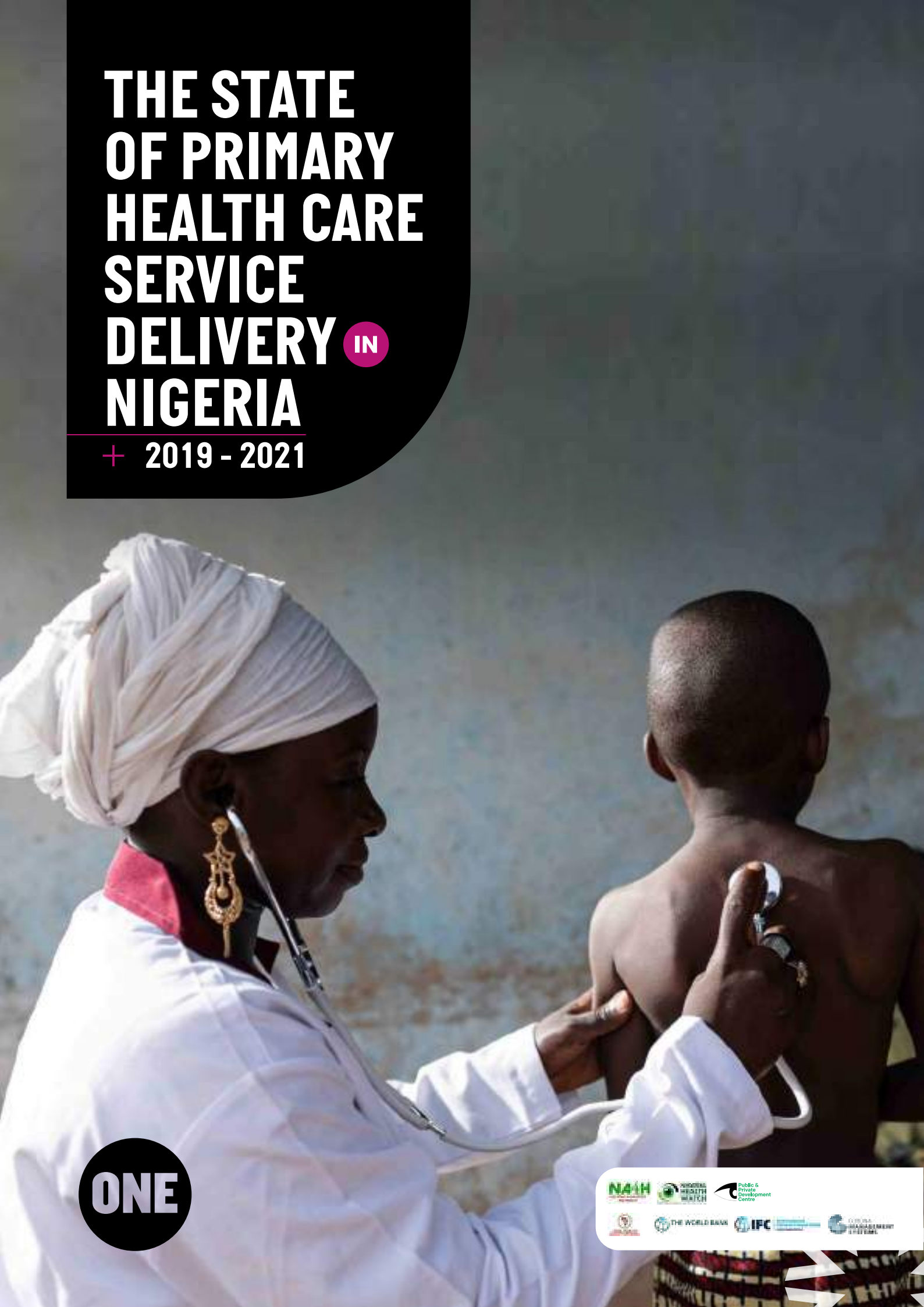
THE STATE OF PRIMARY HEALTH CARE SERVICE DELIVERY IN NIGERIA

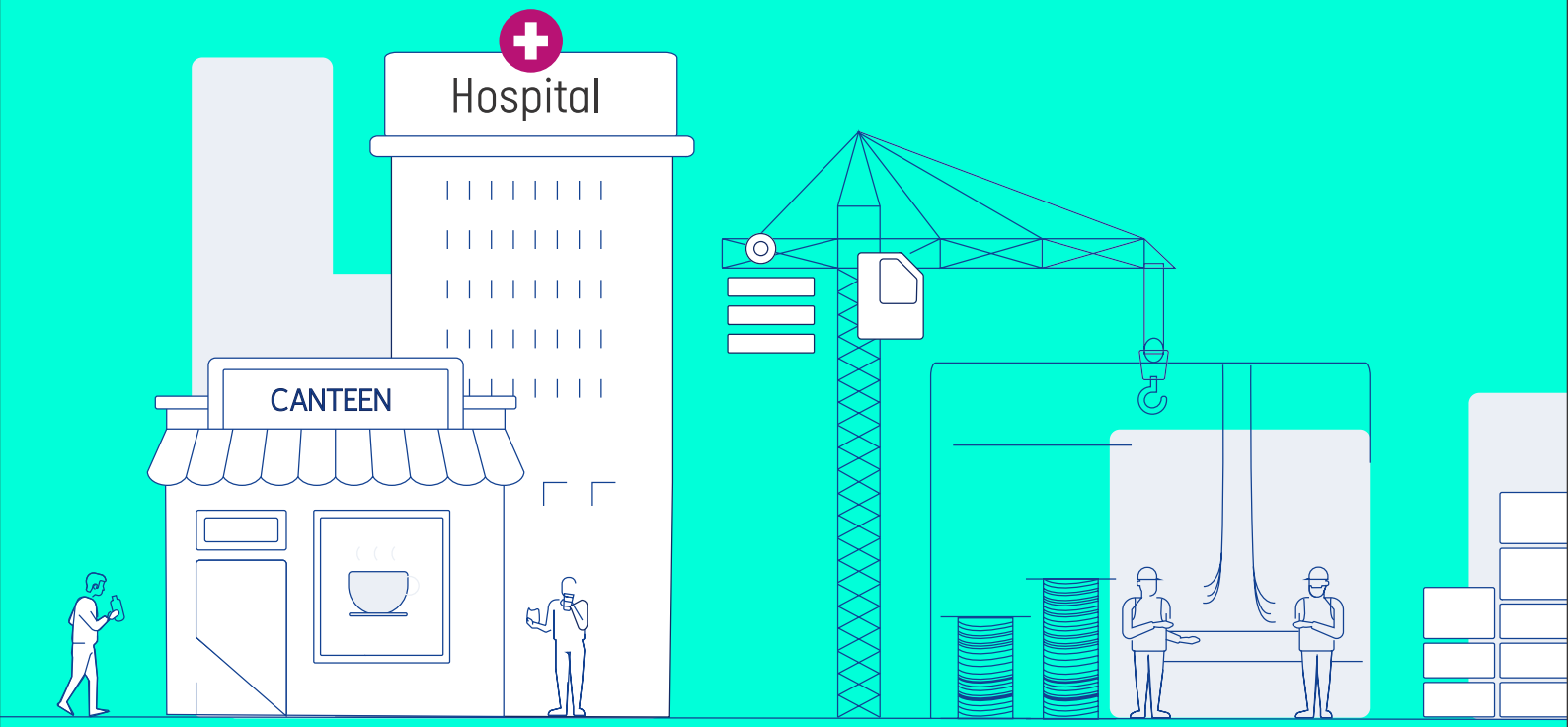
+ 2019 - 2021



ONE

80%

For this report, the gold standard is that less than 5% of eligible health facilities are reporting stock outs of health products for TB control, 80% of eligible health facilities providing reports in the review quarter (used instead of month, based on the reporting systems available), the state has adequate stock available for three select health products to support outbreak response (with adequacy as defined by the minimum and maximum stock levels within the reporting framework), and the state has strong supply chain governance through its logistics technical working groups and logistics management coordinating units or drug management agencies.



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*The World Bank/IFC Team were instrumental in providing technical assistance to review and distill the different components of the Basic Health Care ProvisionFund. This allowed the development of an objective set of indicators with which this fund could be assessed, forming a critical foundation for this scorecard report.

List of Abbreviations

ACT	Artemisinin-based combination therapy
BCG	Bacille Calmette-Guerin
BHCPF	Basic Healthcare Provision Fund
BMPHS	Basic Minimum Package of Health Services
CBO	Community-Based Organisation
CHIPS	Community Health Influencers, Promoters, and Services
CHW	Community Health Workers
COVID-19	Coronavirus disease
CMS	Corona Management Systems
CRF	Consolidated Revenue Fund
DAH	Development Assistance for Health
DFF	Decentralised Facility Funding
ECP	Emergency Care Providers
EMT	Emergency Medical Treatment
FBO	Faith-Based Organisation
FCDO	Foreign, Commonwealth, and Development Office
FCT	Federal Capital Territory
FETP	Field Epidemiology Training Program
FG	Federal Government
FMOH	Federal Ministry of Health
FRN	Federal Republic of Nigeria
GGHE	General government health expenditure
GHSA	Global Health Security Agenda
HIS	Health Information System
HIV	Human Immune-deficiency Virus
HRH	Human Resource for Health
HSS	Health systems strengthening
ICT	Information and Communications Technology
IDI	In-depth Interviews
IDSR	International Disease Surveillance and Response
IFC	International Finance Corporation
IHR	International Health Regulations
IMF	International Monetary Fund
KII	Key-Informant Interviews
LMIS	Logistics Management Information System
MDA	Ministries, departments, and agencies
MOC	Ministerial Oversight Committee
MSP	Minimum Service Package
MSPAN	Multisectoral plan of action on nutrition
N4H	National Advocates for Health
NASSCO	National Social Safety-net Coordinating Office
NDHS	National Demographic and Health Survey

NEMTC	National Emergency Medical Treatment Committee
NEMSAS	National Emergency Medical Service and Ambulance System (NEMSAS)
NFETP	Nigeria Field Epidemiology Training Program
NGF	Nigeria Governors' Forum
NGO	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information Systems
NPHCDA	National Primary Healthcare Development Agency
PENTA3	Third dose of the pentavalent Vaccine
PHC	Primary Healthcare Centres
PHCUOR	Primary Healthcare Under One Roof
PIU	Programme Implementation Unit
PPDC	Public & Private Development Centre
SDG	Sustainable Development Goals
SEMTC	State Emergency Medical Treatment Committee
SHIA	State Health Insurance Agency
SMOH	State Ministry of Health
SPHCDA	State Primary Healthcare Development Agency
SPHCDB	State Primary Healthcare Development Board
SSHDP	State Strategic Health and Development Plans
TB	Tuberculosis
TGE	Total government expenditure
UHC	Universal Health Coverage
UK	United Kingdom
US	United States
VAN	Visibility and Analytics Network
WHO	World Health Organisation
WHSSP	Ward Health System Service Package

Executive Summary

This report therefore set out to synthesise findings from an analysis and ranking of health system performance across States that includes an assessment of compliance of the States to the sections of the National Health Act and National Health Policy and an overview of the state of healthcare delivery in the 36 states in Nigeria

Health outcomes in many low and middle-income countries, including Nigeria are poor. Yet, safe, effective, and affordable prevention strategies and treatments exist globally, for most of the implicated afflictions, constituting a human crisis which the World Health Organisation (WHO) places squarely on the shoulders of failed health systems[1].

The shortcomings of the health system in Nigeria are further complicated by a governance system which sees the health sector operate as multiple independent units within a federated system.

This is driven by the constitutional mandates that define health as a sector of government for which the 36 states and the Federal Capital Territory (FCT) have autonomy in their governance and management responsibilities[2]. This arrangement places the burden of responsibility of inconsequential health outcomes quite significantly at the door of State leadership.

Governance and leadership of health systems indeed play a critical role as a building block of the health system, and manifests through leadership of system design, policy guidance, oversight, regulation, accountability, and coalition building. This report therefore, set out to synthesise findings from an analysis and ranking of health system performance across States that includes an assessment of compliance of the States to the sections of the National Health Act and National Health Policy and an overview of the state of healthcare delivery in the 36 states of Nigeria and the FCT.

The aim of this report is to analyse and rank health system performance across the 36 States and the FCT using a select group of health systems indicators. Indicators that showcase population-level results of the performance of the health system were selected and State performance on these indicators drawn from nationally accepted data – the 2018 National Demographic and Health Survey (NDHS)[3].

Indicators that then highlight what financial, human, and material resources each State has been putting into the health system and what key processes and activities each State has been providing leadership for, were also selected. These input and process indicators were carefully selected through a consultative process and allow for an analysis of State leadership and effort to improve on the outcomes from the 2018 NDHS.

The underpinning hypotheses for this report are that:

1 **Poor health** outcomes across majority of States from the 2018 NDHS can only be changed if the State provides key financial, human, and material resource investments into its health system, and provides leadership of evidence-based processes to translate these resources to results for the people

2 **Good health** outcomes from a handful of States from the 2018 NDHS can only be sustained and improved on, if the State builds on and improves provision of key financial, human, and material resource investments into its health system, and continues to provide leadership of evidence-based processes to translate these resources to results for the people.

In recognising that for many States with poor health outcomes, current State leadership have had a unique opportunity to transform health outcomes, it is also recognised that the handful of States with good health outcomes could be completely derailed in the absence of purposeful leadership for health in the State.

The key objectives of this report therefore include:

1. To assess health outcomes achieved by State governments in Nigeria by October 2019, against global and local benchmarks

2. To assess the human, material, and financial resources provided, and the processes put in place by State governments in Nigeria by December 2021, to improve health outcomes in the State

3. To conduct a comparative analysis of the efforts of State governments in Nigeria by December 2021, to improve health outcomes in the State

4. To propose system-specific interventions, built on the available global and local evidence, that can improve health outcomes in States by December 2022.

This assessment and report were developed using adapted qualitative research methodology, with secondary data analysis of existing reports, consultative in-depth and key-informant interviews from across the States, and validation of findings by key health systems actors at national and sub-national levels.

The assessment was conducted under the leadership of the ONE Campaign, in partnership with National Advocates for Health (N4H), Nigeria Health Watch, Public & Private Development Centre (PPDC) and Corona Management Systems (CMS), with technical support from the World Bank/International Finance Corporation (IFC) and the United Kingdom (UK) Foreign, Commonwealth, and Development Office (FCDO). The Presidential Reform Committee on the Basic Health Care Provision Fund (BHCPF) led by the Bureau for Public Sector Reforms (BPSR) also provided steering leadership on specific aspects of the assessment.

The assessment was based on fieldwork across all 36 States in Nigeria and the FCT, using purposeful sampling which was most appropriate[4], and accommodating the diversity of the country and the the States, including differences in socio-religious and cultural practices which influences health-seeking behavior[5].

Data was collected by desk reviews and secondary analysis, and through Key-Informant Interviews (KII) and In-depth Interviews (IDI), with adult community residents and health workers from selected health facilities to supplement information from health systems managers. Participants were selected using a stratified purposive sampling method. Community residents and health workers were included as key informants, to enhance the credibility of the findings, by cross checking their responses with the answers provided by health systems managers[6,7].

For this assessment, twenty (20) indicators were identified, cutting across inputs, processes, and outcomes. These indicators are not exhaustive but provide a platform for a detailed analysis of the performance of the health system in a State and identify some of the most critical aspects for improvement. These indicators also align with the recent report of the Lancet Nigeria Commission on opportunities for health systems strengthening (HSS) in Nigeria[8] and in the technical briefs of the recently concluded primary healthcare summit in Nigeria[9].

The twenty indicators selected for this assessment and report include:

1. Current implementation of the BHCPF in the State
2. Budgetary commitments to Health by the State
3. Status of Health legislation and policy in the State
4. Availability of select human resources for health
5. Implementation of innovative strategies like task shifting and task sharing for essential health services among available human resources for health
6. The strength of strategic and operational planning for health in the State
7. The availability of a defined minimum service package and a strategic approach to fiscal space expansion in the State
8. State management of available human resources for health
9. Stock performance for select health products in the State

10 State reporting on health service delivery for essential health services

11 Vaccination coverage for the Bacille Calmette-Guerin (BCG) vaccine which often reflects an entry into the vaccination programme

12 Vaccination coverage for the third dose of the pentavalent vaccine (Penta 3) which often reflects sustained utilisation of the vaccination programme

13 Proportion of children who are Underweight, which often reflects acute malnutrition

14 Proportion of children who are Stunted, which often reflects chronic malnutrition

15 The proportion of children who die before their fifth birthdays

16 The proportion of pregnant women who receive antenatal care from a skilled provider

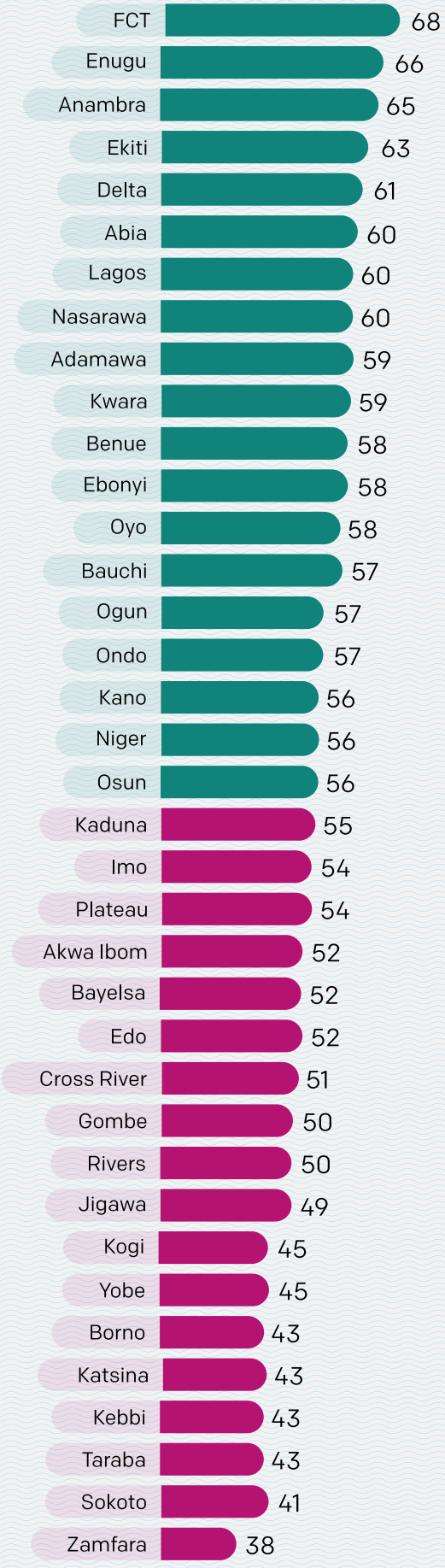
17 The proportion of pregnant women whose babies are delivered by a skilled provider

18 The proportion of married women whose needs to delay, space, or limit the number of children that they have is not met

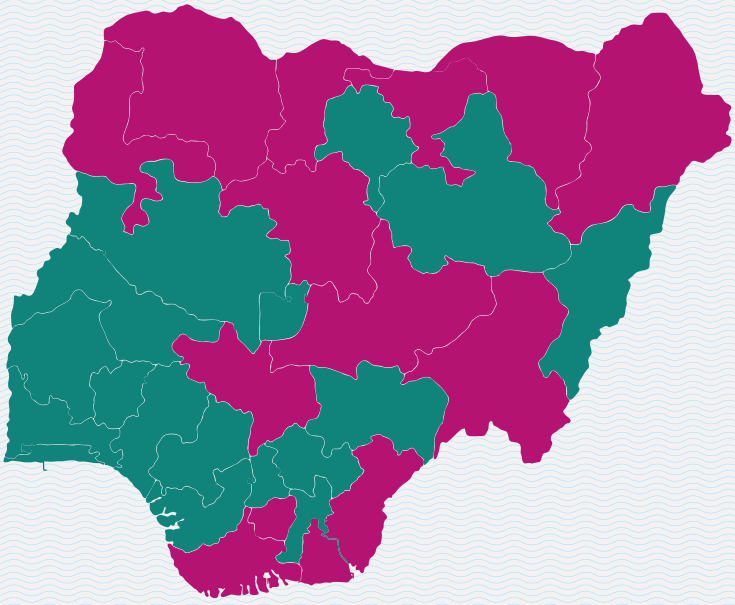
19 The experience of community members when they assess health services from public facilities in the State

20 The state of select public facilities in the State.

The findings from this report do ultimately awaken cautious optimism for health delivery across States.



Findings from the assessment unfortunately reflect a stark reality in Nigeria and for many states.



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With findings reflect that Zamfara state is the worst State in Nigeria, to be a citizen in need of healthcare and the FCT is the best place to get access to healthcare services.

The findings from this report do ultimately awaken cautious optimism for health delivery across States. In finding that the key challenges driving poor performance amongst States are not insurmountable, this report aligns with many other reports, and yet, this report also provides citizens with a tool to demand that the necessary steps be taken to address these challenges.

Unfortunately, the findings clearly reflect that Zamfara state is the worst State in Nigeria, to be a citizen in need of healthcare. Although the findings recognise that the FCT is the best place to need healthcare in Nigeria, the differences between States and the FCT, and within States and the FCT, clearly highlight that access to and utilisation of health services continues to be marred by stark inequities across Nigeria.

Background

Health outcomes in many low- and middle-income countries, including Nigeria are poor. Yet, safe, effective, and affordable prevention strategies and treatments exist globally, for most of the implicated afflictions, constituting a human crisis which the World Health Organisation (WHO) places squarely on the shoulder of failed health systems[1].

The WHO asserts that "fair and inclusive health systems are a bedrock of social stability, resilience and economic health"[10] and that a stronger health system is a rudimentary aspect of efforts to improve health outcomes and societal well-being[11].

Health Systems are built with the people it will serve as its key focus, and a health system is expected to perform certain functions, referred to as the "building blocks" of the health system[1].

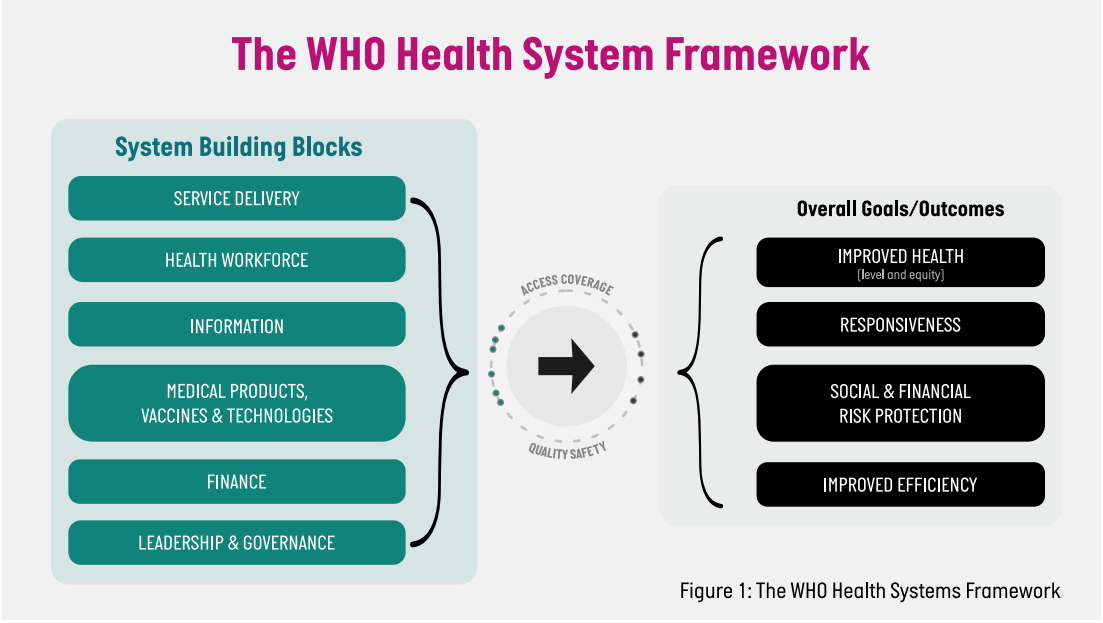

Figure 1: The WHO Health Systems Framework

Health Systems are a lattice, comprising numerous interactions across the building blocks, which define the quality of the service, provided by the system to the people, and provide a platform to assess the strength of the health system.

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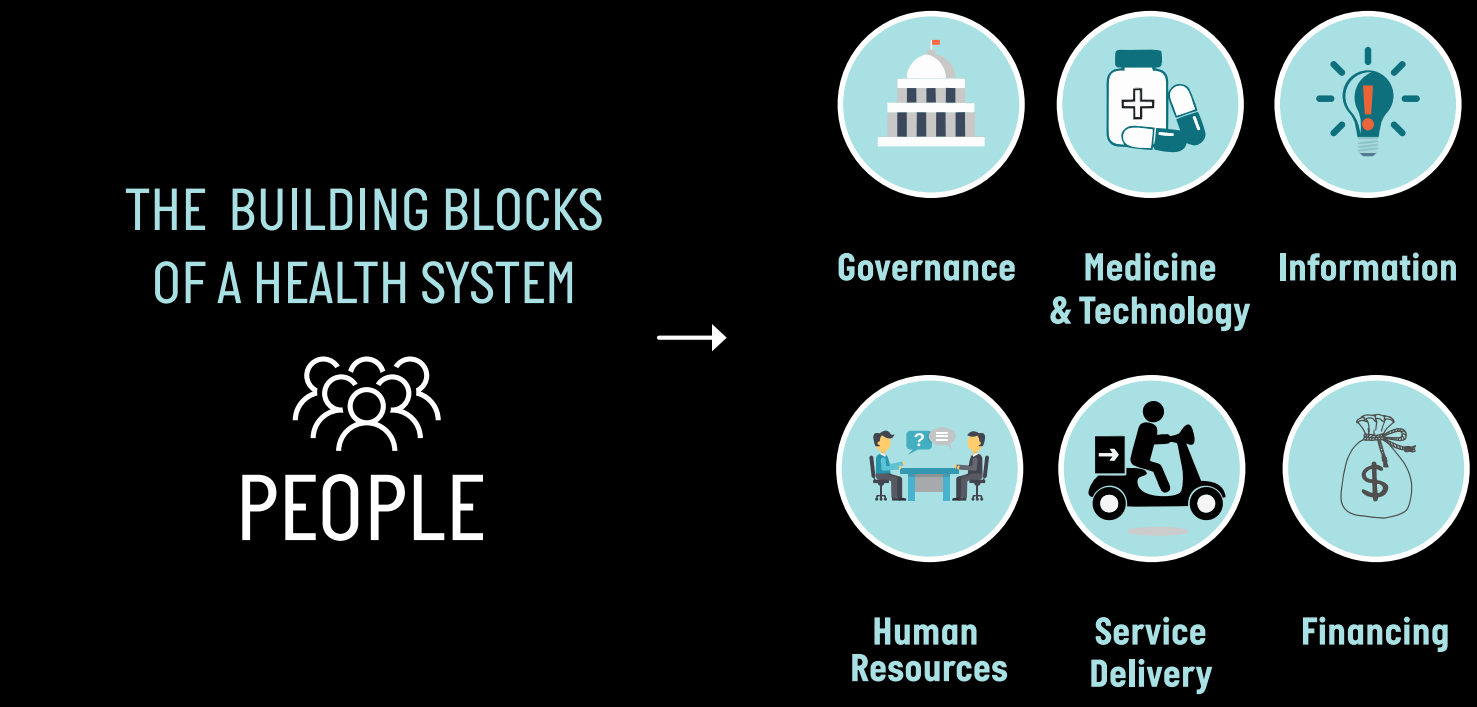


Figure 2: The Building Blocks of a Health System

Health indicators evaluate the strength of a Health System by assessing these building blocks, and on most indicators, Nigeria is performing poorly[12]. This is compounded by a health sector characterised by wide regional, rural-urban and socioeconomic disparities in coverage[13], emphasising a need for a review of the health system, towards health systems strengthening (HSS).

The Nigeria National Health System (NHS) is designed as a 3-tier structure, with responsibilities at the federal, state and local government levels, with all 3-tiers having some role to play across the building blocks of a health system[12]. The federal tier oversees policy and technical support to the overall health system, deals with the national health management information system, deals with international relations on issues of health and provides health services through the tertiary and teaching hospitals. The state tier oversees the regulation and technical support for primary healthcare services and provides health services through the secondary hospitals. The local government tier oversees primary health care and coordinates the service delivery at this level.

Health is on the concurrent legislative list of the Constitution of the Federal Republic of Nigeria (FRN)[2]. This grants the States autonomy to manage their health systems and to provide leadership of the governance structures for health within the State, through the State Ministry of Health (SMOH) and its departments and agencies. This also places accountability for poor health outcomes largely on the shoulder of the State Governments. An analysis of the health system towards health systems strengthening must place emphasis on a review of the performance of the building blocks of the health system at sub-national levels, particularly the States.

In the context of primary healthcare, this decentralisation of authority and decision-making in Nigeria – including the community development committees who are part of this leadership and governance structure[14–17] holds significant potential to empower the health facility and the health workforce in the delivery of services and in strengthening connections to the community. These can have a direct effect on service availability, community demand, and utilisation of services.

Governance and leadership of health systems indeed plays a critical role as a building block of the health system, and manifests through leadership of system design, policy guidance, oversight, regulation, accountability, and coalition building. The broader governance arrangements within a country have been documented to have effects on health outcomes in that locality[18], with the World Bank and the International Monetary Fund (IMF) clearly documenting demonstrable associations between governance and child health[19,20]. These effects of governance on health appear to be more linear, with bad governance almost clearly

Governance and leadership of health systems indeed plays a critical role as a building block of the health system, and manifests through leadership of system design, policy guidance, oversight, regulation, accountability, and coalition building.

$34 per person.

associated with poor health outcomes.

