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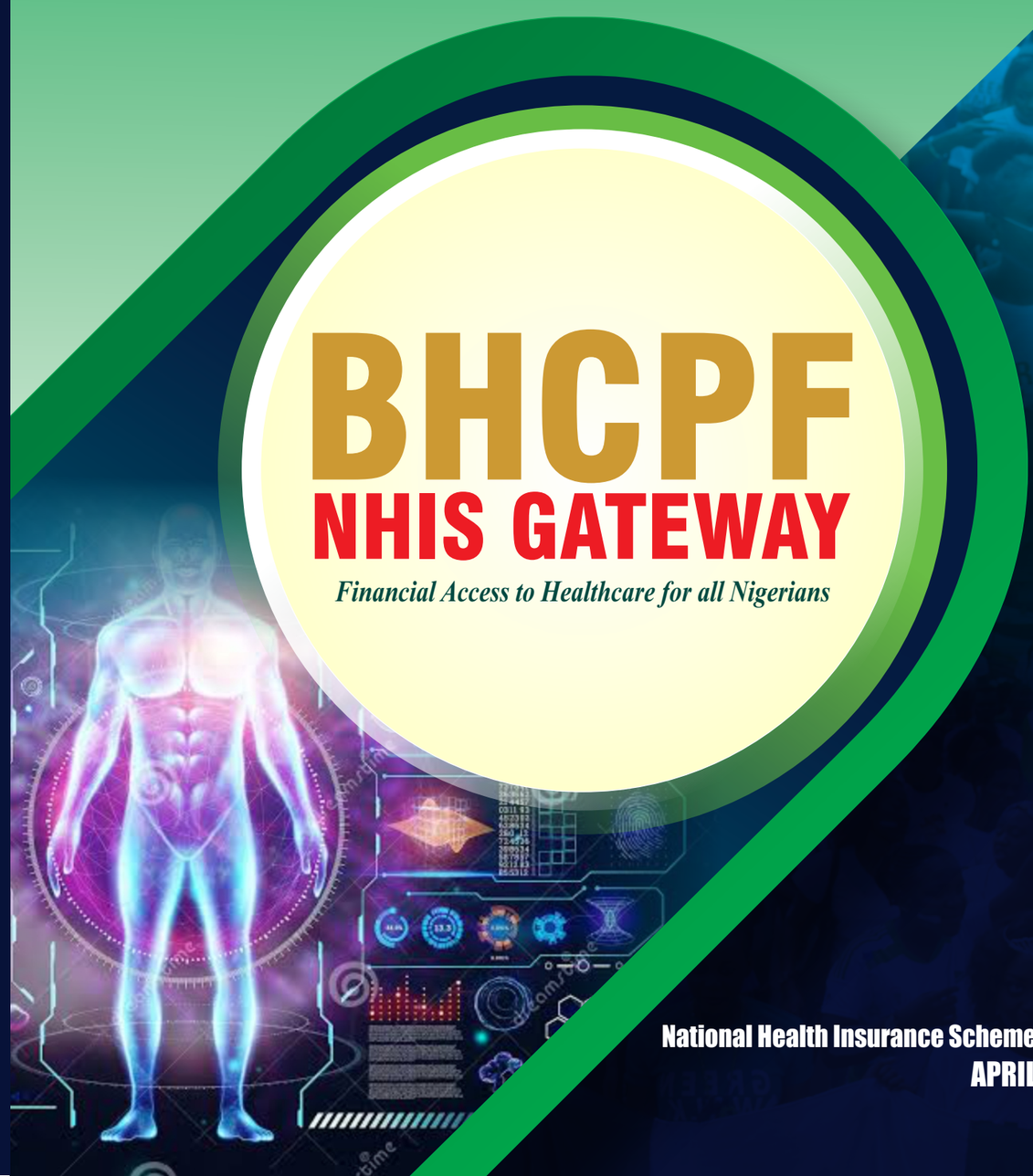
IMPLEMENTATION PROTOCOL FOR THE NHIS GATEWAY OF BASIC HEALTH CARE PROVISION FUND (BHCPF)



