by establishing the systems that would allow for the following:** *(Note: these areas align with the intermediate results indicators):*
    a) **Provision of free services in private and public PHCs.** Patients would receive services for free at the point of care, thereby removing a demand-side obstacle to seeking services. The project aimed to have

[17] National Bureau of Statistics and UNICEF. 2017. *Multiple Indicator Cluster Survey, 2016-17. Survey Finding Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund.

[18] An incorrect PDO was included in the theory of change in the PAD. It read: "Strengthened Health System Management for the operationalization of BHCPF in selected states". However, the PDO in the rest of the document was consistent with the PDO in the GFF Grant Agreement. The team explained that the diagram was created prior to finalization of the PAD and inadvertently not updated. The correct PDO, which is consistent with the GFF Grant Agreement and other parts of the PAD, reads: "The objective of the project is to establish the accreditation, verification, and payment mechanisms for the operationalization of the Basic Health Care Provision Fund (BHCPF) in the Participating States."

at least one functional facility in every ward, with a focus on reaching the rural areas, where poverty rates are higher. Targeting the poor in those areas, with a focus on women and children, would improve health care access and protect the poor from large health-related expenses.

b) **Prioritization of essential services at the primary care level:** The project financed a package of high-impact, highly cost-effective RMNCAH+N interventions, and supported the NHIS and SSHIAs (State Social Health Insurance Agencies) to adapt the BMPHS to local needs, implementation, and financing realities, in line with the GFF Investment Case.

c) **Support of strategic purchasing arrangements to enhance PHC performance.** The project supported a shift from paying for inputs to strategic purchasing via two purchasing mechanisms (i.e., NPHCDA and NHIS gateways).[19] This reform was important given low productivity of health care providers in Nigeria. Box 1 gives more details on each of these gateways and their payments.

d) **Improved timeliness and credibility of funds paid to providers.** The payments made to public facilities through the NPHCDA gateway needed to be in line with the Operational Manual, whereas the payments made through the NHIS gateway needed to be verified *ex-poste.* At the same time, a mechanism needed to be designed to ensure funds arrived on time.

e) **Increased supervision**: Building on the experience of NSHIP, the increased supportive supervision was expected to lead to improvements in quality of service delivery.

f) **Empowerment of states and local communities.** The reform in the public facilities was designed to increase community representation in the planning and allocation of resources and to increase supervision in the use of funds, thereby strengthening accountability and ensuring communities have a say in the use of resources, are aware of their rights and can use grievance redress mechanisms to hold stakeholders accountable for provision of high-quality care for the services offered.

15. **By establishing the accreditation, verification, and payment mechanisms and then operationalizing them in the pilot states, the project was expected to contribute to the achievement of five main PDO indicators (and two sub-indicators). These indicators (see specific wording of indicators in results framework and Table 3) essentially measure progress against the following objectives:** increased availability and timeliness of financing to facilities (PDO 1, 2, 2a, 2b) improved credibility of financing (PDO 3); improved 'readiness' of facilities to provide PHC services (PDO 4); and increased number of vulnerable beneficiaries reached through subsidized health insurance (PDO 5).

16. **The pilot project would directly feed into the longer-term plan of implementing the BHCPF nationwide with the government's own domestic financing.** The project aimed to first establish the accreditation, verification, and payment mechanisms needed for BHCPF operationalization at the national, state, and local level, test that implementation in the pilot states. The systems developed under the project would then be used for nationwide roll-out. However, this expansion would only be possible through the provision of additional public financing, which was expected to come from the FGoN's 1% allocation of the CRF. The pilot would therefore need to demonstrate that funds allocated to the BHCPF would be well spent. The design of the pilot, and the reform that would follow, included a design of an allocation framework and financing mechanisms that would transfer resources from the federal level to the subnational level (into bank accounts at the facility level that were established for the first time), encourage subnational governments to prioritize PHC expenditure at the state and LGA level, incentivize strong performance, and promote equitable access to services. These elements would fundamentally change the way FGON resources would flow in the future in order to: (a) ***increase public financing for health; b) increase efficiency of health expenditures;*** (c) ***reduce out-of-pocket expenditure*** for essential health services (through provision of free services and a mechanism that would target the poorest

[19] The terms NPHCDA and NHIS gateways are used in the Grant Agreement.

individuals); (d) ***increase utilization of essential health services*** (by addressing demand-side barriers such as the cost of health services, as well as supply-side barriers such as quality of care); (e) ***improve quality of care at PHC facilities*** (through the incentives offered by the accreditation, verification and payment processes)**;** and (f) ***improve PHC management*,** by strengthening community participating, supervision and accountability. In the long term, the BHCPF would improve health outcomes, reduce under-five and maternal mortality rates, and increase financial protection.

Figure 2. Theory of Change for the Basic Health Care Provision Fund

PDO: To establish the accreditation, verification and payment mechanisms for operationalization of the BHCPF in participating states

Long term outcomes expected from nationwide implementation of Government's BHCPF program (which the project pilot-tested)

Activities → Outputs (and intermediate results) → Outcomes → Long-term outcomes

Activities

National level systems strengthening
- Establish BHCPF Secretariat and operational costs
- Conduct assessments of NHIS for readiness to deliver essential health services
- Open Program Accounts (TSA) and design guidelines for funds flow
- Design poverty-weighted allocation formula for transfers
- Design and implement guidelines for disbursement of funds to PHCs by state
- Establish annual national program audit

State-level and facility level activities (NPHCDA)
-Identification of one PHC/ward for baseline assessment
- Establish Health Facility Management Committee (HFMCs) in community
- Open facility-level bank accounts
- Upgrade selected health facility (infrastructure/health workforce)
- Capacity building/training for HFMC on management (book-keeping, prioritization of needs, health workforce motivation, improved quality, etc.)
- Design annual quality improvement plans (QIP) and quarterly business plans (QBP)
- Review and approval of annual QIP and QBP by the SPCHDA/NPHCDA respectively
- Procurement of essential medicines
- Quarterly Statement of Expenses and Audit of Facility level Accounts
- Provide integrated supportive supervision by the SPHCDA

State-level and facility level activities (NHIS)
- Health insurance documentation with the SSHIA (PHC location, account details)
- Contractual agreement signing with PHCs/ empanelment as health service providers
- Claims collation at the PHC level and submission to the SSHIA (2018 OM)
- Claims verification by SSHIA
- Identification of beneficiaries
- Enrollment of beneficiaries and assignment to PHC facility as the primary health service provider
- Beneficiary verification
- Quarterly verification of service delivery and client experience reports
- Purchase of PHC services through performance-based financing
- Design and implementation of a grievance redress mechanism

Outputs (and intermediate results)
- People receive free essential PHC/RMNCAH services in public and private facilities (IRI 1,2,3,4)
- Public and private facilities prioritize delivery of a package of high-impact PHC & RMNCAH services (IRI 1,2,3,4)
- Public facilities that meet a minimum set of requirements (accreditation) and report on use of funds receive quarterly operational funds
- Accredited facilities are also eligible to contract with health insurance agency (NHIS gateway) for provision of services to poor
- Performance-based payments made to the providers via NHIS gateway are verified to ensure credibility
- Facilities operating under the BHCPF receive payments on time (IRI 5a, 5b and 5c)
- Facilities receive regular supervision at facilities (IRI 6)
- Communities are represented in the management of public facilities (IRI 7)

Outcomes
- **Operationalization of the BHCPF**
- Increased availability and timeliness of operational financing in public PHC facilities (PDO1)
- Increased number of facilities receiving performance-based financing payments for health insurance provision in public and private sector (PDO2a and 2b)
- Improved credibility of performance-based financing for health insurance provision (PDO3)
- Improved 'readiness' of facilities to provide PHC services (PDO4)
- Increased number of beneficiaries reached with subsidized social health insurance (PDO5)

Long-term outcomes
- Increased public financing for health
- Increased efficiency of health expenditures
- Reduced out-of-pocket expenditures for essential health services
- Increased utilization of essential health services
- Improved quality of care in PHC facilities
- Improved management of PHC facilities

Higher-level outcomes
- Improved health outcomes
- Reduced under-five mortality rate
- Financial risk protection

Critical Assumptions:
1) Poor quality of care is a critical bottleneck for improving utilization; 2) Mitigating supply-side issues will improve utilization of health services; 3) Reducing cost of health services will improve utilization; 4) Poor management is a barrier to improving quality of care in public facilities; 5) There is a demand for health financing through FFS mechanism among public and private providers.

Box 1. Overview of the NPHCDA and NHIS gateways of the BHCPF and their payment mechanisms:
The definitions presented here from the Grant Agreement are important for later parts of the document, particularly the section on "Other Changes".

NPHCDA gateway: used a 'decentralized facility financing' (DFF) approach to deliver high impact maternal and child health services through the provision of block grants to eligible public sector public health care facilities. Communities and PHC facilities needed to meet accreditation and verification criteria before they could receive funds; accreditation criteria would also become more stringent over time and needed to be maintained. This funding was channeled through quarterly lump-sum payments, referred to as 'block grants'. This type of reform typically improves the supply-side 'readiness' of facilities- a proxy for quality.

NHIS gateway: This gateway used "Performance Grants" to reimburse providers in the NHIS to deliver high-impact RMNCAH+N services through accredited public and private providers using a performance-based provider payment arrangement. The claims filed by the facilities were then verified and beneficiaries were also verified to ensure their poverty status. The NHIS gateway planned to structure these performance-based grants to providers using a *"Fee-For-Service"* approach, but the Grant Agreement defined *"Performance Grant" (Annex, # 20) as "a grant provided or to be provided to an eligible Beneficiary who shall have met the selection criteria set out in the BHCPF Operational Manual".* This type of reform essentially expanded health insurance to vulnerable populations and is often described a 'demand-side' reform because funding follows the beneficiaries who are enrolled.

Note that the PAD uses the term "DFF mechanism" interchangeably with "NPHCDA gateway", and "Fee-For-Service mechanism" interchangeably with "NHIS gateway". The Grant Agreement mainly uses the terms Block Grants and Performance Grants to refer to the NPHCDA and NHIS gateways, respectively. This ICR therefore uses the terms interchangeably to ensure clarity and consistency with the wording of the results framework.

Project Development Objectives (PDOs)

17. **The PDO was to establish the accreditation, verification, and payment mechanisms for the operationalization of the BHCPF in the participating states.** The PDO was identical in the Grant Agreement and the PAD and remained the same over the life of the project.

18. **The ICR authors decided to not separate the PDO into various parts for the assessment because accreditation, verification, and payment work together to operationalize the BHCPF, as was the intention of the project from the outset.** In fact, in the Grant Agreement, the PDO is mentioned as a single objective, rather than multiple objectives. This is because only accredited and verified facilities receive payment, and verification is also done following payment. However, the discussion of the ICR ratings is organized as much as possible around the various steps in this chain.

Key Expected Outcomes and Outcome Indicators

The achievement of the expected outcomes is assessed using the indicators in Table 1.

Table 1. PDO Level Indicators and Intermediate Results Indicators

PDO Level Indicator	**Unit**
PDO Indicator 1: Number of public primary health centers receiving operational expenses via Decentralized Facility Financing (DFF) mechanism	#
PDO Indicator 2: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by public and private	#
PDO Indicator 2a: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, public	#
PDO Indicator 2b: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, private	#
PDO Indicator 3: Percentage of health facilities financed through the FFS mechanism whose claims are found to be valid (less than 10% discordant from their claims) as independently verified	%
PDO Indicator 4: Average health facility quality-of-care score	#
PDO Indicator 5: Number of beneficiaries receiving services financed through the FFS mechanism	#
Intermediate results indicators	**Unit**
IRI 1: Number of outpatient visits per year, children, and adults (sum of Abia, Niger, and Osun)	**#**
IRI 2: Percentage of children (12–23) months with Pentavalent 3 vaccination (average in three states of Abia, Niger, and Osun)	**%**
IRI 3: Percentage of births attended by skilled health personnel (average of Abia, Niger, and Osun)	**%**
IRI 4 (CRI): People who have received essential health, nutrition, and population (HNP) services	**#**
IRI 4a: People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	**#**
IRI 4b: Number of children immunized	**#**
IRI 4c: Number of deliveries attended by skilled health personnel	**#**
IRI 5: Number of project facilities receiving payments on time	**#**
IRI 5a: Number of public FFS facilities receiving payments on time	**#**
IRI 5b: Number of private FFS facilities receiving payments on time	**#**
IRI 5c: Number of public primary health centers receiving operational expenses through DFF mechanism on time	**#**
IRI 6: Percentage of health facilities enrolled in the DFF payment system that received supervision in the last quarter	**%**
IRI 7: Percentage of public health facilities in the project area with functioning management committees having community representation	**%**

Components

19. **The project financed two components.** Component 2 can be viewed as the support function and focused more on the 'establishment' of systems mentioned in the PDO, whereas Component 1 focused more on the 'operationalization' through the piloting of the NPHCDA and NHIS gateways. The FGON BHCPF OM formed the basis for project implementation and was a condition for effectiveness of the project. At the time of Grant Agreement signing and project implementation, the 2018 BHCPF OM had been endorsed by the Minister of Health and the Head of the Nigerian Health System and approved by the National Council on Health.

Component 1. Strengthening PHC Services through the BHCPF (Planned: US$17M; Advanced: US$10 M; Disbursed: $5.289M)

20. ***Subcomponent 1a: Strengthening service delivery through the Fee-For-Service approach (NHIS gateway: Planned: US$8.9 M; Advanced: $5.26M; Disbursed: $1.578M)***

21. **The NHIS gateway was designed to pay for health services using a performance-based payment to improve quality and staff productivity.** Public and private facilities were expected to meet accreditation criteria to become empaneled with the BHCPF and receive reimbursement for their services. This approach was designed to encourage competition between public and private facilities, provide beneficiaries with a choice of where they access care, and transfer monthly payments to accredited public and private PHC providers based on the number of service bundles provided.[20] These accredited providers were to be enrolled in the NHIS gateway through service contracts with State Social Health Insurance Agencies (SSHIA) and paid using the preapproved tariff for the program (See Box 1 for original payment mechanism design). Private sector providers were not restricted in the use of the funds received but were encouraged to use the funding for continuous quality improvement to retain accreditation, as outlined in the BHCPF OM; public PHC facilities were required to use the funds exactly as outlined in the BHCPF OM. Payment verification included rigorous ex-post verification of the facilities' use of funds to ensure they were used to strengthen PHC service delivery.

22. **The NHIS gateway enrolled BHCPF beneficiaries to ensure that public funds subsidized the poorest and most vulnerable Nigerians.** This is essentially an expansion of the insurance offered by the NHIS, which until now covered mainly government employees. Beneficiaries in the community would have a choice of which accredited private or public facility to use, and the money would therefore follow the patient. Beneficiaries would be selected, verified, and enrolled.

Subcomponent 1b: Strengthening service delivery through Decentralized Facility Financing (NPHCDA gateway: Planned: US$8.1 M; Advanced: $4.74M; Disbursed: $3.711M)

23. **The NPHCDA gateway was designed so that public PHCs that met the accreditation criteria would receive quarterly grants as a complement to their operating budget**, in line with an improvement plan that would be monitored closely. Each ward was required to nominate at least one public PHC (with a maximum of three) for a baseline assessment by the NPHCDA. A checklist was used to assess the availability and quality of infrastructure, equipment, services, drugs, and supply chain capabilities; financial management capabilities; health management information systems capabilities; governance structures; staff competencies; and general details of the facility i.e., catchment area population, opening hours, utilization

[20] Beneficiaries in the community were expected to have a choice of which accredited private or public facility they wanted to use. This feature was less important for the pilot project, where just one PHC facility was selected per ward.

of services, etc. The baseline assessment was used to select a focal PHC facility for the ward. Once identified, accredited facilities could receive quarterly payments through the NPHCDA gateway, implemented as DFF. This process could also be a step toward accreditation through the NHIS gateway described above because PHCs could use the funds to make upgrades needed for accreditation on the NHIS gateway, which was planned to be more stringent.

24. **The NPHCDA gateway also targeted the poor using a geographic approach**. Public PHCs were the first point of care for the poor, and the scheme aimed to prioritize at least one PHC per ward in urban and rural areas. Although the OM states that "all Nigerians shall be eligible for the BMPHS", in the initial five years of implementation, priority would be given to the rural poor because of the way the allocation formula was set up (see Assessment of Efficacy). On both gateways, beneficiaries would be given a card that entitled them to access free care for key RMNCAH+N conditions at accredited facilities.

Component 2. Health systems management strengthening to support BHCPF implementation (Planned: US$3M; Advanced: $1.5M; Disbursed: US$882,137)

25. **This component aimed to build and strengthen the institutions and systems required for the implementation of the BHCPF.** These included support at the national level (subcomponent 2a) and state level (subcomponent 2b).

***Subcomponent 2a: Strengthening the BHCPF national institutions and systems (Planned: US$1.5M; Disbursed:* US$254,761)**

26. **The BHCPF Secretariat supported the activities of the National Steering Committee (NSC) by serving as the Project Coordinating Unit and overseeing all BHCPF operations.** As described in the OM, the NSC Secretariat (referred to as the 'BHCPF Secretariat') was set up to carry out daily responsibilities, including monitoring and coordinating the activities of the NPHCDA and NHIS gateways. The World Bank project would finance a) the operational cost of running the Secretariat, including office expenditures; b) hiring of consultants; c) technical assistance and capacity building to monitor and coordinate the activities of implementing entities on the project at the federal and state level; d) establishment of a transparent facility accreditation system to improve quality of care; e) development and piloting of a verifiable payment and information and communication technology (ICT) system for the BHCPF; f) design of a citizen grievance redress mechanism that would allow citizens to provide feedback of negative experiences; g) hiring of the external auditors for the project; and h) the staffing of the project implementing units (PIUs) that would be embedded within NPHCDA and NHIS. The Secretariat doubled as the main PIU for the project. Accountants were seconded from the Federal Project Financial Management Division (FPFMD) of the Office of the Accountant General of the Federation to monitor the project's fiduciary arrangements. This was a key development for ensuring fiduciary safeguards (See more in Efficacy Assessment).

Subcomponent 2b: Strengthening the performance of state-level implementing agencies (Planned:US$1.5M; Disbursed:* US$627,376M*)

27. **This subcomponent provided operational support and performance frameworks for the state-level agencies responsible for implementing the NHIS and NPHCDA gateway systems.** The project supported the operating cost needed for the SPHCDAs (State Primary HealthCare Development Agency) and SSHIAs to implement their functions under the BHCPF. These responsibilities included a) supervising and mentoring public and private health facilities to meet quality standards; b) making timely payments to providers

through both gateways; c) ensuring timely and accurate ex ante verification of quality and quantity of services by providers; and d) training and orientation of providers on the NPHCDA gateway.

28. **Across both gateways, state-level verification ensured that states and local government authorities had met all criteria in identifying one PHC per ward and had completed mandatory capacity building exercises**. These agencies then accredited public and private facilities to deliver services of acceptable quality, verify and process claims, and strengthen the supervision and mentoring of public facilities. The project provided a share of the operating costs for the SPHCDAs and SSHIAs to implement these functions under the BHCPF, with ad hoc staff support. These functions included: a) supervising and mentoring public and private health facilities to meet quality standards; b) ensuring timely and accurate ex-ante and ex-post verification of the quality and quantity of services by providers; and c) the training and orientation of providers on the NPHCDA and NHIS systems.

29. **Key features of the design of the BHCPF were worked out in more detail during implementation and are described under Section II: Assessment of Outcome.**

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION (IF APPLICABLE)

Revised PDO and Outcome Targets

30. The PDO and all aspects of the Results Framework remained the same throughout the life of the project.

Revised PDO Indicators

31. There were no changes to the PDO Indicators throughout the life of the project.

Revised Components

32. The project components remained the same throughout the life of the project. The project did not undergo any restructuring.

