Nigeria: Results Based Financing

Knowledge & Learning Case Study

Acronyms

BHCPF –
Basic Health care Provision Fund

CRF—
Consolidated Revenue Fund

HSDP—
Health Systems Development Fund

NHAct –
National health Act

NCDC—
Nigeria Centre for Disease Control

DFF –
Decentralized Facility Financing

MOF—
Ministry of Finance

NHIS—
National Health Insurance Scheme

PBF –
Performance based Financing

RBF—
Results Based Financing

GoN—
Government of Nigeria

FMoH—
Federal Ministry of Health

NSHDP –
National Strategic Health Development Plan

NPHCDA—
National Primary Health Care Development Agency

RMNCHA-N---
Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition

PHCUOR—
Primary Health Care Under One Roof

PHC—
Primary Health Care

WB—
World Bank

WDC—
Ward Development Committee

Before You Begin

Case Study Purpose & Objectives

The purpose of a Knowledge & Learning Case Study is to impart one country's experience with the GFF process so that other countries can learn from it.

The Nigeria team has reflected on their GFF experience in order to share with you their successes, challenges, and lessons learned. We hope that you will use and adapt this knowledge in your own country to:

- **Gain** a view of the GFF approach and process in the context of real-world experiences
- **Identify** challenges or setbacks you might face when undergoing similar processes or projects
- **Consider** new ideas and perspectives
- **Build** competence around a technical topic
- **Foster** discussion among your country team
- **Compare and contrast** Nigeria's situation with your own country's context

Focus Questions

Think about these questions as you review the case study. After reviewing the case study, you will have an opportunity to discuss these and other questions with your country team.

- **What strategies** did Nigeria use to institutionalize RBF?
- What particular **challenges** did they face?
- What were their **keys to success**?
- How did some key stakeholders **move** from resistance toward RBF to being a proponent of RBF?

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INTRODUCTION

Conceptualizing the NSHIP

- Between 1990 and 2010, Nigeria recorded modest improvements in key health indicators despite the implementation of numerous health sector reforms including establishing the National Health Insurance Scheme. Likewise, the first national health policy with primary health care as the cornerstone was introduced in 1988. Given the need to ramp up interventions to meet the Millennium Development Goals, Nigeria developed the National Strategic Health Development Plan (NSHDP, 2010-2015) and the model for the implementation of the Primary Health Care Under One Roof (PHCUOR) policy approved by the National Health Council in 2010.
- All the interventions and projects in Nigeria were input based with marginal impacts on the health sector despite the resources provided. About this time, encouraging results came from the implementation of Results Based Financing (RBF) in Rwanda. The World Bank, in support of the Government of Nigeria (GoN), proposed the introduction of RBF starting with a 4.5-year project named the Nigeria States Health Investment Project (NSHIP).
- The introduction of results-based financing approaches marked a radical departure from input-based financing that up until this point was the model for implementing health sector interventions. Several innovations like paying for results or outputs, separation of functions, facility autonomy, clearly defined governance arrangements, as well as capacity building, were introduced. The project was developed in consultation with various actors at Federal and State levels, and consensus was reached on the components of the project and implementation in accordance with global best practices for RBF.
- The implementation of a results-based financing project was designed as a pilot to give Nigeria policy options in the quest for a sustainable means of providing health care for the country. The PHCUOR and the NSHDP created the enabling environment for results-based financing to be conceptualized and “marketed” to internal and external stakeholders. Conceptualizing NSHIP as a policy dependent project built support for the project. Furthermore, results-based financing was implemented using the existing systems and structures thereby strengthening and reforming the national health systems’ operational framework to implement whichever RBF model the country chose to adopt after the pilot project was completed.