BHCPF
NHIS GATEWAY

Financial Access to Healthcare for all Nigerians

National Health Insurance Scheme (NHIS)
APRIL, 2022

IMPLEMENTATION PROTOCOL FOR THE NHIS GATEWAY OF BASIC HEALTH CARE PROVISION FUND (BHCPF)

BHCPF

NHIS GATEWAY

Financial Access to Quality Healthcare for all Nigerians

National Health Insurance Scheme (NHIS)

April, 2022

TABLE OF CONTENTS

LIST OF ACRONYMS

BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CRF	Consolidated Revenue Fund
CU5	Children Under Five
DPG	Development Partners Group
FCT	Federal Capital Territory
FMoF	Federal Ministry of Finance
FMoH	Federal Ministry oAf Health
METFC	Ministerial Emergency Treatment Fund Committee
MOC	Ministerial Oversight Committee
HCH	Honourable Commissioner for Health
HCP/F	Health Care Provider/Facility
HHMB	Hospitals Health Management Board
HMH	Honourable Minister of Health
HMO	Health Maintenance Organization
LGA	Local Government Area
LGHA	Local Government Health Authority
NBS	National Bureau of Statistics
NEMTC	National Emergency Medical Treatment Committee
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
PHC	Primary Health Care
PHCP	Primary Health Care Provider
QIC	Quality Improvement Committee
QIP	Quality Improvement Plan
QMS	Quality Management System
SDG	Sustainable Development Goal
SEC	State Executive Council
SHC	Secondary Health Care
SHCP	Secondary Health Care Provider
SPHCB/A	State Primary Health care Board/Agency
SSHIA	State Social Health Insurance Agency
SSHIS	State Social Health Insurance Scheme
TSA	Treasury Single Account
UHC	Universal Health Coverage
WDC	Ward Development Committe

GLOSSARY OF TERMS

Term	Definition
Actuary	A statistician who calculates risks and probabilities for a payment plan especially for insurance and pensions.
Administrative charge	Amount set aside as fee to run the operations of the Gateways.
Affordability	The ability to p ay for health services, so that the subscriber of the health service does not suffer financial hardship when using them.
Benefit	This means a profit or advantage of any kind derived from a Scheme
Capitation	A payment method in which all providers in the payment system are paid, in advance, whether the enrollee uses the services or not, a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period.
Enrollee	An eligible person who is enrolled in a health insurance scheme health plan or the eligible person's qualifying dependent.
Fee-for-service (FFS)	A payment model based on payment per service rendered to an enrollee by a health care provider for health services not classified under capitation.
Financial catastrophe	High out-of-pocket payments for health services in the presence of low household financial capacity and an absence of prepayment mechanisms results to household's inability to pay for health care and other necessities. This high expenditure for health care result in households or individuals reducing or becoming unable to pay for necessities like food, clothing and even education of children.
Health care provider	This is any government or private health care facility, hospital, maternity center, community, pharmacies and all other service providers, accredited for the provision of prescribed health services for insured persons and their dependents.
Local government	Public administration at local level exercised through representative councils established by law, exercising specific powers within a defined geographical area. These powers give the Local Government substantial control over local affairs as well as the staff to direct the provision of services and implement projects, which complement the activities of the State and Federal Governments.
Medical documents	These include all prescriptions, laboratory forms, excuse duty, death certificate and other documents used in the management of patients.
Medical practitioner	A person with a medical related qualification that can register with the Medical and Dental Council of Nigeria.
National Health Insurance Scheme (NHIS)	This is a social health insurance scheme in Nigeria, established by the National Health Insurance Scheme Act of 1999 of the Federal Republic of Nigeria Laws No. 42 VOL II 2004.
National Primary Health Care Development Agency (NPHCDA)	Corporate body established by Decree 29,1992 with statutory responsibilities of providing policy and guidance, technical support and resource mobilization to states and LGAs for the implementation of primary health care.