Other Changes

33. **Two important changes were made to the National BHCPF Program that affected project implementation:**

34. **A) Expansion of Phase 2 of the reform earlier than planned (domestic financing and launch of National roll-out):** The preparation of the OM and the World Bank financed pilot project led to considerable dialogue regarding the importance of the BHCPF, and the coalition that the FGON had formed began to gain momentum (See Factors during preparation, which describes the increase in political momentum to deliver on the BHCPF implementation). In November 2018—just three months after the project was approved (August 13, 2018)—the FGON amended the 2018 appropriations bill, committing to finance one percent of the CRF earlier than expected, originally through a Service Wide Vote (SWV) (a temporary contingency line item) rather than the Statutory Fund (which was guaranteed by law). The significance of these different mechanisms is described under the Efficacy Assessment. Politically, this was viewed as a major milestone for the GoN and a positive signal that the FGON had faith in the design of the BHCPF system that had been designed during the preparation of the project. However, it meant the government would then move to implementing Phase 2 (expanding geographic distribution of the BHCPF) before the pilots of Phase 1 were completed. A year had been spent preparing the national, state, and local levels, and now there was pressure to rapidly expand to other states given that the government funding had been committed. The project states essentially became ‘lead states’, as the ‘mechanics’ of accreditation, verification, and payment were taken up by other states; experiences and lessons were also shared through a series of workshops organized by

the BHCPF Secretariat with support from the World Bank project team. In July 2019, the FGoN transferred funds to an additional 13 states (beyond the three World Bank-supported states), but with much less technical support than was given to the three pilot states.

35. **B) Changes to the operational manual.** The 2018 BHCPF OM was the basis for project effectiveness and was in use for the first 13 months of the project. As with specific-purpose intergovernmental fiscal transfers as the BHCPF, a new political cycle (with new leadership at the FMOH and National Assembly) in Nigeria shifted the political economy surrounding the management of the fund and the FMOH called for a review of the OM in September 2019. This review brought to light sensitive issues around the control of funds and other political economy sensitivities that were prevalent during the design of the OM. Eleven months later, in August 2020, the new manual was ratified and approved by the National Council on Health. The most consequential aspects of the OM changes were a) dissolution of the BHCPF Secretariat; and b) a change to the fiduciary safeguards including weakened oversight and unclear arrangements in implementing mandatory financial audits for the BHCPF. Other changes to the manual were not structural and include changes to the NHIS gateway: a) the mode of payment of providers was adjusted to a per capita payment (but still remained a 'performance grant')[21]; and b) changes were made to the beneficiary selection methodology, which made it more difficult to reach the original target. A full description of the changes to the NHIS gateway are discussed in Annex 6-4. The changes to the beneficiary selection process are described under the discussion of the Efficacy rating.

36. **The changes to the operational manual affected the continued disbursements of World Bank funds under the project.** In view of the issues raised by the OM review and its revision, the FGON and the World Bank decided that it would be best to close the project at the due date rather than restructure the project with these weaker fiduciary arrangements. From this point on, uncommitted project funds in the federal level BHCPF account (i.e., 'upstream funds) remained unused, but the project continued to disburse 'downstream funds', i.e., those funds that had already been allocated to states. Because of the way the project was designed (with 85% of the resources allocated to Component 1, which focused on 'operationalization' of the fund through testing of the BHCPF at the facility level), the project disbursement rate was low because the extent of 'operationalization' was severely affected by the COVID-19 pandemic and the delays caused by the OM review process. This is the reason for the inconsistency between the amount that was disbursed to the CBN's Designated Account (which was recorded in the system at the time of the ICR (US11.5 million)) and the amount utilized by the project ($US 6.2 million), and there have been delays in the reimbursement. This is discussed further under Environmental, Social and Fiduciary Compliance.

37. **Following the decision to close the project on the original timeline, the World Bank team continued to provide support to the reform and worked to further strengthen the fiduciary arrangements in the new OM.** The BHCPF Secretariat was replaced with new staff that carried out the same functions, although was renamed the Ministerial Operations Committee (MOC) Secretariat, in line with the new Ministerial Operations Committee, which replaced the National Steering Committee. The BHCPF, as a flagship program for UHC in Nigeria, meant that the World Bank team was committed to continuing its engagement and policy dialogue on the program. Furthermore, the BHCPF represents the long-term Government and World Bank commitment for Nigeria's Universal Health Coverage aspirations. The engagement was productive as it led to the reconstitution of the BHCPF Secretariat (although renamed the Ministerial Operations Committee

[21] The plan was to provide PHC providers with a fee for bundles of services (known as fee-for-service in the PAD). The mechanism was modified such that primary care providers receive capitation payments (a fee per enrollee per year). The fee for bundles of services (fee-for-service) was retained for payments to secondary providers on the NHIS gateway. However, in the Grant Agreement the NHIS gateway is still referred to as "performance grants".

Secretariat). As the new Secretariat initially struggled with project implementation, especially regarding the verification, payment, and accounting functions, the World Bank provided technical support to allow the program to be restarted. The World Bank continued its technical and analytical support and closely worked with the Government, and the new Secretariat to ensure high fiduciary standards of the OM. The new Secretariat secured approval for the reinstatement of the fiduciary safeguards outlined in the original OM (including the reposting of staff from the Federal Project Financial Management Division (FPFMD) of the Office of the Accountant General of the Federation. The national program now operates under these arrangements, which is in line with the original design. Efforts to strengthen the fiduciary arrangements are discussed in the Efficacy Assessment and Lessons sections.

38. **Table 2 provides a timeline of key milestones in the project, including the various delays caused by the review of the OM.**

Table 2. BHCPF Implementation Milestones

DATES	BHCPF IMPLEMENTATION MILESTONES
August 2018	World Bank Board Approval of the GFF Funded BHCPF Grant
November 2018	Inclusion of government funding for the BHCPF in the amount of 1% of the Consolidated Revenue Fund in the 2019 Appropriation Bill (through Service Wide Votes category – a contingency line item)
January 2019	Project became effective
May 2019	BHCPF pilot launched in project states through NPHCDA gateway
July 2019	Disbursement of resources to additional 13 states as the first tranche national BHCPF scale-up disbursement
September 2019	Commencement of the revision of the 2018 BHCPF OM by the GoN and pausing of the 'upstream' disbursement on the grant (i.e., new allocations to states); downstream disbursements continued (i.e., funds that had already been sent to states could be sent to facilities)
January 2020	BHCPF begins operationalization through NHIS in public facilities of project states
March 2020	COVID-19 declared a pandemic (See Factors affecting implementation)
August 2020	Ratification and approval of the revised BHCPF OM at the National Council on Health
October 2020	Reconstitution of the financial agreement with aligned fiduciary safeguards and acceptance of reconstitution of the National BHCPF Secretariat
December 2020	Reposting of Accountants and Auditors from the FPFMD to the BHCPF National Secretariat and complete realignment of the GoN program with the Financial Agreement for the World Bank supported GFF BHCPF grant
January 2021	Continuation of implementation of the BHCPF in alignment with the financial agreement
June 2021	Closure of the World Bank supported component of the BHCPF

Rationale for Changes and Their Implication on the Original Theory of Change

39. **When the Operational Manual – a condition of project effectiveness - was modified, the FGoN and the World Bank agreed to not restructure.** With such low disbursement of project funds at this time, it may have seemed appropriate to restructure the project under other circumstances, but a decision was made by the FGoN and the World Bank to not do so given the structural issues related to the fiduciary changes and

the dissolution of the BHCPF Secretariat. While a revision of the results framework would have improved clarity, this was a minor detail in comparison to these larger structural issues. These decisions around the closure of the project were reflected in the Implementation Status and Results Reports (ISRs), aide-memoires, and discussions with the task team. This decision to close on the original timeline was also made easier given that the pilot had already achieved much of its 'proof of concept' in establishing and operationalizing the BHCPF in public facilities. Furthermore, the national scale-up (Phase 2), which occurred earlier than planned, was already underway and was a major focus of the FGON. The theory of change did not change, but the changes meant that some of the results indicators and their targets would be difficult to achieve, and some would require clarification. However, the project was still able to report progress against these indicators using the definition in the Grant Agreement.[22] This is discussed later in the Efficacy Assessment.

II. OUTCOME

A. RELEVANCE OF PDOs

Assessment of Relevance of PDOs and Rating

Rating: High

40. **The project objective was and remains highly relevant.** It corresponds directly with the FGoN's current development priorities in human capital development and the health sector. The BHCPF is also reflected in the FGoN's fiscal sustainability plan approved as the medium-term expenditure frameworks (MTEF) (2022-2024). The inclusion of the BHCPF as a statutory transfer in the MTEF is both a fiscal commitment as well as an accountability device to secure payment for primary health care.

41. **The project was relevant to the World Bank Country Partnership Framework (2020) at closing.** The project objective is captured under the investing in human capital pillar where one of the stated core objectives is improving primary healthcare. The project contributed to the second main pillar of the FGoN Economic Recovery and Growth Plan, which aimed at investing in people through human capital development. The BHCPF is also the key vehicle for PHC revitalization featured prominently in the successor to the ERGP – the Nigeria National Development Plan (2021-2025)[23], which was approved by the Federal Executive Council in December 2021. The relevance of the project is further noted in the NHSDP II, which called for the BHCPF as the platform for achieving Nigeria's Universal Health Coverage aspirations.

42. **The project was also relevant in that it brought forward lessons from many years of engagement into the design of a government reform.** For example, the project's design capitalized on lessons documented in the *2016 Performance and Learning Review*, which noted the importance of strengthening the role of social protection programs in distributing resources, improving PHC—particularly maternal and child health—in the health sector, and reducing the vast inequities surrounding access and quality of services in the sector. The FGON's Operational Manual on which the pilots were based drew on lessons from NSHIP (as a follow-

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[22] PDO Indicators 2, 2a and 2b, 3 and 5 use the term "Fee-for-Service mechanism", while Intermediate Result indicators 5a and 5b use the term "Fee-for-Service facilities" in the wording of the indicator. Box 1 explained the interchangeable use of the terms "Fee-for-Service", "Performance Based grant", and "NHIS gateway". Despite the change in the way providers were paid, it was still a "performance based grant" used on the NHIS gateway and results are therefore reported on the original results framework.

[23] Federal Ministry of Finance, Budget and National Planning. National Development Plan (NDP) 2021-2025.

on project) and the IFC's regional Health in Africa Initiative, which focused on expanding health insurance across Africa while targeting private sector participation and strengthening public sector collaboration.

43. **The operational mechanisms established under the BHCPF project were important for demonstrating the credibility of the health sector to use public financing to achieve results in a decentralized context.** The *2016 Performance and Learning Review* had also cited the importance of improving state financial sustainability through the use of federal transfers channeled to the state level in a way that brought about accountability for results. These transfers were an important feature of the design of the BHCPF project, and the experiences of the UBEC program was taken into consideration, as mentioned earlier. The focus on stronger PFM systems was in line with the Systematic Country Diagnostic (SCD) which noted that realizing gains in the health sector would require stronger governance and PFM systems.[24]

B. ACHIEVEMENT OF PDOs (EFFICACY)

Assessment of Achievement of Each Objective/Outcome

Rating: Substantial

44. **There were twelve indicators used to measure the progress of the project.** The results framework includes five PDO indicators (with two sub-indicators on PDO-level Indicator 1), and 7 intermediate result indicators (including three sub-indicators for IRI 4 (the corporate results indicators) and 3 sub-indicators for IRI 5). Of the five PDO-level indicators, three were achieved, one was partially achieved and another one was not achieved. Of the seven IRIs, six were achieved and one was substantially achieved (see Table 3). While the PDO is rated as a single objective, the discussion of the Efficacy ratings is organized as much as possible around the various steps in the chain (accreditation, verification, and payment). Supplemental information, (including 18 key informant interviews with heads and staff members of state ministries of health and implementing agencies in the project states (Annex 6-10), and data on the implementation of the government program as of December 2021), is also brought into the assessment to describe how the national program is being operationalized. This information included: Government Integrated Financial Management System (GIFMIS) data on payments to states and facilities; utilization data from the Nigeria Health Management Information System (NHMIS), ISRs, aide memoires, two Lessons Learned workshops and key informant interviews. This supplemental information is important given the intention of the project to serve as a pilot that would inform nationwide scale-up.

45. **Before discussing the details of the indicators to monitor the project's progress, a big picture 'storyline' of the achievements attributable to the activities of the project is given in Box 2.**

[24] World Bank Group, 2019. Nigeria Systematic Country Diagnostic: Moving toward a Middle-Class Society: Nigeria on the Move: A Journey to Inclusive Growth

Box 2. What did the establishment and operationalization of the accreditation, verification and payment mechanisms achieve and why was this important for PHC in Nigeria?

1) **The project designed a financing system that changed the 'rules of the game' around PHC resource flows and accountability arrangements.** The project piloted a shift from a system that paid for inputs regardless of performance and degree of 'readiness' to one that held stakeholders at multiple levels accountable for the delivery of quality services. The project did this through two 'gateways' – the NPHCDA gateway increased supply-side readiness of facilities in exchange for regular and timely operational expenditures, and the NHIS gateway expanded health insurance to the poor with public financing; both gateways financed a prioritized cost-effective set of RMNCAH+N services. The project also brought more money to facilities for the operating budget, disbursed funds contingent on service delivery 'readiness' (accreditation) and appropriate documentation of the use of funds (verification), and targeted resources to the most vulnerable. The design encouraged community participation in planning and oversight of the funds. The objectives were fully achieved on the NPHCDA gateway and substantially achieved in public facilities on the NHIS gateway. However, the mechanics of the BHCPF were established but not operationalized for private facilities on the NHIS gateway (see discussion in Efficacy Assessment).

2) **The project aligned with PFM reforms to strengthen accountability and transparency.** The project was designed to increase credibility of the health sector by demonstrating that public funds could be used to achieve results. The reform was one of fiscal decentralization whereby federal funds flowed from the federal level through state budgets and directly into the bank accounts of facilities. This was an achievement because most PHC facilities in Nigeria had never had bank accounts or received operating funds; but this also required much effort to build capacity of staff, including through the development of explicit work plans that would guide the use of funds, reporting on the use of funds, and verifying that the funds were used as intended. The project was also the first World Bank financed project in Nigeria to channel funds through the Central Bank of Nigeria's (CBN) account (using what is referred to as the Treasury Single Accounts – an essential tool for consolidating and managing government's cash resources in that it allows 'traceability' of expenditures and minimizes the need for borrowing). Donor funds were comingled with domestic funds. The use of FGoN systems was an important step forward for building the 'plumbing' system through which the FGoN could mobilize more resources for the nationwide roll-out of the BHCPF program that would follow. The project funds, as well as the FGoN funds that were comingled in the same CBN account, were subject to the same fiduciary standards as a World Bank financed project. These strong fiduciary controls are in place today even in the absence of World Bank financing. This is discussed in more detail later under the Efficacy Assessment.

3) **The project leveraged domestic financing and catalyzed a mechanism to bring additional resources to PHC on an annual basis.** The project had an end-goal of sustainability in mind, given that the project was intended to serve as a 'proof-of-concept' that would inform a reform that would use the same system to roll out to other states but with domestic financing (in the amount equal to 1% of the Consolidated Revenue Fund (CRF), as defined by the National Health Act). The FGoN's financing of the 1% CRF (first through a temporary mechanism and later through the Statutory Fund), is important because it brings resources over and above those budgeted for the health sector through the 'regular' budget process and also leads to a predictable resources stream to finance operating budgets of PHC facilities (when they meet specific criteria). The small investment by the GFF trust fund leveraged more than US$200 million (88 billion Naira) in domestic financing since the start of the project (See Annex 4). The Statutory Fund is now financed on an annual basis and used to channel domestic funds to all states, including the pilot states that were once financed by the GFF grant (See Annex 6-8).

4) **In line with the intention of the project to catalyze the operationalization of the BHCPF reform, the mechanics of accreditation, verification, and payment were taken up by non-pilot states and are now being rolled out in public facilities nationwide across all states and the FCT, in select facilities.** Given the challenging context of Nigeria, the national program still faces many challenges, but the mechanisms for revamping PHC financing have largely been established and operationalized in the public sector.

*Table 3. Progress on PDO and IR indicators in the World Bank-supported BHCPF Project States**

Project Development Objective: To establish the accreditation, verification and payment mechanisms for the operationalization of the BHCPF in the participating states.	**Baseline (A)**	**End Target (B)**	**Achieved in project states (C)**	**Achievement in project states (%) (C-A/B-A)**
Indicators related to accreditation				
PDO-Level Indicator 4: Average health facility quality-of-care score	28	43	71.6	291% (Surpassed)
Indicators related to verification (including enrolment and verification of beneficiaries and verification of payment)				
PDO-Level Indicator 3: Percentage of health facilities financed through the FFS mechanism whose claims are found to be valid (less than 10% discordant from their claims) as independently verified	-	90	100	111% (Surpassed)
PDO-Level Indicator 5: Number of beneficiaries receiving services financed through the FFS mechanism	-	600,000	74,930	12% (Not achieved)
Indicators related to payment				
PDO-Level Indicator 1: Number of public primary health centers receiving operational expenses via Decentralized Facility Financing (DFF) mechanism	-	800	898	112% (Surpassed)
PDO 2: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by public and private	-	1,000	645	65% (Partially achieved)
PDO-Level Indicator 2a: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, public	-	750	645	86% (Achieved substantially)
PDO-Level Indicator 2b: Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, private	-	250	0	0% (Not achieved)
IRI 5: Number of project facilities receiving payments on time	-	950	898	95% (Achieved substantially)
IRI 5a: Number of public FFS facilities receiving payments on time	-	500	795	159% (Surpassed)
IRI 5b: Number of private FFS facilities receiving payments on time	-	200	0	0% (Not achieved)
IRI 5c: Number of public primary health centers receiving operational expenses through DFF mechanism on time	-	450	898	200% (Surpassed)
Other indicators demonstrating intermediate results of BHCPF operationalization (as per theory of change)				
IRI 7: Percentage of public health facilities in the project area with functioning management committees having community representation	-	75	100	133% (Surpassed)
IRI 1: Number of outpatient visits per year, children, and adults (sum of Abia, Niger, and Osun)	294,915	1,000,000	1,181,776	126% (Surpassed)
IRI 2: Percentage of children (12–23) months with Pentavalent 3 vaccination (average in three states of Abia, Niger, and Osun)	57	67	68.70	117% (Surpassed)
IRI 3: Percentage of births attended by skilled health personnel (average of Abia, Niger, and Osun)	70	75	79.47	189% (Surpassed)
IRI 4 (CRI): People who have received essential health, nutrition, and population (HNP) services	0	850,000	945,420	111% (Surpassed)
IRI 4a: People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	0	650,000	756,336	116% (Surpassed)
IRI 4b: Number of children immunized	0	200,000	302,534	151% (Surpassed)
IRI 4c: Number of deliveries attended by skilled health personnel	0	100,000	60,506	61% (Not achieved)
IRI 6: Percentage of health facilities enrolled in the DFF payment system that received supervision in the last quarter	-	75	90	120% (Surpassed)

Achievement: Surpassed – 100%+; Achieved/Substantially – 85%+; Partially Achieved – 65%-84%; Not Achieved – < 64%
*In the final ISR, reporting on PDO indicators 1,2, 4 and 5 and IRI 6 included data beyond the 3 project states. Table 3 above reports only on the project states. Relative to the final ISR, PDO5 shifted from ‘surpassed’ to ‘not achieved’; PDO2 moved from ‘surpassed’ to partially achieved’; and PDO2a moved from ‘surpassed’ to ‘substantially achieved’.

i) ESTABLISHMENT AND OPERATIONALIZATION OF ACCREDITATION IN EACH OF THE PARTICIPATING STATES:

46. **The accreditation process for public facilities introduced a culture of accountability that fostered quality improvements.** The project put in place a checklist that needed to be met to achieve certain criteria before funding could be received. Baseline and follow-up assessments were designed and conducted to monitor adherence to these criteria during supervision visits and regular reporting. Facilities were held accountable for quality of care through quality-of-care scorecards (as a prerequisite for receiving funds and for continuous receipt of funds). PDO-Level Indicator 4 shows that the facilities' average quality of care score improved over the life of the project, from a baseline of 28 out of 100 to an average in the three states of 71.6 (almost a 300% increase) (Table 4). These scorecards are now part of the nationwide BHCPF reform. Annex 6-5a and Annex 6-5b include photographs of facilities before and after upgrades under the BHCPF to give a sense of the types of investments made to prepare for accreditation.