Overview of the NSHIP

The NSHIP was launched in 2011 by the World Bank in response to the call by the Federal Ministry of Health (FMoH) in Nigeria for investment in the Nigeria health system through its 2010 investment case proposal. The objective of NSHIP was to "increase the delivery and use of high impact maternal and child health interventions and to improve the quality of care at selected health facilities in the participating states." The focus was to increase the proportion and number of 12–23-month-old children fully immunized; proportion and number of births attended by skilled health providers; average health facility quality of care score; the number of outpatient visits by children under five; and the number and female proportion of direct project beneficiaries. By the end of 2016, the GoN had generated evidence on the potential impact RBF can have on health care delivery in Nigeria though a mid-term review of the NSHIP project, which was conducted in 757 health facilities in 27 local government areas in three States of Nigeria; and in health facilities in 91 LGAs in five additional financing states in the North-East.

The status of the Healthcare system in Nigeria before introduction of NSHIP

- **The health indices were poor**: Nigeria had made limited progress with delivering key health interventions despite several decades of input-based health system financing and human capital investments. With 545 maternal deaths for 100,000 live births in 2008, Nigeria contributed to 10% of global maternal deaths. The under age five child mortality rate was 157 per 1,000 live births in 2008 and the mortality rate was declining too slowly to achieve the MDG 4 target of less than 67 per 1,000 live births by 2015. This was despite relatively high levels of health spending, compared to other parts of Africa: total health spending in Nigeria was estimated at around US$30 per capita, amounting to about 6.5% to 7.4% of the GDP.
- **The supply of health care was poor**. Coverage of key interventions was low even by sub-Saharan African standards; Although there were 33,303 general hospitals, 20,278 primary health centres and posts, and 59 teaching hospital and federal medical centres, services remain inadequate, poor quality and did not reach the poor. Interregional and intraregional as well as interstate disparities in health outcomes were wide; and the poor had far worse health outcomes than the rich. Release of operational funds was unpredictable thereby making facilities depend on user fees to operate. Nigeria has one of the highest out-of-pocket expenditures on health in the world which had averaged about 69% in the last decade.
- **The demand for facility-based care was low** largely because the healthcare delivery system was unresponsive to the needs of communities. Less than 50% of births are assisted by skilled birth attendants in Nigeria, a trend that has not significantly improved since 2003. The full immunization coverage was still as low as 1% in Jigawa, 1.5% in Yobe, 1.6% in Zamfara and 8.3% in Katsina in 2003.
- **The PHC delivery system was fragmented and broken down**: while the Federal, State, and Local government were all responsible for financing elements of the primary health care (PHC) delivery system, the system was extremely poorly financed and operationalized. Many PHC were shut down, others were overstaffed with extremely low productivity, and those being run by public staff were just pharmacy outlets.

The World Bank funded RBF project design in Nigeria

RBF in Nigeria was designed as a three-arm study.

- The Performance Based Financing (PBF) arm: Health facilities in PBF LGAs received quarterly payments based on the quantity and quality of services provided. Several mechanisms were put in place to achieve this and also ensure integrity and separation of functions. The State Primary Health Care Boards that served as the Purchaser signed contracts with selected primary and secondary health facilities for the provision of defined quantity of MCH services. Each type of service had a tariff, and the payments reflected the number of services provided which were reported monthly. The quantity of services was verified ex-ante by local Verifiers and ex post by an external Agency, the Results based Financing Technical Assistant (RBFTA).
- RBF also put in place mechanisms to improve quality of services. The LGA PHC Department undertook quarterly supervision using a quantitative supervisory checklist that covered 15 domain areas. The RBFTA verified the quality reported by the LGA PHC Department. The quality scores were used to calculate the quality bonus which was added to the sum obtained from quantity of services.
- Payments were transferred electronically to facility bank accounts with the Officer in Charge and the Ward Development Committee Chair. The facilities could use up to 50% of the earnings on operational costs and up to 50% on staff performance bonuses.
- In addition, RBF aimed to strengthen existing governance structures. The Federal and State Ministries of Health provided oversight while the National Primary Health Care Development Agency provided technical assistance to the State PHC Boards. The State Ministry of Health and the LGAs received incentives for attaining specific targets.