Health Service delivery deals with "how inputs and services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time"[1]. These services are typically provided at home, at the workplace, in the community and in health facilities. The health system in Nigeria is comprised of public, private for-profit, non-governmental organizations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), and traditional health care providers. Health providers include unregistered and registered providers ranging from traditional birth attendants and individual medicine sellers to modern hospitals.

According to Nigeria's health facility database (the master facility list), around two out of every five registered health facilities are privately owned[21]. Private for-profit health facilities and the FBO facilities are reported to provide around 80% of health services to Nigerians [22]. The State Governments play a critical role both in providing services through public facilities and in ensuring appropriate regulation of private providers.

The provision of health services requires adequate financing, and trained staff working with the right medicines and equipment. Commodity or health product availability at the point of care is therefore an instrumental aspect of health service delivery. Despite significant and consistent investment in procurement and supply chain management systems in Nigeria, health service delivery in Nigeria continues to be reportedly riddled by commodity stock outs especially in public primary health facilities[23,24].

The main categories of the health workforce in the Nigerian healthcare system are doctors, nurses (including public health nurses), midwives, community health practitioners (officers, extension workers, and community health influencers, promoters, and service agents), pharmacists, medical laboratory scientists, dentists, physiotherapists, radiographers, and health record officers. Nigeria has previously been reported to have one of the largest supplies of human resources for health in Africa[12], yet recent efflux of health workers and the large disparities in the distribution of the health workers pose a major challenge. Most doctors and nurses work in private practices or public secondary and tertiary level hospitals and urban areas typically have more health workers than rural areas[25].

In the face of these Human Resource for Health (HRH) challenges in Nigeria, "functional HRH planning and management units with sufficient personnel and adequate human resources planning skills within the SMOH and Federal level are generally not adequate"[12]. Collection of strategic information to monitor the availability, distribution, and performance of health workers is inadequate, and the policies are unclear, on how many of the States and the country at large plans to scale-up numbers and skills of health workers in ways that are relatively rapid and sustainable, and how stakeholders and other sectors need to be engaged.

Access and utilisation of available health services have been clearly identified as critical outcomes that contributes to improved health

Between 1985 and 1993, per capita investment in health in Nigeria was at about $1per person, compared to the international recommended level of $34 per person.

and well-being[26]. The availability and accessibility of health services, in combination with the community-level demand for these health services are expected to ultimately cumulate in utilisation of these health services. Utilisation also then serves as a reflection of both service delivery capacity and demand for services[27]. Increasing access and utilisation of available health services requires significant country commitment to both demand and supply-side financing of health.

Between 1985 and 1993, per capita investment in health in Nigeria was at about United States (US) $1 per person, compared to the international recommended level of US$34 per person[28]. Since 2001, Nigeria has consistently committed less than 7% of the total national annual budget to health, leaving a major gap in the financial resources required to drive the health system. Majority of States in the country, also fail consistently to allocate up to 15% of their total state annual budget to health, in line with the Abuja declaration[29–31], with poor budget performance and fund releases that fall way short of the allocations reported every year.
To ameliorate some of the funding gaps, section 11 of the National Health Act of 2014 established the Basic Health Care Provision Fund (BHCPF)[32]. The BHCPF is composed of 1% of Consolidated Revenue Fund (CRF) of the federal government and any additional contributions from other funding sources including donors. BHCPF is designed to support the effective delivery of Primary Healthcare services, provision of a Basic Minimum Package of Health Services (BMPHS), and Emergency Medical Treatment (EMT) to all Nigerians.

Since its inception however, the performance of this fund continues to fall short of expectations and need.
Whilst widespread consensus exists on the need to strengthen health systems[33], there is continued debate on exactly how individual countries or sub-national geographies should do it[34]. The WHO sets the standard on how to strengthen health systems, by calling for efforts, focused on improving service delivery, financing, creating resources, and improving stewardship[33]. HSS can therefore be achieved through "enabling implementation of evidence-based policies, developed through analysis and stakeholder dialogue, and supported by improvements in governance and stewardship to translate these policies into action on the ground"[35].

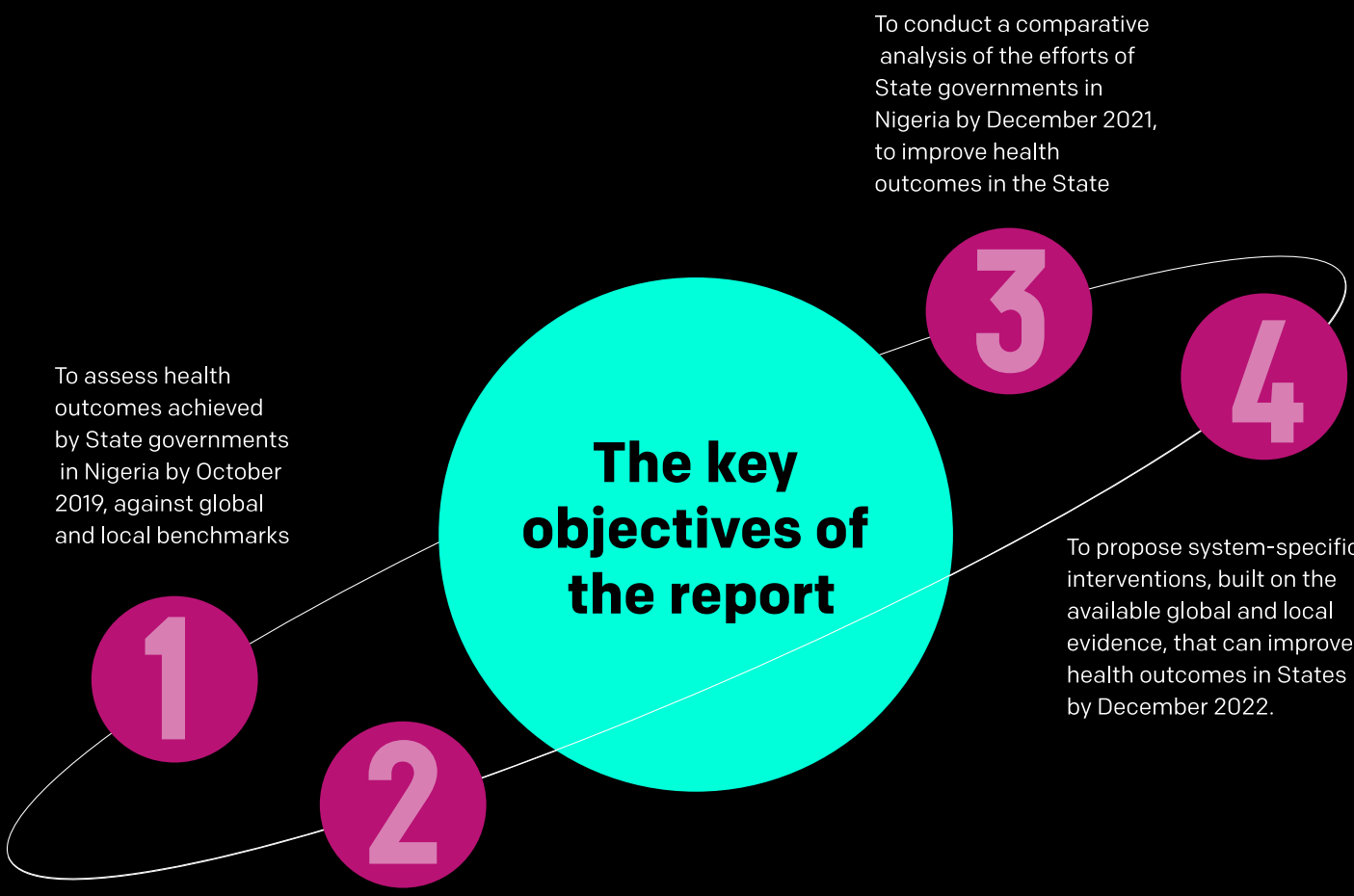
Weak governance and accountability structures however continue to pose an obstacle to any concrete efforts at HSS[13], by hampering efforts to increase efficiency and effectiveness, and efforts to minimise resource misuse[36], and this is the case across Nigeria. Sadly, these limitations and drawbacks to HSS culminate in weak infrastructure for the delivery of health services, health worker shortages, stock outs of health products, high out of pocket expenses for health, poor user experiences when using available health services, and poor health outcomes among others.

Since 2001, Nigeria has consistently committed less than 7% of the total national annual budget to health, leaving a major gap in the financial resources required to drive the health system.

Aims and Objective

This report sets out to unify findings from an analysis and ranking of health system performance across States that includes an assessment of compliance of the States to the sections of the National Health Act and National Health Policy and an overview of the state of healthcare delivery in the 36 states in Nigeria and the Federal Capital Territory (FCT). The report also seeks to offer a set of recommendations for improvement by the states.

The aim of this report is to analyse and rank health system performance across the 36 States and the FCT using a select group of health systems indicators.



Methodology of the Assessment

This assessment and report were developed using adapted qualitative research methodology, with secondary data analysis of existing reports, consultative in-depth and key-informant interviews from across the States, and validation of findings by key health systems actors at national and sub-national levels.

Qualitative research generally follows a constructivist worldview, which holds that reality is in the eye of the beholder; that is, there is no single reality for a given phenomenon, but multiple, relative dimensions of reality that can only be partially captured using subjective, naturalistic methods[37]. The uncertain, exploratory course of qualitative inquiry demanded that the research design be flexible and the investigators responsive to the emerging findings[38].

The assessment was conducted under the leadership of the ONE campaign, in partnership with National Advocates for Health (N4H), Nigeria Health Watch, Public & Private Development Centre (PPDC), Corona Management Systems (CMS), and with technical support from the World Bank/International Finance Corporation (IFC) and the United Kingdom (UK) Foreign, Commonwealth, and Development Office (FCDO). The Presidential Reform Committee on the BHCPF also provided steering leadership on specific aspects of the assessment.

The assessment was based on fieldwork across all 36 States in Nigeria and the FCT, using purposeful sampling which was most appropriate[4], and accommodating the diversity of the country and the differences in the States, including differences in socio-religious and cultural practices which influences health-seeking behavior[5].
Data was collected by desk reviews and secondary analysis, and through Key-Informant Interviews (KII) and In-depth Interviews (IDI) with adult community residents and health workers from selected health facilities to supplement information from health systems managers.

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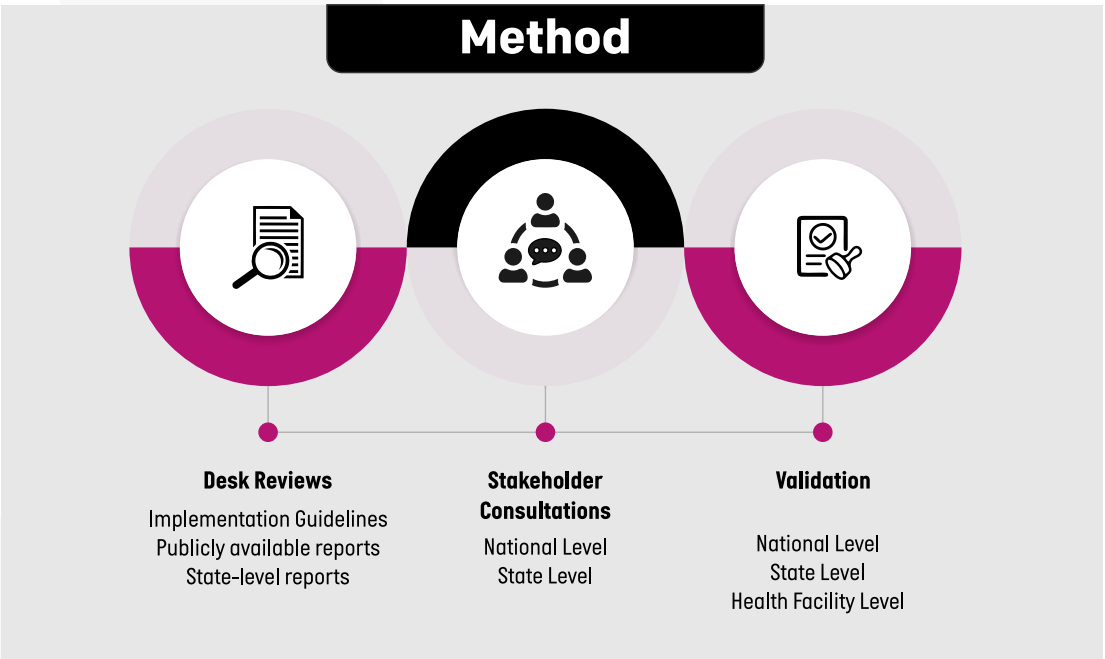


Figure 3: Overview of the methodology of the assessment

The data was collected over a three-month period, with a total of 161 interviews. All interviews were semi-structured, using an interview guide with open-ended questions. All interviews were conducted to ensure anonymity and responses were recorded only using field notes. Before commencement of the fieldwork, interview guides were pre-tested and modified accordingly. Interview guides and focus areas of assessment were also validated through a stakeholder meeting before collection of data.

The data collected from interviews were analysed using a thematic analysis. Themes were derived using an deductive approach39 towards meeting the objectives of the assessment. Verbal informed consent was obtained from all participants prior to the commencement of any interviews and confidentiality of participants was ensured by not recording the names of any respondents.

All findings were also validated through a stakeholder meeting, after analysis of data and prior to dissemination of results. Additional technical engagements were held with the World Health Organisation country team, to contextualise findings and support in drawing nuanced conclusions.
State ministries of health were contacted to provide an additional layer of validation.

Additional validation sessions were held with representatives of some States who responded to the requests, enabling the provision of additional insights and in some cases, to commit to working on the identified gaps. Some of the states who participated in the validation presented strong cases on why the states were on a clear path for improvement.

Majority of the states declined the request to participate in an additional validation of the results. Efforts to share findings with the leadership of the Federal Ministry of Health prior to publication of this report were unfortunately unsuccessful.

Criteria for Assessment and Ranking

The criteria for assessment and ranking for this report have been selected to address the key aims and objectives of the assessment and ranking. At the national level, the key focus of the assessment is on the implementation of the BHCPF, as proscribed by the law[32] and articulated in the implementation guidelines[40]. The BHCPF is composed of 1% of Consolidated Revenue Fund (CRF) of the FG and contributions from other sources including donors. The BHCPF is disbursed through three gateways in Nigeria, including the National Primary Healthcare Development Agency (NPHCDA) gateway, the National Health Insurance Scheme (NHIS) gateway and the National Emergency Medical Treatment Committee (NEMTC) gateway.

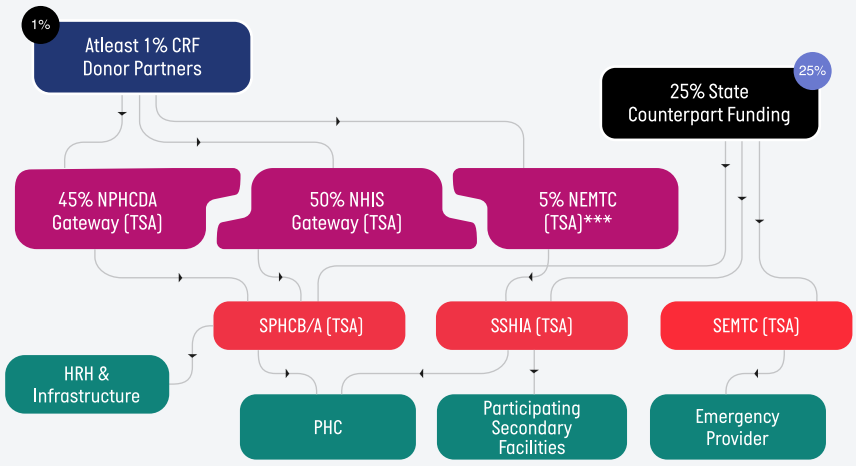


Figure 4: Overview of the Basic Healthcare Provision Fund Framework [Source: BHCPF Guidelines]

The BHCPF is financed primarily by the Federal Government and towards strengthening funding for health and strengthening availability of the funding from the fund, it is important to track key National level throughouts on the fund.

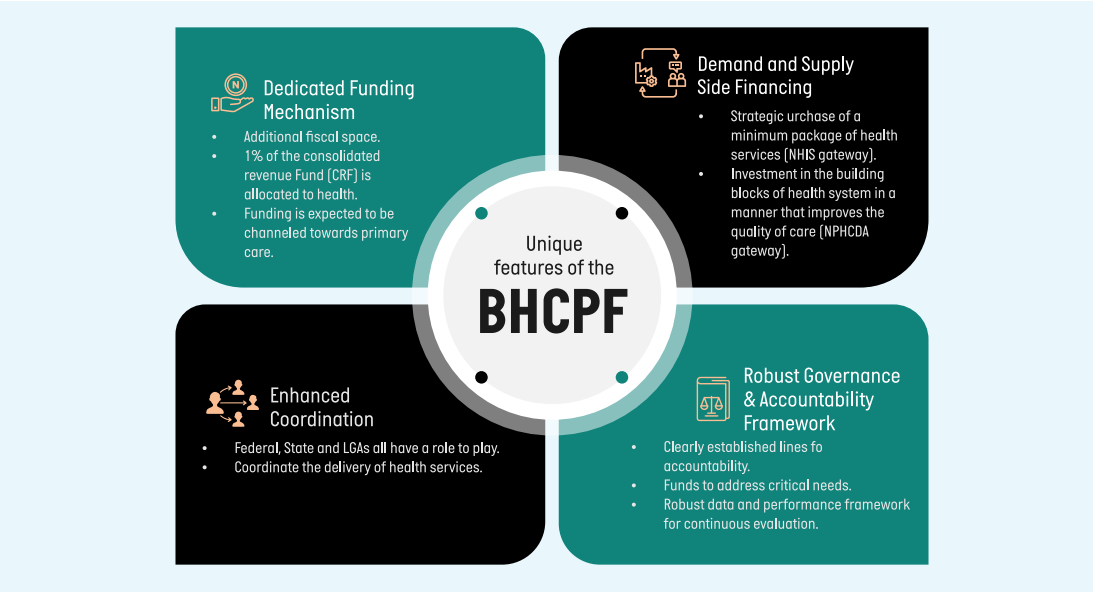
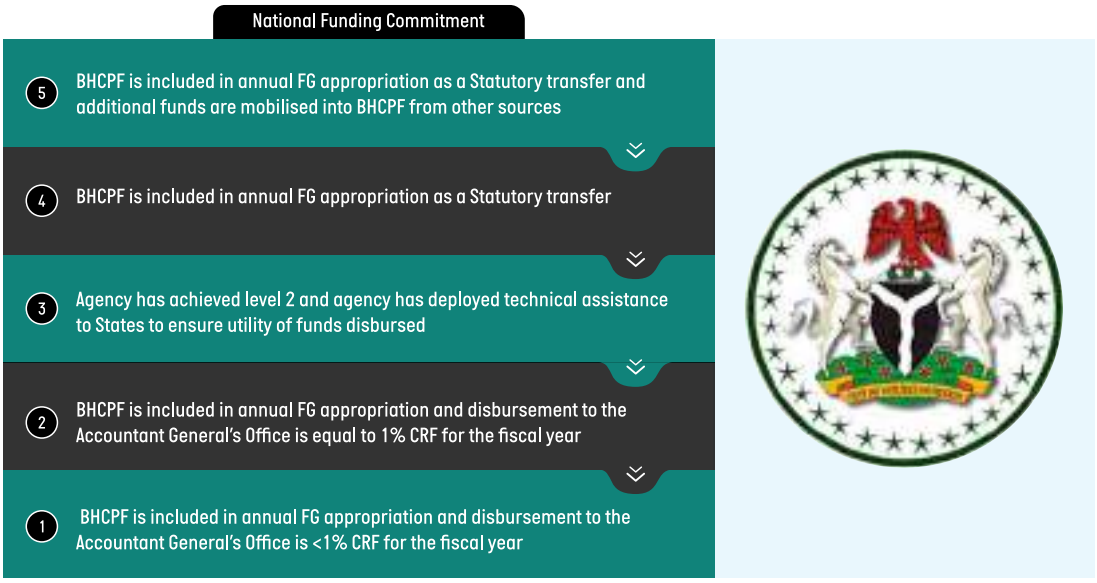


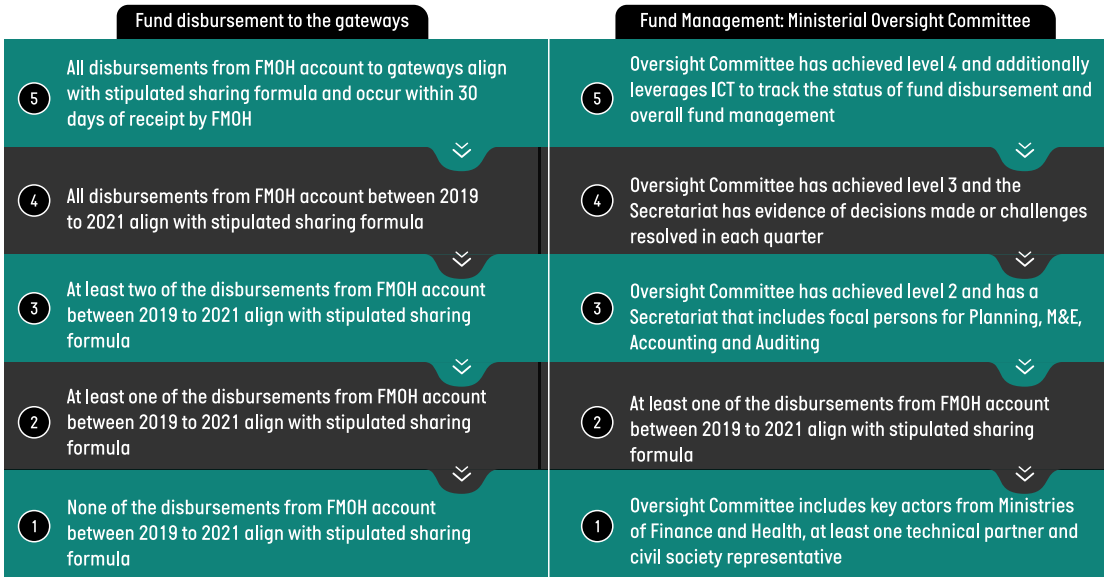
Figure 5 Summary of unique features of the Basic Healthcare Provision Fund Framework (Source: BHCPF Guidelines)

To track the performance of the BHCPF, key measures have been defined for each of the different core actors that drive its implementation. One measure has been developed to assess the performance of the FG, exploring the commitment of the FG to implement this fund as defined with the relevant section of the National Health Act of 2014.

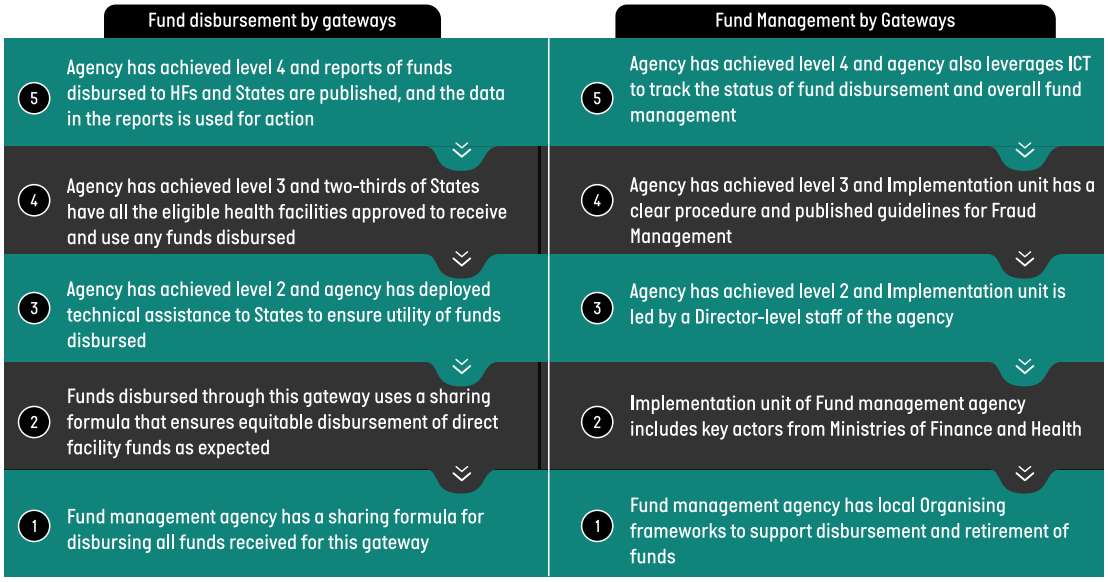


Two measures have been developed to assess the performance of the Federal Ministry of Health (FMOH) in ensuring that funds are speedily disbursed to the different gateways as stipulated by law and to assess the functionality of the Ministerial Oversight Committee (MOC) and its secretariat in providing the needed transformational leadership.

These measures are particularly keen on exploring the shared responsibilities of both the Ministry of Health and the Ministry of Finance in the management of this critical national fund.



When States meet the criteria for funding from the BHCPF, funds can only be disbursed to States from each gateway if the custodian of the gateway has received funds. However, it is important to assess the performance of the three different gateways in providing technical assistance to States to enable them meet criteria for funding and in the gateway's disbursement of the funds to States through a clearly curated and managed sharing formula. It is also important to assess the capacity of the different gateways to manage all aspects of the fund from their gateways, including the strategies for fraud management and the strategies to ensure transparent citizen engagement in their disbursement of these funds. To this end, two measures have been defined to assess the performance of each of the three gateways at the national level.



At sub-national level, unpacking health delivery by States and the FCT, required identifying a broad theory of change, to provide guidance for the development of the ranking system. Based on the aims and objectives of this assessment and ranking, and the broad theory of change to unpack health delivery at sub-national level, twenty measures were identified.

These measures were broadly grouped across key health systems inputs, a targeted set of processes, and health systems outcomes at population level. These measures were also carefully selected to cut across the building blocks of the health system as proposed by the WHO. Five input and five process indicators have been selected for this assessment, with eight population-level outcomes and two experiential measures of citizen interaction with the health system.

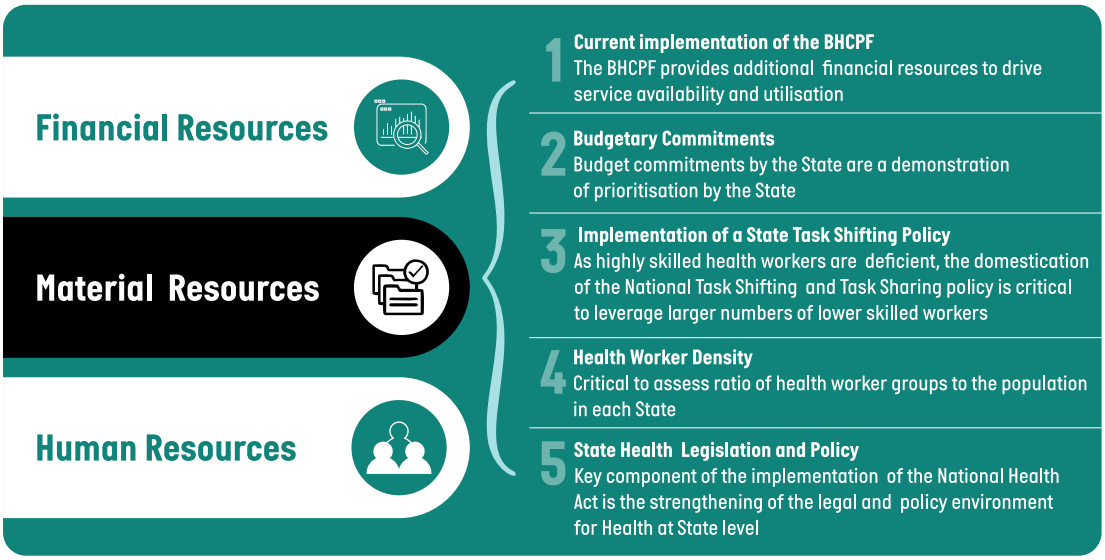
Across each measure selected for this assessment and ranking, a grading system from one (1) to five (5) has been defined. This will ensure that state-level assessment and rankings total up to a score of one hundred (100) points, with a maximum of five points attainable for each of the twenty selected measures and a minimum of one point attainable.

It is important to clearly state that the twenty selected measures are in no-way exhaustive of all the different components and measures which can be used to assess health delivery at the State level, yet these measures combine and reflect many existing measures and approaches and provide a key lens for assessing the performance of States in health.

Input Measures

To drive health delivery within the States, the human, financial and material resources that are committed by the State are critical to any eventual improvements in health outcomes. A key part of the assessment and ranking therefore looks carefully at some of these that States have committed to health.

Some of these input measures also provide low-hanging fruits for State Governors to demonstrate political will in strengthening health outcomes in their States. These therefore are key measures to both assess and rank State performance, but to also shape recommendations in line with global and local evidence.



1 Current implementation of the BHCPF

To properly understand, track, and reform the performance of the BHCPF at the sub-national level where it is needed, it is important to align on the result that the fund is expected to achieve. The guidelines for the implementation of the BHCPF clearly articulate the expectations from the funds disbursed through each of the three gateways[40,41].

The 50% of the funds from the NHIS gateway is used in paying for a Basic Minimum Package of Health Services (BMPHS) to be provided in primary and secondary levels of care to Nigerians. The BMPHS covers the entire spectrum of care (preventive, promotive, curative, and rehabilitative), and includes elements of emergency care at both primary and secondary levels. Purchase of PHC services is via capitation based on total enrolees, while for secondary care payments it is based on fee-for-service mechanisms.

The benefit package for BMPHS, has been actuarially valued at an estimated N12,000 per capita, which is remitted as a premium per annum per covered member to State Health Insurance Agencies (SHIAs) by the NHIS. The end target of this gateway in terms of processes and outputs is:

- Access to health services is created at accredited and empanelled health facilities, for poor and vulnerable individuals who have been enrolled unto a social health insurance scheme
- Capitations are provided to these health facilities for primary care and claims from secondary facilities are processed for fee-for-service
- These enrolees start to utilise care from the facilities.