Table 4. Average Health Facility Quality-of-Care Score (on a scale of 1 to 100) (PDO Indicator 4)

	Baseline	Target	Final Score (June 2021)	Total achievement in project states
Abia	29	43	78	
Niger	24	43	62	
Osun	31	43	75	
Average in project states/nationwide in June 2021	28	43	71.6 (56*)	291% (Surpassed)

*National average at project appraisal was 34.4 (FMOH, 2016) and increased to 56 by June 2021.[25]

47. **One facility in every ward:** The project was close to accrediting one facility per ward, with the exception of two wards in Niger state, which faced severe security challenges in border communities. Across the three states, NPHCDA accredited 898 public facilities, and 645 of these were also accredited by NHIS. There were shortcomings in operationalizing the accreditation and payment of private facilities. This is discussed in the sub-section on payment to facilities below, as the issue was related to the empanelment of providers.

48. **An adaptation was made to the accreditation process that informed nationwide scale-up:** The BHCPF project had always planned that a single public facility could receive accreditation from both the NPHCDA and NHIS gateways. This was a rational decision given that wards would not have had the resources to accredit more than one facility per ward. While the NHIS gateway was originally intended to have more stringent criteria, the NHIS gateway adopted the criteria for the NPHCDA gateway, and the two agencies moved to a joint accreditation process. This reduced duplication and helped to make progress on the NHIS gateway, which was delayed due to several reasons. Another important adaptation was that the initial accreditation became provisional (even when states faced shortcomings on the readiness checklist) with the agreement that facilities would proceed to full accreditation after one year by developing a quality improvement plan, including specific indicators, targets, persons responsible, and quarterly milestones that aligned with quality improvement plans. Given that facilities were starting from such a low base, this modification allowed facilities to access funds and allowed beneficiaries timely access to care, while creating a culture of accountability and continuous quality improvement.

[25] FMoH, 2016. National Health Facility Survey, 2016. Available at: https://ngfrepository.org.ng:8443/jspui/bitstream/123456789/3147/1/NHFS-Final-Report-for-Printing_VI.pdf

ii) ESTABLISHMENT AND OPERATIONALIZATION OF VERIFICATION ACROSS THE PARTICIPATING STATES

49. **The implementation of the BHCPF relies on verification arrangements at the state, beneficiary, and facility level, as described below.** State-level verification was a *prerequisite* for participating in the program and these criteria were established in the first year of the project; they are now used for nationwide scale-up.

50. **STATE LEVEL VERIFICATION: The project was successful in establishing and operationalizing the state-level verification requirements in each of the three states.** These steps overlap with the accreditation process outlined above and are articulated in Annex 6-3. The states were required to make an upfront payment of N100 million (US$330,000) as 'counterpart funding' used to: set up the governance structure; pay for training at the facility and community level on the new BHCPF operations; finance facility upgrades; and hire new staff. Project funds were used by states to set up State Steering Committees, develop the legal framework for SPHCDA and SSHIA, and build capacity of staff.

51. **The verification process catalyzed the institutionalization of the state-health agencies, particularly on the NHIS gateway.** Both were accomplished in each of the pilot states, but SPHCDAs were better prepared, having already been established prior to the BHCPF project. The SSHIAs needed to be established before activities could commence, leading to delays in testing the NHIS gateway (See Annex 6-6 for a detailed description and timeline of establishment of the agencies). The project tried to mitigate these delays through additional operational support to SSHIAs.

52. **BENEFICIARY ENROLMENT AND VERIFICATION: One of the greatest challenges of the project was establishing the process that would enroll and verify poor and vulnerable beneficiaries into the program (on the NHIS gateway).** The project team spent considerable time supporting the state and ward-level agencies to develop strategies to overcome these challenges. These adaptations are summarized below:

    a) **Identification of beneficiaries required local strategies for validation.** The original OM did not specify how the poor and vulnerable individuals should be selected and in rural areas, where the majority of people are poor, the program began enrolling anyone in the project areas who had a demand for services as a means of "geographic targeting". However, before this process could really be tested, the OM was revised and called for use of the National Social Register to identify beneficiaries. Operationalizing this proved difficult, however: across the three states, officials faced challenges with the validation of the Register. For example, during verification, numerous people on the list of extremely poor persons had died, migrated, advanced their economic situation, or, for other reasons, were not poor. Thus, the three states adopted different identification and revalidation strategies to confirm poverty status using their own data, while giving priority to women of reproductive age and children. These strategies were incorporated into the National Secretariat's training programs for other states (See Annex 6-4, Section 2b for examples).

    b) **Building institutional capacity with social protection was critical.** Several underlying institutional capacities needed to be developed, in conjunction with social protection agencies. The National Identity Management Commission (NIMC) was responsible for issuing National Identification Numbers (NINs) to the poor and vulnerable in the state, which was a requirement for enrollment in the BHCPF and other services. However, the NIMC offices faced significant operational challenges, both in terms of operational funding and equipment needed to register beneficiaries. The project then adapted the process so that SSHIAs could issue their own NINs for the poor and vulnerable.

c) **Community sensitization was essential in regaining trust of beneficiaries.** The changes to the OM caused a problem in that people who were previously told they were eligible had to be told that they were ineligible. This created distrust in the BHCPF program, according to key informant interviews. A key lesson was the importance of using community mobilization (e.g., traditional rulers, social mobilization officers, ward development committees, etc.) to sensitize communities about the need to reach the most vulnerable.

53. **While the beneficiary enrolment and verification were adequately established, the Project had less time to operationalize it.** Only 74,930 beneficiaries (12 percent of the target) were enrolled, verified, and received services through the NHIS gateway (See PDO 5 in **Table 3**). Abia and Osun States had already begun paying using the fee-for-service mechanism and had to switch; Niger state began paying in line with the 2020 BHCPF guidelines using capitation. One factor that played a role in not meeting the target was that when changes were made to the NHIS gateway, a cap was placed on the number of beneficiaries that could be enrolled in a state. This issue is explored later under the payment section. By the end of June 2021, the BHCPF government program (including the pilot states) had reached a total of 633,446 beneficiaries through the NHIS gateway nationwide.

54. **PAYMENT VERIFICATION: The design and implementation of payment verification mechanisms introduced accountability into the PHC system and complemented ongoing PFM reforms.** There are three ways that the BHCPF program (starting with the three pilot states) changed accounting audit and external oversight of the health sector: *First,* states improved the quality and timeliness of accounting and reporting practices. Public PHCs under the project developed quarterly business plans, in collaboration with the HFMCs, and these plans guided the utilization of resources on both gateways. All plans needed to be approved by the SPHCDAs before funds were disbursed. Funds were almost entirely allocated to service delivery, as per the OM guidelines, with no provision for procurement. *Second,* the project improved internal audit and controls ensuring that problems of improper management of resources are detected and corrective measures undertaken immediately. All public facilities in the project-provided statement of expenses (SOEs), payments vouchers (PVs) and receipts quarterly to SPHCDAs. These are collated and audited as part of internal fiduciary safeguards at the state and national implementation levels.[26] **Table 3** shows that the project surpassed its target of ensuring that claims processed through the NHIS gateway were found to be valid, as independently verified, in 100% of facilities. The *third* relates to external audit and oversight, which provides a basis for external accountability. The project appointed an external auditor through the office of the auditor-general of the federation to review the flow and utilization of resources under the program. These features are now part of the national program.

55. **The project also experienced some challenges with verification.** The ISR from October 2019 noted the long delays in conducting the claims verification training, which was completed in December 2019. This delay in training affected the ability to put in place the verification arrangements. In part this was due to insufficient capacity on the SSHIA gateway. With all the changes to the NHIS gateway and the impending closure of the project, it would have been too risky to develop the ICT platform for the NHIS gateway at a time when the

26 For the NPHCDA gateway, fiduciary verification took place at two levels: SPHCDA verified that expenditures were in line with workplans and document appropriately, and NPHCDA verified the submissions of the SPHCDAs. For the NHIS gateway, the claims verification is done at two levels: At the state level the SSHIAs verifies all claims submitted to the agency for reimbursement. The NHIS then does a secondary check on payments/reimbursements made by the SSHIAs.

project was moving to closure. This lack of an ICT system continues to be a shortcoming for the national program.

iii) ESTABLISHMENT AND OPERATIONALIZATION OF PAYMENT ACROSS THE PARTICIPATING STATES:

56. **This section is organized by the flow of funds, starting with the payment of project resources from the federal level to states and then discussing payment from the states to facilities.**

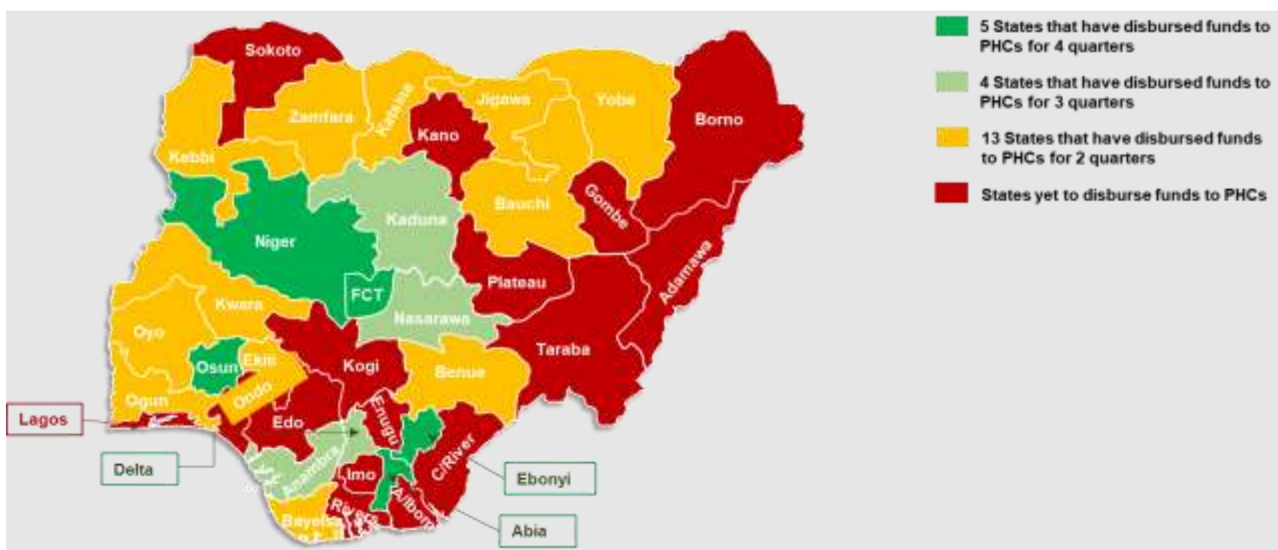
Payment to the three pilot states

57. **One of the most important aspects of the design of the project was the allocation formula for transferring project (and eventually government) funds to states.** Intergovernmental fiscal transfers are an important tool for redistributing resources in fiscally decentralized countries. However, Nigeria's resource allocation formula in health had traditionally allocated based on inputs, e.g., the number of hospital beds and health personnel, which were likely to be higher in wealthier states. The BHCPF project designed this formula to allocate resources to states based on the poverty rates in the region. The FGoN adopted this allocation model not just for GFF resources but also for government co-mingled funding that was allocated to the other states; this is a direct result of the project and will lead to increased prioritization of areas with high levels of poverty.

Payment to facilities in the project states

58. **The project exceeded the number of public facilities receiving operational expenditures through the NPHCDA gateway.** In the three participating states, 898 public PHCs were accredited through the NPHCDA gateway and received payments (surpassing the target for PDO Indicator 1). By the end of the project, Abia, Osun, and Niger, along with Ebonyi and FCT had disbursed four quarters of DFF payments to PHCs through the NPHCDA gateway (See Figure 3**Figure 3**). Another four states had disbursed funds to PHCs for 3 quarters; 13 states had disbursed funds to PHCs for 2 quarters; and the remaining 16 states were not yet authorized to receive funds.

Figure 3. Disbursements of BHCPF Funds to PHCs in Nigeria through the NPHCDA gateway, June 2021



Source: Adapted from Lessons Learned Workshop, NPHCDA Power Point presentation, June 2021

59. **The project made substantial progress on accrediting and paying public facilities through the NHIS gateway, but this was not without challenges**. A total of 645 public PHC facilities were accredited and receiving payment by the NHIS at the end of the project (86 percent of the target for PDO Indicator 2a) (See **Table 3**).[27] The ISR from the May 5, 2020 mission notes that 508 public facilities had already been operationalized and were receiving services. This was more than half the target for the project. However, the project still faced the continuous challenge of identifying beneficiaries, and the capacity of SSHIA was also lacking. This is discussed in more detail under 'Key Factors During Implementation'. It was not until the last six months that the project began making progress on operationalizing payment to public facilities on the NHIS gateway.

60. **The public facilities through the NPHCDA and NHIS gateways were paid on time and the target was surpassed for public facilities**. This includes facilities receiving payments from the NHIS gateway (IRI 5a) and public PHCs receiving operational funding through the NPHCDA gateway (IRI 5c).
61. **Not a single private provider was empaneled under the NHIS gateway.** There were four main reasons for the lack of progress with private facilities. The *primary factor* is the provision that the BHCPF should aim to have one accredited health facility per ward; in all instances there was a public PHC that met the criteria and limited resources to accredit a private facility. Thus, the joint accreditation between NPHCDA and NHIS resulted in public PHCs being prioritized in each ward. *Second*, on the NHIS gateway, the NHIS imposed a budgetary limit per ward when they began paying providers on a per capita basis; this cap was set at 150 beneficiaries per ward. *Third,* in areas where it was possible to empanel private providers, the same provider was already receiving a higher payment from the SSHIAs for other health insurance enrollees (N750 per enrollee per year, compared with N500 through the BHCPF to cover the poor). This was a major disincentive for private providers to participate in the NHIS gateway. *Fourth*, in some of the Local Government Areas (LGAs) of participating states, particularly in remote and rural settlements, there are no private facilities, (although the exact number of wards without a private facility could not be quantified). Thus, PDO indicator 2b was not achieved, which led to PDO Indicator 2 being only partially achieved. Similarly, since no private facilities were paid, no progress was made on timeliness of payment to private facilities (IRI 5b in **Table 3**).

Public financial management

62. **The project was more than a PHC financing reform; it was also a PFM reform.** The PFM achievements are discussed below:
    a) **The project channeled funds through the Treasury Single Accounts (TSA).** The TSA is a banking arrangement that consolidates government financial resources in one bank account or multiple bank accounts linked to a main account. It allows the Treasury to have full visibility of accounts of Ministries, Departments and Agencies (MDAs). The use of TSA accounts for the BHCPF program through the verification arrangements created an unparalleled level of accountability and transparency in public financing for health.
    b) **The project aligned with government systems, while establishing systems to minimize fiduciary risk.** A critical agreement between the Federal Ministry of Finance, the Ministry of Health, and the World Bank was made prior to appraisal whereby BHCPF project funds would be 'comingled' with government resources and housed in a single account at the Central Bank of Nigeria (see Annex 6-7). This was the first IPF in Nigeria to be channeled this way. To mitigate fiduciary risk, the project ensured that the same fiduciary standards of a World Bank project were applied to this account. The risk was mitigated by using

[27] NPHCDA Desk Records, from Nigeria Health Management Information System.

the Office of the Accountant General of the Federation as the accounting staff, rather than the traditional accounting staff in the FMoH. *The Federal Project Financial Management Division (FPFMD) is the department in the OAGF that carries out accounting functions for all IFI based transactions of the GON).* FPFMD staff from within this office were tasked with managing government and project funds (as part of the BHCPF/MOC Secretariat), and funds in the joint ('comingled') account were subject to the fiduciary processes of the World Bank. A memo in Annex 6-9 shows that after the review of the BHCPF manual, during which time there was a move to change the fiduciary mechanisms, the BHCPF Secretariat took steps to ensure fiduciary safeguards for the fund, as designed by the World Bank financed project, were reinstated. These arrangements continue today and are expanded to the rest of the states after the closure of the Project supporting the three pilot states.

c) **Several levels of supportive supervision were put in place,** including at the ward, LGA, state, and national level, to monitor and hold facilities accountable for conducting activities in line with their work plans. The project surpassed its target on supervision in NPHCDA-contracted facilities (IRI6 in Table 3).

d) **The project established effective audit systems.** First, there was a requirement to undertake External audits by the Office of the Auditor General of the Federation (OAuGF) annually. Secondly, there is a mandatory use of an internal auditor who provided additional assurances that prior to implementation and disbursement of funds all fiduciary controls are in place.

e) **Improved budgeting and auditing processes at all levels through appropriate technical assistance.** In collaboration with the States' Fiscal Transparency, Accountability and Sustainability PforR (P162009), the project aimed to improve fiduciary capacity and accountability at the state level. A key focus was the introduction of medium-term expenditure frameworks (MTEFs), which introduced predictability into the budget process. The project provided technical assistance to allow for this to happen, with support from the Health Financing ASA.

Institutionalization of the statutory transfer for the BHCPF

63. **The BHCPF was institutionalized during the project as a Statutory Transfer.** The BHCPF was first financed as Service Wide Vote (SWV), and this was considered a milestone. However, it meant that the funds were not guaranteed because this category of the budget is reserved for unforeseen expenditures and contingencies, thereby making the SWV a 'soft earmark'. Additionally, any unspent funds are returned to Treasury after the fiscal year. In November 2019, the Statutory Transfer (planned as part of the NHAct and the OM) was institutionalized as part of the 2020 budget; this is evidence of the 'operationalization' of the BHCPF. This was considered a 'win' for PHC financing in Nigeria because the PFM rules around the Statutory Transfer meant that the FGoN could retain funds. This was important for two operational reasons: a) the unpredictability of claims for health care services would mean that there needs to be a reserve of funds in case claims exceed the earmark in a certain year; and b) claims for services may be incurred in one financial year but not reported until the next financial year (known as accrual accounting), posing a problem if funds are already returned after the financial year.[28] A statutory transfer also ensures that funding is safeguarded from budget cuts or allocation decisions because statutory transfers are considered a "first line charge", paid before the regular budget process, which allocates funds across Ministries, Departments and Agencies (See Annex 6-7). **Table 5** demonstrates the value of the Statutory Fund. It shows that in 2019, the funds allocated through SWVs needed to be returned to treasury because they were unspent. The project played a key role in making this happen: it developed the mechanisms needed for the operationalization of the project, which served as a 'proof-of-concept'; and project staff led several events and provided technical assistance on budgeting for health and worked closely with the Budget Office of the Federation to ensure the funding for the Statutory

[28] World Bank, 2019. Health Financing in Nigeria: Raising revenue and enhancing financial protection for health, Internal report.

Fund were included in the Medium-Term Expenditure Framework. The statutory transfer funds the national program, including the project states.

Table 5. Allocation for the BHCPF in Government of Nigeria appropriations

Year	Amount (Naira, billions)	Share of Projected CRF (%)	Amount Released (Naira, billions)	Balance Returned (Naira, billions)	Type of Transfer
2019	55.1	1	35	8.5	Service wide vote*
2020	44.5 (26.46)***	1 (1% of actual)	26.46	0	Statutory transfer**
2021	35.03	1	35.03	0	Statutory transfer
Total (excluding returned)			87.99 ($218M)		

*A Service Wide Vote is an earmark allocation in the budget which can be returned to the treasury if unspent. **A statutory transfer is a first line charge earmark which must be implemented "first off the top" and not returned to the Treasury if unspent. ***The budget for the BHCPF was revised downwards following the COVID-19 revenue shortfalls that took place in 2020.

Progress on intermediate results due to operationalization of the BHCPF

64. **As explained in the theory of change, there were four intermediate results expected from the operationalization of the accreditation, verification, and payment mechanisms.** Progress against each of these is discussed below.