The World-Bank funded RBF project design in Nigeria, II

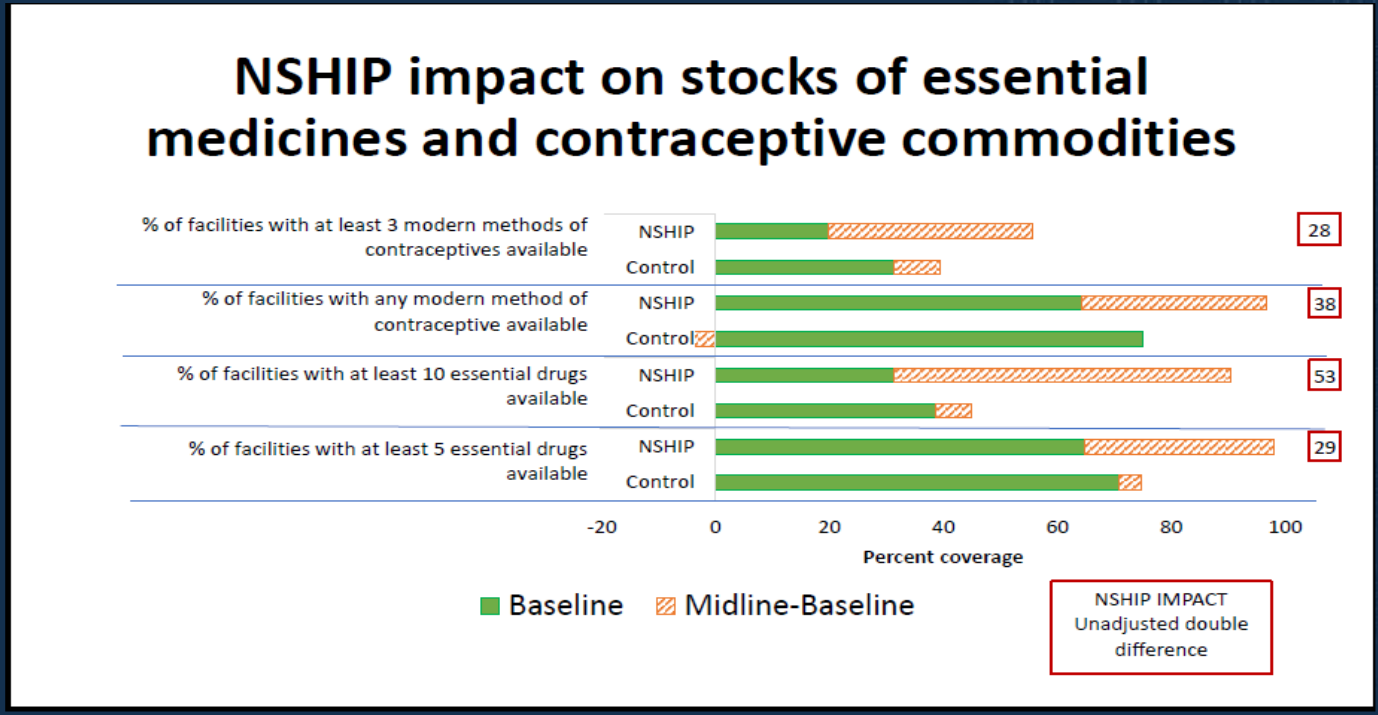
- The **Direct Facility Financing (DFF) arm** involved providing funds to the health facility bank accounts to meet their operational requirements. To qualify, the facility had to prepare a quarterly operational plan, get the plan approved by the Local Government PHC Coordinator; and the State Primary Health Care Board acting as the service purchaser, pays the facility. The funds are not subjected to preapproval or preaudit of transactions. Rather accountability for spending is dependent on the budget and expenditure control as part of the liquidation process. The budgetary allocation was dependent on the earnings of the PBF sites in each state. The DFF sites were allocated the other 50% of the earnings of the PBF sites. Both the PBF and DFF implementing health facilities had autonomy to decide how funds received would be utilized.
- The h**ealth facilities in control States** (Taraba for Adamawa, Benue for Nassarawa and Ogun for Ondo) were the third arm. These facilities operated the input-based finance model wherein funding for the operations of the health facility were dependent on government releases; priority was given to spending on health administration rather than service provision by the facilities; there was little or no ownership of facility activity at the local level, and all financial decisions were controlled centrally. Also, the unreliability of operational support allowed for a wide variety of user fee regimes, low levels of accountability, and at times impede access for priority conditions such as maternity care.