NPHCDA is responsible for implementation of the 'NPHCDA Gateway', which represents 45% of the BHCPF in line with the National Health Act 2014. These funds are transmitted through the SPHCBs to eligible public PHCs as Decentralised Facility Funding (DFF) to meet operational costs, including provision of essential drugs, vaccines and consumables, provision and maintenance of facilities, equipment and transport, community outreaches, and human resource development. Following presidential launch in January 2019, implementation of the gateway commenced with receipt of the first tranche of funding in May 2019 and second tranche in September 2020. It is expected that one Primary Healthcare Centres (PHC) identified from each ward is designated as the BHCPF facility and each PHC receives 300,750 per quarter for DFF, an amount determined based on a rapid OpEx assessment conducted by the NPHCDA and stakeholders.

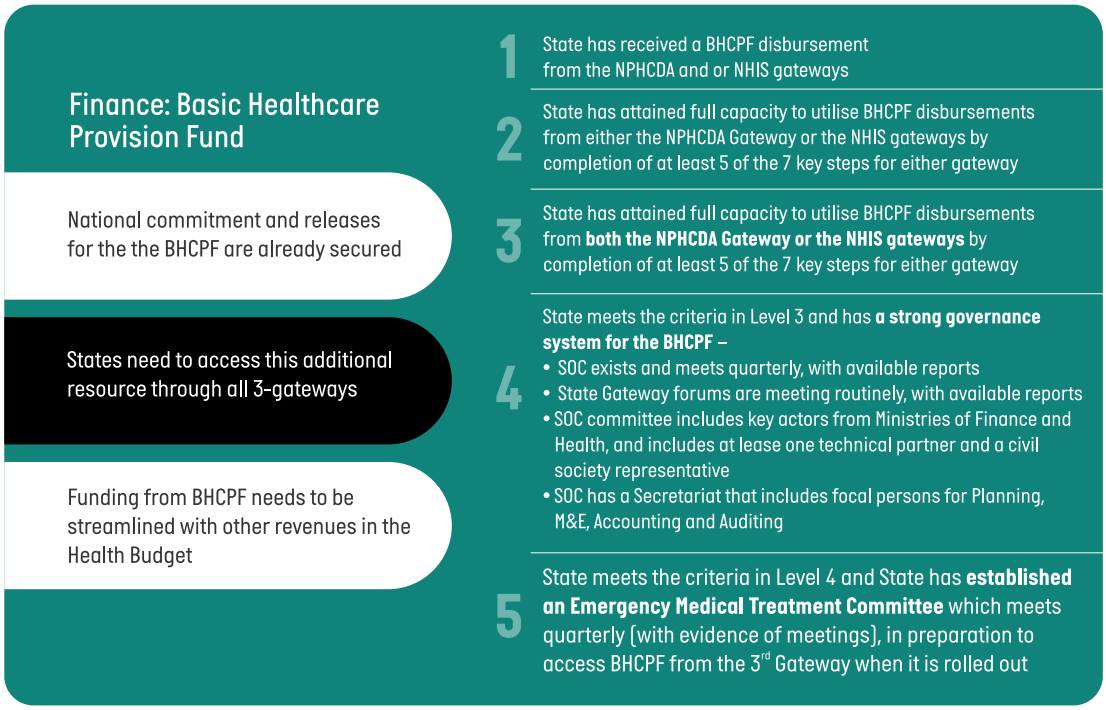
The end target of this gateway in terms of processes and outputs is that on public PHC receives funds every quarter and will utilise and report on the funds to facilitate the next disbursement.

These end targets then set the stage for uninterrupted and improved quality of key services and improvements in health outcomes from the fund.

The third gateway of the BHCPF is for EMT which is administered by a committee appointed by the National Council on Health: The National Emergency Medical Treatment Committee (NEMTC). NEMTC operates through the State Emergency Medical Treatment Committee (SEMTCs), working in synergy with any existing State level Emergency Agencies. The core focus of the EMT Gateway is the establishment and operationalisation of a National Ambulance Service; and enabling capacity for emergency response at individual/client level inclusive of public health emergencies.

NEMTC works with states to identify, qualify, and recruit emergency care providers (ECPs) and map emergency treatment centres at all levels of care.

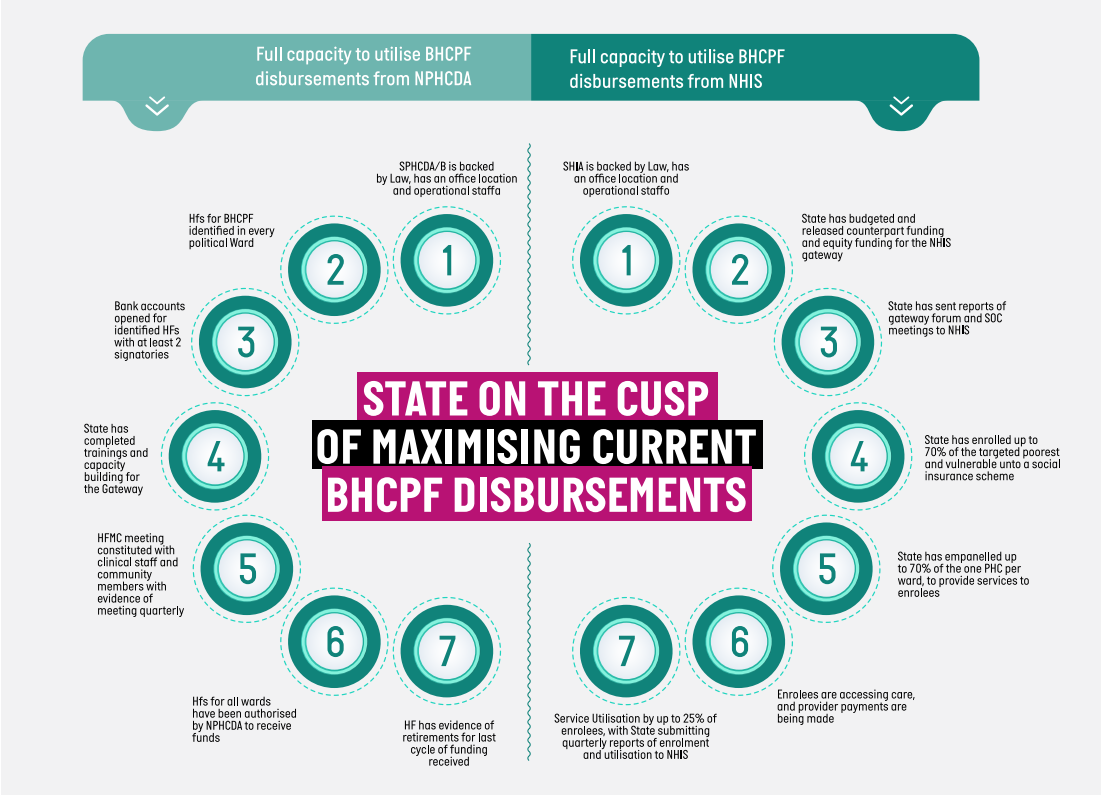
Operations of the EMT Gateway would systematically be de-centralised as state capacity and structures are developed and strengthened. ECPs would then be reimbursed using a Fee-for-Service tariff system following verification by states using the SSHIAs' mechanisms. This gateway is currently in its infancy and is yet to be fully operationalised.



The assessment of the implementation of the BHCP by States explores the capacity to assess and utilise these resources from the NHIS and NPHCDA gateways, the functionality of the oversight and coordinating mechanisms at state-level, and the readiness of the States to access the funds from the NEMTC gateway.

The mechanisms and steps required for States to access and effectively utilise resources from the BHCPF through the NPHCDA and NHIS gateways are detailed to explain the ranking item that defines full capacity to utilise disbursements from both gateways.

The National Emergency Medical Treatment Committee (NEMTC). NEMTC operates through State Emergency Medical Treatment Committee (SEMTCs), working in synergy with any existing State level Emergency Agencies.

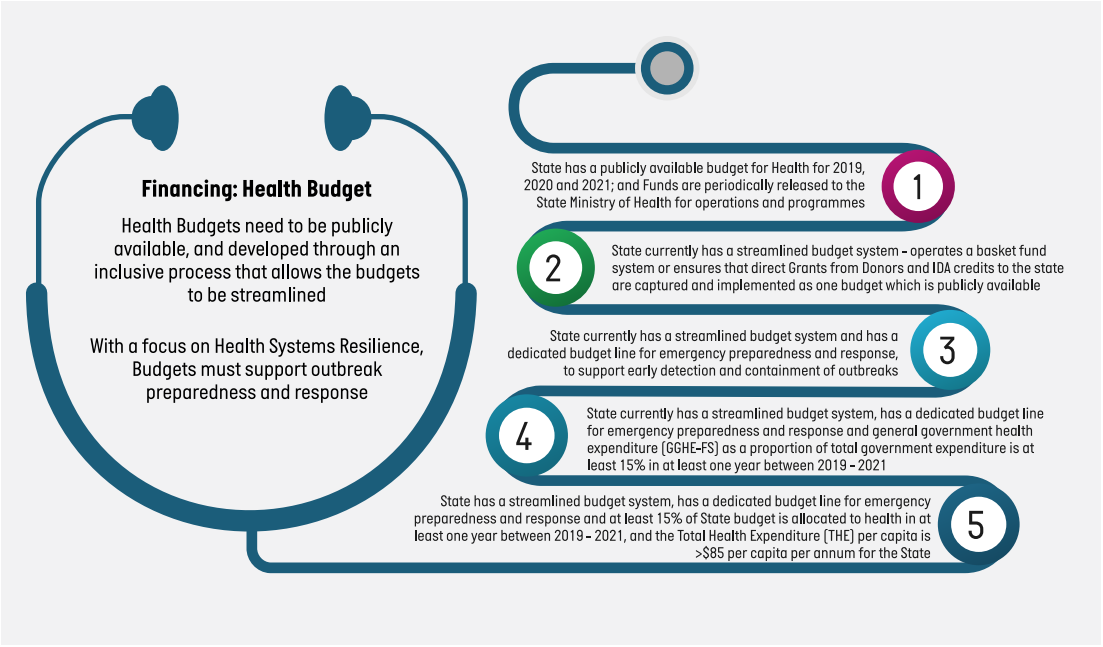


2 Budgetary Commitment

Political leaders across the world have reaffirmed their commitment to eradicating global poverty and improving the lives of the poor. The Federal and State governments continue to promote a variety of pro-poor and social safety-net programs as part of their commitment to improving the lives of the country's poorest citizens, and while these programs are implemented, every Nigerian must hope that the lives of the poorest can be better. While enhancing health and life expectancy is a goal in itself, it is also a means of reducing poverty across the country.

Health investments improve health outcomes, which translate into increased working capacity and productivity, and consequent higher or sustained wages and economic growth. To bring millions of Nigerians out of poverty and drive both economic growth and development, sincerity of purpose, strong political will, and a commitment to evidence-based development programming will be required. The State Budget must indicate this degree of commitment to evidence-based health programming, as the budget is a vital tool for demonstrating a state's goals and priorities. The Abuja declaration clearly articulates the benchmark for allocation of resources to health, with the expectation that States will commit at least fifteen percent (15%) of the annual total government expenditure (TGE) to general government health expenditure (GGHE)[29].

Although many States in Nigeria will argue that the budget allocations to the SMOH, funding for health infrastructure projects occurring in other ministries, departments, and agencies (MDAs) outside the purview of the SMOH, and other government spend should be counted in assessing this 15% allocation, this fragmented approach introduces inefficiencies, reduces public visibility of government spend, and weakens accountability.



Nigeria's administrative and political structure makes it difficult to implement laws at all three levels of government.

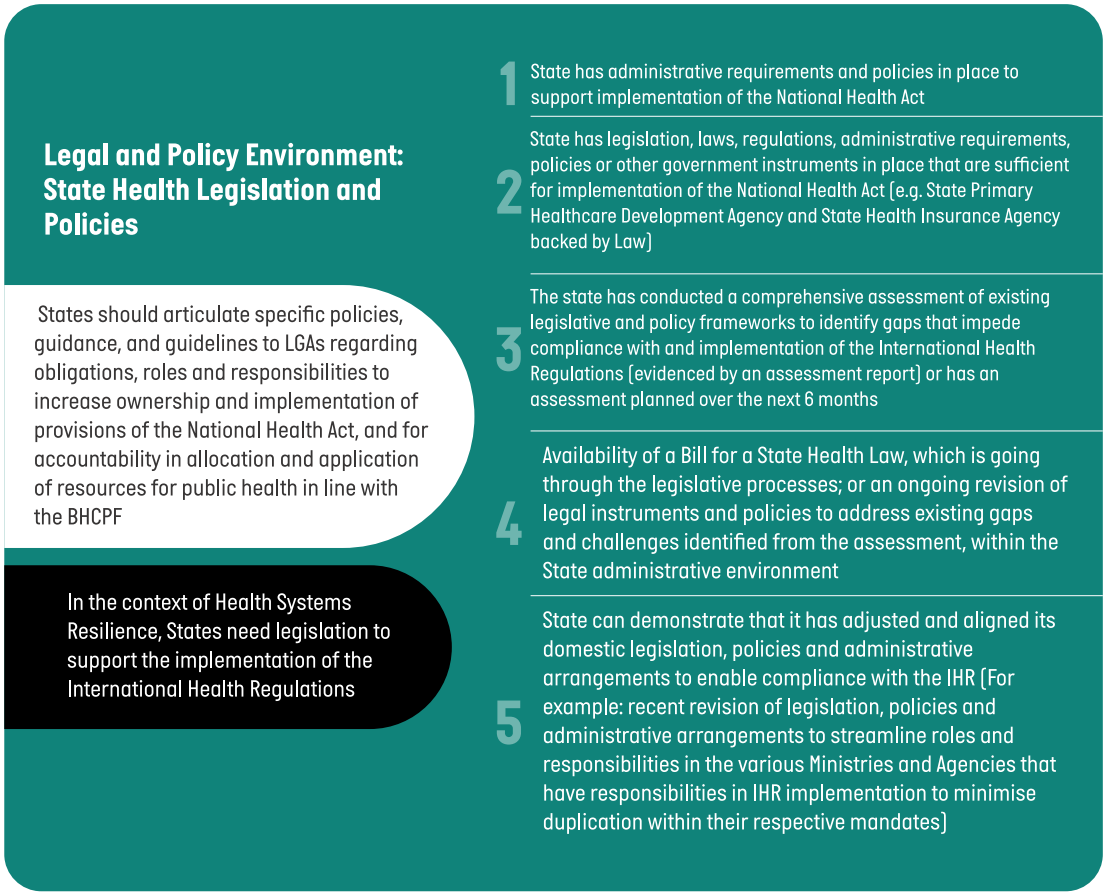
For this report, the gold standard is that a State must have a publicly available budget, which captures all funding sources (including funding from the BHCPF and from any Development Assistance for Health (DAH) received directly by the State), which includes a budget line for outbreak preparedness and response, is at least 15% of total government expenditure, and the total health expenditure of the State exceeds US$85 per capita per annum.

When conducting this assessment and in developing this report, there is a clear recognition that government allocations to GGHE alone are an insufficient measure of financial commitment. There is consensus that fund releases by State governments for health and appropriate, efficient, and transparent fund utilisation are the hallmarks of measuring government's financial commitment to health.

3 Health Legislation and Policy

Nigeria has enacted several laws which address health care and public health and specifically support country efforts to achieve universal health coverage and meet the Sustainable Development Goals as proposed by the United Nations. The country has at least 10 national laws, guidelines, or policies in place, as well as a regional agreement with five neighbouring nations that serves as a framework for some of these efforts[42]. Some of the laws, regulations, policies, and guidelines include the 1999 constitution of Federal Republic of Nigeria (Sec. 169 of) as amended, the National Health Act of 2014, the Quarantine Act of 1926, the International Health Regulations (IHR) through the International Disease Surveillance and Response (IDSR) among others.

Nigeria's administrative and political structure makes it difficult to implement laws at all three levels of government. As previously discussed, the states' administrative semi-autonomy has created an additional layer that frequently obstructs the implementation of laws, many of which were adopted years ago and do not reflect the current state of health in the country or globally. From a global perspective, strong public health legislation and policies, resulting in the creation of a favourable environment for health and dedicated public health funding mechanisms are considered a best practice. Regrettably, this best practice does not exist across many States in Nigeria.



The Field Epidemiology Training Program (FETP) is a competency-based training and service program in applied epidemiology and public health that builds capacity in strengthening disease surveillance and response system.

For this report, the gold standard is that a State has legislation, laws, regulations, administrative requirements, policies, or other government instruments in place that are sufficient for implementation of the National Health Act and the State can demonstrate that it has adjusted and aligned its domestic legislation, policies, and administrative arrangements to enable compliance with the IHR.

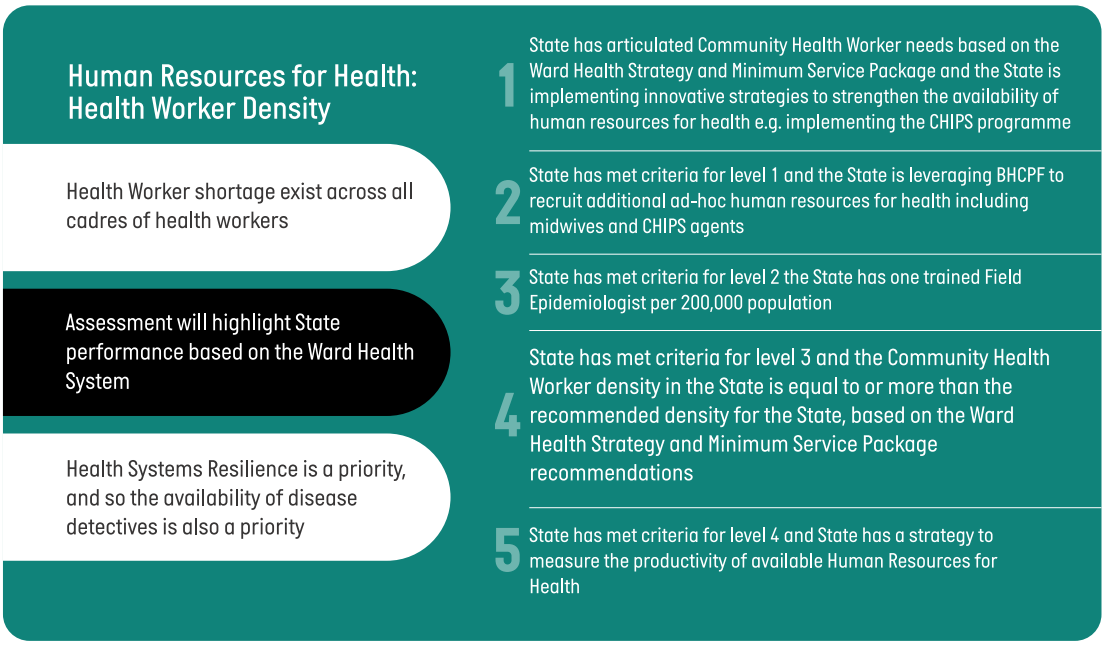
4 Health Worker Density

The insufficient quantity and proportion of various cadres of healthcare professionals required to deliver services in health facilities can be identified as a key contributor to poor health outcomes in Nigeria. Health work shortages in in the country cuts across all cadres of the worker force and there is a need for a relevant, coherent, and sustainable strategy for the employment, retention, and replenishment of the health workforce.

At state-level, there is both an absolute health worker shortage across the majority of states and a relative shortage driven by maldistribution in favour of urban tertiary health facilities. As much as there is a need to produce doctors, nurses, pharmacists, and all other critical frontline health workers, and deploy them to be at the forefront of delivering essential health services, the reality across Nigeria and many low and middle-income countries is that there just are not enough of these workers available to deliver those services.

Community Health Workers (CHWs) are usually the first contact at the community levels and are available to offer a diverse range of health services. These community health workers have the requisite knowledge from their training to provide essential health services and are the foundation of the Ward Health System[43,44]. The country has designed and continues to implement several innovative strategies to complement these community health workers and to strengthen service availability. These are a critical component of assessment of the health workforce that are captured in this report.

Additionally, the global community recommends that all countries and sub-national geographies must have one trained Field Epidemiologist per 200,000 population. These disease detectives have gained increasing importance since the global coronavirus disease (COVID-19) pandemic and are instrumental to



For this report, the gold standard is that a State is implementing innovative human resource for health strategies like the Community Health Influencers, Promoters, and Services (CHIPS) programme, is leveraging the BHCPF through the NPHCDA gateway to recruit adhoc human resources for health, has one trained Field Epidemiologist per 200,000 population, has a community health worker density that matches the provisions of the Ward Health System and the Minimum Service Package (MSP), and the State has put in place a clear strategy to measure the productivity of its health workforce.

When conducting this assessment and in developing this report, there is a clear recognition that there is a strong need for both Country and State for the production, employment, retention, and replenishment of the health work force across all cadres. There is a strong consensus that there can be true case of good performance with the health workforce if the health worker densities of doctors, nurses, pharmacists, medical laboratory scientists, and all other critical frontline health workers remain abysmal. There is therefore an overwhelming commitment to ensuring that subsequent annual versions of this report probe further and assess States on a wider spectrum of human resource for health densities.

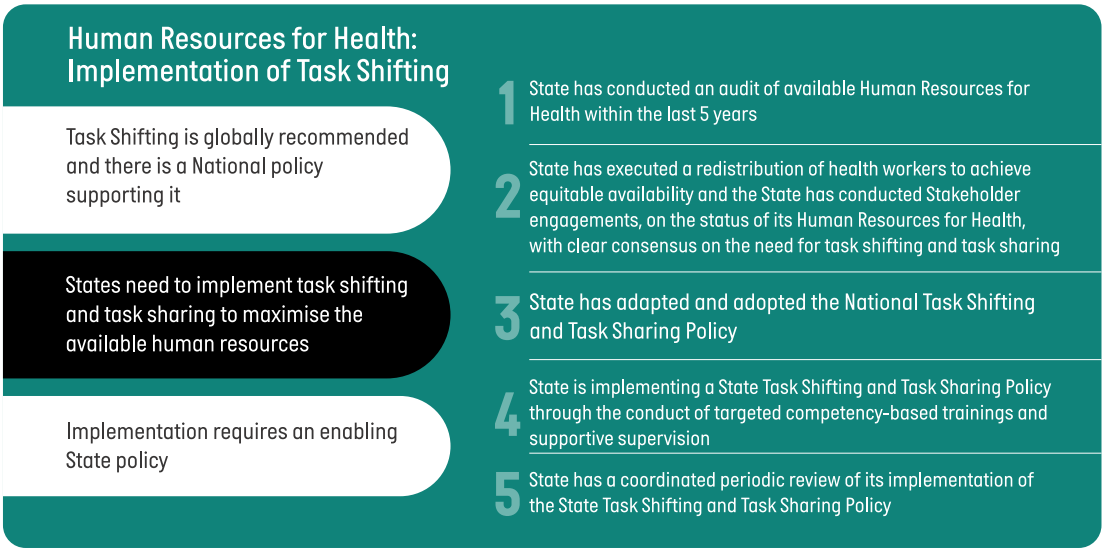
5 Implementation of a Task Shifting Policy

The shortage and unequal distribution of competent cadres of the health workforce to offer services where they are most needed is one of the biggest impediments to access to essential health services in Nigeria. Almost all cadres of health care workers are in short supply across the country, resulting in underutilisation of these health services. Even though Nigeria continues to invest in pre-service education for these cadres to solve these shortages, the country will need decades to reach the desired threshold of health personnel to deliver quality services.
This challenge is further complicated by the freeze on employment in public service, by many State governments due to overhead costs from salaries and wages, both hampering employment of health workers and replenishments following death and attrition.

Despite these challenges, there are many employed Community Health Workers, who are usually the first contact for many individuals and families at the community levels, and are available to offer essential health services, if trained to competency and supervised to deliver these services particularly to vulnerable and under-served populations.
However, there needs to be an enabling policy, that provides a backbone for strengthening the capacities of these community health workers to deliver the services.

The Federal Government of Nigeria recently revised the National Task Shifting and Task Sharing policy and to address this issue at state-level, the Federal Ministry of Health recommended that States should adapt and adopt the task shifting policy, to support implementation in the States.

Adapting and adopting the task shifting and task sharing policy will provide the policy thrust for States to that increase availability of essential health services, by leveraging on the current distribution and reach of community health workers. With a state task shifting and task sharing policy, the number of health workers who can potentially provide these services will be significantly increased and this holds huge potential for expansion of access to essential health services in the State.



6 Process and Output Measures

Even with the investment of significant human, financial, and material resources into health delivery in the States, there is a need for States to put in place key processes for system effectiveness and efficiencies, towards improving health outcomes.

A key part of the assessment and ranking therefore looks carefully at some of these processes and the accompanying outputs that States can put in place. Some of these process and output measures again readily provide low-hanging fruits for State Governors to demonstrate political will in strengthening health in their States.

Like the inputs, these process and output measures are key to both assessing and ranking State performance, and to shaping recommendations

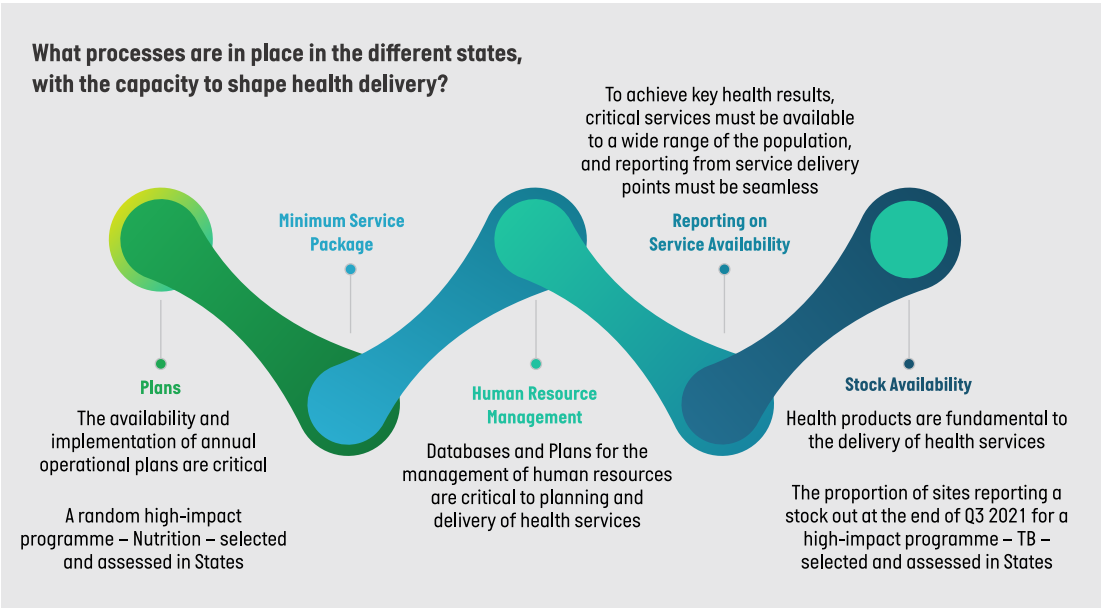


Figure 8: Overview of the process indicators for the ranking of Health Delivery across States

7 Annual Operational Plans

Nigeria has extremely high malnutrition rates that are unevenly distributed across the country. The biggest burden is caused by stunting, a symptom of chronic malnutrition, and micro-nutrient deficiencies. Stunting rates have remained stable since 2008, indicating a long-term nutritional problem in Nigeria, with millions of children at danger of dying or failing to reach their full potential[45].

Country and state efforts to address the malnutrition burden in Nigeria is a critical marker of political commitment to health, to educational excellence, and to sustained economic growth when children achieve their full potential. The Nigeria Governors Forum Secretariat has designed and currently implements a nutrition scorecard to engage Governors on key nutrition commitments with that will shape the enabling environment for improved nutrition action in Nigeria. A critical part of this scorecard is the establishment of a Multisectoral Plan of Action on Nutrition (MSPAN), reflecting consensus on the value of strategic and operational planning for a critical programme.

Strategic and Operational Planning

Focus on the Nutrition Program, as a window into Health Systems operations

Recognise that National direction is towards integrated Annual Operational Plans that support budget development

1. State has conducted a Situational Analysis of the State's Nutrition Programme (or a Health Systems Situational Analysis), evidenced by the reports of the analysis and availability of SSHDP
2. State has developed an AOP for the Nutrition programme for 2021 or an integrated AOP for all programmes (including the Nutrition programme) for 2021 aligned to the SSHDP
3. State has evidence of implementation of the AOP for Nutrition for 2021 or the integrated AOP for all programmes (including the Nutrition programme) for 2021 (evidenced by activity reports)
4. State conducts quarterly review of the implementation of the AOP for 2021(evidenced by quarterly implementation reports)
5. State has an approved MSPAN (June 2021) and has commenced or finalised development of an AOP for Nutrition for 2022 or integrated AOP for all programmes (including the Nutrition programme) for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

For this report, the assessment on strategic and operational planning explores how well a State has articulated and measures the implementation of annual operational plans that are drawn from a multi-sectoral and multi-year strategic plan from 2021, and the progress of the State in rolling out annual operational plans for 2022.

Although it is recognised that States may be performing well in the development of multi-year strategic and annual operational plans for other vertical disease control programmes, this assessment has been conducted with a focus on the Nutrition programme, recognising the wide- and far-reaching consequences of malnutrition for health, education, and the economy.

When conducting this assessment and in developing this report, there is a clear recognition that the State Strategic Health and Development Plans (SSHDPs) have wound down and that assessing performance now is critical to set the stage for the development of the next SSHDP. There is also a strong consensus on the need for multi-sectoriality in the subsequent SSHDP and that the lessons from the development of the MSPAN are critical to successfully deploying this across health.