65. **Increased availability/timeliness of financing at PHC level.** Overall, the project increased the availability and timeliness of resources. Timeliness of payment was discussed above, and the indicators are shown in Table 3. The main indicator "number of project facilities receiving payments on time" (IRI 5) was achieved substantially with progress in public facilities for the NHIS (IRI 5a) and NPHCDA gateway (IRI 5c) gateways surpassed, but no progress in private sector facilities (IRI 5b). This shift to ensure the frontlines are financed is one of the most important ingredients for countries to make progress to UHC because it means that providers have funds available to deliver the services covered by the benefit package when they need them, without having to resort to out-of-pocket payments from individuals. Another important aspect of the financing was that it gave providers autonomy to use resources as needed as long as it was in line with the OM guidelines around eligible expenditures.

66. **Increased utilization of prioritized essential services.** A true test of the operationalization of the BHCPF is whether it was used to deliver services to individuals. Targets for all four main indicators measuring utilization of services were surpassed. In the project states, 1,181,776 outpatient visits were made in the pilot states during the life of the project (IRI1 in Table 3); and the coverage rate for three doses of Pentavalent vaccine increased from 57% to 68.7 percent in the pilot states (IRI 2 in Table 3). The percent of births attended by skilled health personnel in the three states also increased from 70% to 79.5% during the project (IRI 3 in Table 3). These increases are notable for two reasons: a) the project only piloted one facility per ward so other facilities still lack the infrastructure and funding needed to be functional; and b) health facilities in Nigeria experienced a disruption of services (lower volumes of patients presenting) as a result of COVID-19. In total, 945,420 people (surpassing a target of 850,000 people) received essential health, nutrition, and population services (IRI 4 in Table 3). The volume of services delivered to women was more than the project targeted (IRI 4a), as was the number of children immunized (IRI 4b). However, the volume of deliveries attended by skilled

health personnel was only 61% of the target, and therefore was not achieved (IRI 4c in Table 3). This is likely a result of lower utilization of services during the COVID-19 pandemic, the delays in setting up the NHIS gateway, and the fact that the BHCPF was not functional in private facilities.

67. **Increased supervision of PHC service delivery.** A key feature of the design was to increase accountability in the use of resources. Thus, supervision of facilities by state agencies was essential to ensure facilities were using funds in line with the operational manual, and to strengthen management capacity and oversight. The target for the project was surpassed; at the end of the project 90% of facilities enrolled in the NPHCDA gateway had received supervision in the last quarter, which surpassed the target of 75% (See IRI 6 in **Table 3**).

68. **Increased community participation:** The project helped to institutionalize a culture of community participation in the planning and monitoring of the BHCPF – a successful ingredient to ensure that the decentralized BHCPF program was adapted to local circumstances. Every ward was required to have a Ward Development Committee (WDC) that was directly involved in the facility's planning and decision-making, including the approval of funding disbursements. By the end of the project, 100 percent of public health facilities in the project area with functioning management committees having community representation, surpassing the target of 75 percent (See IRI 7 in Table 3). The members of the WDC were incorporated into the HFMCs and a WDC member was a co-signatory to all PHC facility plans, budgets, and payments. An interview from the last ISR mission helps to explain the importance of this community participation:

> *"Communities now see facilities as their own – since the ward development committees are part and parcel of the management system, they participate immensely in activities.... they organize clean-ups ...and they make sure facilities have the capacity for financial management"*
>
> - Emeka Sopuruchi, Official from Abia State, final ISR mission interviews

69. **The design of the BHCPF project also introduced the following features to increase community accountability:** a) made citizens and providers aware of their entitlements through community sensitization and by advertising the services beneficiaries were entitled to receive on signs outside the facilities; b) tracked citizens awareness of their rights; and c) established a grievance redress mechanism (GRM) to deal with complaints from the community, providers, and state-level implementers. While the GRM is functional at base level, it would benefit from: a) accelerating dissemination of the GRM and encouraging stakeholders to use it; b) introducing anonymity to reduce the fear that exists among the beneficiaries when reporting their grievances to authorities; and c) training the grievances redress committees on good will, empathy, and professionalism in handling grievances from the beneficiaries.[29] When the program was expanded, this model of community participation was replicated nationwide in all public PHC facilities receiving the BHCPF grant.

Justification of Overall Efficacy Rating

70. **The PDO was to establish the accreditation, verification, and payment mechanisms for the operationalization of the BHCPF in the participating states.** Substantial progress was made throughout the project, despite the challenges faced. The accreditation, verification and payment mechanisms were fully established on both gateways and were operationalized in public facilities, but not in private facilities. This rating is the same as the last ISR.[30] The supplementary information that shows how the program has scaled

[29] Personal communication with BHCPF Task Team. January 2022

[30] Consideration was given to the fact that the last ISR reported not just on the project states but also on the states that had implemented the BHCPF during the timeframe of the project but this did little difference to the overall rating.

up until beyond the pilot states is helpful for demonstrating that the project paved the way for the national program, as intended.

71. **The processes and procedures leading to the outcome of the pilot project were adopted for the national operationalization of the BHCPF.** All 36+1 Nigerian states have now started to operationalize the BHCPF through the NPHCDA and NHIS in select public facilities, adopting the processes developed for the three participating states under the project. Although the project did not engage private sector facilities as planned (seen as a minor shortcoming), the systems and structures were developed should the GoN decide to engage private sector facilities in the future. This inability to engage the private sector also demonstrates that while all other assumptions behind the project's theory of change were correct, the TOC was incorrect in assuming there was demand to engage the private sector. More work will be needed to understand the challenges of engaging the private sector in the participation of PHC service delivery for the poor.

C. ACHIEVEMENT OF PDOs (EFFICIENCY)

Rating: Substantial

ALLOCATIVE EFFICIENCY *(High)*:

72. **The BHCPF project addresses the mismatch between the disease burden and public financing allocations to health in Nigeria.** The BHCPF prioritizes spending on *primary* versus *secondary and tertiary health services*. The financing of an explicit benefit package *(Basic Minimum Package of Health services)* with a focus on cost-effective interventions through the BHCPF can be regarded as an *explicit* decision to focus on expanding primary care coverage as an expenditure management policy. This package would also lead to prevention or treatment of roughly 72 percent of the disease burden in Nigeria. See additional analysis in Annex 4, which shows common cost-benefit ratios for RMNCAH+N interventions.

73. **The project took a pro-poor implementation approach through the following actions:**
    a) The project accredited and made functional, a public health facility in all but two wards of the three states, prioritizing those located in rural and underserved geographical locations.
    b) The prioritization of public PHCs in the NPHCDA gateway is in line with the services more commonly used by the poor and vulnerable (which disproportionately use public PHCs).
    c) The Basic Minimum Package of Health Services that prioritized a highly cost-effective package of interventions focused on the most common health conditions facing the poor and vulnerable in Nigeria, including women and children. This package was adapted to the local context, depending on the most important priorities in the state.
    d) Enrollment on the NHIS gateway, combined with the verification process outlined in the Efficacy section, prioritized the poor and vulnerable for the delivery of health services, and the three states worked through the implementation arrangements to establish, test, and operationalize options for validating the national registry.
    e) The allocation criteria developed for the determination of states allocation in the BHCPF was designed based on criteria inclusive of national poverty estimates rather than simply allocating funds to states based on population size, as had occurred in the past. This represented a shift from allocating funds based on inputs (e.g., numbers of facilities, beds, etc.), which favored better off areas.

TECHNICAL EFFICIENCY *(High)*:

74. **The project put in place accountability mechanisms at the facility, ward, and state level that aim to bring about efficiency gains in PHC expenditure in Nigeria.** *First,* low spending in Nigeria is a source of inefficiency, due to facilities not having the right mix of inputs to improve health outcomes, so allocating more funds to PHC in a way that creates incentives for quality is a step in the right direction. *Second*, the accreditation and verification processes ensure that public financing can only flow to those facilities that meet quality criteria, increasing the likelihood that services delivered will produce the right mix of services, and giving communities and providers an incentive to increase quality to meet accreditation and verification criteria. This intervention minimized stock outs of essential medicines and supplies in public health facilities thereby limiting unnecessary client referrals and incomplete treatments. *Second*, by using work plans, training, and support supervision in public facilities, the project improved the capacity of service providers to use resources judiciously. *Third*, all the implementing entities in the BHCPF in the participating states maintained financial records of their transactions thus contributing to improvements in governance and accountability. Taken together, these changes began to introduce a new culture around accountability that will hopefully become institutionalized in the long term. New financing rules and mechanisms will also give local providers greater control over the use of operating funds while creating strong incentives to improve the reach, quality, and efficiency of services.

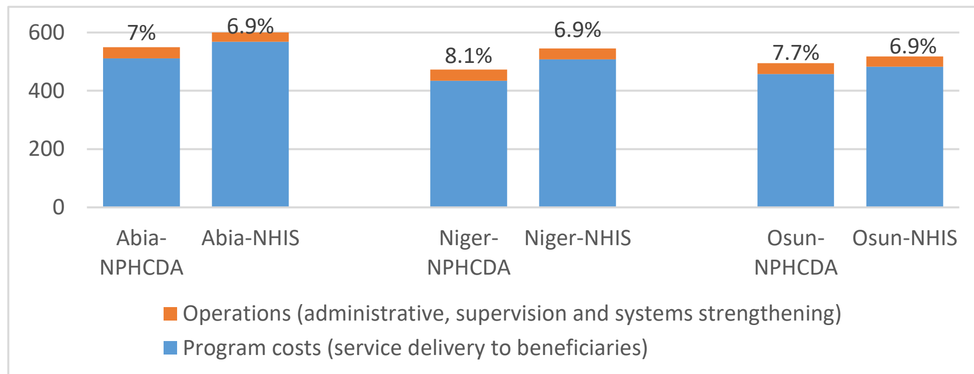
75. **The project piloted a low-cost model of care that focused on getting the majority of funds to the frontlines for service delivery.**

76. **Figure 4** shows the allocations made to the project states during the life of the project. The low operational cost of the project (just 7.2% on average allocated for administrative support, supervision and systems strengthening) illustrates how the BHCPF is used predominantly to deliver a highly cost-effective program of services to beneficiaries.

77. **With the implementation of the BHCPF nationwide, Nigeria is now well positioned to shift from a focus on vertical programs toward a focus on PHC, with donors aligning to the BHCPF through use of country systems.** This is particularly important now that key donors such as Gavi and Global Polio Eradication Initiative – key financiers of immunization services in Nigeria- are transitioning their support. In fact, the BHCPF was viewed as an important part of the Gavi transition plan (also known as the National Strategy for Routine Immunization and Primary Health Care Systems Strengthening). The BHCPF and the ability to comingle funds while providing strong fiduciary controls, provides an opportunity to better align donor financing. Already, BMGF has allocated funds to the CBN account in the amount of US$2 million. Increasing alignment and use of government systems is in line with the aid effectiveness agenda as it is central to building stewardship, improving accountability and efficiency, promoting institutions building and sustainability, and improving development outcomes. This is the subject of a substantial body of work, which is summarized in a recent World Bank report.[31]

[31] Piatti M, Hashim A, Alkenbrack S, Gurazada S. Following the Government Playbook: Channeling Development Assistance for Health through Country Systems. World Bank.

Figure 4. World Bank BHCPF payments to NHIS and NPHCDA and allocation for operations (administrative, supervision and systems strengthening) vs. service delivery, Naira, millions



Source: NHMIS data, from NPHCDA and NHIS, December 2021

IMPLEMENTATION EFFICIENCY *(Modest)*:

78. **The project experienced substantial implementation delays that were mainly outside the control of the project.** The main challenges were a) the review of the OM and subsequent negotiations over structural changes (including the dissolution and resolution of the BHCPF Secretariat, along with the changes in the fiduciary mechanisms); and b) the COVID-19 pandemic, which led to lower volumes of service delivery (See Factors Affecting Implementation). There were also implementation delays that occurred because the country lacked institutional capacity, including the undeveloped system for targeting the poor and issuing national identity numbers, and the low capacity of SSHIAs, which slowed down progress with the NHIS gateway. The GoN's use of the TSA system also took time as there were bureaucratic delays in opening Bank accounts and transferring the funds from the federal to state level. Additionally, at the facility level, most public PHCs were opening bank accounts for the first time, leading to some delays.

79. **However, there were also some delays that could have been better anticipated by the project.** The delays in the claims training and setting up of the ICT system were mentioned under the Efficacy section under Payment Verification. While these delays were likely due to multiple factors (including changes in leadership, delays due to COVID-19 and the delays due to the operational manual review), the World Bank project could have better anticipated the need to prioritize the establishment of the ICT platform for the management of gateway operations and interconnectivity with the national NHIS platform.

80. **Despite the challenges and implementation delays faced throughout the project, it was notable that the project was able to stay on course to achieve most of its targets, with less funding disbursed than expected.** The project was able to establish the accreditation, verification and payment mechanisms and operationalized this in public facilities on the NPHCDA and NHIS gateway, with just under 31 percent of a $20 million grant disbursed across the national level, three states, and local levels. Thus, the project was highly efficient in its implementation. Because the main driver of disbursement was the volume of services delivered, the low disbursement is understandable in the face of the many hurdles faced by the project, including disruption of services due to COVID-19. With more time, the project may have had more time to make progress on the NHIS gateway with public sector facilities. At the end of the project, the planned funds for service delivery on the NHIS gateway had only disbursed 18 percent of its planned budget, while the

NPHCDA gateway disbursed 46 percent of its planned funds for DFF. However, it is not clear that more time would have allowed the project the time needed to operationalize the NHIS gateway for private facilities, as this remains a challenge in the national program and new modes of reaching this group of providers may need to be worked out.

Assessment of Efficiency and Rating

81. ***Allocative efficiency is rated High, technical efficiency is rated High, and overall implementation efficiency is rated Modest; the overall rating is Substantial.*** The project's goal was to establish the accreditation, verification, and payment mechanisms needed for nationwide rollout of the BHCPF, and to catalyze the implementation of the national program, which had not been launched prior to the design and approval of the project. Even with the changes to the project, the implementation delays due to COVID-19, and the closing of the project one year early, the project was efficient—it achieved major milestones in a condensed period while catalyzing the development of processes and systems that are now under implementation throughout the country. The delays and lack of disbursement did not materially prevent the achievement of the three PDO outcomes on the NPHCDA gateway but did likely exacerbate the challenges that that project already faced in implementing the NHIS gateway. However, the funds were not fully utilized, representing a missed opportunity for another operation. Therefore, on balance, efficiency is rated as Substantial.

D. JUSTIFICATION OF OVERALL OUTCOME RATING

82. **The project was highly relevant to the development priorities of Nigeria and the PDO was largely achieved in an efficient manner, with much less funding than expected, while overcoming many unforeseen circumstances.** The project had some shortcomings, mainly the lack of progress with the private sector and a very short amount of time to test the NHIS gateway through higher volumes of service delivery. However, the project largely achieved its objectives, despite the difficult circumstances faced with changes to the OM and the COVID-19 pandemic. The impact of the operationalization of the BHCPF is evident given that all states in Nigeria are now implementing the program designed by the project, and with domestic financing. The overall outcome rating for the project is **Satisfactory** based on a High rating for Relevance, Substantial rating for Efficacy, and Substantial rating for Efficiency. This rating is higher than the Moderately Satisfactory rating given to the project at the last ISR because more information was available and because sufficient time had passed to be able to reflect on the overall impact of the project in catalyzing the implementation of the BHCPF reform nationwide.

E. OTHER OUTCOMES AND IMPACTS (IF ANY)

Gender

83. **The project prioritized access to essential health services for women and for the conditions and services that they need most.** The Project targeted the poor and vulnerable and 65.7% of the beneficiaries were women in the three states[32], in line with the RMNCAH+N GFF Investment Case and the NSHDP II, as prioritized within the BMPHS. This was important for addressing immediate health needs, but also because poor RMNCAH+N outcomes in Nigeria contribute to poor gender inequality. The percent of births attended by skilled health personnel in the three states increased from 70% to 79.5% during the project. This was important not just for increasing maternal health outcomes but for serving as a platform on which to deliver other maternal and child and nutrition services. A recent story from a facility in Beji, Niger State, that was

[32] Power point presentation based on data from NPHCDA and NHIS, Lessons Learned Presentation, June 2021.

supported by the project, explains how quality of care for women seeking antenatal care increased as a result of the BHCPF because basic infrastructure and medicines were available, and services were provided for free; this increased demand at the facility for using services.[33]

Institutional Strengthening

Establishment of systems and governance structures and strengthening of agencies

84. **The BHCPF project is unique in that it did not create a parallel system for the national program, opting instead to strengthen the institutions that are now rolling out the nationwide reform.** All national level implementing agencies have mainstreamed BHCPF implementation into the organogram, including the National Steering Committee (NSC), a National Secretariat (functioning as Project Coordinating Unit), and an arrangement whereby the FPFMD would oversee the project's financial management. The Project Implementation Units (PIUs) were also embedded within NPHCDA and NHIS throughout the life of the project. The clarity created by these institutional arrangements has led to a much better understanding of project implementation even in the face of delays. At the level of the FMOH, a new secretariat of the MOC under the leadership of a director has also been set up. By the end of the project, the Secretariat had organized two MOC meetings, and sought and obtained approval of key memos like fiduciary strengthening in the BHCPF, as well as a plan to transition the World Bank states to receive funds from the GON.

85. **The project also strengthened institutional arrangements at the state level, which is important given that the BHCPF was a model of fiscal decentralization.** Capacity of government agencies was low, and the project focused on building the capacity of State Steering Committees, State Primary Health Care Development Agencies, State Social Health Insurance Agencies, and State Project Financial Management Units (PMUS). An interview with a state level official during the virtual ICR mission illustrates how the project served as a catalyst to institutionalizing these governance structures:

> *"In 2018, SSHIA was passed. The BHCPF project was instrumental in setting up the Niger state agency. The Niger state government may not have prioritized it otherwise. The state had been talking about insurance agencies for some time and the BHCPF catalyzed the situation."*
>
> - *Dr. Mohammed Usman, CEO of Niger State Health Insurance Agency*

Strengthening of fiduciary arrangements and implementation of public financial management reforms

86. **The project expanded the reach of the GoN's ongoing public financial management (PFM) reform.** Implementing the BHCPF enshrined health sector accountability and transparency at a scale never previously achieved. *First,* the introduction and use of Medium Term Expenditure Frameworks (MTEFs) by the FGoN added much value: it reduced the volatility in revenue collection and disbursement of funds to Ministries, Departments and Agencies; it enabled more timely disbursement of funds to MDAs; it allowed for multi-year expenditure controls; it improved overall budgetary discipline; and it increased the ability to take future fiscal challenges into account when preparing annual budgets. The MTEF also includes funding for BHCPF program execution through the statutory fund. Second, the use of Treasury Single Accounts by government institutions like NHIS and NPHCDA—and their state implementing counterparts for the BHCPF program and operations—improved fund flow and tracking in the sector. *Third*, the comingling of government and World Bank project resources meant that for the first time, government budgetary processes and resources in Nigeria had mirrored fiduciary safeguards as those of foreign grants and loans in alignment with global good practices. In

[33] Abubakar, B. Beji Primary Health Centre: Leveraging the Basic Health Care Provision Fund to Improve Service Delivery. Nigeria Health Watch. February, 2022. Available at: https://nigeriahealthwatch.com/beji-primary-health-centre-leveraging-the-basic-health-care-provision-fund-to-improve-service-delivery/

fact, there was an effort to undo this strong fiduciary arrangement, but the scheme was then adjusted back to the original design of the project, with FPFMD oversight. Fourth, electronic payments down to the facility level improved the flow of funds to facilities. This also enhanced the transparency of facilities' resource utilization and centrally committed resources allocated to purchasing essential health services. *Finally*, the adoption of bottom-up expense documentation and audits (both internal and external) in the BHCPF design introduced a culture of accountability and transparency in the use of public resources. This was important given that facilities in Nigeria previously had little experience managing funds prior to the BHCPF.

87. **Role of State Governments in Making Focal Facilities ready for BHCPF Implementation.** The BHCPF implementation in 2018 reprioritized PHC as a principal component of revitalizing PHC in Nigeria. The implementation of the project signaled the commencement of the BHCPF, and states released funds to ensure that public PHCs were ready to receive Federal grants. For example, the Niger state government did a complete refurbishment of public PHCs beyond the project wards, in preparation for the program implementation.