The NSHIP tier implementation structure in Nigeria

- One of the goals of NSHIP was to strengthen the health system. Consequently, the project latched unto existing structures, engaged five tiers of actors ,and made them functional.
- First, the **federal level** actors - the Federal Ministry of Finance, FMoH, and the National Primary Health Care Development Agency – were engaged. These actors provided financial guidance, stewardship and technical leadership to the project. Specifically, the Federal Ministry of Finance as borrower on behalf of GoN, ensured accountability and financial transparency; the FMoH was the regulator and custodian of project stewardship while the Primary Health Care Development Agency was the purchaser of services.
- The s**tate level** actors: the State Ministry of Health provided oversight and supervision while the State Primary Health Care Development Agency/Board was the purchaser of services. The State Primary Health Care Development Agency/Board engaged with the local government through the project implementation unit, to facilitate the implementation of the project.
- The **local government level** actors RBF Steering Committee was a new structure introduced to govern the PBF and DFF at the LGA level.
- The **facility level** actors were the facility service providers. They provided maternal and child health services and community outreaches to underserved communities.
- The **ward level** actors were the Ward Development Committees (WDC) comprising representatives of community groups that supported client mobilization activities and were represented in the Health Facility RBF Committee. Their representation enabled the community to participate in the management of the facility. In addition, the WDC held regular meetings with the health facility for updates and facilitating cordial relationship with service recipients.

The impact of the NSHIP Project: Mid-Term Review Report

In 2017, NSHIP stakeholders conducted an internal mid-term review. The review demonstrated the potential impact and sustainability of RBF in Nigeria, and the contributions of RBF to improving the key Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition (RMNCH-N) indicators and the health system. The report showed that although the NSHIP project States recorded significantly better results than the control States, there was no significant difference in the outcomes in the PBF and the DFF LGAs. The cost of implementing the DFF was estimated to be about 40-45% lower than the costs for the PBF . This finding provided the FMoH with evidence for use of the DFF as the policy option for implementing the Basic Health Care Provision Fund (BHCPF).



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INSTITUTIONALISATION: NSHIP

Institutionalization of RBF in Nigeria

- **Institutionalization** is a continuum that comprises core components that are compatible with political and public administration systems. NSHIP Institutionalization requires:

Key Components

- Integration of RBF principles of separation of functions, fiscal decentralization, autonomy and payment for results into healthcare policies and systems including budget initiatives by both internal and external audiences.
- Legislation in place by the central government to both support implementation of RBF and require evaluations using well-defined, widely accepted, and understood methodologies.
- Ensuring reforms in public financial management systems make provisions for payment for results (Output based financing)
- Incremental expansion of RBF to every level of the health system from the community to the General Hospital level.
- Adequate financial provisions for RBF in budget.
- Deliberate planning and setting up structures to support RBF.
- Provisions for knowledge generation, learning, and adaptation

Key Success Factors

- Being country led or managed.
- Receiving strong acceptance and buy-in from stakeholders, policy makers, implementers, and donors.
- Openness and accountability by the health systems and local, district, and national levels to developed unbiased evaluations and share the findings with stakeholders and donors.
- Clear definitions of the roles and responsibilities of key actors in government, civil society organizations, and development partners
- Support from the Ministry of Finance & Budget Office