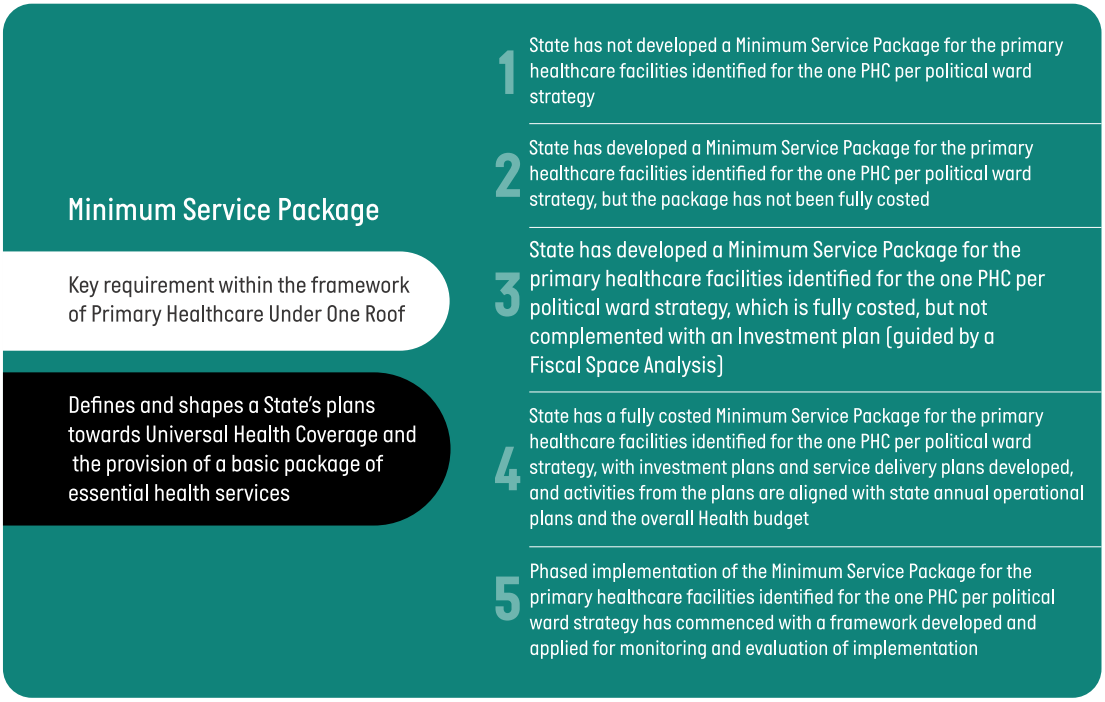
8 Minimum Service Package

As part of measures to achieve universal health coverage in Nigeria, the NPHCDA developed the minimum service package (MSP) for primary health care through the Ward Health System Service Package (WHSSP). The MSP is a guaranteed minimum priority set of health care interventions or services that is provided at primary and/or secondary facilities daily and always through government financing mechanisms with the aim of concentrating scarce government resources on interventions which will provide the best 'value for money' gains.

The MSP describes a priority set of health services and interventions which should be provided in PHC centres on daily basis, always, and at little or no cost to clients, at a cost that government and partners can afford.

The guiding principles for the ward health system align with NPHCDA's vision for PHC and factors ward-specific context.

All recommendations for states to adapt and cost their MSP for their ward health system are derived from the revised ward health system document and are coherently aligned with other PHC strategies. The MSP adaptation, costing and investment planning processes are state-led and inclusive of all relevant stakeholders ensuring the MSP output is all inclusive and widely accepted.



The process of developing a robust and implementable MSP plan includes adapting the requirements for PHC service delivery to include at minimum PHC interventions and support services for each facility type including delivery channels, Staff number and cadre for each type of health facility, and PHC facility types and number, including infrastructure and equipment requirement. This is followed by a computation of the costs of the inputs, needed to deliver all prioritised PHC services to the defined population in need including Human resources for health, Services, commodities, and supply chain, and Infrastructure and equipment procurement and maintenance costs.

The MSP process ultimately hinges on developing a practical and realistic MSP Investment plan following determination of the state's available human resources for health and PHC fiscal space, alignment on investment decisions and trade-offs such as the types of services to be included in the investment plan on a year-by- year basis, considering the fiscal ceiling, and finally, development of a 3-5 year investment plan (service delivery plan) tailored to current and projected resources available to the state.

For this report, the gold standard is that a State has developed and costed its MSP, developed a practical and realistic investment plan aligned with the state health budgets and the fiscal space, and has commenced phased implementation of the MSP in the State.

9 Reporting on Service availabilty

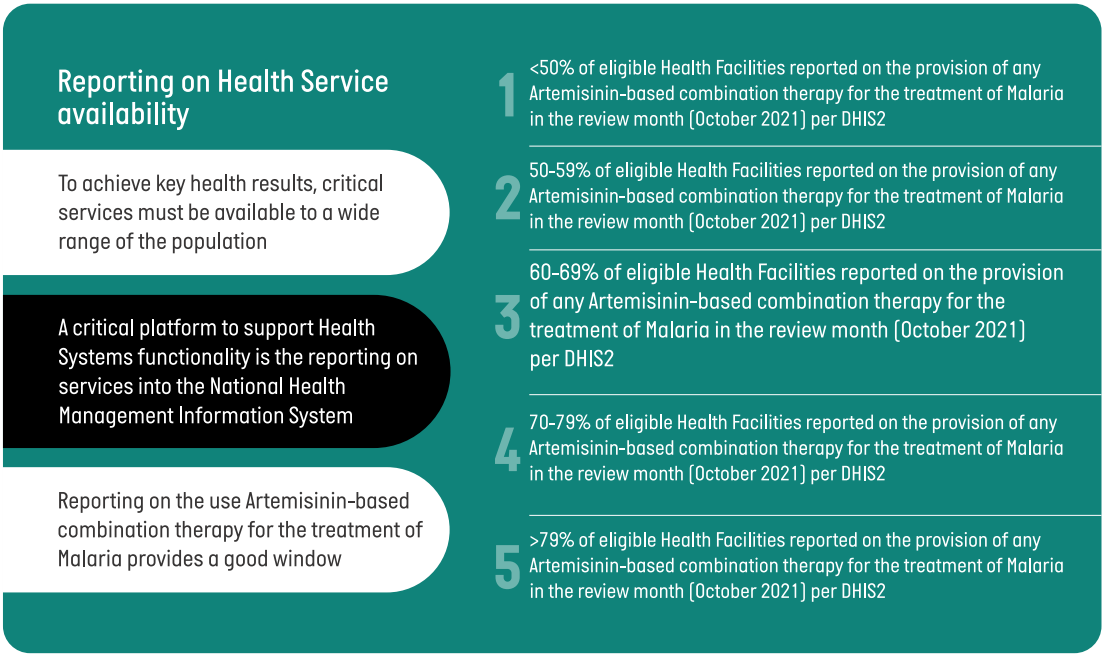
Health Information systems play a critical role in providing visibility about available health services in select health facilities, local government areas, or states within the country. It provides critical data for health planning, programme design, and programme implementation. The visibility that these systems provide also support an assessment of the capacity of states and local government areas, as well as health facilities to deliver essential health services.

In Nigeria, the health information system (HIS) cuts across many government institutions and multiple reporting platforms[46] and is defined by the country policy that drives the National Health Management Information Systems (NHMIS)[47]. One of the key instruments of reporting on this platform is the District Health Information Systems version 2.0 (DHIS2) platform, where reporting on health services is provided from the health facility, aggregated at the local government level, and ultimately collated at the state level.

Reporting on the DHIS2 is one of the platforms that provides visibility on health delivery, particularly providing facility-based visibility on health service provision. This allows for inferences on both service availability and

utilisation, depending on the relevant assumptions. For this report, the assessment has focused on the reporting for the treatment of malaria from health facilities in a state.

The analysis focuses on the proportion of health facilities in a state reporting the provision of Artemisinin-based combination therapy (ACT) – the current gold standard for the treatment of malaria.



The basis on this analysis is to ascertain the extent to which states are driving appropriate malaria service delivery and the level of visibility into that effort that states have, based on reporting from the health facility level. Good reporting for this indicator will typically occur at a nexus of product availability at the health facility, patient attendance at the facility for cases of malaria, health worker capacity to provide this treatment and to report on it, and health facility capacity to provide reports up the chain of command to the state.

For this report, the focus is on health worker and health facility capacity to provide reports and the gold standard is that at least 80% of health facilities in a State reported on the provision of any ACT for the treatment of Malaria in the review month, recognising that a report on zero services provided is also a report.

10 Health product stock performance

Health product or commodity security is a cornerstone of health service delivery and one of the building blocks of the health system.

The availability of these products at the last mile where citizens utilise health services is a determinant of outcome within the population, and this availability results from a multi-pronged and multi-layered effort.

For a medicine, consumable, or any other health product to be available at the point of use, there needs to be alignment between manufacturing, forecasting, procurement, distribution, and broader supply chain management within a country and on the global landscape.

Recognising the popular allusion that 'no commodity, no programme,' the country and the states have consistently invested in these procurement and supply chain management systems, over the years.

In Nigeria, reporting on the availability of health products goes through a myriad of platforms. The availability of bundled vaccines was reported through the Visibility and Analytics Network (VAN) dashboard and now through an adapted vaccine Logistics Management Information System (LMIS), overseen by the NPHCDA. The availability of health products for Malaria, HIV, and Family Planning are reported through a different LMIS platform, overseen by the FMOH, working with the different programmes and agencies involved in these areas.

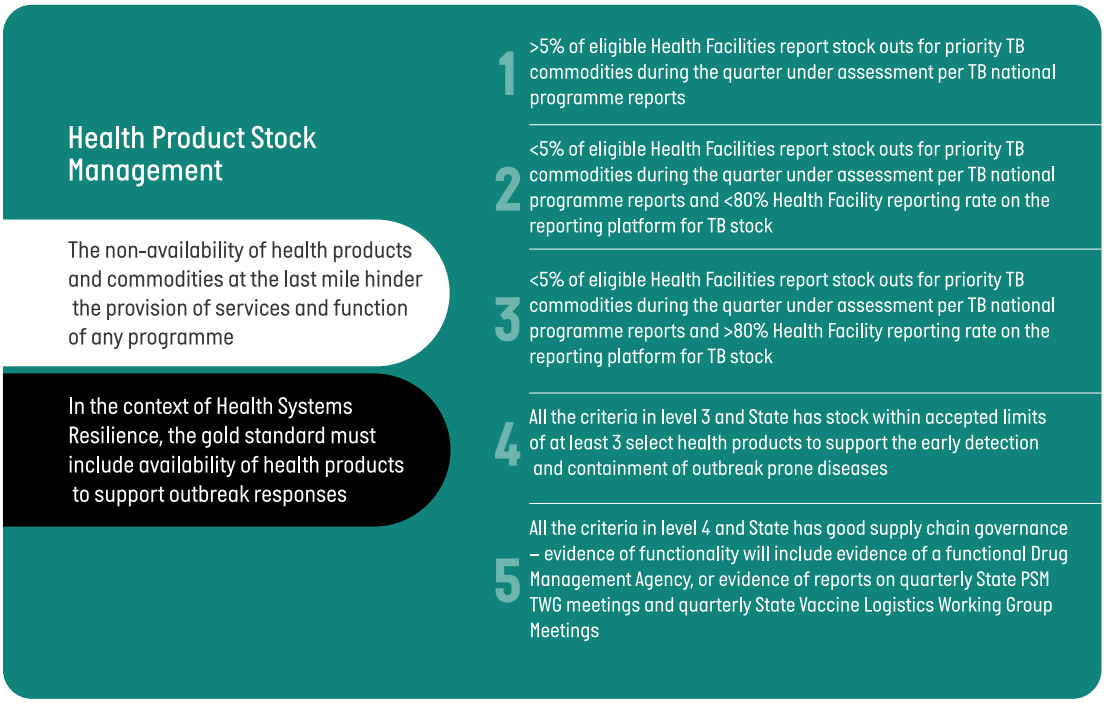
The availability of health products for TB control are reported through yet another 'pick and pack' reporting platform, also overseen by the FMOH and the National TB control programme. Finally, the availability of health products for the containment of outbreaks are reported through another platform called the 'LoMIS', overseen by the Nigeria Centre for Disease Control (NCDC).

These myriad of reporting platforms clearly demonstrate a lack of synergy among agencies for health commodity security, which will in turn

impact on the states.

This report assesses the results of these investments, using a specific vertical disease control programme as a primary case study and taking into consideration the lessons learnt from the recent COVID-19 pandemic and the attendant challenges in the availability of health products for outbreak response and containment.

The report assesses reporting on TB control commodity stock performance and health facility reporting rates from eligible facilities, along with availability of health products for outbreak containment and the robustness of state supply chain governance systems within this very challenging environment.

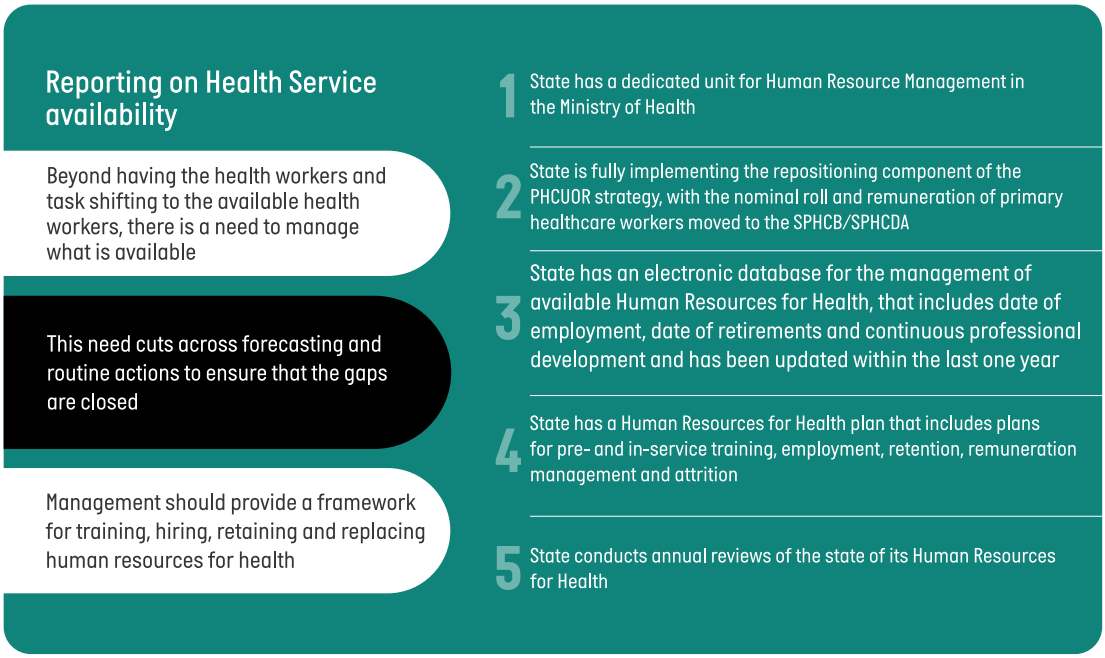


For this report, the gold standard is that less than 5% of eligible health facilities are reporting stock outs of health products for TB control, 80% of eligible health facilities providing reports in the review quarter (used instead of month, based on the reporting systems available), the state has adequate stock available for three select health products to support outbreak response (with adequacy as defined by the minimum and maximum stock levels within the reporting framework), and the state has strong supply chain governance through its logistics technical working groups and logistics management coordinating units or drug management agencies.

11 Human Resource Management Systems

The challenge with the absolute shortages of human resources for health has been identified as a major limitation to improving health outcomes and the instrumental role of innovation in this area has also been highlighted. It is imperative for states to adopt, adapt, and implement an array of innovation ranging from the roll out of CHIPS[48] agents to the implementation of task shifting and task sharing[49–53] to help close the gap in the numbers of health workers and in the efficient use of the available health workers through a policy drive.

Yet the challenge of human resource for health management spans training, employment, retention, and replacement for deaths and attrition. Retention additionally encompasses broad aspects of management including distribution, remuneration, and management of promotions and career progression. It is therefore important to assess the work of the different states in this area, in line with national policies and strategies.



The primary healthcare under one roof (PHCUOR) strategy provides a policy direction and platform to support the re-positioning of primary health workers from the local government service commission to the state primary healthcare development boards (SPHCDB) and or agencies (SPHCDA). This re-positioning ensures that primary healthcare workers are managed by the agency of government charged with delivering results in primary healthcare, rather than by a broader governance arrangement at the local government level.

All states of the federation have a SPHCDA or SPHCDB and are expected to have repositioned staff from the local government service commission to these agencies, with personnel file and nominal rolls now managed by the SPHCDA/SPHCDB. Additionally, states are expected to leverage technology to further support this management of human resources for health, to position the state strongly to forecast human resource for health needs.

For this report, the gold standard is that the state has repositioned primary healthcare staff from the local government service commission, with personnel file and nominal rolls now managed by the SPHCDA/SPHCDB, the state has an electronic human resource register to support personnel management, the state has articulated a human resource for health plan to drive forecasting, production, employment, retention, and replacement of human resources for health, and the state routinely reviews this human resource for health plan as it is progressively implemented.

For this report, the gold standard is that the state has repositioned primary healthcare staff from the local government service commission, with personnel file and nominal rolls

Outcome Measures

The ultimate result of all investments and processes in health are defined by population level outcomes and results, and therefore we must assess these outcomes and weight them strongly. It is also important to assess these outcomes using a standardised system. Indicators that showcase these population-level results of the performance of the health system were selected and state performance on these indicators drawn from nationally accepted data – the 2018 National Demographic and Health Survey (NDHS)[3].

The input and process indicators selected for this report allow for an analysis of State leadership and effort to improve on the outcomes from the 2018 NDHS.
The underpinning hypotheses for this report are that:

1. Poor health outcomes across majority of States from the 2018 NDHS can only be changed if the State provides key financial, human, and material resource investments into its health system, and provides leadership of evidence-based processes to translate these resources to results for the people

2. Good health outcomes from a handful of States from the 2018 NDHS can only be sustained and improved on, if the State builds on and improves provision of key financial, human, and material resource investments into its health system, and continues to provide leadership of evidence-based processes to translate these resources to results for the people.

In recognising that for many States with poor health outcomes, current State leadership have had a unique opportunity to transformational leadership to improve health outcomes, it is also recognised that the handful of States with good health outcomes could be completely derailed in the absence of purposeful leadership for health in the State.

Select Reproductive, Maternal, Newborn, Child, Adolescent Health, including Nutrition Indicators
In assessing the population-level results of all the investments and processes within the health system, a select group of high-impact indicators have been selected for analysis for this report. These indicators are globally recognised as some of the most critical population-level measures of success in the health system, aligning with the sustainable development goals (SDGs)[54–58] and some measures of universal health coverage (UHC)[56,59–61].

For this assessment, eight health outcome indicators were identified. These indicators are not exhaustive but provide a platform for a detailed analysis of the performance of the health system in a state and help identify some of the most critical aspects for improvement. These indicators also align with the recent report of the Lancet Nigeria Commission on opportunities for health systems strengthening (HSS) in Nigeria[8] and in the technical briefs of the recently concluded primary healthcare summit in Nigeria[9].
The eight health outcome indicators selected for this assessment and report include:

1. Vaccination coverage for the Bacille Calmette-Guerin (BCG) vaccine which often reflects an entry into the vaccination programme
2. Vaccination coverage for the third dose of the pentavalent vaccine (Penta 3) which often reflects sustained utilisation of the vaccination programme
3. Proportion of children who are Underweight, which often reflects severe acute malnutrition
4. Proportion of children who are Stunted, which often reflects chronic malnutrition with its attendant impact on health, education, and the attainment of full potential for affected children
5. The proportion of children who die before their fifth birthdays, largely due to preventable causes that cut across vaccine preventable diseases, malnutrition, malaria, and issues tied very closely to water, sanitation, and hygiene around the child,
6. The proportion of pregnant women who receive antenatal care from a skilled provider, to identify high-risk pregnancies, to plan for delivery, and to support appropriate care
7. The proportion of pregnant women whose babies are delivered by a skilled provider, with its implications for the management of high-risk situations including post-pregnancy bleeding – a leading cause of preventable maternal deaths
8. The proportion of married women whose needs to delay, space, or limit the number of children that they have is not met, with the attendant impact of these frequent and poorly spaced pregnancies on preventable maternal and child deaths.

	Outcome Indicators	Grading				
		1	2	3	4	5
11	Access to Health Services – Proportion of children age 12-23 months who received BCG vaccination at any time before the survey (according to a vaccination card or the mother's report) (NDHS 2018)	1-20%	21-40%	41-60%	61-80%	>80%
12	Continued Utilisation of Health Services – Proportion of children age 12-23 months who received the third dose of Pentavalent vaccination (Diphtheria-Tetanus-Pertussis containing vaccine) at any time before the survey (according to a vaccination card or the mother's report) (NHS 2018)	1-20%	21-40%	41-60%	61-80%	>80%
13	Proportion of children under age 5 classified as malnourished according to Height for age scores below -2 Standard Deviations (Stunting) (NDHS 2018)	>40%	31-40%	21-30%	11-20%	≤10%
14	Proportion of children under age 5 classified as malnourished according to Weight for age scores below -2 Standard Deviations (Underweight) (NDHS 2018)	>40%	31-40%	21-30%	11-20%	≤10%
15	Deaths of Children less than 5 years old, per 1,000 live births for the 10-year period before the survey (NDHS 2018)	>200	151-200	101-150	51-100	≤50
16	Proportion of women age 15-49 who had a live birth in the 5 years preceding the survey, who received antenatal care from a skilled provider for the most recent birth (NDHS 2018)	1-20%	21-40%	41-60%	61-80%	>80%
17	Proportion of live births in the 5 years preceding the survey assisted by a skilled provider (NDHS 2018)	1-20%	21-40%	41-60%	61-80%	>80%
18	Percentage of currently married women age 15-49 with unmet need for Childbirth Spacing (NDHS 2018)	>25%	21-25%	16-20%	11-15%	≤10%

Figure 9: Overview of some of the outcome indicators for the ranking of Health Delivery across States

In analysing these eight indicators across states using data is accepted nationally and by all states, this assessment highlights a state of health across the country that the government and all stakeholders already agree is the stark reality.

The key issue here, however, is that this reports then seeks to connect these poor health outcomes as validated by all stakeholders in 2018, and the current investments and processes by state leadership with a view to establish which states are doing what is required based on global best practices to change their narratives or to build on a history of acceptable results.

The bottom line across these indicators is that all states must do whatever is necessary to end preventable maternal and child deaths, and states must be reminded of the realities and the challenge that they are expected to overcome.

Community and experiential Health Indicators
Beyond the hard facts of the health outcomes, as documented in the 2018 NDHS, it is also important to explore the current realities on the experience of citizens when accessing health services from the public sector and the infrastructural deficit at the primary healthcare level, within the public sector.

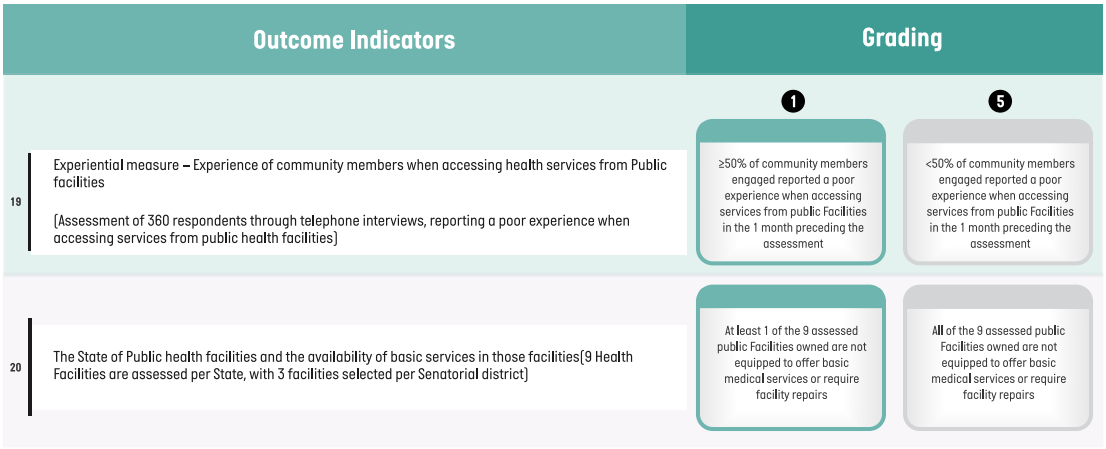


Figure 10: Overview of the experiential outcome indicators for the ranking of Health Delivery across States

This report explores the experience of randomly selected community members when assessing health services from public health facilities, with bad experiences defined by an array of issues from long wait times, closed facilities, unavailability of health products, staff attitude, and the processes in place in the health facility to facilitate their use of care.

The report additionally explores the state of health facilities with three randomly selected PHCs per senatorial district, assessed for the state of the infrastructure and the availability of key equipment and materials for the delivery of essential health services.

Whilst the findings from this aspect of the assessment is expected to either corroborate or refute findings from the national agency in charge of the primary healthcare system[9], the focus on this aspect is to ensure that an analysis of health delivery in the state clearly articulates the perspectives of the end-users who the health system is expected to serve.

Health Systems are built with the people it will serve as its key focus, and a health system is expected to perform certain functions, referred to as the "building blocks" of the health system

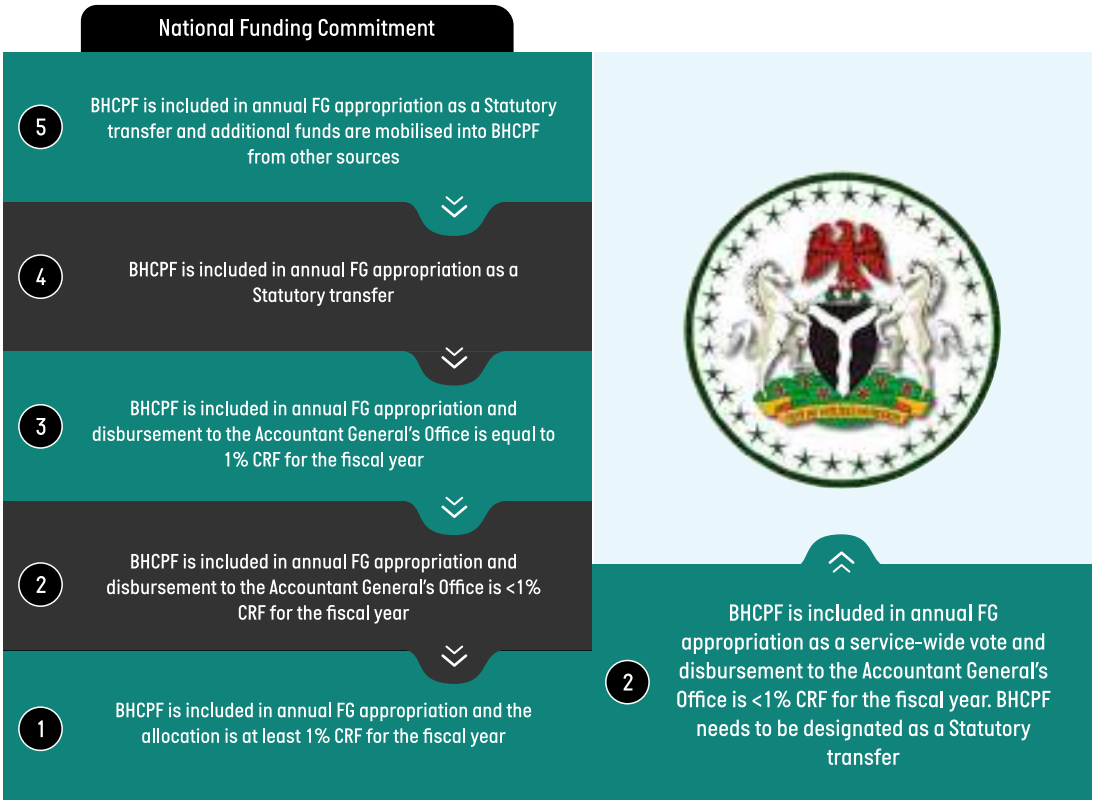
Basic Health Care Provision Fund - National Outcomes

Federal Government

In line with the provisions of the National Health Act and the guidelines for the implementation of the BHCPF, the FG are expected to provide at least 1% of the CRF as a statutory transfer and mobilise additional resources to increase the size of the funds. Although funds have recently been released from the FG for the BHCPF, the 1% CRF has not been fully provided.

The eight health outcome indicators selected for this assessment and report include:

1. Vaccination coverage for the



Additionally, the allocation to the BHCPF driving current fund release is provided as a state-wide vote, rather than a statutory transfer. Although this does confer a small advantage to the BHCPF in the case that the revenue of the federation increases during a fiscal year, a statutory transfer ensures sustained and predictable funding for the BHCPF.

Since its inception, the FG has also not succeeded in mobilising additional financial resources for the BHCPF beyond the 1% CRF. The FG faces an urgent need to expand the fund pool for the BHCPF. This can be achieved through channelling the recent additional taxes on alcoholic and sugary beverages towards funding the BHCPF.

The FG can also leverage its political will to both increase the allocation to 2% CRF and to explore expanding the allocation to go beyond the revenue of the FG and to include the revenue of the federation.

This will of course require negotiations with state leadership through the Nigeria Governors' Forum (NGF). Since states are the main beneficiaries of the BHCFP through its different gateways, there is a strong argument for the FG to provide leadership of resource mobilisation for the BHCPF by exploring these channels.

The FG also has a critical role to play in driving shared leadership of the BHCPF oversight committee, across both the ministries of health and finance. The BHCPF is ultimately a fund, and shared leadership between these two ministries will strengthen ownership, increase implementation capacity, and strengthen oversight on the funds.