Mobilizing Private Sector Financing

88. **The BHCPF leveraged additional resources outside the government.** The implementation of the BHCPF, with community participation and ownership built into the model of accreditation, brought about commitment, ownership, and reprioritization of resources at the state level. Community organizations and women's groups invested their own resources into quality improvements—facility upgrades and human resource upgrades, in particular—as outlined in the quality improvement plans.[34] Several community age-grade groups in Abia State also made significant infrastructural upgrades to several PHCs in the state, following the design of the annual quality improvement plans. In over 50 PHCs, these community groups also provided additional grants to the BHCPF to improve the minimum stock level for essential medicines.[35] However, these resources were not tracked by the project.

89. **The financing mechanism set up for the BHCPF is well equipped to receive donor financing in the future, and donors, foundations, and community organizations have contributed to the BHCPF.** The National Health Act of 2014 serves as a strategic and predictable financing instrument that will pool at least 1 percent of Consolidated Revenue Fund from the GoN, grants from donors, and funds from other sources, including the private sector. Additional financing from donors outside the GFF grant included US$2 million from the BMGF, with commitments from the FCDO for financing over five years. By building a transparent financing scheme with high fiduciary standards, the government is now well equipped to mobilize private financing from foundations and philanthropists in the future.[36]

[34] Personal communication with NPHCDA Abia state official during final ISR mission

[35] Personal communication with World Bank task team and NPHCDA and NHIS participants during Lessons Learned Workshop, June 2021

[36] Note that partners including USAID, FCDO, and WHO also provided technical assistance to advance state-level implementation, but outside the BHCPF CBN account.

Poverty Reduction and Shared Prosperity

90. **To address the World Bank's objective of reducing poverty, the project's main beneficiaries were from the lower/bottom two income quintiles statewide in the selected states.** The project calculated the number of poor and vulnerable by weighting the national poverty index for each state and factoring that into the allocation formula. On the NHIS gateway, the National Social Registry and community identification were used to enroll the poor and vulnerable within the LGAs. During implementation, the beneficiary identification process used in NHIS facilities was improved upon by using individual targeting and mapping of the poor within cities and rural communities. This process ensured that the project only enrolled poor beneficiaries and prevented leakage to the better off.

Other Unintended Outcomes and Impacts

91. **BHCPF facilities had additional funding that allowed them to procure essential commodities before the FGoN was able to provide them to facilities, thereby minimizing disruption of services.** The HFMCs at participating BHCPF facilities reported that they were better positioned to prioritize/reprioritize needs at the facility level during the COVID-19 because of the autonomy granted to respond to the most pressing needs. For example, 332 public PHCs in Osun used facility funding from the BHCPF to purchase personal protective equipment (PPE) with the operational funding they received at the facility level before the national procurement made PPE widely available. The immediate availability of PPE following the COVID-19 outbreak in Nigeria ensured the continuous delivery of essential health services and the motivation of clinical staff at the PHC level.[37]

92. **In addition to ensuring one functional facility in every ward, the BHCPF-accredited facilities often became sub-referral centers for smaller PHCs and immunization outposts where only limited services for the integrated management of child health services were available.** This model allowed improved delivery of essential primary care, especially to residents of rural areas, who are often the poorest and who, in the absence of quality public health care services, may forego care or incur financial impoverishment by seeking services in the private sector.

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

92. **Political momentum to deliver on the implementation of the BHCPF.** As mentioned in the context, the FGoN had launched a three pronged plan to deliver on the promise of the NHAct of 2014: the drafting of the OM, the World Bank/GFF-financed project, and an advocacy effort to build a coalition of supporters. This included a global coalition to support the implementation of the BHCPF, including the World Bank, the Bill and Melinda Gates Foundation, the Director General of WHO, Gavi, Global Fund, and other donor organizations. Civil society groups also advocated financing of the 1% of the CRF. The FMoH also held targeted discussions with the President, Vice President, Minister of Finance, and the leaders of both houses of the National Assembly, among others.[12] In addition to the dialogue around the project, this additional advocacy likely played an important role in the government's 2018 appropriations bill, which committed the BHCPF funds first through a Service Wide Vote, and then in 2020 through a Statutory Transfer. There was also increased momentum to

[37] World Bank, BHCPF Aide-memoire, December 18, 2020

deliver on the promise of the BHCPF given the National Economic Council's Human Capital working group's agenda to strengthen human capital.

B. KEY FACTORS DURING IMPLEMENTATION

93. **The key changes to the project insofar as its link with the nationwide roll-out, as well as the changes to the OM, were described earlier.** The changes to the OM are elaborated in Annex 6-4, and other challenges are mentioned here: a) the NHIS gateway b) the increased responsibilities of staff due to Phase 2 of the reform being moved up; and c) delays caused by the COVID-19 pandemic.

94. **A) The design of the NHIS gateway was a challenge to begin with for several reasons that extend beyond this ICR. Some of these challenges are outlined below:**

   i. **Leadership gaps at NHIS**: For the better part of project implementation, the NHIS was without substantive leadership. As a result, staff and stakeholders could not engage with the institution in a manner that facilitated swift decision-making or implementation. A new CEO for the NHIS was appointed by the President on 1st July 2019.
   ii. **The SSHIAs in the three states were new entities:** The implementation of the NHIS was dependent on the functional capacities of SSHIAs. In the three pilot states, only Niger state had a law establishing a state health insurance agency before the pre-planning of the BHCPF pilots. Across the project states and Nigeria at large, SSHIAs were new ventures of sub-national government with very minimal operational capacity. Operational and technical inadequacies within the SSHIAs affected the NHIS gateway operationalization as anticipated. These inadequacies translated into a delay in the enrollment of beneficiaries and access to services in the NHIS gateway (See more details in Annex 6-6).
   iii. **Implementation of the NHIS gateway requires beneficiary identification, verification, and enrolment:** Nigeria is yet to have a National Social Registry that is widely acceptable by all state governments. The eligible beneficiaries of the BHCPF were the poor and vulnerable and without clear guidance from the National level this led to considerable delays on this gateway. It was important to be able to identify the poorest beneficiaries given that the resources for the BHCPF were limited so resources needed to ensure the most vulnerable were targeted. This was particularly important when the FGoN agreed to shift to a capitation payment and imposed a cap on the number of beneficiaries that could be reached.
   iv. **Alignment with SSHIAs:** There was a challenge in integrating the benefit package and tariffs established by the state and the BHCPF, with what private providers were already providing and receiving through the NHIS insurance scheme. This issue also became a challenge for nationwide roll-out.
   v. **Lack of ICT infrastructure:** The scale of the BHCPF implementation would have benefitted from the availability of an ICT platform to track beneficiary enrolment, encounters and payments. While the project design incorporated this activity, the lack of leadership at the NHIS was one factor that contributed to the delays.
   vi. **Fall-out from the changes to the Operational Manual:** The NHIS gateway was most affected by the changes in the OM, as implementation on this gateway depended on an agreed benefit package and tariffs to be paid to providers. During the review process, it took substantial time resolving these issues and agreeing on the design, which delayed implementation.

95. **B) Increased responsibilities of project staff and BHCPF Secretariat due to early scale-up.** In late 2019, the

pilot states became learning hubs, paving the way for other states to implement as the BHCPF funds were released. This increased pressure on government agencies to support the nationwide rollout at a time when they were still setting up and testing the patency of the BHCPF systems in the three states. The project team also became stretched as they provided technical support to the BHCPF National Secretariat, National Implementing Entities (NHIS and NPHCDA), and state-level entities, while helping to broker knowledge sharing meetings and workshops to prepare all states for rollout. The World Bank mitigated the impact on the project by bringing in other partners (Results from Development, Policy Project) and staff from the World Bank's Health Financing ASA (P162108) to support training of government officials for the implementation of the BHCPF (See more details under Bank Performance).

96. **C) The COVID-19 pandemic also affected project implementation significantly.** During lockdowns, national implementing entities were unable to travel to undertake critical onboarding activities following the approval of the new manual. State level officials were also unable to travel to ensure their TSA accounts were activated (TSA accounts could only be opened at the CBN (Central Bank of Nigeria) in Abuja). Facility staff had problems with opening commercial bank accounts amongst others. Additionally, some training had to be conducted in person and was therefore delayed by many months due to travel restrictions, resulting in lost time for project implementation. However, following easing of the lockdown the project experienced rapid progress in implementation.

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF MONITORING AND EVALUATION (M&E)

Rating: Substantial

M&E Design

97. **The design of the M&E is rated as Modest.** The M&E design added considerable value to both the pilot and the reforms that would follow. The objective of the project, and the links with the broader FGoN's reform to implement the BHCPF nationwide were clear. The BHCPF project used a mix of existing sources of data but also developed many new mechanisms for monitoring the quality of primary health care services and flow of funds, while putting in place mechanisms to use data for course-correction and scale-up**.** While the M&E system was based on a strong theory of change and results framework with measurable indicators, there were important shortcomings that, if addressed, would have helped to better understand what constituted 'success' of the project, given the close links to the FGoN reform. More process-level indicators in the results framework (for example, 'number of facilities that are accredited' or 'number of facilities that have opened Bank accounts') could have helped to monitor whether the pilot was on track. For this reason, this ICR redid the TOC to better illustrate the pathways through which the project was expected to lead to a systems change through the operationalization of the BHCPF. The reason for this was more so that people not familiar with the details of a complicated health reform could better understand it. The TOC also now reflects the full range of long-term outcomes, including increased public financing for health and more efficient use of financing. As mentioned earlier, the project was designed to demonstrate to the Ministry of Finance and other stakeholders that allocations to the health sector could be well spent.

M&E Implementation

98. **The M&E implementation is rated as Substantial and had many strengths.** Most of the data needed for M&E were collected, collated, and analyzed by the respective national and state implementing agencies, and by LGA authorities, both in real time and during integrated supportive supervision visits. The project had intended to track health outcomes using the 2019 SMART survey, before the results of SMART were rejected by the World Bank due to operational gaps identified (separately from this project). In the absence of this, the project team used multiple data sources to triangulate health indicators through the Federal Ministry of Health Multi-Source Data Analytics and Triangulation (MSDAT) Platform, which includes data from surveys and routine monthly data from the Nigeria Health Management Information System (NHMIS). The project also strengthened supervision across state, local government and facility levels and embedded in this supervisory function were clearly defined M&E roles. For example, all facilities underwent a baseline survey before accreditation, and this was repeated over time. The main shortcoming was delayed implementation, which affected the establishment and timely use of M&E systems, for example, the National DHIS created a module to track all the indicators used in the BHCPF, but the indicators were incorporated later than planned. Finally, in the last ISR, the project team reported on data outside the three project states as the program had expanded to other states. As per the PAD and the Grant Agreement, the project should have reported only on the 'participating states', which is defined as each of Abia State, Niger State and Osun State.

M&E Utilization

99. **The M&E results utilization is rated Substantial for reasons discussed below:**
    - The World Bank and government teams regularly monitored the results framework and used the information to communicate progress to decision makers and inform implementation. E.g., BHCPF-MOC, NHIS, NPHCDA, State Implementing Entities, and HFMCs used data to monitor performance and identify areas for additional operational support. For example, at the national level, NPHCDA and NHIS presented collated reports quarterly to MOC; the state level agencies mirror this reporting.
    - The quarterly reporting system instituted on the NPHCDA gateway provided real time data for monitoring utilization at the facility level and quality scores and service experience, allowing for course-corrections and additional operational support.
    - On the NHIS gateway, monthly client utilization records were used to validate the capitation payments and monitor signs of over-utilization risk and actuarial validation. These data were also used by the World Bank to assess progress and make decisions for the future, or design corrective actions.
    - Data on progress of the project states (and eventually other states) were presented regularly to the Nigerian Legislatives, the State Executive Council, and the Development Partners' Group & Donors as part of the continuous advocacy for improved resource mobilization for BHCPF implementation.
    - There is a good record of decision-making in the World Bank Aide Memoires, and Implementation Progress Reports.

Justification of Overall Rating of Quality of M&E

100. **Overall Rating Quality of M&E: The overall level and quality of M&E is rated Substantial;** the M&E system was overall appropriately designed, but given that this was a complicated project, there were some moderate weaknesses in the design that made it more complicated than necessary to assess the 'success' of the project. Information was regularly collected by the GoN at all levels and implementing agencies on the main indicators and was used for decision-making purposes. Several additional studies and analytical work were also conducted including the baseline assessment and the follow-on quality of care assessments. The evaluation

reports on the program provided sufficient information on the project indicators and additional analysis of the various impacts.

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

101. **The project complied with all World Bank Group environmental and social safeguard guidelines.**

Environmental Compliance

102. **The project was assessed as Category B and planned mitigation activities were completed.** The project triggered Operational Policy 4.01 on Environmental Assessment due to potential environmental concerns around the handing of health care waste resulting from project-related activities such as vaccination and routine immunization that generate health care waste (e.g. expired vaccines, sharps, etc.). An Environmental and Social Management Framework was developed and disclosed and the FMOH has also updated and disclosed its health care waste management plan, which guided the project.

Social Compliance

103. **The BHCPF project design integrated social safeguard considerations, and World Bank social safeguards were respected throughout project implementation.** The project achieved positive social impacts and benefits by supporting improved access to essential health services for millions of Nigerians. It also helped the GoN to move closer to its UHC aspirations. The project did not finance any activities necessitating land acquisition that would result in: a) the involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods, or resources; or b) the involuntary restriction of access to legally designated parks and protected areas, resulting in adverse impacts on the livelihoods of the displaced persons. The project increased community member awareness and ownership of PHC by including WDCs in HFMCs and ensuring that they were cosignatories to the new funds available to healthcare facilities. The project operationalized a project-level GRM, assigning a focal point at the national, state, and facility levels to receive/resolve complaints and update a GRM register. Beneficiary communities and individuals who may have been adversely affected by project operations or unfairly excluded from benefiting from the BHCPF Project were given the right and platforms through which to complain and channel their grievances for redress. Grievances and complaints were channeled through GRM committees at both facilities and state implementing entities level. Grievances related to beneficiary identification and targeting were also adequately addressed on the NHIS gateway during the beneficiary enrollment and community targeting campaign, where validation and re-ranking of the National Social Register revisited based on the situation at the time of enrollment. This was complemented by the continuous case management throughout the project implementation cycle, which allowed the verification and addressing of the appealing households' case. The project had a good record of GRM utilization and response.

Fiduciary compliance

104. **The project was fiduciary compliant.**

Financial Management Compliance

105. **The FM arrangements of the project were assessed as Moderately Satisfactory at closing and presents fiduciary risks as moderate.** The project faced some persistent issues during implementation, including when the first BHCPF Secretariat was dissolved as there were no OAGF officers to document expenditures in Client Connection. After the reconstitution of the BHCPF Secretariat, the accounting officers ensured the continuous uploading of all backlogged and new expenses and at the time of closing, all project expenditures had been fully documented. FM compliance continued to improve steadily over the life of the project and

the project is now fully FM compliant. As previously described in this ICR, the project was not fully disbursed when it closed. Due to several operational delays and the COVID-19 pandemic, only US$11.5 million was advanced to the Designated Account, and the project was only able to utilize US$6,172,069.31. Thus, US$5,327,930.69 will need to be refunded to the World Bank. The MOH processed the refunds through the CBN ahead of the December 31, 2021 deadline, but this was returned due to procedural errors. Because the funds sit in the GoN account, unlike traditional World Bank financed projects, the reimbursement requires the involvement of the FMOH DFA. The refund is expected to be completed by April 30, 2022.

Procurement Compliance

106. **The project was procurement compliant.** Procurement under the BHCPF followed the World Bank and National Procurement Procedures. Contracts administrations were reliable, timely, and transparent. At the facility level, procurements were according to business plans and the health facility management committee met weekly to review contract administration. The State implementing entities provided an Oversight of the procurement function at the PHC facilities improving reliability and transparency. Procurement performance rating at closing was Moderately Satisfactory. While ending on a positive note, procurement during the life of the project suffered at times from various irregularities. These included procedural delays and glitches (like a failure to enter documentation in the Systematic Tracking of Exchange in Procurement system) and timeliness of preparing and processing procurement actions.

C. BANK PERFORMANCE

Quality at Entry: Satisfactory

107. **The quality of the World Bank performance was Satisfactory.** The team worked closely with the government to prepare the project in a timely fashion, which was a challenge given that the Operational Manual was a condition of effectiveness and there were delays in its approval. The World Bank preparation team had a good skill mix and was resourceful in calling upon experts throughout the World Bank to inform the design of the project, including PFM specialists from governance, health financing experts, and social protection experts, and used good practices in health financing and PFM to guide the project design. The World Bank learned from the NSHIP project and built on its experience by applying its most successful features and dropping shortcomings. By qualifying it as a follow-on project, the project was consistent with the World Bank strategy being implemented at the time of project appraisal (i.e., in line with the CAS (Country Assistance Strategies); this helped to ensure the project did not suffer from fiduciary, environmental/social or safeguard issues. The team also had a good handle on the politics of Nigeria and took steps to respond to calls from the Ministry of Finance to ensure this reform would ensure transparency and accountability of funds flow, thereby increasing credibility of the sector.

108. **The World Bank agreed to align to the FGoN's OM as a condition of effectiveness; the team knew the risks but also knew that the returns could be significant given that the FGoN saw the pilot project as a chance to lead the implementation of the long-awaited BHCPF reform.** Potential risks were accurately assessed (as substantial) and mitigated, particularly given that this project was unique in its use of the government's banking system. The World Bank also helped leverage international partners to commit to the implementation of the BHCPF. The Bill and Melinda Gates foundation released US$2 million for the operational support of the BHCPF and purchase of essential health services while the UK-FCDO committed about £70M for the purchase of essential health services. This support would ensure that there was a coalition of support aligning with the FGoN and was expected to mitigate the risks by ensuring that the BHCPF had adequate support.

109. **There were some things the project team could have better anticipated during the design, but many of these observations benefit from hindsight and are discussed in the Lessons and Recommendations section.** The project was very ambitious in delivering on its agenda and because it was a pilot project, there was always an expectation that the team would need to be flexible and that many lessons would be learned along the way that would inform the national scale-up.

Quality of Supervision: Satisfactory

110. **The quality of the World Bank support was Satisfactory.** According to the key informant sessions with the state and national implementing entities of the BHCPF, the quality of technical support and supervision was outstanding. The task team remained focused on the development impact and was aware that this was a bold reform that had the potential to transform health service delivery in Nigeria. The reform became the subject of much of the policy dialogue with the World Bank over the life of the project and the World Bank also convened many meetings to increase the visibility of the project and the overall BHCPF reform, which was known as 'Huwe'.[38] They used a direct continuous supervisory approach with the national implementing entities and regular missions were carried out by a state level health financing specialist across the three participating states. This continued in person until the start of the COVID-19 pandemic when these engagements became virtual. Project staff also extended their support to non-pilot states when the government of Nigeria began scaling the program nationwide. During all task team's missions, the client and health colleagues benefited from the support of highly qualified World Bank experts to advise on fiduciary management (FM and procurement), environmental safeguards, and social protection/targeting of beneficiaries. Reporting was regular: ISRs were produced in a timely manner, and aide-memoires or back-to-office reports were produced after each mission. These reports provided a clear picture of the progress made by the project and informed the decision-making process. Tools such as quarterly reviews and ISS (Integrated Supportive Supervision) at the LGA and state levels facilitated the monitoring of project progress and allowed for timely corrective action.