The Basic Health Care Provision Fund for Nigeria - I

- In October 2014, following a decade of intense negotiations between various interest groups, the GoN signed into law the National Health Act (NHAct). The Act, for the first time, provides a legal framework for the provision of health care services to all Nigerians and for the organization and management of the health system. The new NHAct aims to give the health system a structure, and substantially increase revenue and improve Primary Health Care (PHC) services.
- The governance structures for the BHCPF are defined in the NHAct. The Act required that the BHPCF be managed by a Technical Working Group, and funds were allocated directly to the NPHCDA, the NHIS, and some operational costs. The FMoH instituted a National Steering Committee headed by the Minister of Health for oversight of the program; and the BHCPF Secretariat, hosted by the Planning and Statistic Division of the FMoH, to facilitate the monitoring of the program.
- The NHAct stipulated disbursement of the funds through the following gateways: NPHCDA to receive 45% of the BHCPF for supply side activities through the State Primary Health Care Boards; NHIS to implement demand creation services through receipt of 50% of the BHCPF; and 5% of the funding was allocated to the Nigeria Centre for Disease Control (NCDC) for emergency preparedness activities – 2.5% for medical emergencies and 2.5% for other emergencies .

The Basic Health Care Provision Fund for Nigeria - I

- The BHCPF is described as a tonic to revitalize the Nigeria health system. It is catalytic funding meant to encourage sub national governments and other partners to invest in health through the pooling of funds for health interventions especially at the PHC level.
- Initial funding for take-off of BHCPF was provided in the 2018 statutory allocation to the tune of N55.1billion. States were to provide a counterpart fund of 25%. Out of the N55.1 billion, 50% of the allocation – N27.55billion was released. There was no disbursement in 2019 and 2020. In 2021, budgetary provision for BHCPF was N35 billion. In addition, the GFF provided N1.4billion and the Gates Foundation promised $2million.
- Various provisions in the Act demand institutional transformation to improve efficiency in the system. In addition, the BHCPF served as a policy lever by influencing states to set up structures like the State Primary Health Care Agencies and State Social Health Insurance Schemes as pre-conditions for accessing the BHCPF.

The Basic Health Care Provision Fund for Nigeria - II

- The BHCPF is the annual government investment mechanism to support PHC. This is the largest government investment in health ever in Nigeria and in Africa. It will ensure continuity and consistency of government investment into the national health system.
- PHC is perceived as the bedrock for access to health care for most Nigerians. The BHCPF ensures that the PHC receives direct funding from the national government. The fund is then supplemented with counterpart funds from the state and local government who did not prioritize health care in their budgetary allocations.
- The Basic Health Care Provision Fund (BHCPF) is an earmarked fund, financed from not less than 1% of the Consolidated Revenue Fund (CRF) of the Federal Government and other sources including donors' contributions. The BHCPF operates a basket fund for health service delivery in Nigeria. Funds are directly disbursed to the PHC facilities from the Central Bank, thereby allowing for operational independence of PHC.
- The State Social Health Insurance Schemes and the State PHC Boards function as the fund holders. At the state level, there is the co-financing arrangement in which the state government contributes to the subsidies.
- The BHCPF had an operational secretariat that coordinated the operations of the Fund, conducted monitoring and supervisory visits to the PHCs, verified claims, supported proper documentation, and acted as a clearing house for all information related to BHCPF operations. No structure of the BHCPF implementation program handled physical cash. The operations of the secretariat enabled audits by all partners who contributed into the basket funds.

Evolution of BHCPF: Organizational and Institutional Arrangements for Operations

- **Inauguration of a Steering Committee with ministerial oversight**. This was critical to ensure accountability for the program. The Ministerial oversight for the BHCPF sent positive signals to stakeholders and donors about the accountability of the BHCPF.
- **Delineation of roles and functions** of the various actors in the health system. The BHCPF required that States set up structures such State Primary Health Care Agencies and State Social Health Insurance Schemes as pre-conditions for accessing the BHCPF. These institutions are critical governance structures that play key roles in supporting the functioning of the PHC to drive the demand for services. Models for the start up process and role delineation have been instituted in the three RBF pilot States “midwives” by the NSHIP.
- **Direct allocation of funds to the PHCs** by the Central Bank based on the facility developed business plan approved by the Local Government and the State PHC Development Agency/Board. This process ensured that health facilities received operational funds regularly based on an approved budget of funds for health facility operational costs, maintenance and repair, drugs and consumables, outreach, and other quality-enhancement measures based on the work plan funded.