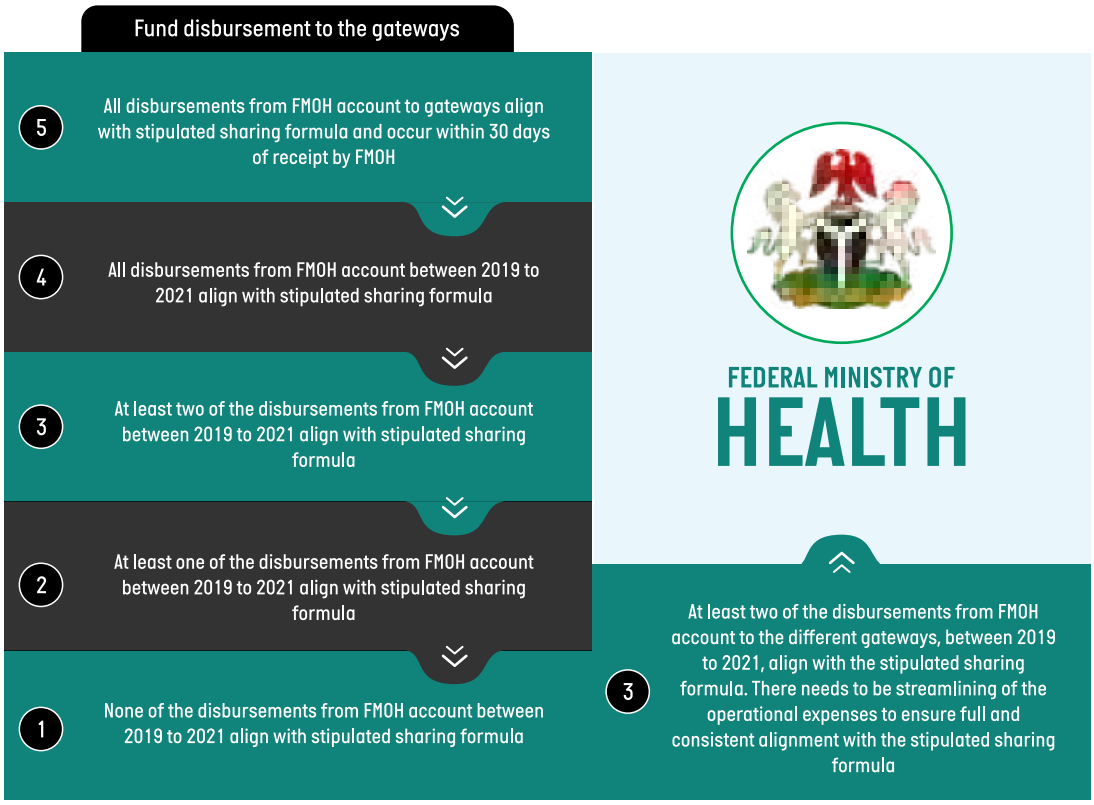
This shared ownership has the ownership to contribute to a stronger commitment from the ministry of finance to mobilise resources for the BHCPF

Federal Ministry of Health

The FMOH is currently the leading ministry for the implementation of the BHCPF, overseeing fund disbursements to the different gateways and leading the MOC. FMOH primarily receives fund releases from the Accountant General's office and then manages disbursement to the different gateways through the previously defined sharing formula.

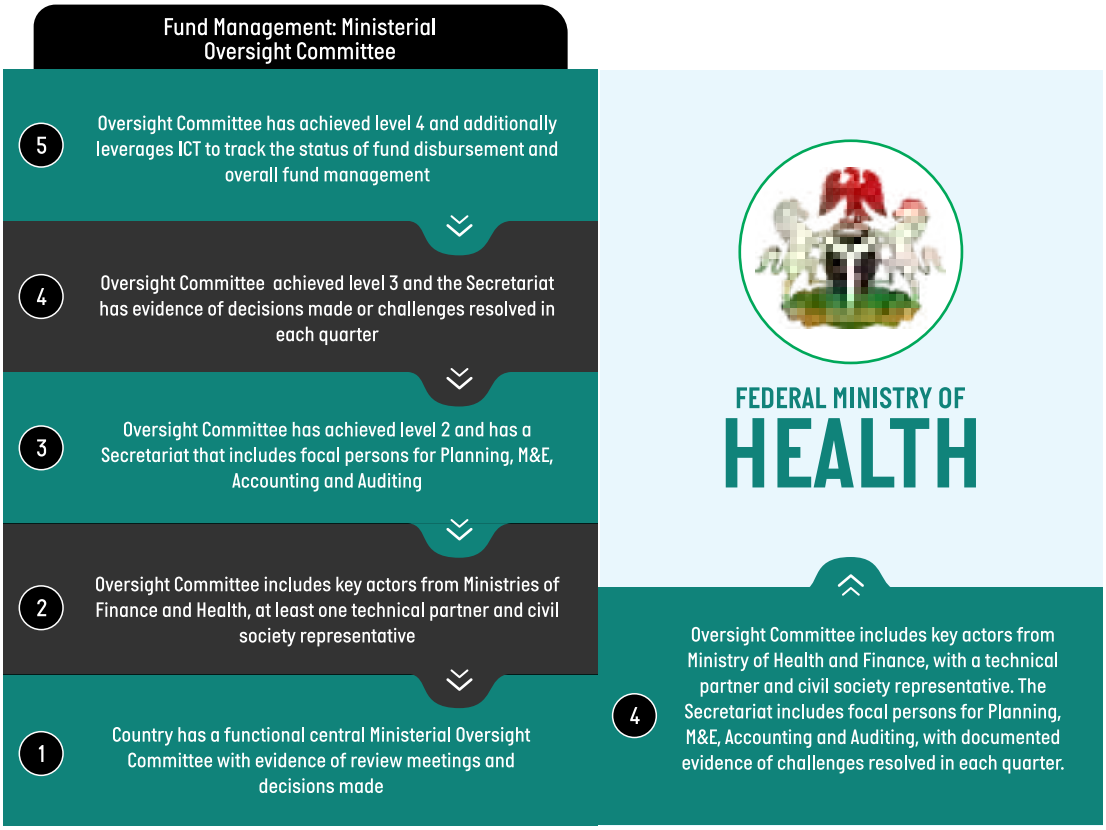
Findings from consultations highlight that not all releases or disbursements from the FMOH to the different gateways have followed the rigidly defined sharing formula. The BHCPF secretariat is housed in the FMOH and is staffed to function as the engine room of the MOC.

There also needs to be a streamlining of the operational expenses of the MOC and the secretariat, to ensure that the allocations to the secretariat are better defined and remain transparent. There is also a need to ensure that funds are disbursed in a timely manner to the gateways.



Although the MOC does not have co-leadership by the ministries of health and finance, the MOC includes actors from both ministries, as well as technical partner and civil society representatives.

The MOC meets periodically, with documented evidence of decisions taken to resolve challenges impeding implementation of the BHCPF.



Although the MOC clearly has a secretariat with focal persons with relevant capacity for planning, monitoring and evaluation, accounting, and auditing, the process of appointing individuals to the secretariat and of ensuring continuing capacity development is unclear.

The performance management structures for the different core functions required in the secretariat can also be strengthened, as this will ensure that the capacity of the secretariat continues to improve, ultimately contributing to more efficient and effective fund management.

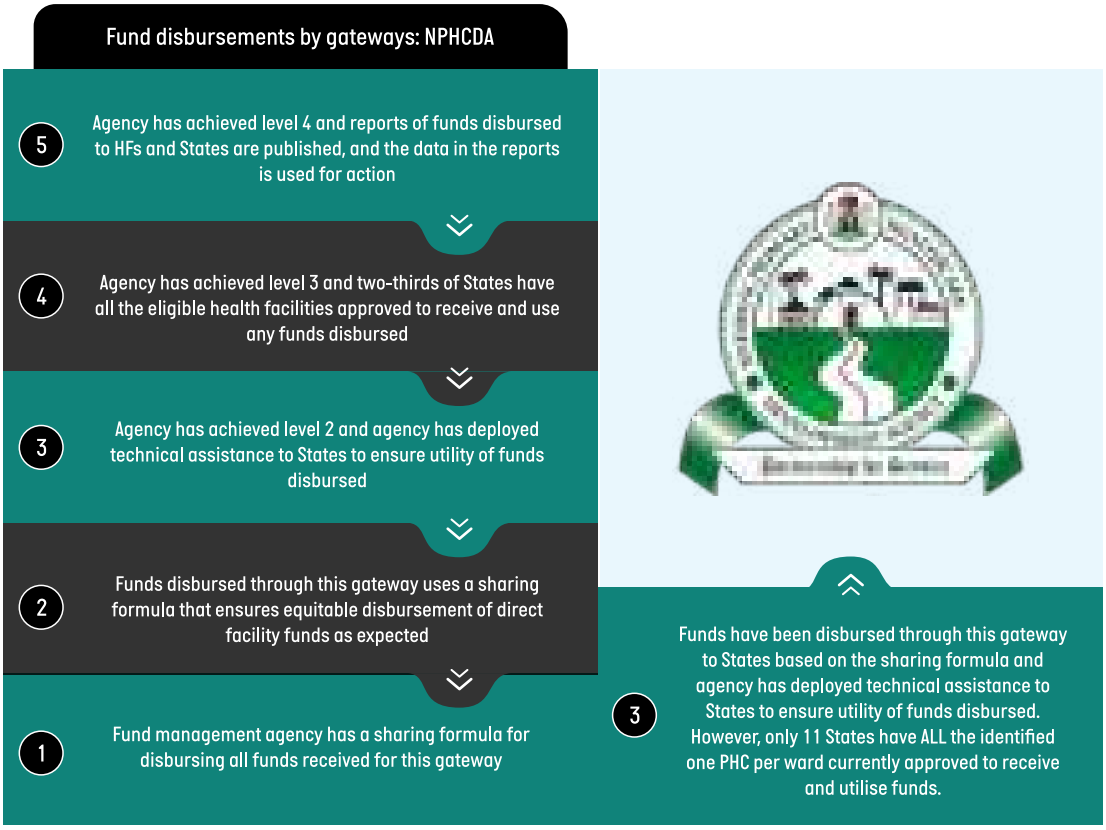
National Primary Health Care Development Agency

Findings from the assessment of the performance of the NPHCDA gateway highlight key areas where success has been achieved and key challenges hampering efforts to maximise the funds from this gateway. The NPHCDA has defined a clear sharing formula as articulated within the guidelines, towards achieving equitable utilisation of the funds through a combination of decentralised facility funds and targeted support for operational costs at state, local government, and health facility level.

NPHCDA has also successfully provided technical assistance to states to put in place the necessary machinery required to access and utilise funds through this gateway. Despite these efforts, less than two-thirds of the states have all eligible health facilities approved to receive and use funds from the BHCPF.

This is of particular concern because the BHCPF funds from the NPHCDA gateway are earmarked to support one PHC per political ward to provide essential health services. This means that when all eligible PHCs in a state are receiving and using funds, one marker of equitable distribution of these funds would be achieved.

These facilities can then leverage the funds to upscale available human resources for health, strengthen health product availability, and increase implementation of targeted service delivery strategies.

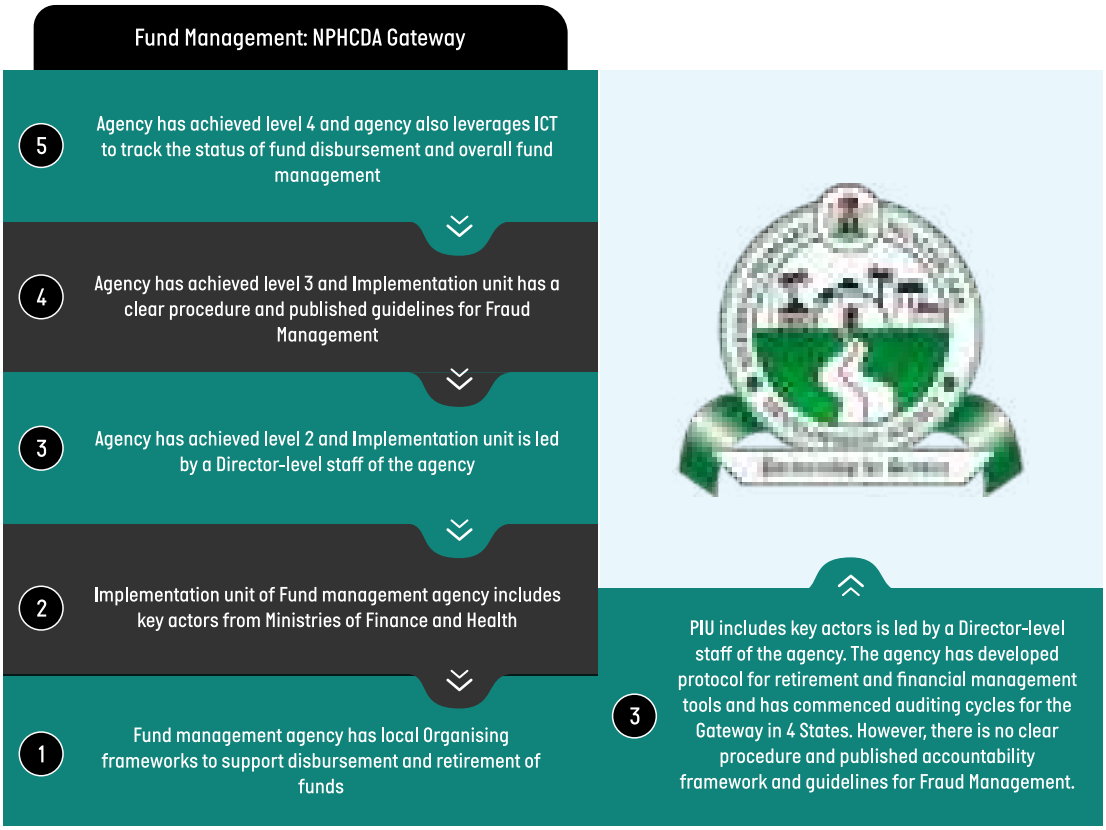


In the current situation however, only eleven states have all the eligible health facilities approved to receive and use funds. A concerning challenge in these eleven states, is that in some of the states, the eligible PHCs do not cover each political ward, with some of the identified eligible facilities located outside the political ward. This again poses a challenge to the focus on equity of the BHCPF.

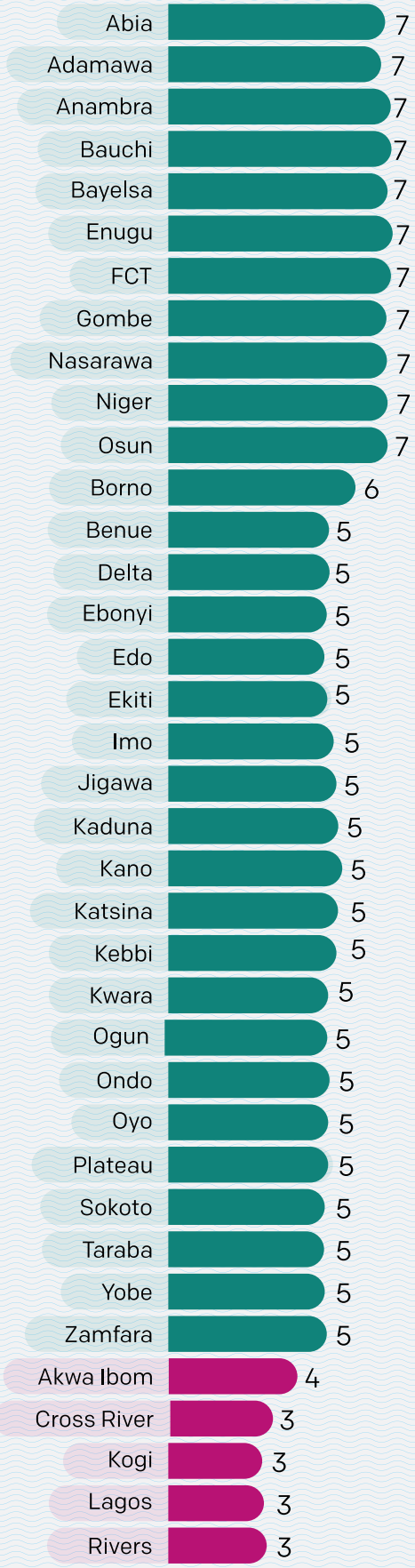
Within the NPHCDA the programme implementation unit (PIU) for the BHCPF is led by a director-level staff in the agency, ensuring senior leadership of the gateway operations.

The fund unit also includes key actors drawn from relevant stakeholders. Although the gateway has a performance management framework with rewards and sanctions for erring states, there is no clear fraud management guideline for the implementation of the fund for the gateway.

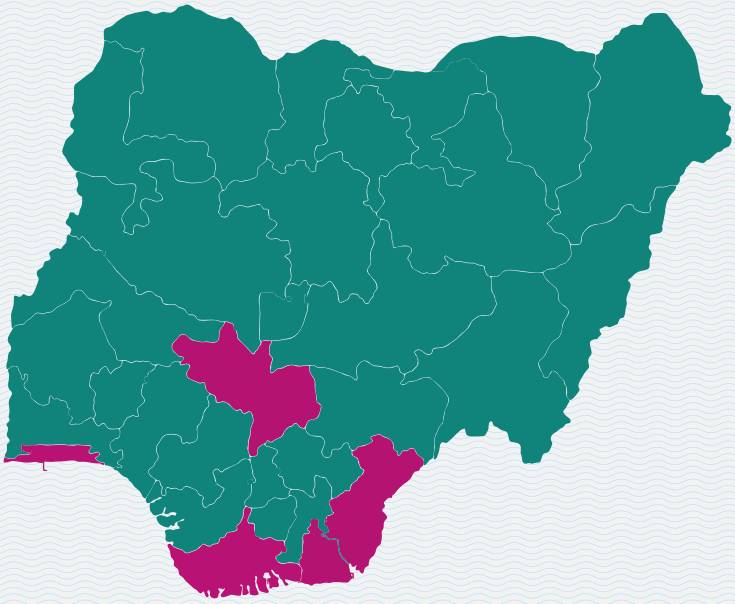
The gateway currently does not leverage information and communications technology (ICT) to track and document all funds receipts and disbursements, creating added difficulty in documentation of fund management.



The performance of the different states on this gateway is a positive upturn across health systems inputs in this assessment and report and highlights possible progress even in the context of a weak health system. The results of desk reviews and consultations on the status of the BHCPF implementation details the performance of States across the NPHCDA gateway.



Based on the key findings on the NPHCDA gateway from the States, a few key themes have emerged for technical reviews on strengthening the BHCPF.



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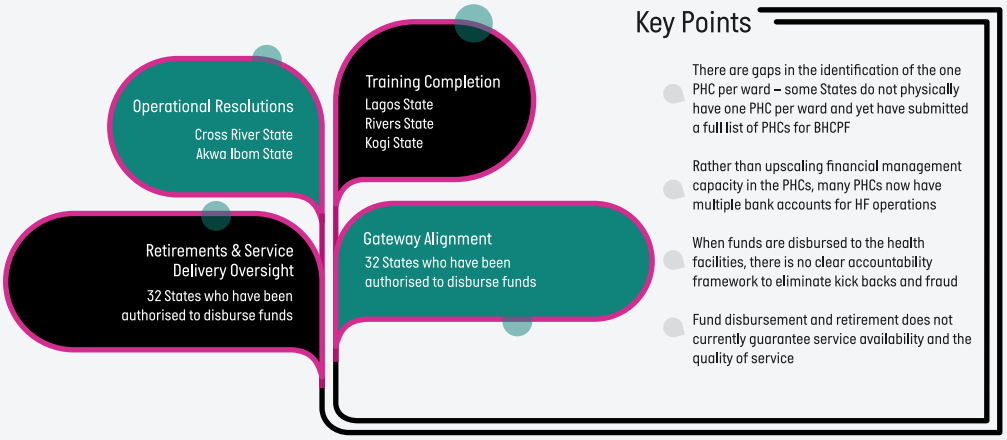
Based on the key findings on the NPHCDA gateway from the States, a few key themes have emerged for technical reviews on strengthening the BHCPF.

Recommendations



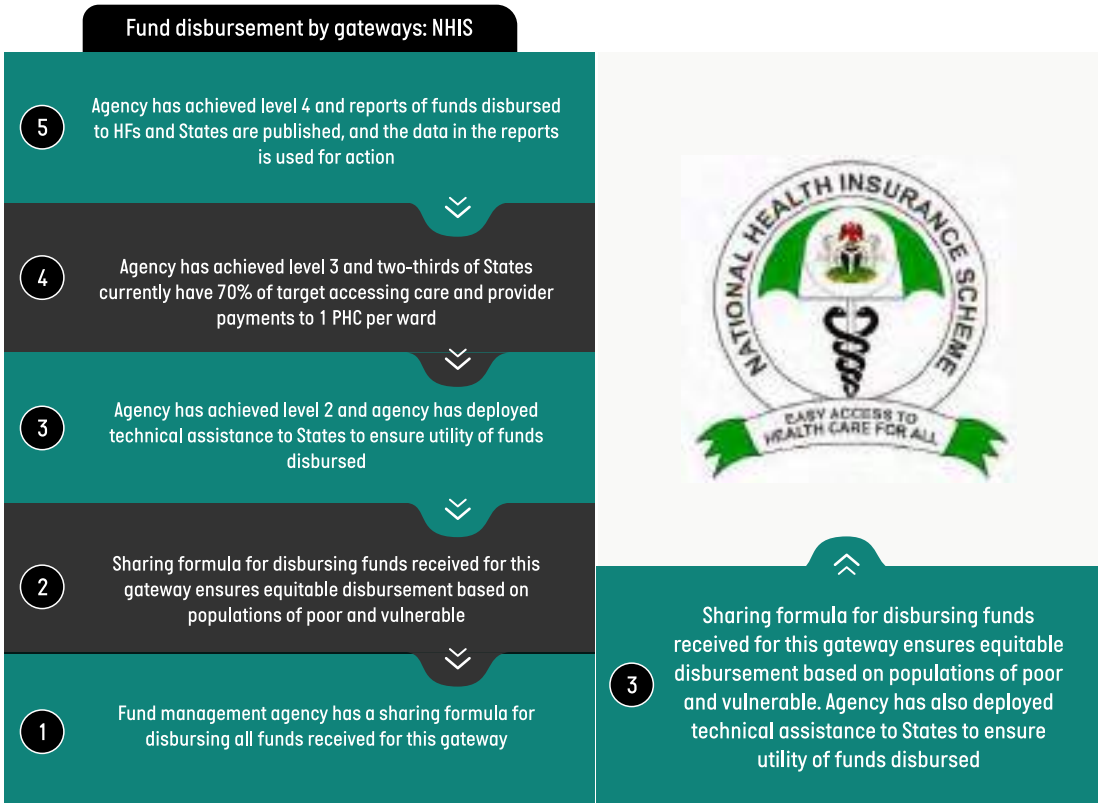
National Health Insurance Scheme

Findings from the assessment of the performance of the NHIS gateway also highlight key areas where success has been achieved and key challenges hampering efforts to maximise the funds from this gateway. The NHIS gateway is designed to prioritise providing health insurance coverage for the poor and vulnerable, with a sharing formula that is premised on this consideration. States are also expected to provide an equity fund and a counterpart fund for this gateway, to scale up coverage of the poor and vulnerable, and to build towards a sustainable fund pool.

Across the states, a combination of strategies has been deployed to document the poor and vulnerable who are eligible for coverage through the NHIS gateway.

One strategy has been the use of social registers maintained in the states by the National Social Safety-nets Coordinating Office (NASSCO), while a second strategy has been community enrolment approach where the poor and vulnerable are identified and documented through the support of community and religious leaders.

Both strategies have been riddled with challenges, with many of the registers maintained by NASSCO turning out to be out of date and not fit for purpose, and the community enrolment fraught with enrolments of individuals who do not fall into the defined category.



The gateway currently does not also leverage information and communications technology (ICT) to track and document all funds receipts and disbursements to states and from states to the health facilities, creating added difficulty in documentation of fund management.

The results of desk reviews and consultations on the status of the Basic Healthcare Provision Fund implementation details the poor performance of States across the NHIS gateway.

Recommendations

Operational Resolutions

Akwa Ibom State
Rivers State

Enrolment Challenges

16 States where access has still not been created

Retirements & Service Delivery Oversight

32 States where the one PHC per ward has not been empanelled as a service provider

Utilization Challenges

All 21 States who have created access and have commenced provider payments

Key Points

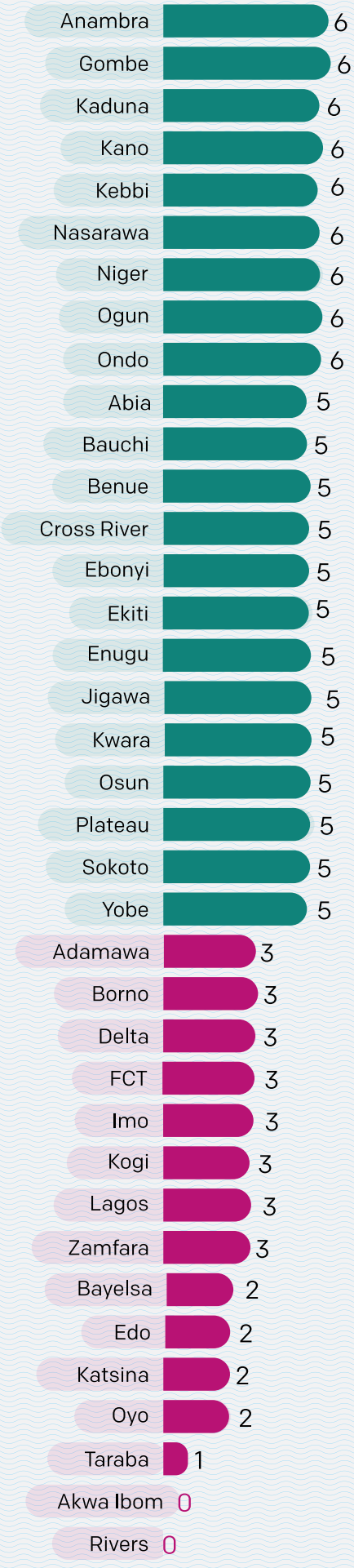
Hybrid use of social register and community-targeting is not ideal. Update of Social register requires cross-sectoral collaboration, but should be mandated

The chance in the guidelines about empanelling private health facilities for primary health services has created confusion among states and may be limiting access in wards without PHCs or in very large wards

One PHC per ward has not been accredited and empanelled in states as providers on the NHIS gateway
There is a poor allighnment between the gateways in many states worsening a limited room for oversight of empanelled public PHCs by the NHIS gateway

States without formal sector health insurance typical lack the required capacity for end to end implementation of this gateway, and have limited room for risk pooling

Utilisation remains abysmally poor in many states where access has been created



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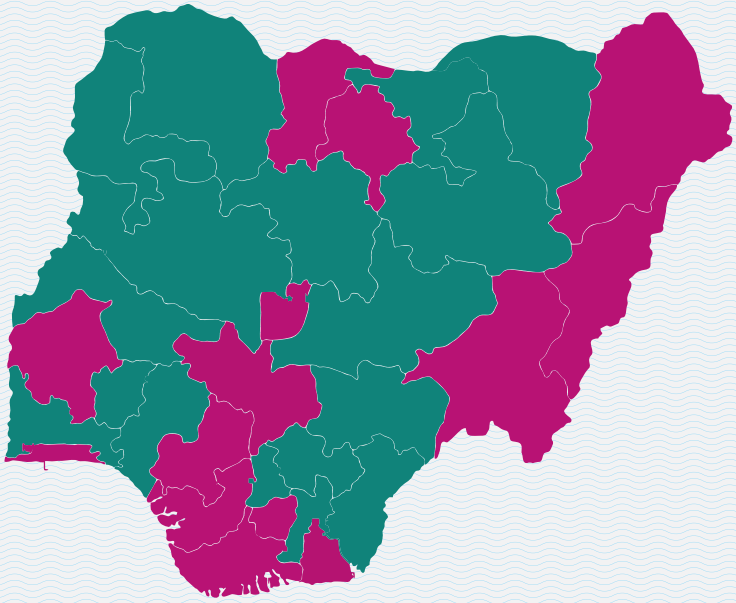

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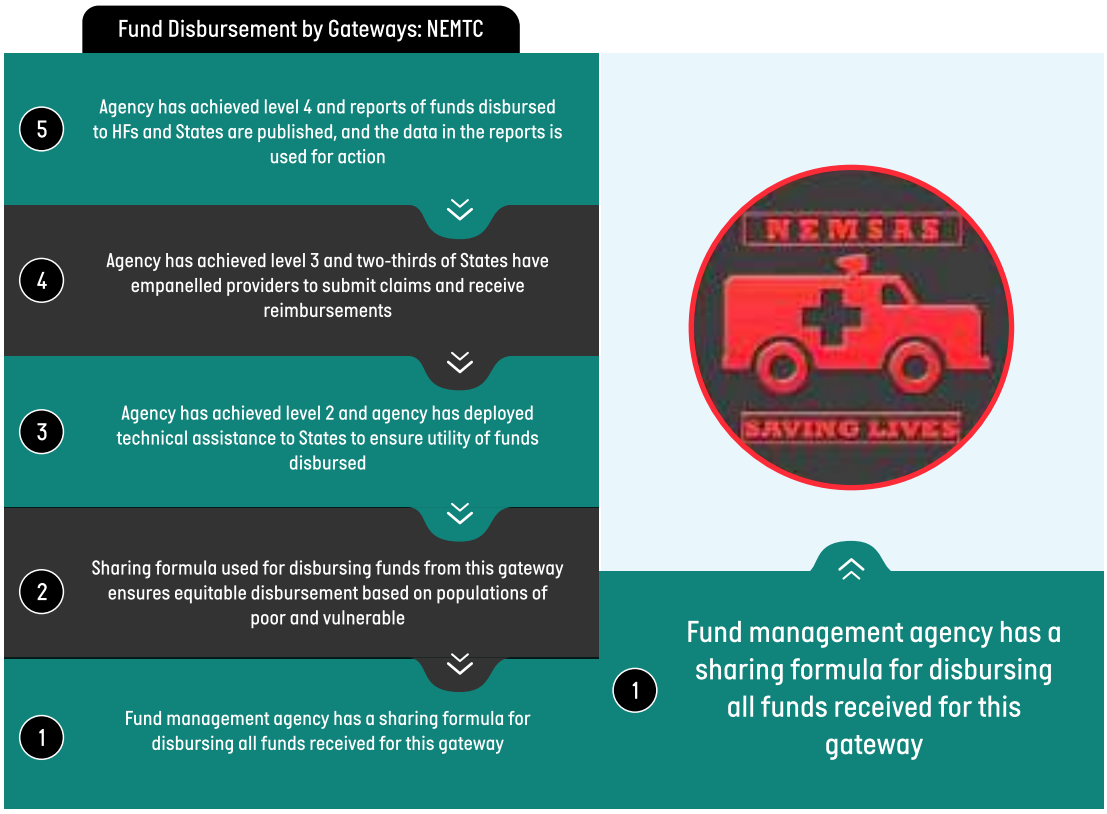
National Emergency Medical Treatment Committee

The NEMTC is the gateway which is still in its infancy. The National Emergency Medical Service and Ambulance System (NEMSAS) is the operational arm of the NEMTC and is designed to support the delivery of emergency medical treatment to citizens through a pooling of assets and infrastructure from an array of stakeholders, and provision of services as a fee-for-service model.