111. **The project faced considerable delays and obstacles and the World Bank remained a trusted partner to the GoN at all levels, understanding that the World Bank's support for the government's flagship reform of the BHCPF was a long-term journey.** During the 8 month period where fund disbursement was paused, the FGoN remained in regular contact with state officials to keep up the momentum. During the travel restrictions imposed by the COVID-19 pandemic, the World Bank continued to conduct trainings both virtually (and later in person when it was possible) and adapted supervision missions to virtual missions but were always available to communicate with project stakeholders (e.g., heads of state agencies, etc.). After the revision of the OM led to dissolution of the BHCPF Secretariat and eventual closing of the project (as originally planned), the World Bank remained a trusted partner, with an eye on ensuring the flagship program of the FGoN's UHC strategy remained on track. See Section on 'Other Changes' for a description of ongoing World Bank support. The World Bank team also brought its comparative advantage in convening stakeholders during and even after the project, to facilitate the FGoN's BHCPF reform. For example, as the FGoN began rolling out the project beyond the pilot states, it was clear that stakeholders had far less exposure to training on health financing, PHC service delivery, and the rationale for the BHCPF design. The World Bank project team supported the BHCPF Secretariat to deliver a training program for all heads of agencies in all states throughout the country, drawing on support from the Health Financing Program ASA to carry out the training and explain the rationale for the design of many of the BHCPF features. Two workshops

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[38] 'Huwe' means 'give life' in the local language.

were held over 5 days each in Abuja. During this training, lessons from the pilot states were disseminated. After the last ISR workshop, the team also held a 'Lessons Learned' workshop with government officials to reflect on the lessons and discuss opportunities and potential challenges facing the agencies with the nationwide roll-out.

112. **There were minor shortcomings in the quality of supervision.** The first was that the last ISR reported on all states, when it should have reported only on participating states. The second was that the Project Team could have facilitated more clearly the communication regarding the transition arrangements at the end of the project as the project funds that remained undisbursed were still not repaid at the time of this ICR.

Justification of Overall Rating of World Bank Performance

113. **The overall World Bank Performance was rated as Satisfactory because of the reported high quality of support offered to the GoN during project design and implementation, as well as the strong supervision, and innovation employed throughout the project, with only minor shortcomings during the project.** Due to the significant amount of work and the strategic relevance of the project to the client, the World Bank continues to lead the development support to the Government of Nigeria on the implementation of the BHCPF.

D. RISK TO DEVELOPMENT OUTCOME

114. **At the policy level, the risk to development outcome is Moderate mostly due to the fiscal situation in Nigeria.** The financing of the BHCPF is a statutory legal requirement directly linked to the Consolidated Revenues of the Federation. Thus, the BHCPF as a statutory Inter-Governmental Fiscal transfer from the National to subnational entities is at risk given that revenues are severely constrained and when there is a downturn in the fiscal position of the GON the allocation of the BHCPF is in turn reduced. Despite these challenges, the FGoN has also taken several positive steps forward to ensure financing for the BHCPF is secure. The BHCPF is captured in the critical GoN documents including the MTEF 2022 – 2024 and the National Development Plan. The Government at all levels is committed to mainstreaming the BHCPF approach, given its focus on demonstrating results, and further documentation of the impact of BHCPF will be important. Furthermore, a new National Health Insurance law is awaiting assent to the President; this law places financing from the BHCPF as the key financing arrangement to fund the participation of the poor and vulnerable in the mandatory insurance program.

115. **There is also a risk of sustaining the gains made under the BHCPF, however this is mitigated through ongoing support from the World Bank, GoN, and other donors.** The second phase of the Multi-Phased Approach (MPA) (Phase II – Expanding PHC strengthening through BHCPF) builds on lessons learned and successes from this project. This phase is not yet under preparation but is expected to support National roll out of the BHCPF by further strengthening investments in primary health care (PHC). In recognition of challenges faced in terms of identification and enrollment of poor and vulnerable the MPA will take advantage of the World Bank financed US$800 million credit for the National Social Safety Net Program Scale-Up (NASSP-SU), which is supporting the establishment of a National Social Registry (NSR). As a result of multiple concurrent shocks, including COVID-19, the poor and vulnerable in Nigeria continue to suffer the catastrophic consequences of high out-of-pocket expenditures for health. Continuation of support through the MPA will enable the Government of Nigeria to cushion the impact of these shocks on the population by financing the provision of affordable and quality health services to 11 million poor and vulnerable beneficiaries and their families, identified from the NSR in rural areas.

116. **But even with the support a systems change that could be compromised by weak capacity of institutions and weak coordination.** In most wards, this is the first time, with the exception of NSHIP, that facilities are receiving funds and there is still low capacity to manage. SSHIAs also require ongoing support for implementation of social health insurance, and much more needs to be done to strengthen the partnerships on social protection to identify the most vulnerable populations. Additionally, capacity for budgeting and planning at the subnational level is weak. There is also ongoing need for strengthened governance and coordination across the many partners providing technical assistance to the FGoN. The World Bank will continue to support these functions through its various projects (See Figure 1) to ensure sustainability.

V. LESSONS AND RECOMMENDATIONS

117. **There are several lessons that emerged from the BHCPF project, as well as recommendations that should guide implementation of the FGoN's BHCPF program and the design of future World Bank operations in Nigeria and other countries.**

Lessons from the BHCF project:

118. **Lesson 1. Health sector reforms such as the BHCPF provide strong incentives to disrupt the status quo; this brings forward strong political economy issues that require flexibility to navigate.** The BHCPF strengthened the incentives for performance and value-for-money at multiple levels, including how resources flow from the national to subnational level, how they are distributed to states and agencies, and what kind of incentives the arrangements bring forth for providers. All of these decisions create political challenges, as was demonstrated by the long delays in getting the Operational Manual approved to begin with, and also through the OM review process. High turnover in political positions in the health sector and in the National Assembly means that priorities may shift, and the advocacy process must be repeated and sustained to ensure the continued support for health reforms. Future projects should be acutely aware of political cycles and the impact on project implementation and ensure that civil society and health advocates are strongly engaged at every stage of the reform. Provider payment reforms are also highly political. The BHCPF project experienced many challenges on the NHIS gateway, including in implementing the performance-based payment in the way it was intended. Even though the original model of payment proposed on the NHIS gateway was built on NSHIP and other global experiences[39] and was expected to increase provider effort, the political economy of the payment mechanism in Nigeria, including how the payment mechanism fits with other payment mechanisms needed to be better understood. In fact, a recent publication by the Lancet recommends that countries move towards a blended capitation payment for primary health care, as it both incentivizes provider effort and can create incentives for efficiency.[40] As the FGoN embarks on further strengthening the BHCPF, with the support of the World Bank and others, it will be important to consider the political economy of any major shifts, as well as the country's capacity to manage the payment scheme.

119. **Lesson 2. Federal funds can be used to influence spending of social programs at subnational levels if designed carefully.** The World Bank's BHCPF project catalyzed the transformation of PHC in Nigeria at scale. Until the implementation of the project, the concept of having at least one functional public PHC per ward in

[39] Fee-for-service was used for the first 10 years of the National Health Insurance Fund in Ghana, where it was instrumental for increasing health care coverage.
[40] Hanson K, Brikci N, Erlangga D et al., The Lancet Global Health Commission on financing primary health care: putting people at the centre. The Lancet Global Health, Vol. 10 No. 5. Available at: https://doi.org/10.1016/S2214-109X(22)00005-5

Nigeria remained a goal articulated over many years but without operationalization. The operationalization of the BHCPF has supported the prioritization and mobilization of additional public financing from the FGoN in a way that could hold subnational levels accountable for using funds and that would encourage quality care through the establishment of better incentives. The Statutory Transfer ensures predictability and allows for the shift towards strategic purchasing/output-based payment. For this reason, countries such as Estonia, Ghana, and the Philippines, which have made good progress towards UHC, have used a similar mechanism.[41] The project also mobilized additional public financing from the subnational level, including from state governors through the N100 million commitment that financed start-up activities, and through community groups and donor organizations, which committed additional resources for PHC improvement due to their ownership in the reforms.

120. **Lesson 3. Health reforms that lead to a systems change are also governance reforms. The intergovernmental transfer changed the flow of funds to the subnational level and introduced mechanisms that provide incentives for improved performance.** The project also required facilities to meet minimum standards, develop explicit workplans that would guide the use of funds, and report on those funds (and verify that the funds were used as intended through the NHIS gateway). SPHCDAs and State Health Insurance Agencies (SHIAs) also expanded their role in monitoring service delivery performance, and in addressing shortfalls. Finally, system-wide, the reliance on an External auditor from the Office of the Auditor General of the Federation (OAuGF) provided additional assurances that services are being delivered and funds are used appropriately. These governance mechanisms have the potential to increase the credibility of the health sector. For this reason, it is important that the World Bank further facilitates coordination between health and governance experts to provide technical support and advice to inform the design of health reforms. The World Bank project team did in fact involve governance colleagues, which was helpful for navigating these shifts in governance arrangements.

121. **Lesson 4: Nigeria's progress on the BHCPF should be seen as an important milestone in the path to UHC, despite the challenges faced in the pilots.** Numerous country case studies demonstrate that progress to UHC is a complex process, fraught with challenges, many possible pathways, and various pitfalls. Moving to UHC is also a long-term policy engagement that often spans many political cycles.[42] A World Bank study of 24 developing countries that have embarked on the journey to UHC found that each of the countries had to overcome a legacy of inequality by tackling both a "financing gap" and a "provision gap"; this requires not just more money but also a focus on fundamentally shifting accountability structures.[43] Nigeria has done just that, but raising more resources at the federal level while changing the rules around service delivery for the poor by shifting toward a more strategic role of purchasing services. The goal of the BHCPF project was to implement a real intervention in a real-life context. While there is still a long way to go – particularly if the NHIS gateway is to be operationalized in private facilities, the BHCPF marks an important milestone in Nigeria's progression to UHC.

Recommendations for World Bank financed projects in Nigeria and beyond:

122. **Recommendation 1. As the FGoN focuses on nationwide implementation of the BHCPF, it should explore opportunities to further increase investment in the program.** The 1 percent CRF amounts to just US$1 per capita, and this fluctuates with the level of revenues, which is still largely oil dependent. As the program is

[41] Cashin C, Sparkes S, Bloom D. 2017. Earmarking for health: from theory to practice. Geneva: World Health Organization.
[42] Reich M, Harris J, Ikegami N, Maeda A, Cashin C, Araujo E, et al, 2015. Moving towards universal health coverage: lessons from 11 country case studies
[43] Cotlear, Daniel; Nagpal, Somil; Smith, Owen; Tandon, Ajay; Cortez, Rafael. 2015. Going Universal: How 24 Developing Countries are Implementing Universal Health Coverage from the Bottom Up. Washington, DC: World Bank.

expanded more financing will be required to ensure full coverage of the BMPHS. Some suggestions for making progress in this area are below:

a) **Increase government revenue:** The BHCPF funds have the potential to increase as revenue increases. The current efforts by the GoN to diversify its revenue base are welcome. The health sector will need to work closely with other sectors to identify opportunities, such as expansion of taxes targeting health-damaging products, like tobacco, alcohol, sugar-sweetened beverages.
b) **Increase prioritization on health:** The COVID-19 pandemic has led to a decline in government revenue, which affects the availability of resources for all sectors. In the current crisis, Nigeria like many countries have adopted a countercyclical health spending strategy in 2020. However, health spending has been historically low. This countercyclical trend seen in the pandemic will need to continue, and more effort is needed to increase prioritization of health in the government budget from the low level of 4.6% in 2019.[44] Calls for increasing the BHCPF statutory transfer to 2% of CRF have been made but would need more work to understand the political economy and to ensure that this would not lead to substitution of resources allocated to health through the 'regular' budget process.

123. **Recommendation 2. World Bank-financed operations in Nigeria and other countries should explore innovative ways to build institutional capacity over the long-term.** Enhanced ownership, coordination, and stewardship arrangements of the FMoH, national and state implementing entities are critical to sustaining and building on the gains made in the BHCPF. As the pace of implementation increases, the oversight functions of the Ministerial Oversight Committee under the leadership of the Honorable Minister of Health must correspondingly increase; the same applies for the S*tate Oversight Committees (SOC)*. The BHCPF was also the first activity the SSHIAs were implementing, and the pace of implementation was slow. Recognizing the importance of building institutional capacity, future Bank projects could be designed to include a complementary advisory project aimed at supporting the technical and institutional capacity of institutions.

124. **Recommendation 3: World Bank-financed operations should work closely with social protection to strengthen identification and targeting systems to better reach the poor and prevent leakage.** The project faced delays because of the lack of a common beneficiary identification program and little guidance on the adoption of the National poverty registry at the state level. Selecting the appropriate target group and minimizing adverse selection, moral hazard and other insurance risks are beneficial to efforts geared toward a successful implementation of the BHCPF. Furthermore, linking beneficiaries of GON safety net programs (See Section on Risk to Development Outcomes) to other programs such as BHCPF would enhance their skills, incomes, and livelihoods—all critical for wealth creation in poor and vulnerable communities. Thus, there are mutually beneficial gains that could be achieved through health colleagues and social protection colleagues working more closely together.

125. **Recommendation 4: Use of government systems should be considered more frequently in World Bank projects as a way to take forward the aid effectiveness agenda.** The aid effectiveness agenda has been calling for use of country systems for decades and this project represents an important step forward that will have lessons beyond Nigeria. The World Bank took a significant risk in using government systems (the OM, government TSAs, the institutionalization of processes and systems that would then be used by the government, the capacity building of national institutions, and the revamping of funding flows from the federal to local level), but in doing so, the project left in place systems that are catalyzing the transformation

[45] PiattiFuenfkirchen, M; Hashim A; Alkenbrack S; Gurazada S. Following the Government Playbook: Channeling Development Assistance for Health through Country Systems. Washington, DC. World Bank.

of PHC in Nigeria. The use of the TSA and the comingling of funds in the Central Bank of Nigeria account, all make full use of government systems that previous World Bank-financed projects had not done. More time should be spent to understand the implications of such a model on World Bank financing in Nigeria. A recent study by the World Bank found that despite repeated commitments of development partners to make greater use of country systems, today, there remains a lack of clarity of what 'country systems' means, misperceptions on what can be done to strengthen them, and lack of progress in using them.[45]

126. **Recommendation 5: The project team should disseminate the lessons from the reform to reach different audiences.** The story of the BHCPF is one that is complex and has the potential to be misunderstood for those not familiar with the details of the model. However, the lessons are highly relevant for so many countries beyond Nigeria, which are pursuing a shift from input-based financing to output-based financing as they progress to universal health coverage. The BHCPF reform was based on good practices and has faced considerable challenges in its first few years of implementation, but it has also achieved a great deal. The World Bank team should consider packaging lessons for different audiences and finding opportunities to disseminate the lessons from the BHCPF. This concept of disseminating lessons in multiple formats could also be extended to the state level to kickstart cross-state learning, which will be essential for achieving impact as the Government of Nigeria continues to expand the BHCPF to reach more wards across the country.

[45] PiattiFuenfkirchen, M; Hashim A; Alkenbrack S; Gurazada S. Following the Government Playbook: Channeling Development Assistance for Health through Country Systems. Washington, DC. World Bank.

ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

A. RESULTS INDICATORS

A.1 PDO Indicators

Objective/Outcome: Component 1: Strengthening Primary Healthcare Services through the BHCPF

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of public primary health centers receiving operational expenses via Decentralized Facility Financing (DFF) mechanism	Number	0.00 01-May-2018	800.00 01-May-2018		898.00 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by	Number	0.00 01-May-2018	1,000.00 01-May-2018		645.00 30-Jun-2021

public and private					
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, public	Number	0.00 01-May-2018	750.00 01-May-2018		645.00 30-Jun-2021
Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, private	Number	0.00 01-May-2018	250.00 01-May-2018		0.00 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of health facilities financed through the FFS mechanism whose claims are found to be valid (less than 10% discordant from their claims) as independently verified	Percentage	0.00 01-May-2018	90.00 01-May-2018		100.00 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Average health facility quality-of-care score	Number	28.00 01-May-2018	43.00 01-May-2018		71.60 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of beneficiaries receiving services financed through the FFS mechanism	Number	0.00 01-May-2018	600,000.00 01-May-2018		74,930.00 30-Jun-2021

Comments (achievements against targets):

A.2 Intermediate Results Indicators

Component: Component 1: Strengthening PHC services through BHCPF

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Number of outpatient visits	Number	294,915.00	1,000,000.00		1,181,776.00

per year, children and adults (sum of Abia, Niger and Osun)		01-May-2018	01-May-2018		30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of children (12-23) months with Pentavalent 3 vaccination (average in three states of Abia, Niger and Osun)	Percentage	57.00 01-May-2018	67.00 01-May-2018		68.70 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of births attended by skilled health personnel (average of Abia, Niger and Osun)	Percentage	70.00 01-May-2018	75.00 01-May-2018		79.47 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
People who have received essential health, nutrition, and population (HNP) services	Number	0.00 01-May-2018	850,000.00 01-May-2018		945,420.00 30-Jun-2021
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	Number	0.00	650,000.00		756,336.00
Number of children immunized	Number	0.00 01-May-2018	200,000.00 01-May-2018		302,534.00 30-Jun-2021
Number of deliveries attended by skilled health personnel	Number	0.00 01-May-2018	100,000.00 01-May-2018		60,506.00 30-Jun-2021

Comments (achievements against targets):

Component: Component 2: Strengthening Health Management systems for the BHCPF implementation

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised	Actual Achieved at

				Target	Completion
Numer of project facilities receiving payments on time	Number	0.00 01-May-2018	950.00 01-May-2018		898.00 30-Jun-2021
Number of public FFS facilities receiving payments on time	Number	0.00 01-May-2018	500.00 01-May-2018		645.00 30-Jun-2021
Number of private FFS facilities receiving payments on time	Number	0.00 01-May-2018	200.00 01-May-2018		0.00 30-Jun-2021
Number of public primary health centers receiving operational expenses through DFF mechanism on time	Number	0.00 01-May-2018	450.00 01-May-2018		898.00 30-Jun-2021

Comments (achievements against targets):

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of health facilities enrolled in the DFF payment system that received supervision in the	Percentage	0.00 01-May-2018	75.00 01-May-2018		90.00 30-Jun-2021

last quarter					
Comments (achievements against targets):					

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Percentage of public health facilities in the project area with functioning management committees having community representation	Percentage	0.00 01-May-2018	75.00 01-May-2018		100.00 30-Jun-2021
Comments (achievements against targets):					

B. KEY OUTPUTS BY COMPONENT

Objective/Outcome 1	
Outcome Indicators	1. Number of public primary health centers receiving operational expenses via Decentralized Facility Financing (DFF) mechanism 2. Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by public and private 2a. Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, public 2b. Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, private 3. Percentage of health facilities financed through the FFS mechanism whose claims are found to be valid (less than 10% discordant from their claims) as independently verified 4. Average health facility quality-of-care score 5. Number of beneficiaries receiving services financed through the FFS mechanism
Intermediate Results Indicators	1. Number of outpatient visits per year, children, and adults (sum of Abia, Niger & Osun) 2. Percentage of children (12-23) months with Pentavalent 3 vaccination (average in three states of Abia, Niger, and Osun) 3. Percentage of births attended by skilled health personnel (average of Abia, Niger & Osun) 4. People who have received essential health, nutrition, and population (HNP) services 4a. People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) 4b. Number of children immunized 4c. Number of deliveries attended by skilled health personnel 5. Number of project facilities receiving payments on time 5a: Number of public FFS facilities receiving payments on time 5b: Number of private FFS facilities receiving payments on time 5c: Number of public primary health centers receiving operational expenses through DFF mechanism on time 6: Percentage of health facilities enrolled in the DFF payment system that received supervision in the last quarter 7: Percentage of public health facilities in the project area with functioning management committees having community representation

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Preparation	
Olumide Olaolu Okunola	Task Team Leader(s)
Daniel Rikichi Kajang	Procurement Specialist(s)
Adewunmi Cosmas Adekoya	Financial Management Specialist
Ovede Benjamin Onigu - Otite	Team Member
Ayodeji Gafar Ajiboye	Team Member
Michael Gboyega Ilesanmi	Social Specialist
Fatimah Abubakar Mustapha	Team Member
Elina Pradhan	Team Member
Maxwell Bruku Dapaah	Team Member
Luc Laviolette	Peer Reviewer
Ruth Adetola Adeleru	Team Member
George Ferreira Da Silva	Team Member
Joseph Ese Akpokodje	Environmental Specialist
Ana Lazara Besarabic	Team Member
Ayodeji Oluwole Odutolu	Team Member
Christoph Kurowski	Team Member
Mei Wang	Counsel
Benjamin P. Loevinsohn	Team Member
Beth Anne Hoffman	Team Member

Ajay Tandon	Peer Reviewer
Supervision/ICR	
Olumide Olaolu Okunola, Ayodeji Gafar Ajiboye	Task Team Leader(s)
Daniel Rikichi Kajang	Procurement Specialist(s)
Akinrinmola Oyenuga Akinyele	Financial Management Specialist
Onoriode Ezire	Team Member
Olakitan Abdulrasheed Jinadu	Team Member
Cindy Ijeoma Ikeaka	Social Specialist
Vivian Obianujunwa Mbusu	Team Member
Michael Gboyega Ilesanmi	Social Specialist
Saudatu Umma Yaradua	Team Member
Fatimah Abubakar Mustapha	Team Member
Elina Pradhan	Team Member
Karine N. MOUKETO-MIKOLO	Team Member
Ogochukwu Joy Medani	Team Member
Ruth Adetola Adeleru	Team Member
Abimbola Ogunseitan	Team Member
Joel Olukayode Ogboye	Team Member
George Ferreira Da Silva	Team Member
Joseph Ese Akpokodje	Environmental Specialist
Frank Anthony Fariello	Counsel
Ana Lazara Besarabic	Team Member
Mary Anika Asanato-Adiwu	Team Member
Joyce Chukwuma-Nwachukwu	Procurement Team

B. STAFF TIME AND COST

Stage of Project Cycle	Staff Time and Cost	
	No. of staff weeks	US$ (including travel and consultant costs)
Preparation		
FY18	15.528	127,548.68
FY19	1.466	14,777.56
FY20	6.275	34,523.47
Total	**23.27**	**176,849.71**
Supervision/ICR		
FY18	15.639	81,938.81
FY19	27.562	182,319.43
FY20	2.740	49,815.07
Total	**45.94**	**314,073.31**

ANNEX 3. PROJECT COST BY COMPONENT

Components	Amount at Approval (US$M)	Actual at Project Closing (US$M)	Percentage of Approval (US$M)
Strengthening Primary Health Care Services through the BHCPF.	17.00	17.00	0
Strengthening Health Management systems for the BHCPF implementation.	3.00	3.00	0
Total	**20.00**	**20.00**	**0.00**

ANNEX 4. EFFICIENCY ANALYSIS

The Efficiency section of the report discussed how the BHCPF pilot was designed as the proof-of-concept for a bold reform that would bring more money to PHC and make more efficient use of those funds. The context section highlighted that this focus on getting better results from health investments was essential given that Nigeria's health outcomes were among the lowest in the world, and government health spending was only $11 per capita. This section elaborates on the efficiency analysis in the main report.