Evolution of BHCPF: Organizational and Institutional Arrangements for Operations

- **NPHCDA Gateway of the BHCPF**: The DFF was found the most suitable gateway for operationalizing the supply side of service to be provided through the NPHCDA. It did not require the intense human and financial capital required by the PBF. Also, the incremental cost-effectiveness ratios of $296 per QALY gained made the DFF cost-effective and the more efficient RBF than PBF for Nigeria (Zeng et al, 2020).
- **Institutionalization of RBF operational systems**: The adoption of the DFF enabled the NSHIP DFF implementation models to be scaled up to other States thereby institutionalizing RBF into the Nigeria PHC financial system. In the States where the NSHIP was implemented, the states have continued to implement the DFF.
- **The BHCPF plan to scale up in phases**. The BHCPF learnt from the NSHIP to scale up in phases. The lessons learnt from the 10 years HSDP 1 and II projects reinforce the need for this. The BHCPF rolled out first in three States, scaled up to 15 states and there are plans to scale to other states that meet the requirements for implementation. Also, the BHCPF will also transit from the DFF to PBF in the medium term as a means of scaling up the performance of the PHC. Though the PBF is nearly twice as expensive as DFF, it saves more years of life compared to DFF; and it is more effective than DFF: PBF outperformed DFF on institutional delivery, and the share of institutional deliveries in PBF areas was10% higher (Yeng et al 2020).

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DISCUSSION – Key Successes

Lessons Learned from RBF Institutionalization in Nigeria

Institutionalization success depends on the Effective Stewardship of Health

- **Committed leaders**: Leadership was the major influencing factor for the institutionalization of the NSHIP. The strong commitment of leadership of the FMoH, NPHCDA, and NHIS and the emergence of 'champions' at the Federal and State levels throughout the period of planning and structure building, were critical to the success of the institutionalization process. The ministries of health played the roles of stewardship in health by resolving the issues of delineated responsibilities and tasks for the strategic management of the health system; and stewardship for health by contextualising the health reforms within the broader social, political, and economic environment in which the health system operates.
- The decision to institutionalize an RBF model for health care delivery in Nigeria took several years of planning. From the period of conceptualization in 2010, through the 4.5 years period of experimenting leading, to the adoption of the DFF as the health service delivery model in 2016. This period included transitions of the NSHIP/BHCPF conceptualization through the management of three health ministers. The commitment of these three leaders to see through a process was also critical to the institutionalization of the NSHIP in Nigeria.
- The commitment of the leadership through the Federal Government enabled ally Ministries, the States, and other agencies enabled the institution of systems and structures that facilitated stakeholder/donor support, capacity building, advocacy, communication, financing, accountability, and transparency.

Institutionalization success depends on stakeholders and donor support

Stakeholders/Donor support

- The institutionalization of the BHCPF program was driven by a wide array of stakeholders, especially civil society organizations and the news media who mounted pressure that led to the first budget allocation to the BHCPF in 2018, four years after signing the legal framework that set up BHCPF.
- The mobilization of lawmakers to support implementation of the BHCPF gave birth to the Legislative Network for Universal Health Care. This body harnessed and aligned the appropriation functions of the lawmakers to press for budgetary provision to BHCPF in 2018.
- The personal involvement of the Minister in governance of BHCPF stimulated donor confidence leading to funding commitments by BMGF, World Bank, and DFID to augment the N55 billion commitment made by the GoN to the BHCPF.

Institutionalization success, competency building and financing

Capacity Building and adaptation

- The BHCPF program benefited from the capacity building efforts of the NSHIP. Capacity building was integral to the success of the NSHIP as RBF was completely new to the Nigeria health system. The capacity building process included in person training provided by three experienced consultants from Rwanda; and the field visits of critical stakeholders to countries where RBF was being implemented like Rwanda. The piloting of the NSHIP project and the BHCPF program provided the opportunity to adapt and make the programs successful.

Advocacy and Communication

- Interpersonal and persuasive skills were needed to get the buy-in of key stakeholders for both the NSHIP and the BHCPF. Messages were tailored to specific stakeholders and audiences. The NSHIP was less difficult to 'sell' as the funding was from the World Bank and it required no counterpart funding for the state. The BHCPF implementation structure was a lot more difficult to 'sell' to technocrats who perceived the FMOH was depriving the NPHCDA and the NHIS control of allocated funds for the BHCPF as stipulated in the NHAct.