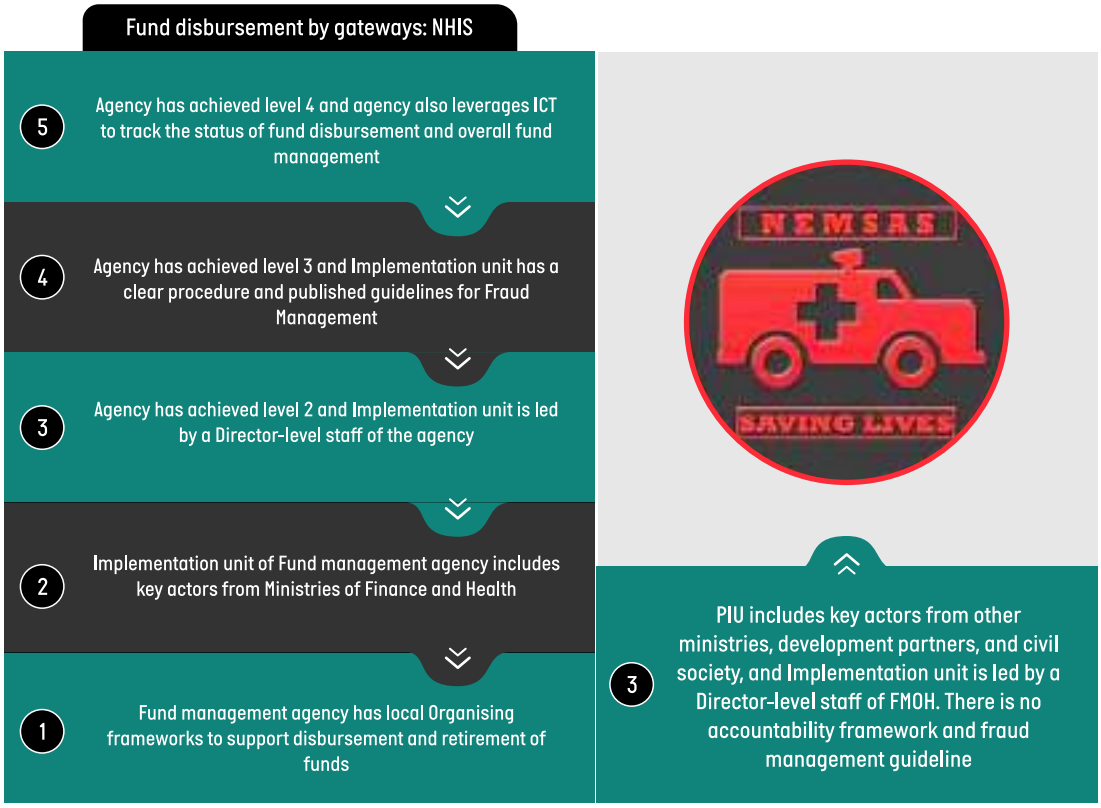
Although NEMSAS has been established, the fund disbursement and utilisation mechanism are not particularly targeted at the poor and vulnerable but is instead designed to coordinate and consolidate emergency medical treatment and pre-hospital care. The mechanisms in place within the fund to foster equity are as such not very clearly articulated.

Additionally, even though NEMSAS have clearly defined the eligibility criteria for states to participate, there is limited technical support to the 36 states and the FCT to support them to meet these criteria and to assess funds from this gateway. NEMSAS have developed an operational manual to guide states in implementation, yet this manual is not yet widely available and state capacity to operationalise this gateway remains low.



NEMTC is led by a director-level staff of FMOH, ensuring senior leadership of the gateway operations. The fund unit also includes key actors drawn from relevant stakeholders.

The gateway currently does not have a clear performance management and accountability framework or fraud management guidelines for the implementation of the fund for the gateway.



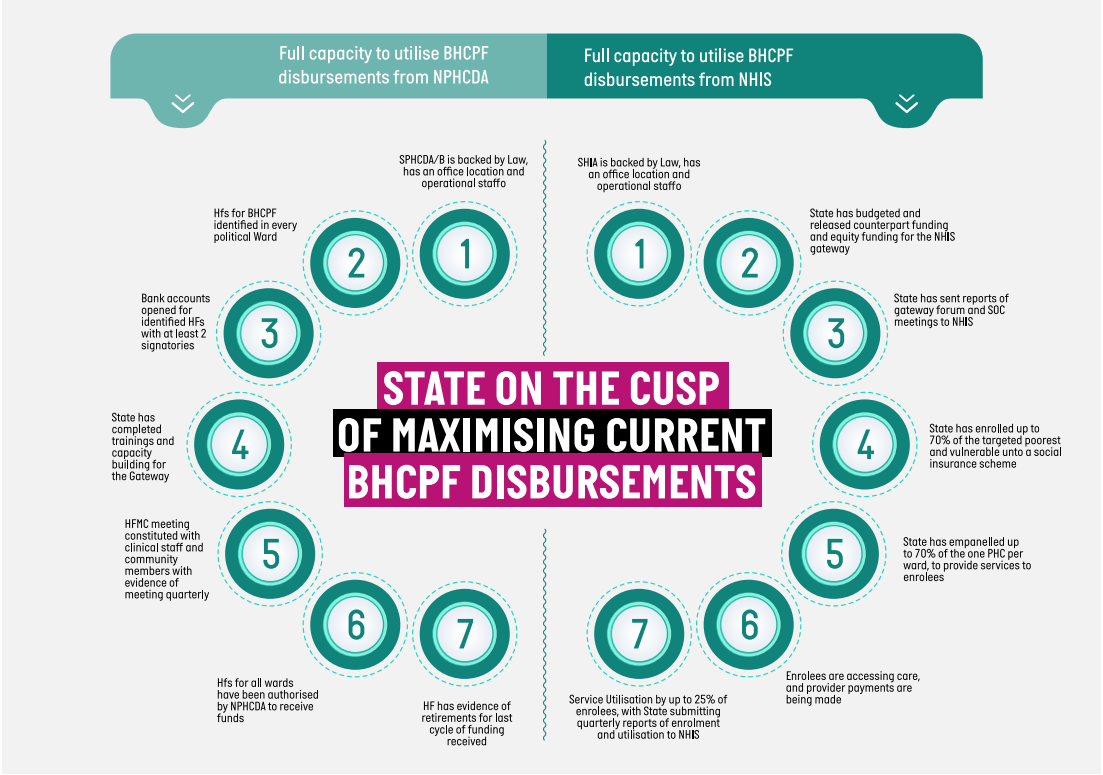
Ultimately, there is a need to urgently review the status of this gateway and to catalyse its operations to ensure that the BHCPF is fully utilised across all three gateways to deliver for Nigerians.

The National Emergency Medical Service and Ambulance System (NEMSAS) is the operational arm of the NEMTC and is designed to support the delivery of emergency medical treatment to citizens through a pooling of assets and infrastructure from an array of stakeholders, and provision of services as a fee-for-service model.

Results of the State of States

Summary of State BHCPF Findings

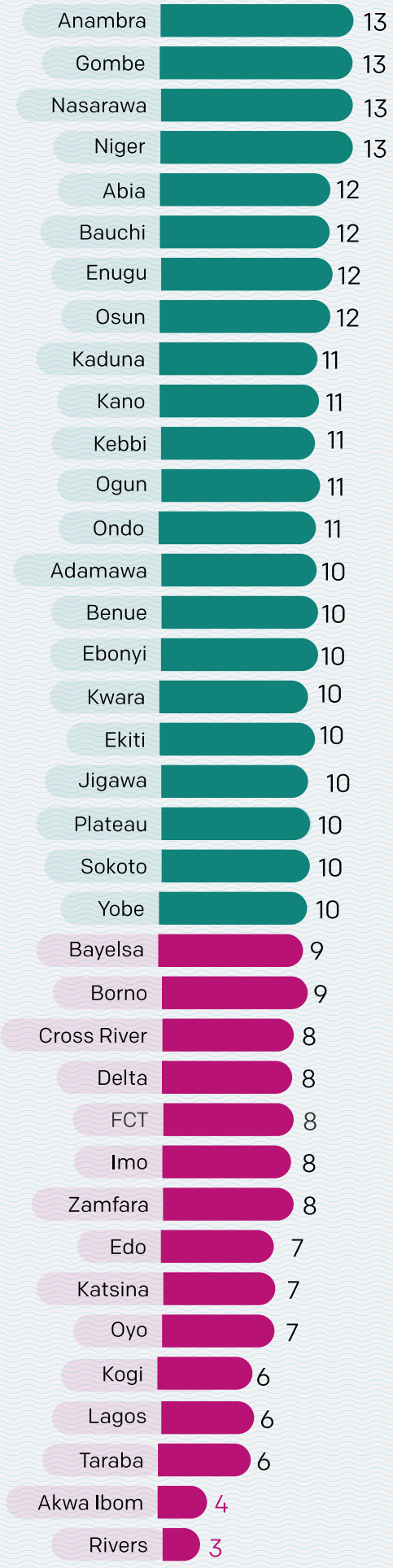
Recognising that States have yet to start accessing funds from the EMT gateway, the results of desk reviews and consultations on the status of the Basic Healthcare Provision Fund implementation focuses on detailing the performance of States across a combination of the NPHCDA and NHIS gateways.



Across each gateway, clear process markers have been identified and each state assessed based on their performance across these markers. These markers focus on the steps and systems in place at the state-level to drive the most rudimentary use of the BHCPF across the two gateways. As such, the markers focus on the steps that each state is expected to take to get the funds disbursed to the facilities for the NPHCDA gateway or deployed for provider payments for the NHIS gateway.

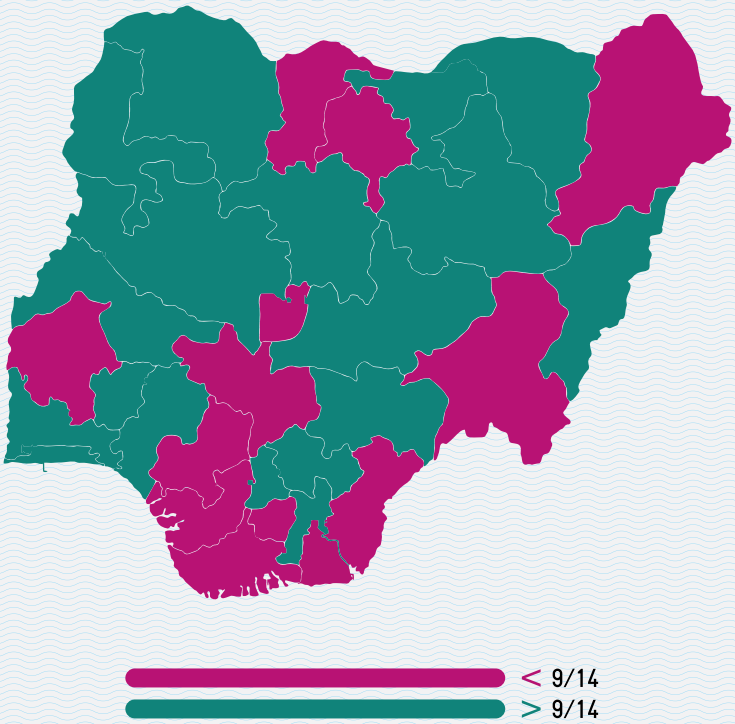
For the NPHCDA gateway, the focus of these markers is to ensure that the identified one PHC per political ward in each state is receiving, utilising, and reporting on funds received from this gateway. The markers currently do not assess the quality of health services provided by these PHCs or the utilisation of services at these PHCs since they started receiving fund disbursements from the BHCPF.

For the NHIS gateway, the focus of these markers is to ensure that the poor and vulnerable have been identified and enrolled unto a social health insurance scheme,
managed by the state health insurance agency, and that accredited providers have started to provide health services to these enrolees and that these providers are receiving provider payments either as capitation or as fee for service, depending on the type of provider and the level of care. The markers also explore the reported rates of utilisation among enrolees.



Although these markers are not exhaustive, they represent the best assessment of the performance of the BHCPF across these two gateways at the state level and provide the best measures of whether the fund is achieving its goals currently.

Subsequent efforts to track the performance of these funds must however go beyond these process markers, to track population-level results from the disbursement of these funds, as well as the effects of the fund on service availability and quality of care.



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Summary of Health Systems Findings

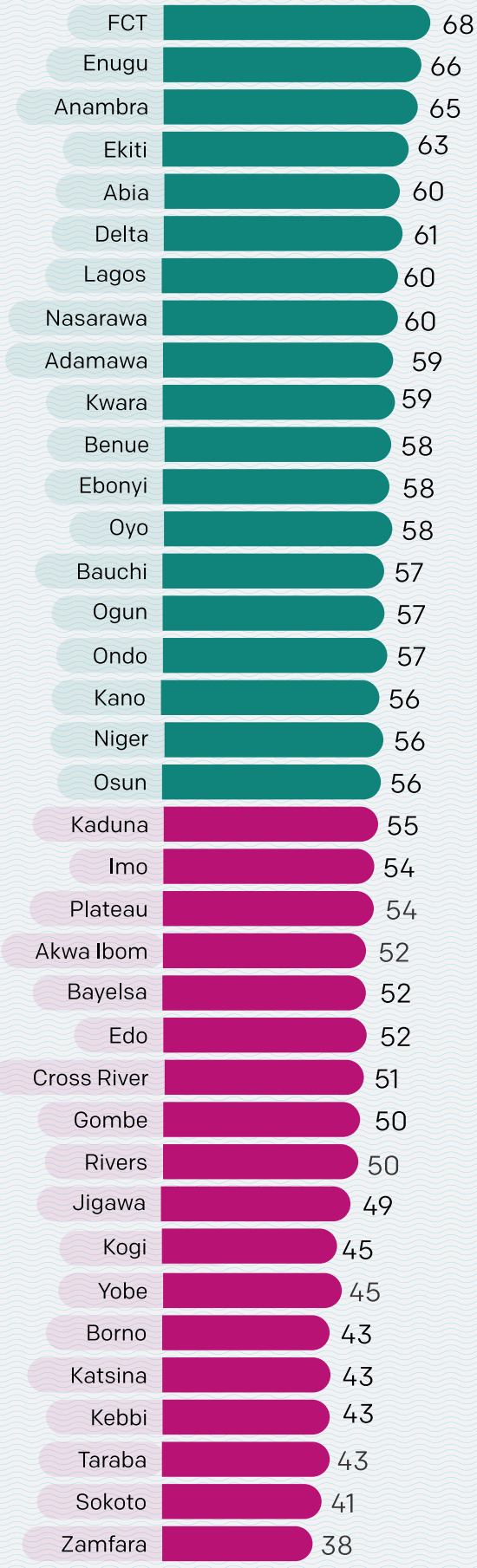
	Source	Consultation +	State AG	Consultation			Consultation +	Consultation +	Consultation	DHIS 2	NHLMIS +	NDHS 2018									TOTAL
S/N	State	Current	Budgetary	Health	Health worker	Implementatio	Annual	Minimum	Human	Reporting on	Health product	U5 Mortality	BCG Coverage	Penta 3	WFA less than -	HFA less than -	ANC from	Delivery by	Unmet need	Experience of	State of Public	AGGREGATE
1	FCT	3	2	4	1	4	3	3	2	5	5	4	5	4	4	3	4	5	5	1	1	68
2	Enugu	4	3	3	1	1	5	3	2	1	5	4	5	5	5	4	5	5	4	1	1	67
3	Anambra	4	2	2	2	1	3	2	2	4	3	4	5	5	5	4	5	5	5	1	1	65
4	Ekiti	4	2	2	1	2	5	3	2	1	5	4	5	5	4	3	5	5	3	1	1	63
5	Delta	2	1	2	2	4	5	2	2	4	5	4	5	4	4	3	4	4	2	1	1	61
6	Abia	4	1	2	2	2	4	3	2	1	5	4	5	5	4	3	5	5	1	1	1	60
7	Lagos	2	3	3	1	4	5	1	2	1	1	4	5	5	4	4	5	5	3	1	1	60
8	Nasarawa	4	2	2	2	4	4	3	2	5	5	3	5	3	3	2	4	3	2	1	1	60
9	Adamawa	3	2	2	2	2	4	1	2	5	5	3	4	4	4	2	5	3	4	1	1	59
10	Kwara	4	1	2	2	4	4	2	2	4	5	4	4	3	4	2	4	4	2	1	1	59
11	Benue	3	1	2	2	4	3	3	2	5	1	4	5	3	4	3	4	4	3	1	1	58
12	Ebonyi	3	1	2	2	4	3	3	2	5	1	4	5	5	4	3	4	3	2	1	1	58
13	Oyo	2	1	2	1	4	5	1	2	4	5	4	5	3	4	2	5	5	1	1	1	58
14	Bauchi	4	3	2	2	4	4	5	3	5	5	3	3	2	2	1	3	2	2	1	1	57
15	Ogun	4	1	2	1	4	3	2	2	1	4	5	4	3	4	3	5	4	3	1	1	57
16	Ondo	4	1	2	2	1	5	2	2	4	1	4	5	4	4	3	5	5	1	1	1	57
17	Kano	4	2	4	1	4	5	4	3	5	1	2	4	3	2	1	4	3	2	1	1	56
18	Niger	4	2	2	1	2	5	3	2	3	5	4	4	2	4	3	3	2	3	1	1	56
19	Osun	4	1	2	2	4	3	1	2	2	1	4	5	5	4	3	5	5	1	1	1	56
20	Kaduna	4	3	3	2	4	5	3	2	5	1	2	3	2	3	1	4	2	4	1	1	55
21	Imo	2	1	2	1	4	3	2	2	1	1	4	5	4	4	4	5	5	2	1	1	54
22	Plateau	4	1	2	1	4	4	2	2	2	3	3	5	4	4	1	4	3	3	1	1	54
23	Akwa-Ibom	1	1	1	1	2	5	1	2	5	1	4	5	4	5	4	4	3	1	1	1	52
24	Bayelsa	2	1	3	2	5	3	1	2	1	5	5	4	3	4	3	3	2	1	1	1	52
25	Edo	2	2	2	1	1	3	2	2	1	1	4	5	5	4	4	5	5	1	1	1	52
26	Cross River	2	1	2	1	4	3	2	3	2	1	4	5	4	4	3	4	3	1	1	1	51
27	Gombe	4	1	2	2	4	4	3	2	5	3	2	3	2	3	1	3	1	3	1	1	50
28	Rivers	1	1	1	1	1	4	2	2	1	1	4	5	4	5	4	5	4	2	1	1	50
29	Jigawa	4	2	2	2	4	3	2	3	5	3	1	3	2	1	1	4	2	3	1	1	49
30	Borno	2	2	2	1	4	4	3	2	3	1	4	4	2	3	1	3	2	2	1	1	47
31	Kogi	1	1	2	1	1	4	1	2	1	1	3	4	3	5	4	4	4	1	1	1	45
32	Yobe	3	2	2	2	2	5	3	2	5	1	2	3	2	1	1	4	1	2	1	1	45
33	Kebbi	4	1	3	1	4	5	1	2	5	3	1	2	1	1	1	1	1	4	1	1	43
34	Taraba	2	1	2	2	2	3	2	2	1	1	3	4	3	3	1	3	2	4	1	1	43
35	Katsina	2	1	2	2	4	4	1	2	3	1	2	3	2	2	1	3	1	3	1	1	41
36	Sokoto	3	1	2	1	4	3	3	2	1	5	2	2	1	1	1	2	1	4	1	1	41
37	Zamfara	3	1	2	1	2	4	1	2	2	3	3	1	1	2	1	2	1	4	1	1	38

For this assessment, twenty indicators were identified, cutting across inputs, processes, and outcomes. These indicators are not exhaustive but provide a platform for a detailed analysis of the performance of the health system in a State and identify some of the most critical aspects for improvement. These indicators also align with the recent report of the Lancet Nigeria Commission on opportunities for health systems strengthening (HSS) in Nigeria[8] and in the technical briefs of the recently concluded primary healthcare summit in Nigeria[9].

The twenty indicators selected for this assessment and report include:

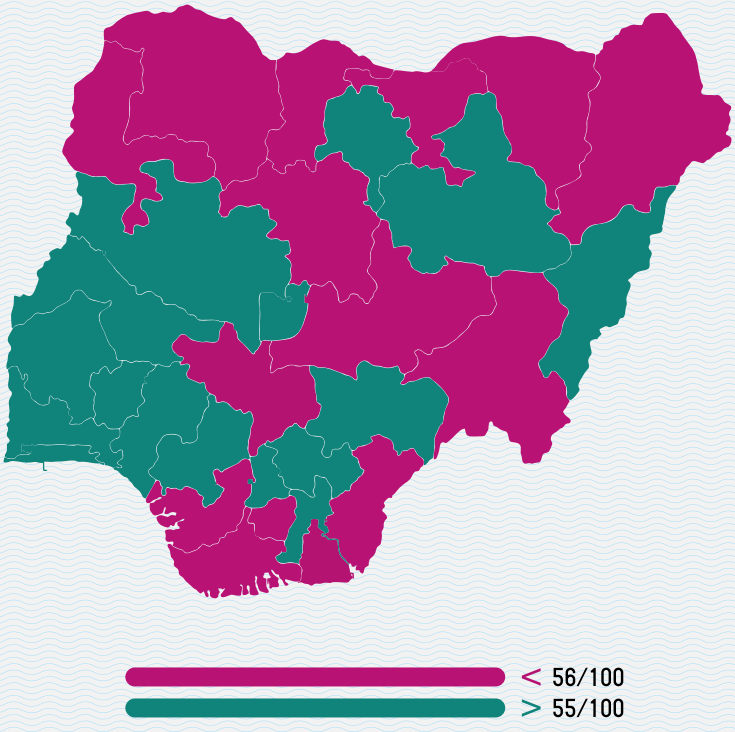
1. Current implementation of the BHCPF in the State
2. Budgetary commitments to Health by the State
3. Status of Health legislation and policy in the State
4. Availability of select human resources for health
5. Implementation of innovative strategies like task shifting and task sharing for essential health services among available human resources for health
6. The strength of strategic and operational planning for health in the State
7. The availability of a defined minimum service package and a strategic approach to fiscal space expansion in the State
8. State management of available human resources for health
9. Stock performance for select health products in the State
10. State reporting on health service delivery for essential health services
11. Vaccination coverage for the Bacille Calmette-Guerin (BCG) vaccine which often reflects an entry into the vaccination programme
12. Vaccination coverage for the third dose of the pentavalent vaccine (Penta 3) which often reflects sustained utilisation of the vaccination programme
13. Proportion of children who are Underweight, which often reflects acute malnutrition
14. Proportion of children who are Stunted, which often reflects chronic malnutrition
15. The proportion of children who die before their fifth birthdays
16. The proportion of pregnant women who receive antenatal care from a skilled provider
17. The proportion of pregnant women whose babies are delivered by a skilled provider
18. The proportion of married women whose needs to delay, space, or limit the number of children that they have is not met
19. The experience of community members when they assess health services from public facilities in the State
20. The state of select public facilities in the State.

Findings from the assessment unfortunately reflect a stark reality in Nigeria and for many states.



Unfortunately, the findings clearly reflect that Zamfara state is the worst State in Nigeria, to be a citizen in need of healthcare. Although the findings recognise that the FCT is the best place to need healthcare in Nigeria, the differences between States and the FCT, and within States and the FCT, clearly highlight that access to and utilisation of health services continues to be marred by stark inequities across Nigeria.

The findings from this report do ultimately awaken cautious optimism for health delivery across States. In finding that the key challenges driving poor performance amongst States are not insurmountable, this report aligns with many other reports, and yet, this report also provides citizens with a tool to demand that the necessary steps be taken to address these challenges.



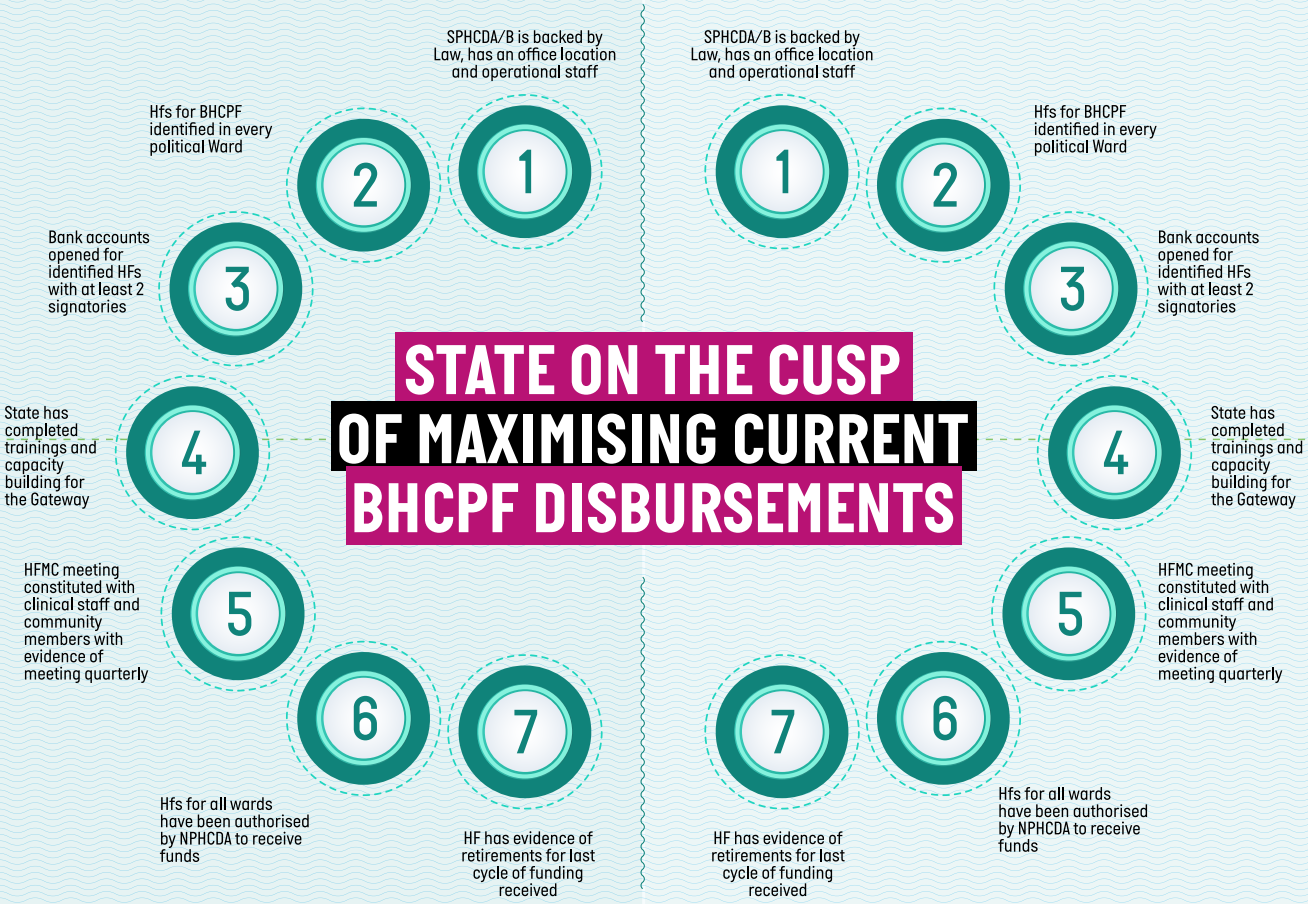
Abia State:

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS



Abia State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and NHIS Gateways, but has failed to provide either its counterpart or its equity funding for the NHIS gateway. Although the state also has an active oversight committee, it has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State also does not have any formal sector health insurance scheme to support risk and financial pooling and strengthen health insurance.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Abia State)

2

Legislation

Abia State has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Abia State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

4

Child Mortality

Under 5 mortality of 86 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

95.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Abia State Publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

3

Minimum Service Package

Abia State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed, but not complemented with an Investment planAct

5

BCG Coverage

95.7% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

95.8% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Abia State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways and has an active oversight committee

2

HRH Management

Abia State is fully implementing the repositioning component of the PHCUOR strategy, with the nominal roll and remuneration of primary healthcare workers moved to the SPHCB/SPHCDA; but there is no electronic Health Workforce registry

5

Penta-3 Coverage

80.4% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 28.5% among currently married women

2

HRH Density

Abia State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to

1

HMIS Reporting

Abia State has only 45% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

22.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Abia State has executed a redistribution of health workers to achieve equitable availability but does not have a task