Allocative efficiency: The BHCPF reform represents a more efficient allocation of resources relative to the model that existed previously, where FGoN resources largely prioritized tertiary care. In Nigeria, seventy-two percent of the burden of disease is due to communicable, maternal, neonatal, and nutritional diseases, which can be prevented and treated at the primary health care level. Among children under five, more than half the disability-adjusted life years can be attributed to diarrhea, lower respiratory and infectious diseases, neglected tropical diseases and malaria. Malaria is the number one cause of premature death in the country and accounts for nearly half of out-of-pocket health expenditures (Institute for Health Metrics, 2017) (Federal Republic of Nigeria, 2017) (Hafez, 2019). Many of these conditions could be prevented and treated by highly cost-effective intervention packages offered at the primary care level. The table below shows the benefit for every dollar spent for common interventions that were part of the BHCPF benefits package (Yamey, et al., 2016) (Table 4-1).

Table 4-1. Benefit cost-ratio of best-buy interventions that are included in the BHCPF

Health focus	Intervention package	Benefit per dollar
Nutrition	Stunting reduction interventions including: micronutrient supplementation; universal salt iodization; calcium supplementation; folate and iron fortification and supplementation; breastfeeding and complementary feeding education; zinc and vitamin A supplementation; community-based management of acute malnutrition	$3-$48
Immunization	Package of vaccines; DTP-Hep Hib or pentavalent; human papillomavirus; Japanese encephalitis; measles; mumps and rubella; rotavirus; pneumococcal conjugate vaccine; yellow fever	
Maternal and child health	Intervention package for maternal and newborn health and child health; immunization, HIV/AIDS, family planning and malaria	$9-$20
Non-communicable diseases	Aspirin therapy at onset of acute heart attack; management of chronic hypertension; 30 % salt reduction in manufactured foods; 125 percent increase in tobacco price; secondary prevention of cardiovascular disease with polypill	$9
Malaria	Malaria control is sub-Saharan Africa	$5

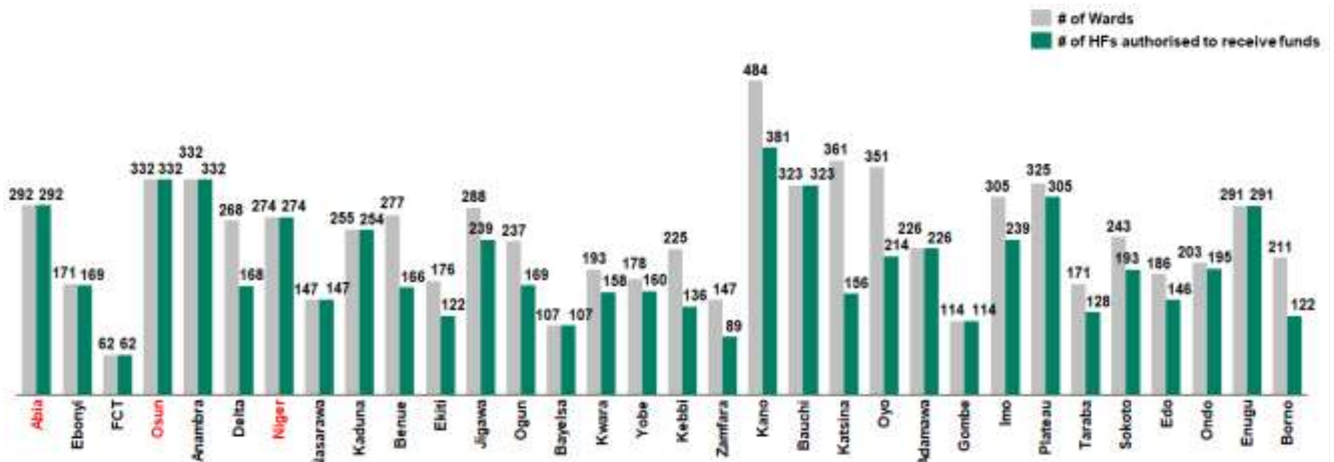
Source: Yamey G, Beyeler N, Wadge H, Jamison D. Investing in Health: The Economic Case. Doha, Qatar: World Innovation Summit for Health, 2016.

Low cost investment relative to the funds leveraged by the FGoN for the national program. Nigeria has historically been one of the lowest spenders on health in the world, which is itself a source of inefficiency. The project disbursed $11.5 million of development assistance but this investment leveraged N87.99 billion (~US$218 million) in domestic funding between the start of the project and December 2021, over and above what was allocated through the regular budget process. This funding included the Service Wide Votes and

Statutory Transfers but excludes the counterpart financing that was used for facility upgrades, hiring of staff, and other investments at the subnational level.

A shift toward better quality by giving PHCs operating budgets with the accountability mechanisms to use it to improve service delivery. Out of 9,211 wards, 6,409 facilities were authorized to receive funds by December 2021, representing 70% of the wards in Nigeria. This increases the availability of functioning PHCs that receive operational funds. A total of 5,829 of these facilities are now receiving funds specifically for service delivery. Already, this is an improvement over the baseline, where only a third of publicly owned PHC facilities received any form of operational funding.[9] See Figure 4-1 below.

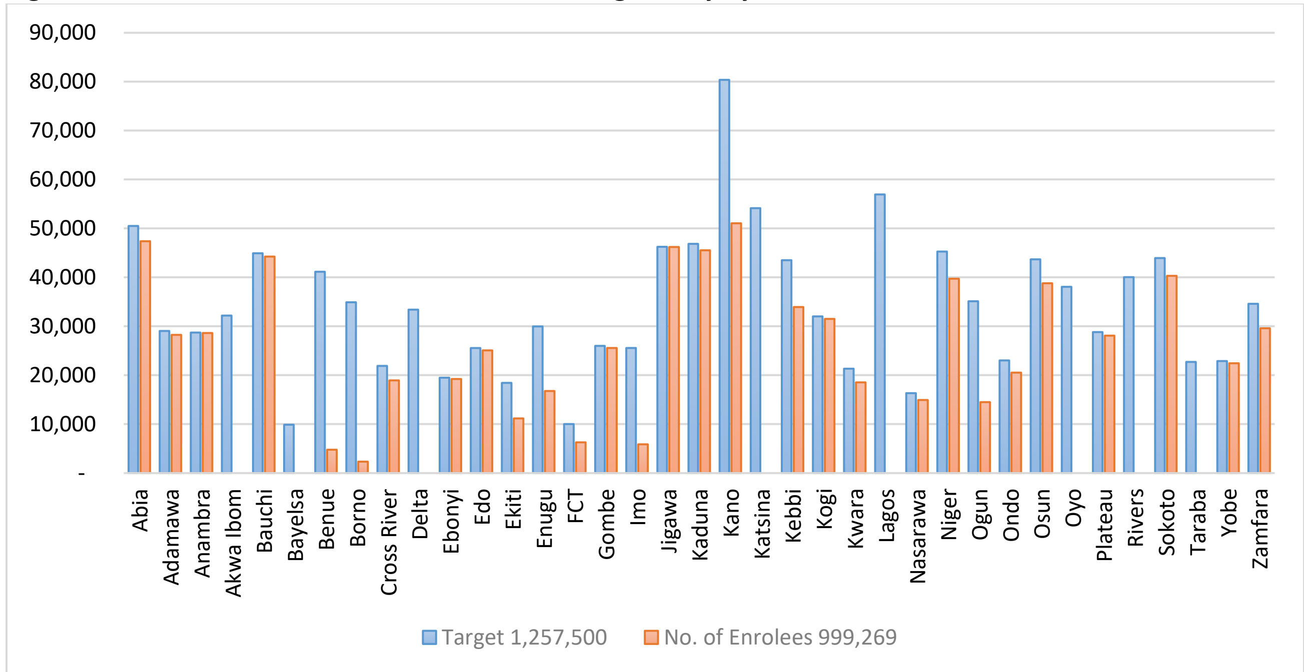
Figure 4-1. Facilities authorized to receive funds in Nigeria.



*Pilot states are in red font.

More people enrolled in health insurance with greater access to services and financial protection. Nigeria's out-of-pocket spending on health in 2018 accounted for 76% of health spending and only 4.2% of the population was enrolled in health insurance. The BHCPF, through the NHIS gateway, has now been expanded throughout the country to enroll the poorest beneficiaries. As of December 2021, 999,269 people were enrolled in the National Health Insurance Scheme for the poor, through the NHIS gateway (See enrolment by state in Figure 4-2 below). This demonstrates that the project was an efficient use of development assistance and had impact beyond the timeline of the project.

Figure 4-2. Enrolment of beneficiaries in the NHIS gateway by state, December 2021



Source: National Health Insurance Scheme (NHIS) November 2021

ANNEX 5. BORROWER, CO-FINANCIER AND OTHER PARTNER/STAKEHOLDER COMMENTS

Dear Olumide,

Thank you for sharing the WB ICR which I reviewed and shared my input with you in March, 2022. Below are my comments:

a. Paragraph 93b should read the other way round as the OM referenced the use of the National Social Register to determine eligibility and specified that only the most vulnerable—children under five, pregnant women, the elderly, the disabled, and other vulnerable groups—were eligible for BHCPF services.

b. On paragraph 107, The project was only able to utilize $6.3million considering that $5.2million was refunded out of the $11.5 million

c. Paragraph 110, the statement "while the UK-FCDO committed about £70M for the purchase of essential health services" is not necessary and should be deleted.

d. It would be nice to mention some impact of the Project on health outcomes.

Overall, the report captured the essentials of the Project.

Please find attached the draft Client ICR. Kindly note that it is still a draft.

Best Regards

Dr. Chris. Osa. Isokpunwu
Director/ Senior Technical Assistant to the Honourable Minister of Health,
Secretary, Ministerial Oversight Committee(MOC) of the BHCPF
Federal Ministry of Health, Abuja, Nigeria

ANNEX 6. SUPPORTING DOCUMENTS

Annex 6-1. **Phasing of World Bank Support to the Implementation of the Basic Healthcare Provision Fund**

1. **The project supported the GoN's commitment to UHC as enacted in the NHAct of 2014**. This commitment was reiterated by the FMOH in the NHSDP II. The GFF aligned its support to this plan through a RMNCAH+N Investment Case (2018–22), which articulates the phased approach of the implementation of the BHCPF. The plan proposed the rollout of the BHCPF in three phases (described below), to allow for critical lessons to be learned and to ensure the systems were developed to inform nationwide rollout.

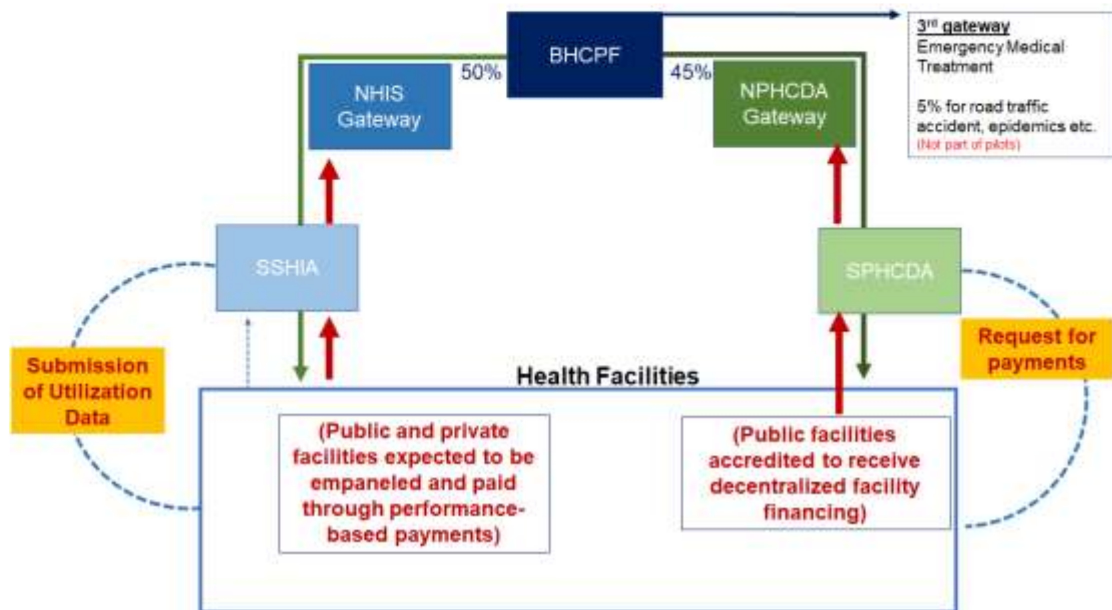
2. **The BHCPF is the principal funding vehicle through which a BMPHS is provided to all Nigerians; it mobilizes significant domestic resources for financing RMNCAH+N and supports Nigeria in its bid to close the RMNCAH+N resource gap.** The financing required from one phase to the other was expected to evolve over time with a gradual but important shift from donor financing to domestic resources. It was envisaged that the support of the World Bank in Phases II and III will be included in the proposed Multi-Phase Programmatic Approach (MPA) for the health sector.

3. **Phase 1: Kick-starting the implementation of the BHCPF (2018–2022)**. Through the GFF-supported grant (US$20 million) the implementation of the BHCPF was piloted in three pilot states as a proof of concept. The GFF grant would support the FMOH to make the case for BHCPF financing in the GON's 2018 budget. This phase emphasized the project focus on results through system strengthening necessary for national rollout, including the implementation of an accreditation framework, and building of a verification and payment system. The GFF-supported pilots would demonstrate program effectiveness and provide the platform to facilitate nationwide implementation of the BHCPF in Phase II, and also allow for learning and course correction as appropriate. An impact evaluation of the BHCPF pilot was also planned to demonstrate the project's effectiveness in improving health outcomes as well as inform future design and rollout.

4. **Phase 2: Scale up BHCPF to all states in the federation (2019–2022)**. This phase was expected to scale up the provision of the BMPHS through the BHCPF to the remaining 33 states + FCT in Nigeria. This geographical expansion phase would enable the national rollout of the BHCPF based on the lessons from the successful implementation of Phase I.

5. **Phase 3: Expansion of package of services (2022–2030)**. Once the BMPHS had been scaled up nationwide through the BHCPF and the necessary institutions and structures were available to ensure the delivery of service to the frontline; the package would be broadened to include additional cost-effective services. This package expansion phase follows the systems strengthening and geographical expansion in the previous phases to allow for substantially scaling up of additional services not listed in the BMPHS.

Annex 6-2. Structure of BHCPF and the three gateways



Annex 6-3. State Level Verification Processes

Readiness criteria for state verification	Explanation	Status/date completed
Expression of interest	States typically write letters to express interest but as part of the project, Abia, Osun, and Niger States were purposively selected.	December 2018
Financial commitment	As per the operational manual, states were required to make an upfront payment of 100 million Naira (US$330,000). State level governments released this and used it for the set-up of state level operations in the pilot states. The counterpart funding was used to set up the governance structures; pay for training at the facility and community level on the new BHCPF operations and guiding PHC management strategy; make operational upgrades; and hire new staff.	May 2019
Establishment of governance structures at state and local level	States were required to set up State Steering Committees and every ward was required to have a Ward Development Committee that was directly involved in planning and decision-making of the facilities, including approval of disbursement of funds. This was accomplished in all states and wards, except for the two wards in Niger State mentioned earlier that faced insecurity challenges.	February 2019
Development of legal framework for state agencies	States needed to have established the legal framework for SPHCDA and be operationally ready for the NPHCDA gateway; for the NHIS gateway, the SSHIA legal framework needed to be established, with staff deployed to manage them. Both were accomplished in each of the pilot states, but SPHCDA was better prepared for this as SPHCDAs had already been established and operating several years before the BHCPF, whereas the SSHIAs needed to be established, resulting in delays in testing the NHIS gateway properly before the project ended. However, the requirement to work through the SSHIAs also helped to catalyze the establishment of the SSHIAs. This is discussed in more detail in the section on Institutional Strengthening.	May 2019
Capacity building	Both Training of trainers and “step down” training was conducted as part of the accreditation process, and then used as verification criteria for the receipt of funds.	December 2019

Annex 6-4. Changes to Operational Manual

1. The most consequential aspects of the OM changes were the following:

a) **Dissolution of the BHCPF Secretariat.** The OM review process questioned the role of the National Steering Committee and its Secretariat. The BHCPF Secretariat tasked with overseeing operations under the 2018 OM was dissolved and project staff were posted out of the Secretariat. This change would mark a departure from the Grant Agreement, which stated that *"the Recipient shall ensure that the National Steering Committee shall maintain, throughout the implementation of the Project, a Secretariat (also functioning as the coordinating unit) with functions, status, staffing and resources satisfactory to the World Bank and as further elaborated in the BHCPF Operational Manual".*[46] This change stalled the transfer of funds and had a negative impact on the day-to-day operations.

b) **Fiduciary management of BHCPF resources.** The dissolution of the BHCPF Secretariat meant that the staff from the FPFMD, who were posted in the Secretariat, could no longer provide oversight. This marked a departure from the Grant Agreement, which stated that sufficiently trained staff from the accounting and internal audit units of the FPFMD, would remain responsible for the overall financial management of the Project. This change resulted in a delay in the retirement of the statement of expenditure and other necessary documentation, and the project lacked government counterparts with a detailed and nuanced understanding of the intricacies of the project design.