Financing

- Direct funding of PHC facilities was a major turning point in the health care delivery model that stimulated quantitative and qualitative changes in the supply of health care services, and improvement in the utilization of the PHC facilities.
- The basket funding mechanism for the BHCPF program was to eliminate duplication of projects and promote efficient use of resources. The concerns about attribution for investments made by donors was addressed through centralized documentation processes by the BHCPF secretariat; a lesson learned from NSHIP.

Accountability and transparency

- Funding for health care delivery in Nigeria still requires donor investment. Instituting accountable and transparent systems will promote these investments. The BHCPF learned lessons from the NSHIP on how to operate systems that will ensure proper documentation, and monitor expenditures to build accountable systems that support donor investment in the health sector.

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DISCUSSION – Challenges

Institutionalization challenges and Effective Stewardship for Health - I

- Multi-sectoral engagement: Effective health care responses require the engagement of other critical stakeholders beyond the health system for any meaningful impact to be made on the national health indicators. These issues include policing on education, environment, agriculture, employment and trade; the specification and enforcement of property rights; levels of corruption; and access to mass media. These factors clearly fall outside the boundaries of the health system but can significantly influence its performance (WHO, 2002).
- Though multi-sectoral engagement will lead to a robust response, this laborious engagement process will require strategic thinking that allows for stepwise engagement of sectors in a country where the national development plans build their development programs around health. It will take this level of laborious multi-sectoral engagement planning to achieve the long-term desired improvement of the national health indices. Otherwise, the current BHCPF that is intrinsically focused on the health sector will only deliver some of the mileage required or the improvement in health of the Nigerian citizens. Sadly, the NSHIP provided no directions for the government to be able to do this limiting the countries' ability to learn.
- Future policy designs for the BHCPF will be hinged on the ability to deploy an integrative thinking approach that does not compromise the speed of delivery while attempting to engage stakeholders broadly.

Institutionalization challenges and the Effective Stewardship for Health - II

- Supportive social systems: Peace and security, continuity in health policies, personnel and institutional arrangements in ministries of health; participation of civil society in improving the design and implementation programmes; and evidence-based decision making are required for measureable impact of the institutionalized RBF (WHO, 2002). The country has faced several crises that undermine peace and security including Boko Haram terrorism, Ebola, cholera, Lassa fever, and the COVID-19 pandemic.
- Timeliness: The delay in agreeing on the BHCPF program by key federal health institution players lead to a 2-year delay. The changes in leadership at the Federal Ministry of Health and the National Assembly in 2017 stalled the BHCPF roll out as new consensus had to be reached again between stakeholders before the project could be rolled out in 2019. At this time, the 1% Consolidated Fund had been depleted from N55 million to N35million due to poor economic growth. The cost of goods also undermined the value of the naira. In retrospect, consensus building on the operation of the BHCPF program could have been held in parallel with efforts to get funds released. Time was essential as the transition of the visionaries of the BHCPF at its infancy derailed the BHCPF program. Two years of nursing the project by the visionaries could have facilitated the institutionalization of the BHCPF on a firm footing and reduced the risk of reversing the project from an output-based to an input-based health financing system.