5

Health Product Management

3.7% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

Underweight Prevalence

14.6% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 2: Summary of recommendations for Abia State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Adamawa State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staffa
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Adamawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway, however, enrolees on the NHIS gateway have not started accessing care and provider payments have not commenced. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state does not have any formal sector health insurance scheme to support risk and financial pooling.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Adamawa State)

2

Legislation

Adamawa State Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Abia State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

4

Child Mortality

Under 5 mortality of 104 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

82.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Adamawa State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

Adamawa State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

5

BCG Coverage

78.8% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

40.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Adamawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways although service utilisation and provider payments from the NHIS gateway have not started

2

HRH Management

Adamawa State is fully implementing the repositioning component of the PHCUOR strategy, with the nominal roll and remuneration of primary healthcare workers moved to the SPHCB/SPHCDA; but there is no electronic Health Workforce registry

5

Penta-3 Coverage

Unmet need for Childbirth Spacing of 10.2% among currently married women

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 28.5% among currently married women

2

HRH Density

Adamawa State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

1

HMIS Reporting

Adamawa State has 89% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

39.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Adamawa State has executed a redistribution of health workers to achieve equitable availability but does not have a task

5

Health Product Management

Adamawa State has 1% of eligible Facilities report stock outs, with 99.5% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance governance

Underweight Prevalence

19.1% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 3: Summary of recommendations for Adamawa State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Provide political leadership to ensure that demand is created for enrolees to utilise care through the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide and equity funds for the NHIS gateway of the BHCPF • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN, a costed MSP, and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • The state needs to create a pipeline for private sector partnerships, especially to support the production and training of human resources for health • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Akwa-Ibom State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

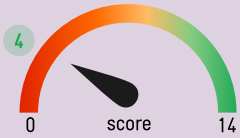
Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staffo
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staffo
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Akwa Ibom State has attained near-full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but all eligible PHCs are not yet receiving and retiring funds. The State does not have an operational State Health Insurance Agency and does not have any capacity to currently utilise funds from the NHIS gateway

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Akwa-Ibom State)

1

Legislation

Akwa Ibom State has Laws, administrative requirements, and policies in place to support implementation of the National Health Act, but which are insufficient

5

Planning

Akwa Ibom State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 98 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

74.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Akwa Ibom State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Akwa Ibom State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

5

BCG Coverage

81.1% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

41.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

BHCPF

Akwa Ibom State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but does not have an operational State Health Insurance Agency and so has no capacity to utilise

2

HRH Management

Akwa Ibom State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

62.2% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 32% among currently married women

1

HRH Density

Akwa Ibom State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

5

HMIS Reporting

Akwa Ibom State has 85% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

19.6% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Adamawa State has executed a redistribution of health workers to achieve equitable availability but does not have a task

1

Health Product Management

Akwa Ibom State has 13.3% of eligible Facilities report stock outs for TB commodities in October 2021

5

Underweight Prevalence

8.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 4: Summary of recommendations for Akwa Ibom State based on findings

Quick Wins	• Provide political leadership for the establishment of a State Health Insurance Agency • Provide counterpart and equity funds for the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Commission the domestication of the national task shifting and task sharing policy, with support from the FMOH • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSP and an investment plan to accompany the fully costed MSP, and ensure that the current MSPAN and the investment plan for the costed MSP both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines, and ensure that family planning, malaria, TB, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong oil and gas community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Anambra State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staffa
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Anambra State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, has provided and released equity funds for at least one round of disbursements from the NHIS gateway, but has failed to provide its counterpart funding for the NHIS gateway. The state has an active oversight committee. The State also has a formal sector health insurance scheme to support risk and financial pooling and strengthen health insurance.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Anambra State)

1 — Legislation

Anambra State can demonstrate that it has Laws, administrative requirements, policies, or other instruments in place that are sufficient for implementation of the National Health Act

5 — Planning

Anambra State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4 — Child Mortality

Under 5 mortality of 58 per 1,000 live births for the 10-year period preceding the survey

4 — ANC by Skilled Attendant

93.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1 — Financing

Anambra State Publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

1 — Minimum Service Package

Anambra State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5 — BCG Coverage

91.8% of eligible children received BCG vaccination

3 — Delivery by Skilled Attendant

94.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1 — BHCPF

Anambra State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and near-full capacity to utilise funds from the NHIS Gatewayfunds from the NHIS gateway

2 — HRH Management

Anambra State is implementing the repositioning component of the PHCUOR strategy

4 — Penta-3 Coverage

87.3% of eligible children received their third dose of pentavalent vaccination

1 — Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 9.6% among currently married womenUnmet need for Childbirth Spacing of 32% among currently married women

1 — HRH Density

Anambra State articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5 — HMIS Reporting

73% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4 — Stunting Prevalence

14% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1 — Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2 — Task Shifting Policy

Anambra State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

1 — Health Product Management

Anambra State has 4.3% of eligible Health Facilities report stock outs for priority TB commodities during the quarter under assessment per TB national programme reports and 100% Health Facility reporting rate on the reporting platform for TB stock

5 — Underweight Prevalence

6.5% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1 — State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 5: Summary of recommendations for Anambra State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Anambra State needs to conduct an assessment of the available Human Resources for Health, effect a re-distribution of primary health workers based on need, and domesticate the national task shifting and task sharing policy • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, an d ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for privat e sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Bauchi State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Bauchi State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, has provided and released equity funds for at least one round of disbursements from the NHIS gateway, but has failed to provide its counterpart funding for the NHIS gateway. Although the state also has an active oversight committee, it has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State does not have any formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Bauchi State)

2

Legislation

Bauchi State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Bauchi State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 147 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

51.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

Financing

Bauchi State has a streamlined budget system and a budget line to support early detection and containment of outbreaks

5

Minimum Service Package

Bauchi State has a framework in place for monitoring its implementation of the Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

3

BCG Coverage

51.2% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

21.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Bauchi State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways and has an active oversight committee

3

HRH Management

Bauchi State has an electronic database for the management of available Human Resources for Health

2

Penta-3 Coverage

32.1% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 20.8% among currently married women

2

HRH Density

Bauchi State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

88% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

54.7% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Bauchi State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

2.2% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

2

Underweight Prevalence

31.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 6: Summary of recommendations for Bauchi State based on findings

Quick Wins	• Provide all rounds of equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community· • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement· • Develop a state MSPAN at both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points

Bayelsa State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

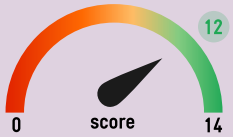
Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Bayelsa State has attained full capacity to utilise BHCPF disbursements from NPHCDA Gateway. State has provided and released equity funds for at least one round of disbursements from the NHIS gateway, but has failed to provide its counterpart funding. Enrolment of the poor and vulnerable unto the social health insurance scheme is still ongoing. The State has a formal sector scheme and an active oversight committee, but has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Bayelsa State)

3 — Legislation

Bayelsa State has plans to conduct an assessment of legislative and policy frameworks within the next 6 months to identify gaps that impede compliance with and implementation of the International Health Regulations

3 — Planning

Bayelsa State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

5 — Child Mortality

Under 5 mortality of 31 per 1,000 live births for the 10-year period preceding the survey

3 — ANC by Skilled Attendant

51.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1 — Financing

Bayelsa State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1 — Minimum Service Package

Bayelsa State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

4 — BCG Coverage

65.5% of eligible children received BCG vaccination

2 — Delivery by Skilled Attendant

27% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2 — BHCPF

Bayelsa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and is finalising steps to attain full capacity to utilise disbursements from the NHIS Gateway

2 — HRH Management

Bayelsa State is implementing the repositioning component of the PHCUOR strategy

3 — Penta-3 Coverage

54.5% of eligible children received their third dose of pentavalent vaccination

1 — Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 29.9% among currently married women

2 — HRH Density

Bayelsa State articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

1 — HMIS Reporting

50% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3 — Stunting Prevalence

24.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1 — Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

5 — Task Shifting Policy

Bayelsa State State has a coordinated periodic review of its implementation of the State Task Shifting and Task Sharing Policy

5 — Health Product Management

2.2% of eligible Facilities report stock outs, with 94.4% Health Facility reporting rate for TB commodities in October 2021; with **acceptable stock for select products for outbreak responses and evidence of good supply chain** governance

4 — Underweight Prevalence

13.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1 — State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 7: Summary of recommendations for Bayelsa State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law· • Complete enrolment of the poor and vulnerable unto the NHIS gateway of the BHCPF and commence service provision • Engage in targeted communications strategies to generate demand among the poor and vulnerable enrolled unto the NHIS gateway of the BHCPF • Develop an electronic workforce registry in the State, to support management of human resources for health· • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services· • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Develop a state MSPAN and an investment plan to accompany a fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • State needs to strengthen investment into its integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Benue State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

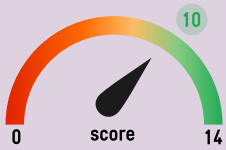
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Benue State has attained full capacity to utilise BHCPF disbursements from both NPHCDA and NHIS Gateways, however some eligible PHCs are not yet receiving and retiring funds from the NPHCDA gateway. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state does not have any formal sector health insurance scheme to support risk and financial pooling.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Benue State)

2

Legislation

Benue State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Benue State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 59 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

74.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Benue State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

3

Minimum Service Package

Benue State has developed a Minimum Service Package for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

82% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

67.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Benue State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, but needs to strengthen the functionality of its oversight and coordinating mechanisms

2

HRH Management

Benue State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

58.7% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 16.7% among currently married women

2

HRH Density

Benue State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

82% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

20.8% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Benue State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

5.4% of eligible Facilities report stock outs for TB commodities in October 2021, with 97.1% reporting rate

4

Underweight Prevalence

12.6% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 8: Summary of recommendations for Benue State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Borno State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

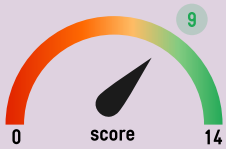
Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Borno State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway, however, enrolees on the NHIS gateway have not started accessing care and provider payments have not commenced. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings for Q3 2021 to NHIS. The state does not have any formal sector health insurance scheme to support risk and financial pooling.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Borno State)

2

Legislation

Borno State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Borno State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

4

Child Mortality

Under 5 mortality of 86 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

50.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Borno State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed, but not complemented with an Investment plan

4

BCG Coverage

82% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

25.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Borno State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but does not yet have full capacity to utilise funds from the NHIS gateway

2

HRH Management

Borno State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

36% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 26% among currently married women

1

HRH Density

Borno State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

3

HMIS Reporting

62% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

45.1% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Borno State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

7.5% of eligible Facilities report stock outs, with 93.1% Health Facility reporting rate for TB commodities in October 2021

3

Underweight Prevalence

28.2% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 9: Summary of recommendations for Borno State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Provide all rounds of equity funds for the NHIS gateway of the BHCPF • Develop an electronic workforce registry in the State, to support management of human resources for health • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Cross River State

Status of Basic Health Care Provision Fund

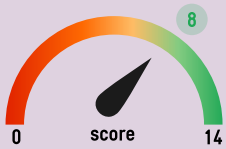
Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA	Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS



Cross River State has attained full capacity to utilise BHCPF disbursements from the NHIS Gateway, but is yet to complete all processes to utilise BHCPF disbursements from the NPHCDA Gateway. The state is yet to resolve all challenges with HF bank accounts and HFMCs, and HFs are yet to be authorised by NPHCDA to commence receipt and utilisation of funds.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Cross River State)

2

Legislation

Cross River State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Cross River State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 80 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

79.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Cross River State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Cross River State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

88.8% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

55.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Cross River State has attained full capacity to utilise BHCPF disbursements from the NHIS Gateway and is finalising steps to attain full capacity to utilise disbursements from the NPHCDA Gateway

3

HRH Management

Cross River State has an electronic database for the management of available Human Resources for Health

4

Penta-3 Coverage

64.1% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 34.5% among currently married women

1

HRH Density

Borno State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

2

HMIS Reporting

53% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

22.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Cross River State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

14.3% of eligible Facilities report stock outs, with 98.7% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

11.8% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 10: Summary of recommendations for Cross-River State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Delta State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

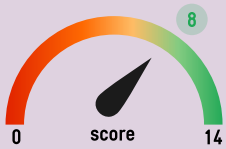
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Delta State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway. Enrolees on the NHIS gateway have not started accessing care and provider payments have not commenced. The state has released equity funds for at least one round of disbursements from the NHIS gateway, but has failed to provide its counterpart funding and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state has a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Delta State)

2

Legislation

Delta State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Delta State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 53 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

73.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Delta State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Delta State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

82.5% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

67.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Delta State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and is finalising steps to attain full capacity to utilise disbursements from the NHIS Gateway

2

HRH Management

Delta State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

71.7% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 23.7% among currently married women

2

HRH Density

Delta State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

4

HMIS Reporting

79% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

23.7% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Delta State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

5% of eligible Facilities report stock outs, with 97.2% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

13% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 11: Summary of recommendations for Delta State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany the fully costed MSP, and ensure that both this investment plan and the MSPAN fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Ebonyi State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

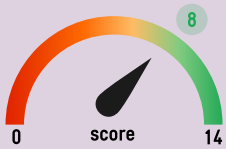
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Ebonyi State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways but all eligible PHCs are not receiving and retiring funds from the NPHCDA gateway. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state does not have any formal sector health insurance scheme to support risk and financial pooling.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Ebonyi State)

2

Legislation

Ebonyi State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Ebonyi State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 91 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

70.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Ebonyi State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

3

Minimum Service Package

Ebonyi State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

95.9% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

52.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Ebonyi State has attained full capacity to utilise BHCPF disbursements from both the NPHCDA and NHIS Gateways

2

HRH Management

Ebonyi State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

82.4% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 23% among currently married women

2

HRH Density

Ebonyi State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

83% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

25.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Ebonyi State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

5.6% of eligible Facilities report stock outs, with 99.1% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

15.8% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 12: Summary of recommendations for Ebonyi State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Create a formal sector health insurance scheme, to drive risk and financial pooling towards universal health coverage • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Edo State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

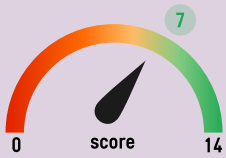
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Edo State has capacity to utilise BHCPF disbursements from the NPHCDA Gateway but all eligible PHCs are not receiving and retiring funds. The State is yet to complete enrolment and enrolees have not started to receive any health care. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State however has a formal sector insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Edo State)

2

Legislation

Edo State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Edo State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 91 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

89.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Edo State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

2

Minimum Service Package

Abia State can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with the International Health Regulations

5

BCG Coverage

95% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

88.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Edo State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but does not yet have full capacity to utilise funds from the NHIS gateway

2

HRH Management

Edo State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

80.7% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 32.7% among currently married women

1

HRH Density

Edo State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

49% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

16% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

1

Task Shifting Policy

Edo State State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

1

Health Product Management

7.9% of eligible Facilities report stock outs, with 99.2% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

10.7% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 13: Summary of recommendations for Edo State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • The state must complete enrolment of the poor and vulnerable into the NHIS gateway of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Ekiti State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

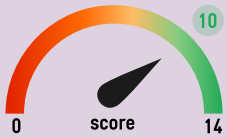
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Ekiti State has attained full capacity to utilise BHCPF disbursements from NHIS and NPHCDA Gateways but some eligible PHCs are not receiving and retiring funds from the NPHCDA gateway. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and although the State has an active oversight mechanism, the State has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS. The State does not have a formal sector insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Ekiti State)

2

Legislation

Ekiti State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Ekiti State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 95 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

90.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Ekiti State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

2

Minimum Service Package

Ekiti State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

94.8% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

87.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Ekiti State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways and has a functional oversight mechanism

2

HRH Management

Ekiti State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

93% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 18.2% among currently married women

1

HRH Density

Ekiti State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

45% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

22.1% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Ekiti State State has executed a redistribution of health workers to achieve equitable availability but does not have a task shifting and task sharing policy

5

Health Product Management

No eligible Facilities reported any stock outs, with 97.5% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

11.1% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 14: Summary of recommendations for Ekiti State based on findings

Quick Wins	• As the state has already committed, the state must finalise all steps as mandated by NPHCDA, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide all equity funds for the NHIS gateway of the BHCPF· • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany a fully fully costed MSP, and ensure that this investment plan and the state MSPAN fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Enugu State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Enugu State has attained full capacity to utilise BHCPF disbursements from NHIS and NPHCDA Gateways. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and although the State has an active oversight mechanism, the State has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS. The State does not have a formal sector insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Enugu State)

3

Legislation

Enugu State has conducted an assessment of legislative and policy frameworks to identify gaps that impede compliance with and implementation of the International Health Regulations

5

Planning

Enugu State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 61 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

94.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

Financing

Enugu State has publicly available budget for Health, with a streamlined budget system and a dedicated budget line for emergency preparedness and response

3

Minimum Service Package

Enugu State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

92.5% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

93% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Enugu State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, and has an active oversight mechanism

2

HRH Management

Enugu State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

80.9% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 13.8% among currently married women

1

HRH Density

Enugu State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

31% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

14.8% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

1

Task Shifting Policy

Enugu State State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

5

Health Product Management

3.4% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

5

Underweight Prevalence

6.1% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 15: Summary of recommendations for Enugu State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Centre of Unity

FCT

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

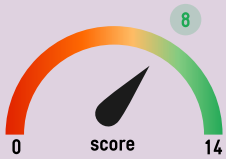
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



FCT has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, although enrolees will commence accessing services in the first quarter of 2022 through the NHIS gateway and all eligible facilities for the NPHCDA gateway are not authorised to receive and retire funds. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway, although the FCT has a functional formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (FCT)

4

Legislation

There is a Bill going through legislative processes and seeks to address gaps and challenges identified from an assessment of the legislative and administrative environment for implementation of the international health regulations

3

Planning

The FCT has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 75 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

87.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

The FCT has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

The FCT has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

87.7% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

71.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

FCT has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, but all eligible facilities for the NPHCDA gateway are not receiving funds and access through the NHIS gateway has not commenced

2

HRH Management

The FCT is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

73.5% of eligible children received their third dose of pentavalent vaccination

5

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 19.1% among currently married women

1

HRH Density

The FCT has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

5

HMIS Reporting

86% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

21.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

The FCT is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

No eligible Facilities reported stock outs, with 99.6% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

12.1% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 12: Summary of recommendations for Ebonyi State based on findings

Quick Wins	• The FCT must finalise all steps, so that health facilities can start accessing funds from the BHCPF· • Mandate the quarterly gateway forum meetings of the FCT primary healthcare development agency and health insurance agency to strengthen implementation of the BHCPF· • Provide equity funds for the NHIS gateway of the BHCPF· • The FCT needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services· • The FCT must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF· • Develop an electronic workforce registry in the FCT, to support management of human resources for healthDevelop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • The FCT needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The FCT needs to cr eate a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The FCT needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Gombe State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Gombe State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee. The State also has a formal sector health insurance scheme to support risk and financial pooling and strengthen health insurance.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Gombe State)

2

Legislation

Gombe State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Gombe State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

2

Child Mortality

Under 5 mortality of 189 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

46.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Gombe State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

3

Minimum Service Package

Gombe State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

3

BCG Coverage

42.5% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

18.8% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Gombe State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, and has an active oversight committee

2

HRH Management

Gombe State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

25.8% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 16.8% among currently married women

2

HRH Density

Gombe State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

82% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

51.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Gombe State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

3

Health Product Management

No eligible Facilities reported stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; however, there were inadequate stock for select products for outbreak responses

3

Underweight Prevalence

30.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 17: Summary of recommendations for Gombe State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Provide equity funds for the NHIS gateway of the BHCPF· • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement· • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health· • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points· • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Imo State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

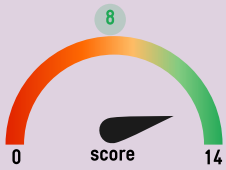
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Imo State has capacity to utilise BHCPF disbursements from the NPHCDA Gateway but all eligible PHCs are not receiving and retiring funds. Enrolees on the NHIS gateway have not started accessing care and provider payments have not commenced. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway, and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The state also does not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Imo State)

2

Legislation

Imo State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Imo State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 87 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

97.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Imo State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Imo State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

92.7% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

98.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Imo State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but does not yet have full capacity to utilise funds from the NHIS gateway

2

HRH Management

Imo State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

79.5% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 21% among currently married women

1

HRH Density

Imo State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

37% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

17.6% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Imo State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

9.2% of eligible Facilities report stock outs, with 89.4% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

10.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 18: Summary of recommendations for Imo State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Develop an electronic workforce registry in the State, to support management of human resources for health • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Jigawa State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

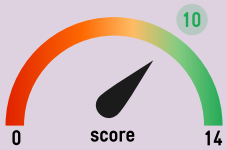
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Jigawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and NHIS Gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA gateway, and the state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee but has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State has a formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Jigawa State)

2

Legislation

Jigawa State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Jigawa State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

1

Child Mortality

Under 5 mortality of 213 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

78.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Jigawa State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

2

Minimum Service Package

Jigawa State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

3

BCG Coverage

53.2% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

20.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Jigawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, and has an active oversight mechanism

3

HRH Management

Jigawa State has an electronic database for the management of available Human Resources for Health

2

Penta-3 Coverage

35.7% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 14.5% among currently married women

2

HRH Density

Jigawa State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

93% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

64% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Jigawa State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

3

Health Product Management

1.6% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; however, there are inadequate stock for select products for outbreak responses

1

Underweight Prevalence

42.3% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 19: Summary of recommendations for Jigawa State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Kaduna State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

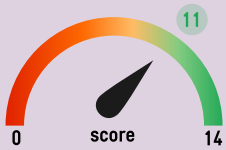
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Kaduna State has attained full capacity to utilise BHCPF disbursements from the NHIS and NPHCDA gateways, although not all eligible facilities are receiving and retiring funds from NPHCDA. The state has released equity funds for at least one round of disbursements from the NHIS, but has failed to provide its counterpart funding for the NHIS gateway. The state has an active oversight committee. The State also has a formal sector health insurance scheme to support risk and financial pooling

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Kaduna State)

3

Legislation

Kaduna State has conducted an assessment of legislative and policy frameworks to identify gaps that impede compliance with and implementation of the International Health Regulations

5

Planning

Kaduna State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

2

Child Mortality

Under 5 mortality of 187 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

69% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

Financing

Kaduna State has a streamlined budget system and a budget line to support early detection and containment of outbreaks

3

Minimum Service Package

Kaduna State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

3

BCG Coverage

51.8% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

26.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Kaduna State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS gateways, and has an active oversight mechanism

2

HRH Management

Kaduna State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

31.9% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 12.3% among currently married women

2

HRH Density

Kaduna State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

90% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

48.1% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Kaduna State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

16.6% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

3

Underweight Prevalence

22.1% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 20: Summary of recommendations for Kaduna State based on findings

Quick Wins	• The state must finalise all steps, so that health facilities can start accessing funds from the BHCPF through the NPHCDA gateway • Provide equity funds for the NHIS gateway of the BHCPF· • Develop an electronic workforce registry in the State, to support management of human resources for health • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that this investment plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Centre of Commerce

Kano State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

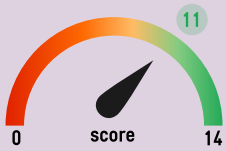
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Kano State has attained full capacity to utilise BHCPF disbursements from the NHIS and NPHCDA Gateways, although not all eligible facilities are receiving and retiring funds from NPHCDA. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee. The State also has a formal sector health insurance scheme to support risk and financial pooling and strengthen health insurance.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Kano State)

4

Legislation

Kano State has a Bill for a State Health Law, which is going through the legislative processes and seeks to address existing gaps and challenges identified from an assessment of the State legislative and administrative environment

5

Planning

Kano State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

2

Child Mortality

Under 5 mortality of 164 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

65.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Kano State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

4

Minimum Service Package

Kano State has a fully costed Minimum Service Package for the one PHC per political ward strategy, with investment plans and service delivery plans aligned with state annual operational plans and the overall Health budget

4

BCG Coverage

61.2% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

21.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Kano State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS gateways, and has a functional oversight mechanism

3

HRH Management

Kano State has an electronic database for the management of available Human Resources for Health

3

Penta-3 Coverage

45.9% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 16.5% among currently married women

1

HRH Density

Kano State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

5

HMIS Reporting

90% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

56.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Kano State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

6.9% of eligible Facilities report stock outs, with 99.6% Health Facility reporting rate for TB commodities in October 2021

2

Underweight Prevalence

30.8% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 21: Summary of recommendations for Kano State based on findings

Quick Wins	• The state must finalise all steps, so that health facilities can start accessing funds from the BHCPF through the NPHCDA gateway • Provide equity funds for the NHIS gateway of the BHCPF • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Katsina State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

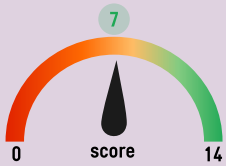
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Katsina State has capacity to utilise BHCPF disbursements from the NPHCDA Gateway but not all eligible PHCs are receiving and retiring funds. The State is yet to complete empanelment of health facilities and enrolees have not started to receive any health care. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State however has a formal sector insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Katsina State)

2

Legislation

Katsina State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Katsina State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 188 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

53.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Katsina State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Katsina State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

2

BCG Coverage

46.4% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

18.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Katsina State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway but does not yet have full capacity to utilise funds from the NHIS gateway

2

HRH Management

Katsina State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

33.7% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 15.7% among currently married women

2

HRH Density

Katsina State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

3

HMIS Reporting

67% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

60.5% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Katsina State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

25.9% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

2

Underweight Prevalence

39.3% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 22: Summary of recommendations for Katsina State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompan y the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Kebbi State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Kebbi State has attained full capacity to utilise BHCPF disbursements from the NHIS and NPHCDA Gateways, although not all eligible facilities are receiving and retiring funds from NPHCDA. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee. The State does not have a formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Kebbi State)

3

Legislation

Kebbi State has conducted an assessment of legislative and policy frameworks to identify gaps that impede compliance with and implementation of the International Health Regulations

5

Planning

Kebbi State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

1

Child Mortality

Under 5 mortality of 252 per 1,000 live births for the 10-year period preceding the survey

1

ANC by Skilled Attendant

14.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Kebbi State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Kebbi State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

2

BCG Coverage

25.6% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

3.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Kebbi State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS gateways, and has a functional oversight mechanism

2

HRH Management

Kebbi State is implementing the repositioning component of the PHCUOR strategy

1

Penta-3 Coverage

10.6% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 11.8% among currently married women

1

HRH Density

Kebbi State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

5

HMIS Reporting

80% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

66.1% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Kebbi State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

3

Health Product Management

No eligible Facilities reported stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; however, there are inadequate stock for select products for outbreak responses

1

Underweight Prevalence

46.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 23: Summary of recommendations for Kebbi State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Develop a state investment plan to accompany a fully costed MSP, and ensure that the NSPAN and this investment plan both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Kogi State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

SPHCDA/B is backed by Law, has an office location and operational staff

Hfs for BHCPF identified in every political Ward

Bank accounts opened for identified HFs with at least 2 signatories

State has completed trainings and capacity building for the Gateway

HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly

Hfs for all wards have been authorised by NPHCDA to receive funds

HF has evidence of retirements for last cycle of funding received

SHIA is backed by Law, has an office location and operational staf

State has budgeted and released counterpart funding and equity funding for the NHIS gateway

State has sent reports of gateway forum and SOC meetings to NHIS

State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme

State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees

Enrolees are accessing care, and provider payments are being made

Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Kogi State does not have capacity to utilise BHCPF disbursements from the NPHCDA or NHIS Gateways. The State is yet to complete capacity building on NPHCDA gateway, enrolees on NHIS gateway have not started accessing care and provider payments have not commenced. The state has failed to provide counterpart or equity funding for NHIS gateway, and has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS. They also do not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Kogi State)

2

Legislation

Kogi State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Kogi State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 148 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

79.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Kogi State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Kogi State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

4

BCG Coverage

80% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

73.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

BHCPF

Kogi State does not have capacity to utilise BHCPF disbursements from the NPHCDA or NHIS Gateways.