2. Other changes to the manual were not structural. However, they were likely critical factors (among other factors) contributing to the project not achieving its indicators on the number of beneficiaries enrolled and the number of facilities paid through the FFS/NHIS gateway. These include:

a) **Changes to the NHIS gateway:** The operationalization of the NHIS was delayed due to many reasons, including the time needed to institutionalize the SSHIAs and capacity constraints. The new manual modified the payment mechanism for the NHIS such that primary care providers receive capitation payments (a fee per beneficiary enrolled for the year), with the 'fee-for-service' (bundled payments for different services) reserved for secondary care on the same gateway. While restructuring of the results framework would have prevented a great deal of confusion for reporting, this type of payment was still considered a performance-based grant, in line with the Grant Agreement so capitation payments on the NHIS gateway were reported against the original framework. The challenge was, however, that the change in payment meant that the target on the number of beneficiaries enrolled per state could never be reached because a cap was placed on the number of beneficiaries. This made it even more important to ensure that the most vulnerable beneficiaries were being reached, as previously the design had hoped to reach many more people.

b) **Changes to the beneficiary selection methodology.** The original OM did not specify who should enroll; it stated only that the scheme was for the poor and vulnerable. In rural areas—where the scheme was implemented and where most individuals could be considered poor—the criteria needed to be explicitly defined because demand for the scheme was high and resources were limited. The revised manual referenced the use of the National Social Register to determine eligibility and specified that only the most vulnerable—children under five, pregnant women, the elderly, the disabled, and other vulnerable groups—were eligible for BHCPF services. Thus, the three states adopted different identification and

[46] Federal Republic of Nigeria and IDA, Global Financing Facility Grant Agreement: Nigeria Basic Healthcare Provision Fund Project. GFF Grant Number TF0A7654

revalidation strategies to confirm poverty status using their own data, while giving priority to women of reproductive age and children. A summary is provided below:

i) Abia State: The state health insurance agency validated the poverty identification strategy with community groups and members. The project first provided training to the Ward Development Committees and Health Management Committees, giving them the responsibility to select the beneficiaries for the program, with the input of community groups and traditional rulers. The lists were then authenticated at the community and state level. The list from the community institution was used to validate the National Social Registry and planned poverty means test was carried out based on the revalidated NSR list. In cases where the discordance between the Community List and the NSR was over 65 percent, the community list was prioritized for the planned poverty means test, and the list of community members enrolled on the BHCPF were sent to the Abia State Ministry of Budgeting and Economic Planning for update of the National Social Register.

ii) Niger state: The SSHIA, in collaboration with the Niger State Ministry of Economic Planning and Youth Development used a list from another World Bank funded program (YOU-WIN), which had mapped over 750,000 persons across Niger state into poverty bands and revalidated the Niger state NSR in 2019. The SSHIA used this YOU-WIN list to target enrollment of BHCPF beneficiaries on extremely- and ultra-poor persons across all LGAs in the state.

iii) Osun state: the SSHIA carried out its own poverty means testing exercise following validation by the State Ministry of Economic Planning. This new poverty list was used to enroll beneficiaries onto the Osun BHCPF NHIS gateway. This strategy was, however, running in parallel to other poverty identification strategies already in place in the state and lacks coordination with other poverty elimination strategies. Thus, to ensure greater alignment with national strategies, this process was discouraged for nationwide rollout, and today, the Osun State Health Insurance Agency has now completed the reconciliation of the BHCPF beneficiaries with the National Social Register.

Annex 6-5a. Visual of facility upgrades in Abia State (before accreditation)

These pictures were taken on missions by World Bank staff and as part of regular reporting by NHIS and NPHCDA to the BHCPF/MOC Secretariat and State level Secretariats. Many of these pictures were presented in a Lessons Learned workshop hosted by the World Bank and heads of agencies.

Annex 6-5b. Purchases and upgrades made in BHCPF facilities as part of the accreditation process

Annex 6-6: The project's institutionalization of State Agencies

1. **The SPHCDAs were better prepared for the implementation of the new processes of the BHCPF in comparison to their SSHIA counterparts.** The early institutionalization of the SPHCDAs (see Table 6-1 below) meant that they already had the PHC management structure to deliver through the NPHCDA gateway. This is particularly true in Abia and Osun, where the states had completely implemented the Primary Health Care Under One Roof strategy, which in addition to the set-up of the SPHCDAs mandated state governments to payroll all PHC staff previously under the local government to the SPHCDAs. This set-up was catalytic to the delivery of the NPHCDA gateway, which was largely implemented with minimal difficulties at the state level. Following implementation of the BHCPF, PHC management and reporting to the SPHCDAs improved significantly with the renewed financing and accountability framework embedded in the BHCPF operations, which grants PHC providers greater flexibility to deliver improved healthcare services to their clients.

Table 6-1. Timelines for establishment of SPHCDAs

	Year of Enactment of SPHCDA Law/Act	Year of Establishment of SPHCDA	Acquisition of Dedicated SPHCDA Building, Agency Staff and Transfer of PHC staff under Agency)	Finalization of the PHCUOR Strategy	Year of Operationalization of the BHCPF
Abia	2014	2015	2016	2018	2019
Niger	2014	2017	2018	N/A	2019
Osun	2011	2013	2014	2017	2019

2. **On the other hand, the establishment of SSHIAs was prompted by the BHCPF operationalization in Nigeria** (see Table 6-2). In the 3 pilot states, only Niger state had a law establishing a state health insurance agency before the pre-planning of the BHCPF pilots. Across the project states and Nigeria at large, SSHIAs were new ventures of sub-national government with very minimal operational capacity. Operational and technical inadequacies within the SSHIAs affected the NHIS gateway operationalization as anticipated. These inadequacies translated into a delay in the enrollment of beneficiaries and access to services in the NHIS gateway. Specifically, the global COVID-19 pandemic also stalled the operationalization of the gateway and utilization of the NHIS gateway grant before the project completion period.

Table 6-2. Timeline for Establishment of SSHIAs

	Year of Enactment of SSHIS Law/Act	Year of Establis hment of SSHIA	Year of Operation alization of the BHCPF	Acquisition of Dedicated SSHIS Building, and Agency Staff	Availability of ICT backed Health Insurance Management Platform	Commencement of State-Supported Social Health Insurance Scheme (Facility empanelment, Beneficiary Enrolment, Provider Payment)
Abia	2018	2019	2021	Yes	Yes	N/A
Niger	2018	2019	2021	Yes	Yes	2021
Osun	2018	2019	2021	Yes	Yes	2019

Abia State: The state health insurance agency validated the poverty identification strategy with community groups and members. The project first provided training to the Ward Development

Committees and Health Management Committees, giving them the responsibility to select the beneficiaries for the program, with the input of community groups and traditional rulers. The lists were then authenticated at the community and state level. The list from the community institution was then used to validate the National Social Registry and planned poverty means test was carried out based on the revalidated NSR list. In cases where the discordance between the Community List and the NSR was over 65 percent, the community list was prioritized for the planned poverty means test, and the list of community members enrolled on the BHCPF were sent to the Abia State Ministry of Budgeting and Economic Planning for update of the National Social Register.

Niger state: The SSHIA, in collaboration with the Niger State Ministry of Economic Planning and Youth Development used a list from another World Bank funded program (YOU-WIN), which had mapped over 750,000 persons across Niger state into poverty bands and revalidated the Niger state NSR in 2019. The SSHIA used this YOU-WIN list to target enrollment of BHCPF beneficiaries on extremely- and ultra-poor persons across all LGAs in the state.

Osun state: the SSHIA carried out its own poverty means testing exercise following validation by the State Ministry of Economic Planning. This new poverty list was used to enroll beneficiaries onto the Osun BHCPF NHIS gateway. This strategy was, however, running in parallel to other poverty identification strategies already in place in the state and lacks coordination with other poverty elimination strategies. Thus, to ensure greater alignment with national strategies, this process was discouraged for nationwide rollout, and today, the Osun State Health Insurance Agency has now completed the reconciliation of the BHCPF beneficiaries with the National Social Register.

Annex 6-7. Flow of Revenue to the Budget and BHCPF

Oil revenue
Customs and Excise
Company Income Tax (CIT)
Value-added tax (VAT)
Excess crude account (stabilization fund)
Budgeted oil revenue
93% and 96% to FAAC after cost of collection
96% to VAT pool after cost of collection
Federation revenue
Derivation account
Federation account (FAAC)
VAT pool
13% derivation back to oil producing states according to their contribution
FAAC distribution:
54.7% to Federal
24.7% to State
20.7% to Local
VAT distribution:
15% to Federal
50% to State
35% to Local
Debt Service
Federal Govt. (consolidated revenue fund)
Statutory transfers (e.g BHCPF)
State Govt.
10%
Local Govt.
Employers
Ministries, departments, agencies ('regular' budget process)
BHCPF fund (comingled)
State IGRs
Local IGRs
Donors (incl. WBG)
NHIS
FMOH
NPHCDA
PHI/HMOs
SSHIAs
SMOH
SPHCDA
LGA Dept of Health
Federal teaching/ tertiary hospitals
State teaching/ tertiary hospitals
State specialist/ General hospitals
Primary health centres
Households

Flow of funds
In-kind flows
Flow of funds for BHCPF

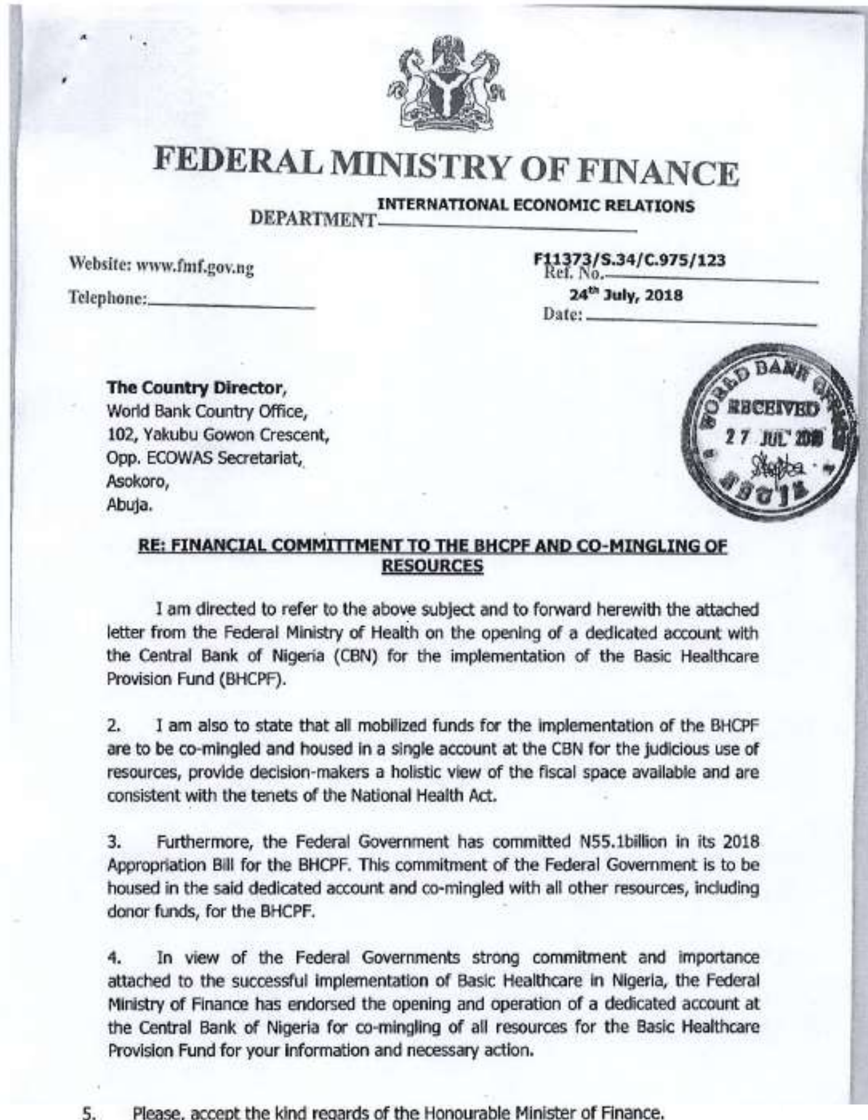
Notes: IGR=Internally generated revenue; N/SHIS=National/State Health Insurance Scheme; F/SMOH=Federal/State Ministry of Health; N/SPHCDA=National/State Primary Health Care Development Agency; LGA=Local government agency

Source: Adapted from Hafez, 2018. Health Financing System Assessment, Nigeria. World Bank (using allocation formulas from 2018).

- Roughly 45 percent of federal revenues are allocated to subnational levels; these are then allocated by subnational governments.
- The consolidated revenue fund is used to first pay statutory transfers and debt payments. The remaining amount is allocated to ministries, departments, and agencies through the regular budget process.
- The BHCPF is a statutory fund that allocates additional funds via the two gateways to NHIS and NPHCDA before being channeled directly to facilities (although it is allocated according to poverty levels in the state and passes through the budget of the state level agencies but is only released at the facility level).

- BHCPF resources from the project were comingled with government funds; other donor funding can also be comingled with this fund to finance the BHCPF.

Annex 6-9. Ministry of Finance Request for Comingling of Donor Funds with FGoN Funds in CBN Account



FEDERAL MINISTRY OF FINANCE

DEPARTMENT INTERNATIONAL ECONOMIC RELATIONS

Website: www.fmf.gov.ng
Telephone:

Ref. No. F11373/S.34/C.975/123
Date: 24th July, 2018

WORLD BANK OFFICE RECEIVED 27 JUL 2018

The Country Director,
World Bank Country Office,
102, Yakubu Gowon Crescent,
Opp. ECOWAS Secretariat,
Asokoro,
Abuja.

RE: FINANCIAL COMMITTMENT TO THE BHCPF AND CO-MINGLING OF RESOURCES

I am directed to refer to the above subject and to forward herewith the attached letter from the Federal Ministry of Health on the opening of a dedicated account with the Central Bank of Nigeria (CBN) for the implementation of the Basic Healthcare Provision Fund (BHCPF).

2. I am also to state that all mobilized funds for the implementation of the BHCPF are to be co-mingled and housed in a single account at the CBN for the judicious use of resources, provide decision-makers a holistic view of the fiscal space available and are consistent with the tenets of the National Health Act.

3. Furthermore, the Federal Government has committed N55.1billion in its 2018 Appropriation Bill for the BHCPF. This commitment of the Federal Government is to be housed in the said dedicated account and co-mingled with all other resources, including donor funds, for the BHCPF.

4. In view of the Federal Governments strong commitment and importance attached to the successful implementation of Basic Healthcare in Nigeria, the Federal Ministry of Finance has endorsed the opening and operation of a dedicated account at the Central Bank of Nigeria for co-mingling of all resources for the Basic Healthcare Provision Fund for your information and necessary action.

5. Please, accept the kind regards of the Honourable Minister of Finance.

Aliyu Ahmed
Director, International Economic Relations
For: Honourable Minister of Finance.

Annex 6-8. Memo on Migration of States Funded by the World Bank/GFF to Federal Government Financing

MINISTERIAL OVERSIGHT COMMITTEE

MEMO ON MIGRATION OF STATES FUNDED BY THE World Bank/GFF TO FEDERAL GOVERNMENT BHCPF FINANCING PLATFORM

The purpose of this memorandum is to seek Committee's consideration and approval to continue the allocation of resources to the three States of Abia, Niger, and Osun on all gateways for the continuous implementation of the BHCPF as designed in the 2020 revised operations' manual

2. In February 2018, the Minister of Health through the Minister of Finance sought the approval of the World Bank to pilot the implementation of the BHCPF in three states of *Abia, Niger, and Osun*. The World Bank subsequently prepared a USD20M facility through grant funding received from the Global Financing Facility. The grant facilitated the initial implementation of the BHCPF and served as an effective advocacy instrument for nationwide scale-up of a clear strategy towards achieving UHC in Nigeria envisioned in the 2014 National Health Act (NHAct).

3. The World Bank supported pilot project in the three states of Abia, Niger and Osun will close on 30th June 2021. For the three states to continue to implement the BHCPF, they have to revert to funding from the Federal Government.

4. Consequently, the Council is invited to note that:

i. the funding from the World Bank/GFF which disbursed a total sum of 11.5M USD to these three states closes on the 30th June 2021. To ensure appropriate transitioning, the three states currently funded under the World Bank/GFF grant are required to revert to funding from the Federal Government appropriation.

ii. Consider and approve the allocation of resources to these three states of Abia, Niger, and Osun on all gateways for the continuous implementation of the BHCPF as designed in the 2020 revised operations' guideline from 02 June 2021 from the available resources in GON appropriation.

MOC Secretariat
June, 2021

Annex 6-9. Memo on Strengthening Fiduciary Arrangement in the Implementation of BHCPF by BHCPF/MOC Secretariat

MINISTERIAL OVERSIGHT COMMITTEE

MEMO ON STRENTHENING FIDUACIARY ARRANGEMENT IN THE IMPLEMENTATION OF BHCPF BY SECRETARY, BHCPF

The purpose of this memorandum is to seek Committee's consideration and approval to strengthen Fiduciary arrangements in the implementation of Basic Health Care Provision Fund (BHCPF). The fiduciary arrangement will strengthen judicious utilization of resources, promote accountability and transparency in use of public funds, as well as provide needed confidence to attract additional investments in the Fund by both Government and Partners and Private Sector.

2. The revised BHCPF guideline was approved by the National Council of Health in August 2020 and prescribes strict adherence to Nigerian public financial management processes that mandate timely, predictable transfers to States by the National Implementing entities, the optimal use of BHCPF funds and transparent, financial management and accounting.

3. The BHCPF Funds, as with all public funds, is subject to Federal Government's extant financial management systems and rules of budgeting, financial instructions and reporting, and auditing. A functional institutional arrangement for BHCPF Financial Management Systems shall ensure that funds meant for service delivery to beneficiaries, are adequate and predictable, equitably and efficiently used, and openly accounted for.

4. Consequently, the MOC is invited to note that:

i. Weak accounting and financial reporting on implementation of the BHCPF results in ineffective realization of the BHCPF vision, with attendant compromise of Nigeria's crucial Universal Health Coverage aspirations, due to resource misapplication and misuse of public funds.

ii. The proposed fiduciary measures are in line with the provisions of the financial regulations, which empower the Accountant General to publish statements of accounts, as required by the Ministry of Finance (FR 107(c).

5. The MOC is requested to approve the following fiduciary safeguards for the Fund:
Implementing entities shall:

a. produce and make available to all Ministerial Oversight Committee (MOC) members **quarterly budget execution report of all BHCPF funds, not later than 30 days after each quarter.** The quarterly budget execution reports will also be published on the FMOH/ FMoFBNP website not later than 30 days after each quarter;

b. produce and **submit for external audit, financial statements of all BHCPF funds,** not later than 3 months after the end of each financial year;

c. **respond to all issues raised by auditors and provide required documents during audits, within 30 days of notification** by auditors and take action on all issues identified by the auditors before the next audit;

d. produce and **make public (on FMOH/FMoFBNP website) financial and of BHCPF funds** not later than 6 months after the end of each financial year;

MOC Secretariat
June, 2021

Annex 6-10. Key Informant Interviews during the ICR Virtual Mission

Principal Officer	Name
Commissioner, Health	Dr. Jonathan Osuji
PS, Health	Mrs. Franca Ekwu
ES, SPHCDA	Dr. Chinagozi Adindu
ES, SSHIA	Dr. Chidi Ubani-Ukoma
BHCPF DO 1	Dr. Ikechi Ogbonnaya
BHCPF DO 2	Emeka Sopuruchi
Commissioner	Dr. Muhammed Makusidi
PS, Health	Dr. Mohammed Gana
ES, SPHCDA	Dr. Ibrahim Dangana
ES, SSHIA	Dr. Mohammed Usman
BHCPF DO 1	Dr Inuwa Junaidu
BHCPF DO 2	Pharm AB Musa
Commissioner	Dr Rafiu Isamotu
PS, Health	Mr. Kayode Adegoke
SA, Public Health*	Pharm. (Dr.) Siju Olamiju
ES, SPHCDA	Dr. Fabiyi
ES, SSHIA	Dr. Oginni
BHCPF DO	Dr. Akintayo

*The SA, Public Health Oversees the BHCPF in Osun
PS=Principal Secretary; ES=Executive Secretary; DO=Desk Officer; SA=Special Advisor to Government