Institutionalization challenges and the Effective Stewardship for Health - III

- **Resource constraints** and the devaluation of the Naira: The dwindling revenue base of the Federal Government led to the shrinking of the absolute size of the 1% CRF allocation to BHCPF – from the proposed N55 billion in 2018 to N35 billion in 2021. Inflation and Naira depreciation further diminished the purchasing power of the Naira. Therefore, it was highly imperative for stakeholders to critically rethink the funding mechanism for the BHCPF and take advantage of the ongoing amendment to the NHAct to institute long term stable mechanisms for funding Health. These include exploring the imposition of health taxes on consumption of unhealthy foods and items such as tobacco, alcohol, refined sugar-based beverages as additional resources to the BHCPF; and/or taxing diaspora remittances. Nigeria has one of the highest remittance rates as a share of gross domestic product, and remittance is three times higher than all Official Development Assistance to Nigeria (World Bank, 2019). Other instruments to explore that are not currently in use in Nigeria include airline ticket or telecommunication taxes; government bonds and guarantees, which are units of debt that a government, can sell to raise funds (they currently form 65% of the IF market not because they are innovative per se, but because they are seldom used by governments for health and development); and emissions permits (every government is supposed to allocate a set amount of environmental emissions permits for each harmful emission) can be auctioned or sold as countries can trade (sell or buy) these permits to those who require them more, thereby raising funds which can be used for development. In addition, Nigeria could trade in Special Drawing Rights allocated by the International Monetary Fund for normal funds for investment in health (Aregbeshola and Folayan, 2021).

Institutionalization challenges and the Effective Stewardship for Health - IV

- **Corruption:** Nigeria has a huge problem with corruption (Corruption perception index 2020). Corruption poses a threat to the transparency and accountability mechanisms institutionalized for the BHCPF program. The conceptualization of RBF, the institutionalization of NSHIP in the BHCPF was handled by three different health ministers. The roll-out of the BHCPF is being handled by a new minister. By 2019 when the BHCPF program was being rolled out on receipt of the first government subvention, the National Steering Committee had been scrapped, the BHCPF secretariat disbanded, and funds were allocated directly to the agencies thus allowing agencies have direct resource control. The BHCPF program also does little in engaging the civil society. The independent fiscal management of their resources by the agencies is not only a threat to accountability and transparency of the BHCPF program and making the program aversive for donor investment, it also will likely reverse the output-based health system back to an input-based health system.
- **Poor engagement of some regulatory agencies**: The focus of the NSHIP and BHCPF was on building the capacity of the PHCs, the State Primary Health Care Development Agency/Board and the LGA PHC Department; there was poor engagement with the State regulatory agency (MoH) and the treasury unit of the Ministry of Finance. This increases the risk for poor fund management.
- **Governance:** The GoN prioritizes infrastructural development. Health is not a prioritized agenda. The poor national prioritization of health increases the risk for undermining the 1% budgetary allocation of the CRF for the BHCPF. Without government direct funding of health, the health reforms cannot survive. Nevertheless, the BHCPF invested efforts in building a transparent and accountable system drawing from the examples of the RBF.

Conclusion

The RBF pilot project in Nigeria facilitated the development of systems and structures for the making of the most ambitious health reform program in Africa – the BHCPF. The 4.5-year program helped with the creation of the political and policy environment that supported the institutionalization of a RBF model (DFF for the short term and PBF for the medium and long term) as an operational model for improving the performance of the PHC. The project also created the needed pool of trained, competent and experienced staff that could support the process of scaling up the RBF in Nigeria during the phased rollout of the BHCPF implementation. The strong governance systems instituted through the NSHIP supported accountability and transparency of the NPHCDA's operations; and the rigorous reporting system with in-build verification and counter verification mechanisms reduced the risk for corrupt practices undermining the BHCPF program. As the BHCPF continues to be rolled out gradually as a Health Reform Agenda for Nigeria, the foothold of NSHIP as a systems strengthening mechanism for the future delivery of PHC in Nigeria. The country can only continue to build on the lessons learnt from NSHIP. The NSHIP had definitely stamped its footprints in the heart of health care delivery mechanisms in Nigeria.

Discussion Questions

- What aspect of the country's case did you find most interesting? Why?
- What new things did you learn?
- Did this case broaden your perspective about a particular issue or topic? Which one?
- What role , if any, do you feel corruption plays in the institution of health reform programs? How can this impact be mitigated?
- Which of the challenges described could you most relate to?
- What is different from your own situation?
- Which of the strategies employed did you find the most innovative?
- Which strategies could be tried in your country? How would they need to be adapted?
- How do you see the key stakeholders impacting the conceptualization, designing, planning and implementation of national RBF programs?
- What processes do you feel can help facilitate the transition of pilot RBF projects into national programs?