2

HRH Management

Kogi State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

55.6% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 25.9% among currently married women

1

HRH Density

Kogi State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

33% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

20% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

1

Task Shifting Policy

Kogi State State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

1

Health Product Management

8% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

5

Underweight Prevalence

10.2% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 24: Summary of recommendations for Kogi State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Domesticate the national task shifting and task sharing policy, to help mitigate the health worker shortages in the state • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Kwara State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

SPHCDA/B is backed by Law, has an office location and operational staff

Hfs for BHCPF identified in every political Ward

Bank accounts opened for identified HFs with at least 2 signatories

State has completed trainings and capacity building for the Gateway

HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly

Hfs for all wards have been authorised by NPHCDA to receive funds

HF has evidence of retirements for last cycle of funding received

SHIA is backed by Law, has an office location and operational staf

State has budgeted and released counterpart funding and equity funding for the NHIS gateway

State has sent reports of gateway forum and SOC meetings to NHIS

State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme

State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees

Enrolees are accessing care, and provider payments are being made

Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Kwara State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA gateway, and the state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee but has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State does not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Kwara State)

2

Legislation

Kwara State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Kwara State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

4

Child Mortality

Under 5 mortality of 74 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

72.8% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Kwara State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Kwara State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

4

BCG Coverage

63.5% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

62.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Kwara State has attained full capacity to utilize funds from the NPHCDA and NHIS gateways, and has an active oversight mechanism

2

HRH Management

Kwara State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

54.5% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 24.4% among currently married women

2

HRH Density

Kwara State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

4

HMIS Reporting

78% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

2

Stunting Prevalence

32.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Kwara State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

2% of eligible Facilities report stock outs, with 94.6% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

18.6% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 25: Summary of recommendations for Kwara State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Centre of Excellence

Lagos State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

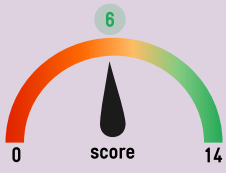
Full capacity to utilise BHCPF disbursements from NPHCDA

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

Full capacity to utilise BHCPF disbursements from NHIS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Lagos State has not attained full capacity to utilise BHCPF disbursements from the NPHCDA gateway, failing to complete capacity building and establishment of HFMCs. The State has enrolled ~60,000 beneficiaries, has empanelled health facilities, and is planning to commence service provision in Q1 2022 through NHIS gateway. The state has failed to provide counterpart or equity funding for NHIS gateway, has not sent reports of gateway forum and SOC meetings from Q4 2021 to NHIS, and does not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Lagos State)

3

Legislation

Lagos State has conducted an assessment of legislative and policy frameworks to identify gaps that impede compliance with and implementation of the International Health Regulations

5

Planning

Lagos State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 59 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

86.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

Financing

Lagos State has a streamlined budget system and a budget line to support early detection and containment of outbreaks

1

Minimum Service Package

Lagos State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

5

BCG Coverage

97.3% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

83.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Lagos State does not have full capacity to utilize funds from the NPHCDA gateway, although the State will commence service provision through the NHIS gateway in Q1 2022

2

HRH Management

Lagos State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

90.8% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 16.5% among currently married women

1

HRH Density

Lagos State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

42% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

17.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Lagos State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

8.2% of eligible Facilities report stock outs, with 94.6% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

13.3% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 26: Summary of recommendations for Lagos State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany a fully costed MSP, and ensure that both this investment plan and the MSPAN fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Nasarawa State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

Nasarawa State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. The state has released equity funds for at least one round of disbursements from the NHIS, but has failed to provide its counterpart funding for the NHIS gateway. The state has an active oversight committee. The State does not have a formal sector health insurance scheme to support risk and financial pooling

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Nasarawa State)

2

Legislation

Nasarawa State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Nasarawa State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 120 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

77.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Nasarawa State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

Nasarawa State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

5

BCG Coverage

87.6% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

57.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Nasarawa State has full capacity to utilise funds from both the NPHCDA and NHIS gateways, and has an active oversight committee

2

HRH Management

Nasarawa State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

59.7% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 23.7% among currently married women

2

HRH Density

Nasarawa State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

80% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

2

Stunting Prevalence

31.4% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Nasarawa State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

4% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

3

Underweight Prevalence

20.5% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

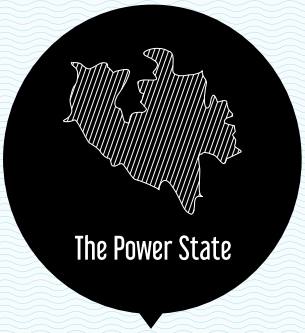
State of Public Health Facilities

zAt least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 27: Summary of recommendations for Nasarawas State based on findings

Quick Wins	• Provide equity funds for the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health



Niger State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

SPHCDA/B is backed by Law, has an office location and operational staff

Hfs for BHCPF identified in every political Ward

Bank accounts opened for identified HFs with at least 2 signatories

State has completed trainings and capacity building for the Gateway

HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly

Hfs for all wards have been authorised by NPHCDA to receive funds

HF has evidence of retirements for last cycle of funding received

SHIA is backed by Law, has an office location and operational staf

State has budgeted and released counterpart funding and equity funding for the NHIS gateway

State has sent reports of gateway forum and SOC meetings to NHIS

State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme

State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees

Enrolees are accessing care, and provider payments are being made

Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Niger State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. The state has failed to provide its equity funds or its counterpart funding for the NHIS gateway. The state has an active oversight committee. The State does not have a formal sector health insurance scheme to support risk and financial pooling

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Niger State)

2

Legislation

Niger State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Niger State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 98 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

41.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Niger State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

Niger State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

4

BCG Coverage

62% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

24.7% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Niger State has full capacity to utilise funds from both the NHIS and NPHCDA gateways, and has an active oversight committee

2

HRH Management

Niger State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

38.8% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 19.2% among currently married women

1

HRH Density

Niger State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

3

HMIS Reporting

62% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

28.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Niger State State has executed a redistribution of health workers to achieve equitable availability but does not have a task shifting and task sharing policy

5

Health Product Management

1.7% of eligible Facilities report stock outs, with 99.8% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

14.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 28: Summary of recommendations for Niger State based on findings

Quick Wins	• Provide equity funds for the NHIS gateway of the BHCPF· • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services, and provide targeted support to health facilities to strengthen reporting • Develop an electronic workforce registry in the State, to support management of human resources for health • Domesticate the national task shifting and task sharing policy to help mitigate some of the challenges of health worker shortages· • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany the fully costed MSP, and ensure that this investment plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Ogun State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

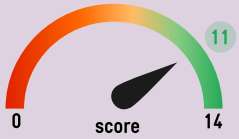
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Ogun State has attained full capacity to utilise BHCPF disbursements from the NHIS and NPHCDA Gateways, although not all eligible facilities are receiving and retiring funds from NPHCDA. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee. The State does not have a formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Ogun State)

2

Legislation

Ogun State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Ogun State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

5

Child Mortality

Under 5 mortality of 30 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

85% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Ogun State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Ogun State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

4

BCG Coverage

74.1% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

79.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Ogun State has full capacity to utilise funds from both the NHIS and NPHCDA gateways, and has an active oversight committee

2

HRH Management

Ogun State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

50.3% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 17.6% among currently married women

1

HRH Density

Ogun State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

45% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

26.6% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Ogun State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

4

Health Product Management

3.7% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses but insufficient evidence of good supply chain governance

4

Underweight Prevalence

16.3% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 29: Summary of recommendations for Ogun State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany the fully costed MSP, and ensure that this investment plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Ondo State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

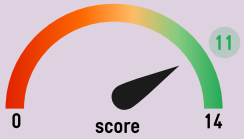
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Ondo State has attained full capacity to utilise BHCPF disbursements from the NPHCDA but all eligible PHCs are not receiving and retiring funds. The state has released equity funds for at least one round of disbursements from the NHIS, but has failed to provide its counterpart funding for the NHIS gateway. The state has an active oversight committee. The State does not have a formal sector health insurance scheme to support risk and financial pooling

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Ondo State)

2

Legislation

Ondo State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Ondo State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 79 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

92% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Ondo State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Ondo State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

83.7% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

86.1% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Ondo State has full capacity to utilise funds from both the NHIS and NPHCDA gateways, and has an active oversight committee

2

HRH Management

Ondo State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

77% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 29.4% among currently married women

2

HRH Density

Ondo State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

4

HMIS Reporting

71% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

20.4% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

1

Task Shifting Policy

Ondo State State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

1

Health Product Management

5.8% of eligible Facilities report stock outs, with 98.2% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

11.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 30: Summary of recommendations for Ondo State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF· • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services, and provide targeted support to health facilities to drive reporting • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commence a formal sector health insurance scheme, to drive risk and financial pooling in the state, towards universal health coverage • Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany the fully costed MSP, and ensure that this investment plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Osun State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Osun State has attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway and NHIS Gateways. The state has released equity funds for at least one round of disbursements from the NHIS, but has failed to provide its counterpart funding for the NHIS gateway. Although the state also has an active oversight committee, it has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State also has a formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Osun State)

2

Legislation

Osun State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Osun State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

4

Child Mortality

Under 5 mortality of 70 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

96.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Osun State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Osun State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

5

BCG Coverage

94.3% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

96% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Osun State has full capacity to utilise funds from both the NHIS and NPHCDA gateways, and has an active oversight committee

2

HRH Management

Osun State is implementing the repositioning component of the PHCUOR strategy

5

Penta-3 Coverage

83.5% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 25.6% among currently married women

2

HRH Density

Osun State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

2

HMIS Reporting

57% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

3

Stunting Prevalence

23.7% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Osun State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

1

Health Product Management

39.1% of eligible Facilities report stock outs, with 99.4% Health Facility reporting rate for TB commodities in October 2021

4

Underweight Prevalence

14.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 31: Summary of recommendations for Osun State based on findings

Quick Wins	• Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Oyo State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

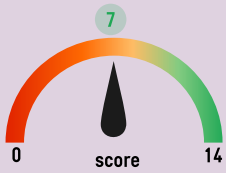
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Oyo State has attained full capacity to utilise BHCPF disbursements from the NPHCDA but all eligible PHCs are not receiving and retiring funds. The State is yet to complete enrolment and enrolees have not started to receive any health care. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway and has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State however has a formal sector insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Oyo State)

2

Legislation

Oyo State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Oyo State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

4

Child Mortality

Under 5 mortality of 64 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

85.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Oyo State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Oyo State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

5

BCG Coverage

88.6% of eligible children received BCG vaccination

5

Delivery by Skilled Attendant

84.6% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Oyo State has full capacity to utilise funds from the NPHCDA Gateway, but has not attained full capacity to utilise funds from the NHIS Gateway

2

HRH Management

Oyo State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

44.3% of eligible children received their third dose of pentavalent vaccination

1

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 30.6% among currently married women

1

HRH Density

Oyo State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

4

HMIS Reporting

73% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

2

Stunting Prevalence

34.5% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Oyo State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

No eligible Facilities reported stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

4

Underweight Prevalence

18% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 32: Summary of recommendations for Oyo State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law· • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany a fully costed MSP, and ensure that this plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Plateau State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

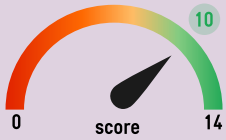
Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS



Plateau State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA gateway, and the state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has an active oversight committee but has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS. The State has a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Plateau State)

2

Legislation

Plateau State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Plateau State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 106 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

72.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Plateau State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Plateau State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

81.9% of eligible children received BCG vaccination

3

Delivery by Skilled Attendant

42.9% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

4

BHCPF

Plateau State has full capacity to utilise funds from both the NHIS and NPHCDA gateways, and has an active oversight committee

2

HRH Management

Plateau State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

71.8% of eligible children received their third dose of pentavalent vaccination

3

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 19.8% among currently married women

1

HRH Density

Plateau State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

2

HMIS Reporting

52% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

44.7% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Plateau State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

3

Health Product Management

3.3% of eligible Facilities report stock outs, with 99.6% Health Facility reporting rate for TB commodities in October 2021; however, there is inadequate stock for select products for outbreak responses

4

Underweight Prevalence

15.3% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 33: Summary of recommendations for Plateau State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

River State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

Rivers State has not attained full capacity to utilise BHCPF disbursements from the NPHCDA Gateway or the NHIS gateway, although the State has received disbursements from the national level

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Rivers State)

1

Legislation

Rivers State has Laws, administrative requirements, and policies in place to support implementation of the National Health Act, but which are insufficient

4

Planning

Rivers State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

4

Child Mortality

Under 5 mortality of 79 per 1,000 live births for the 10-year period preceding the survey

5

ANC by Skilled Attendant

81% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Rivers State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Rivers State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

5

BCG Coverage

83.8% of eligible children received BCG vaccination

4

Delivery by Skilled Attendant

78.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Sokoto State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways

2

HRH Management

Rivers State is implementing the repositioning component of the PHCUOR strategy

4

Penta-3 Coverage

74.5% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 23% among currently married women

1

HRH Density

Rivers State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

23% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

4

Stunting Prevalence

16.8% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

1

Task Shifting Policy

Rivers State State has conducted an audit of available Human Resources for Health within the last 5 years, but has no records of a re-distribution to meet needs

1

Health Product Management

10.7% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

5

Underweight Prevalence

7.4% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

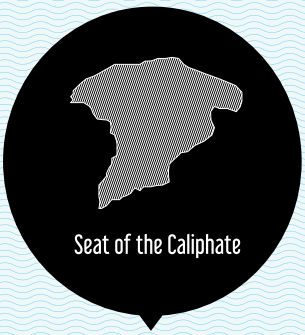
State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 34: Summary of recommendations for River State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Provide political leadership for the establishment of a State Health Insurance Agency Provide counterpart and equity funds for the NHIS gateway of the BHCPF • The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Domesticate the national task shifting and task sharing policy • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health



Sokoto State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Sokoto State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways. All eligible PHCs are however not receiving and retiring funds for the NPHCDA gateway, and the state has failed to provide either its counterpart or its equity funding for the NHIS gateway. The state has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS and the State does not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Sokoto State)

2

Legislation

Sokoto State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Sokoto State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

2

Child Mortality

Under 5 mortality of 197 per 1,000 live births for the 10-year period preceding the survey

2

ANC by Skilled Attendant

24.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Sokoto State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

3

Minimum Service Package

Sokoto State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

2

BCG Coverage

35.6% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

9.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Sokoto State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways

2

HRH Management

Sokoto State is implementing the repositioning component of the PHCUOR strategy

1

Penta-3 Coverage

7.2% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 13% among currently married women

1

HRH Density

Sokoto State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

1

HMIS Reporting

47% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

54.8% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

4

Task Shifting Policy

Sokoto State is implementing a State Task Shifting and Task Sharing Policy through the conduct of targeted competency-based trainings and supportive supervision

5

Health Product Management

0.8% of eligible Facilities report stock outs, with 99.4% Health Facility reporting rate for TB commodities in October 2021; with acceptable stock for select products for outbreak responses and evidence of good supply chain governance

1

Underweight Prevalence

42.8% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 35: Summary of recommendations for Sokoto State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Taraba State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Taraba State has attained full capacity to utilise BHCPF disbursements from the NPHCDA but all eligible PHCs are not receiving and retiring funds. The State has established a State health insurance agency, but has not attained full capacity to utilise funds from the NHIS gateway. The State does not have a formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Taraba State)

2

Legislation

Taraba State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

3

Planning

Taraba State has evidence of implementation of the Annual Operational Plan for Nutrition for 2021

3

Child Mortality

Under 5 mortality of 129 per 1,000 live births for the 10-year period preceding the survey

3

ANC by Skilled Attendant

57.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Taraba State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

2

Minimum Service Package

Taraba State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, but the package has not been fully costed

4

BCG Coverage

69.9% of eligible children received BCG vaccination

2

Delivery by Skilled Attendant

30.4% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

BHCPF

Taraba State has attained full capacity to utilise BHCPF through the NPHCDA gateway only

2

HRH Management

Taraba State is implementing the repositioning component of the PHCUOR strategy

3

Penta-3 Coverage

41.7% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 13.1% among currently married women

2

HRH Density

Taraba State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

1

HMIS Reporting

48% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

41.9% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Taraba State State has executed a redistribution of health workers to achieve equitable availability but does not have a task shifting and task sharing policy

1

Health Product Management

12.4% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

3

Underweight Prevalence

21.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 36: Summary of recommendations for Taraba State based on findings

Quick Wins	• Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Domesticate the national task shifting and task sharing policy • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services· Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Yobe State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

1. SPHCDA/B is backed by Law, has an office location and operational staff
2. Hfs for BHCPF identified in every political Ward
3. Bank accounts opened for identified HFs with at least 2 signatories
4. State has completed trainings and capacity building for the Gateway
5. HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly
6. Hfs for all wards have been authorised by NPHCDA to receive funds
7. HF has evidence of retirements for last cycle of funding received

1. SHIA is backed by Law, has an office location and operational staf
2. State has budgeted and released counterpart funding and equity funding for the NHIS gateway
3. State has sent reports of gateway forum and SOC meetings to NHIS
4. State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme
5. State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees
6. Enrolees are accessing care, and provider payments are being made
7. Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Yobe State has has attained full capacity to utilise BHCPF disbursements from NPHCDA and NHIS gateways, although not all eligible facilities are receiving and retiring funds from NPHCDA. The state has released equity funds for at least one round of disbursements, but has failed to provide its counterpart funding for the NHIS gateway. The state has not sent reports of any gateway forum and SOC meetings from Q4 2021 to NHIS but the State has a formal sector health insurance scheme.

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Yobe State)

2

Legislation

Yobe State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

5

Planning

Yobe State has an approved MSPAN (June 2021) and has an AOP for Nutrition for 2022, aligned to the MSPAN/SSHDP, and based on performance of previous Action Plans

2

Child Mortality

Under 5 mortality of 152 per 1,000 live births for the 10-year period preceding the survey

4

ANC by Skilled Attendant

66.3% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

2

Financing

Yobe State has publicly available budget for Health, with a streamlined budget system that captures inflow from other sources

3

Minimum Service Package

Yobe State has developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy, which is fully costed. This is however not complemented with an Investment plan that is guided by a Fiscal Space Analysis

3

BCG Coverage

44.7% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

17.8% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Yobe State has attained full capacity to utilise funds from both the NPHCDA and NHIS gateways, but has challenges with the oversight and coordinating mechanisms

2

HRH Management

Yobe State is implementing the repositioning component of the PHCUOR strategy

2

Penta-3 Coverage

29% of eligible children received their third dose of pentavalent vaccination

2

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 20.6% among currently married women

2

HRH Density

Yobe State has articulated Community Health Worker needs based on Ward Health Strategy and is leveraging BHCPF to recruit additional ad-hoc human resources for health

5

HMIS Reporting

82% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

57.2% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Yobe State State has executed a redistribution of health workers to achieve equitable availability but does not have a task shifting and task sharing policy

1

Health Product Management

7% of eligible Facilities report stock outs, with 100% Health Facility reporting rate for TB commodities in October 2021

1

Underweight Prevalence

41.9% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 37: Summary of recommendations for Yobe State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law· • Domesticate the national task shifting and task sharing policy, to help mitigate the challenges with health worker shortages • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement • Develop a state investment plan to accompany the fully costed MSP, and ensure that this plan and the MSPAN both fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Zamfara State

Status of Basic Health Care Provision Fund

Summary of Health Systems Findings

Full capacity to utilise BHCPF disbursements from NPHCDA

Full capacity to utilise BHCPF disbursements from NHIS

SPHCDA/B is backed by Law, has an office location and operational staff

Hfs for BHCPF identified in every political Ward

Bank accounts opened for identified HFs with at least 2 signatories

State has completed trainings and capacity building for the Gateway

HFMC meeting constituted with clinical staff and community members with evidence of meeting quarterly

Hfs for all wards have been authorised by NPHCDA to receive funds

HF has evidence of retirements for last cycle of funding received

SHIA is backed by Law, has an office location and operational staf

State has budgeted and released counterpart funding and equity funding for the NHIS gateway

State has sent reports of gateway forum and SOC meetings to NHIS

State has enrolled up to 70% of targeted poorest and vulnerable unto a social insurance scheme

State has empanelled up to 70% of the one PHC per ward, to provide services to enrolees

Enrolees are accessing care, and provider payments are being made

Service Utilisation by up to 25% of enrolees, with State submitting quarterly reports of enrolment and utilisation to NHIS

STATE ON THE CUSP OF MAXIMISING CURRENT BHCPF DISBURSEMENTS

Zamfara State has attained full capacity to utilise BHCPF disbursements from the NPHCDA and NHIS Gateways, although all eligible facilities for the NPHCDA gateway are not authorised to receive and retire funds and enrolees are yet to commence accessing services through the NHIS gateway. The state has failed to provide either its counterpart or its equity funding for the NHIS gateway, although the State has a functional formal sector health insurance scheme

Summary of Health Systems Findings

Performance Across Indicators Used for Ranking (Zamfara State)

2

Legislation

Zamfara State can demonstrate that it has Laws, administrative requirements, policies or other instruments in place that are sufficient for implementation of the National Health Act

4

Planning

Zamfara State conducts quarterly review of the implementation of the Nutrition AOP for 2021, but does not have an approved MSPAN

3

Child Mortality

Under 5 mortality of 130 per 1,000 live births for the 10-year period preceding the survey

2

ANC by Skilled Attendant

35.2% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

1

Financing

Zamfara State has a publicly available budget for Health and Funds are periodically released to the State Ministry of Health for operations and programmes

1

Minimum Service Package

Zamfara State has not developed a Minimum Service Package for the primary healthcare facilities identified for the one PHC per political ward strategy

1

BCG Coverage

16.2% of eligible children received BCG vaccination

1

Delivery by Skilled Attendant

12.5% of women aged 15-49 years who had a livebirth in the 5 years preceding the survey received ANC from a skilled provider

3

BHCPF

Zamfara State has attained full capacity to utilise funds from both the NPHCDA and NHIS gateways, although enrolees on the NHIS gateway have not started accessing care

2

HRH Management

Zamfara State is implementing the repositioning component of the PHCUOR strategy

1

Penta-3 Coverage

10.8% of eligible children received their third dose of pentavalent vaccination

4

Unmet need for Childbirth Spacing

Unmet need for Childbirth Spacing of 15% among currently married women

1

HRH Density

Zamfara State has articulated Community Health Worker needs based on the Ward Health Strategy and Minimum Service Package

2

HMIS Reporting

53% of eligible Health Facilities reported on the provision of any Artemisinin-based combination therapy for the treatment of Malaria in October 2021 per DHIS2

1

Stunting Prevalence

50.8% of children have Height for Age scores that are -2 standard deviations below the Mean z-score

1

Health Service Experience

≥50% of community members engaged reported a poor experience when accessing services from public Facilities in the 1 month preceding the assessment

2

Task Shifting Policy

Zamfara State State has executed a redistribution of health workers to achieve equitable availability but does not have a task shifting and task sharing policy

3

Health Product Management

2.3% of eligible Facilities report stock outs, with 99.7% Health Facility reporting rate for TB commodities in October 2021; however, there is inadequate stock for select products for outbreak responses

2

Underweight Prevalence

32.5% of children have Weight for Age scores that are -2 standard deviations below the Mean z-score

1

State of Public Health Facilities

At least 1 of the 9 assessed public Facilities owned are not equipped to offer basic medical services or require facility repairs

Summary of Key Steps to Improvement

Table 38: Summary of recommendations for Zamfara State based on findings

Quick Wins	• The state must complete all required trainings, establishment of health facility management committees, and regularisation of primary health facility bank accounts in all wards, so that health facilities can start accessing funds from the BHCPF • Provide equity funds for the NHIS gateway of the BHCPF • Mandate the quarterly gateway forum meetings of the SPHCDA and SHIA to strengthen implementation of the BHCPF • The state needs to commence payment of capitations to eligible health facilities, so that the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF can start to access services • The state must develop and implement a communications strategy, to generate demand for services among the poor and vulnerable who have been enrolled into the NHIS gateway of the BHCPF • Commission a legal assessment and provide political leadership for the drafting and passage of a comprehensive State health law • Domesticate the national task shifting and task sharing policy, to help mitigate challenges with health worker shortages • Develop an electronic workforce registry in the State, to support management of human resources for health • Develop a health system-wide accountability and performance management framework, and engage technical assistance to support its implementation • Nominate a cohort of staff from the relevant MDAs for training as field epidemiologists in the NFETP and provide funding for their full training· • The State needs to review its current strategy for health product distribution and invest in strengthening the last-mile delivery of health products • Fund the printing and distribution of the NHMIS reporting tools for all health services, including HIV services
Other key recommendations	• Commission a development of a state HRH strategic plan that models HRH needs and provides a pathway for training, recruitment, retention, career development, and replacement· • Develop a state MSPAN and an investment plan to accompany the fully costed MSP, and ensure that both plans fit into the State Strategic Health and Development Plan III (SSHDP III) and forms the basis for state budgeting for health • State needs to invest in an integrated logistics and supply chain management system, to leverage gains and experience from ensuring last mile availability of vaccines and TB control health products, and ensure that family planning, malaria, and HIV control commodities are also available at service provision points • The state needs to create a pipeline for private sector involvement in overcoming the health infrastructure deficit in the state, by aligning with the new national drive to adopt a PHC building on its strong diaspora community • The state needs to take a multisectoral approach to investments in health, by ensuring that health is mainstreamed in all policies and that state budgets deliberately target key social determinants of health

Lesson Learned

For this assessment, there was a need to engage with stakeholders from within and outside government, ensuring that the key issues that underpin health delivery in the country and across the states were clearly articulated. This consultative process was critical to ensure a fair and transparent process was deployed for this assessment. Efforts were also made to seek validation of findings from government.

One lesson from the conduct of this assessment has been the key value-add of including state-actors in the development of the assessment tool, including consensus on the key indicators for the assessment. This provides important perspective and ensures that the analysis of the data that is collected during the assessment produces the needed insights and actionable recommendations.

A key lesson from this assessment revolves around the need for stakeholders' participation in the design and implementation of similar assessments, towards ensuring that a wide array of expert opinions is brought to bear in delivering an assessment that meets its intended uses and serves the identified users.

A final key lesson from this assessment is that the tracking of budget allocations and fund releases only provide a microcosm of the information needed to ensure financial and programmatic accountability.

There is a clear need to ensure that efforts are ramped up to track actual utilisation of resources in health, including through support for open governance systems. This is critical, if we are to ensure that increased allocation of resources to health also translate to effective, efficient, and transparent utilisation.

There is a clear need to ensure that efforts are ramped up to track actual utilisation of resources in health, including through support for open governance systems.

Conclusion

Over the years, there have been several reports and accompanying strategies on how best to build a strong and resilient health system in Nigeria. Despite this myriad of reports, the health system continues to under-perform and health outcomes remain poor.

Life expectancy remains low, and the country continues to rank very poorly in the incidence of preventable maternal and child deaths when compared with countries of similar wealth and even with poorer countries. This clearly understates the fact that the poor performance of Nigeria's health system reflects both inadequate resourcing and inefficient and ineffective use of available resources.

Yet Nigeria has demonstrated a capacity to deliver health systems goals when least expected to. The success with polio eradication, containment of Ebola virus disease during the recent outbreak in West Africa, the containment of the COVID-19 pandemic, and incremental progress in improving child survival over the years all showcase a capacity to deliver results when political will and leadership commitment are on the table.

This makes room for cautious optimism, despite a grim outlook across many states where there is a consistent failure in health delivery.

The identification of key quick-win activities for many states, which clearly align with the recent recommendations from the national primary healthcare summit and the Lancet Nigeria commission provides a pathway for current leadership to solidify a legacy of catalysing change in the health system in the different states.

There is indeed a unique opportunity for citizen-led advocacy, recognising that the onus of health delivery lies with states and that there is no shortage of technical capacity on what needs to be done and how to get it done. It is now imperative for citizen voices to be heard to demand the change we would like to see in the health system.

Life expectancy remains low, and the country continues to rank very poorly in the incidence of preventable maternal and child deaths when compared with countries of similar wealth and even with poorer countries.

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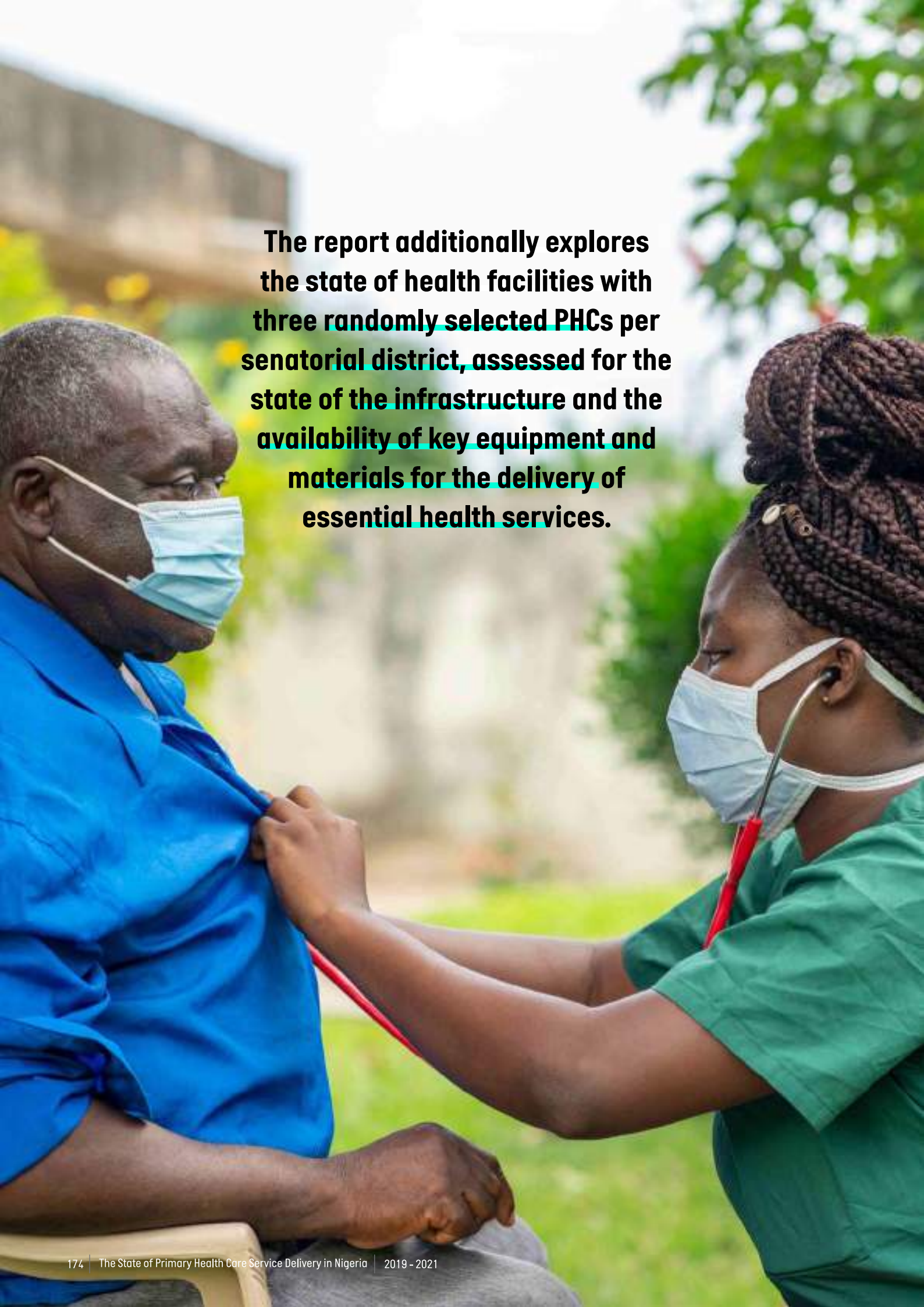

The report additionally explores the state of health facilities with three randomly selected PHCs per senatorial district, assessed for the state of the infrastructure and the availability of key equipment and materials for the delivery of essential health services.

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