GLOSSARY OF TERMS

State Social Health Insurance Agency/ State Contributory Health Management Agency	State Social Health Insurance Agency / State Contributory Health Management Agency: An Agency established by law at state government and FCT level to administer the state social health insurance / contributory health schemes.
Pooling	The accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures.
Primary-level Healthcare Facility	A health care facility typically staffed by general practitioners and/or nurses with limited laboratory services for general but not for specialized pathological analysis; bed size ranging from 0-20 beds; often referred to as first level of care.
Provider Payment Mechanism	The mechanisms used to transfer payments for services rendered from the purchaser or a proxy to the health care provider. The Provider Payment Mechanism accomplishes far more than simply the transfer of funds to cover the costs of services.
Secondary-level Healthcare Facility	A health care facility highly differentiated by function with five to ten clinical specialties; bed size ranging from 20-100 beds; often referred to as Specialist Hospital
Social Health Insurance Scheme (SHIS)	A health insurance scheme provided by government to its citizens, especially to low- and middle-income populations.
Specialist Care	This is care provided by secondary-level healthcare facilities. Such care focuses on specific organs or diseases (cardiology, neurology, oncology etc.) including special diagnostic and therapeutic services such as biopsy or dialysis.
Strategic Purchasing	This is the planning and purchasing of preventive, curative and rehabilitative clinical services to meet the health needs of a population. It is the link between resources mobilized for universal coverage and the effective delivery of quality service.
Tertiary-Level Healthcare Facility	A health care facility with highly specialized staff and technical equipment, (Cardiology, Intensive Care Unit (ICU) and specialized imaging units); clinical services are highly differentiated by function; might have teaching activities; bed size ranging from 100 - 800 beds; often referred to as Teaching or Tertiary level hospital.
Universal Health Coverage	A process that ensures all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.
User fees	Charges levied on any aspect of health services at the point of receiving health care or service delivery.
Vulnerable	This term may refer to the following categories of people (a) pregnant women, (b) children under five (5) years (c) the elderly >85 years, (d) the disabled, (e) the poor and others falling within the group.

LIST OF FIGURES AND TABLES

OVERVIEW OF THE PROTOCOL

The National Health Act of 2014 mandates the establishment of an earmarked fund called the Basic Healthcare Provision Fund (BHCPF) for the effective delivery of Primary Health Care (PHC) services, provision of a Basic Minimum Package of Health Services (BMPHS) and Emergency Medical Treatment (EMT) for all Nigerians.

The National Health Act prescribes that the BHCPF would be funded through a Federal Government (FG) annual grant of not less than one percent of its Consolidated Revenue Fund (CRF), grants by international donor partners and funds from other sources.

This NHIS Gateway Implementation protocol was derived from the 2020 BHCPF Guidelines for ease of administration and to guide the effective implementation of the NHIS gateway.

The protocol is organized into six chapters. Chapter one gives an overview of NHIS, chapter two describes the BHCPF including its aim and objectives, chapter three details the governance and administrative structure of the NHIS Gateway while chapter four details the beneficiaries of the program, services offered, provider payment mechanisms, enrolment process/es, funding, roles of key stakeholders, among others. Chapter five describes the Monitoring and Evaluation processes and chapter six details the offences and sanctions of the NHIS gateway.

CHAPTER ONE

NATIONAL HEALTH INSURANCE SCHEME (NHIS)

1.0 OVERVIEW OF NHIS

The NHIS was established as a corporate body (NHIS Act CAP N42 (LFN) 2004, Part I) with the mandate to ensure that Nigerians have financial access to qualitative and affordable healthcare, as well as regulate and manage all stakeholders of the scheme. The mandate is reinforced by the existence of relevant legislative and policy instruments including the National Health Act, the National Health Policy, National Strategic Health Development Plan and the National Health Financing Policy and Strategy with appropriate provisions and clearly set objectives and targets towards the over-arching achievement of Universal Health Coverage (UHC). The NHIS vision, mission, core values and position statement is presented in figure 1.

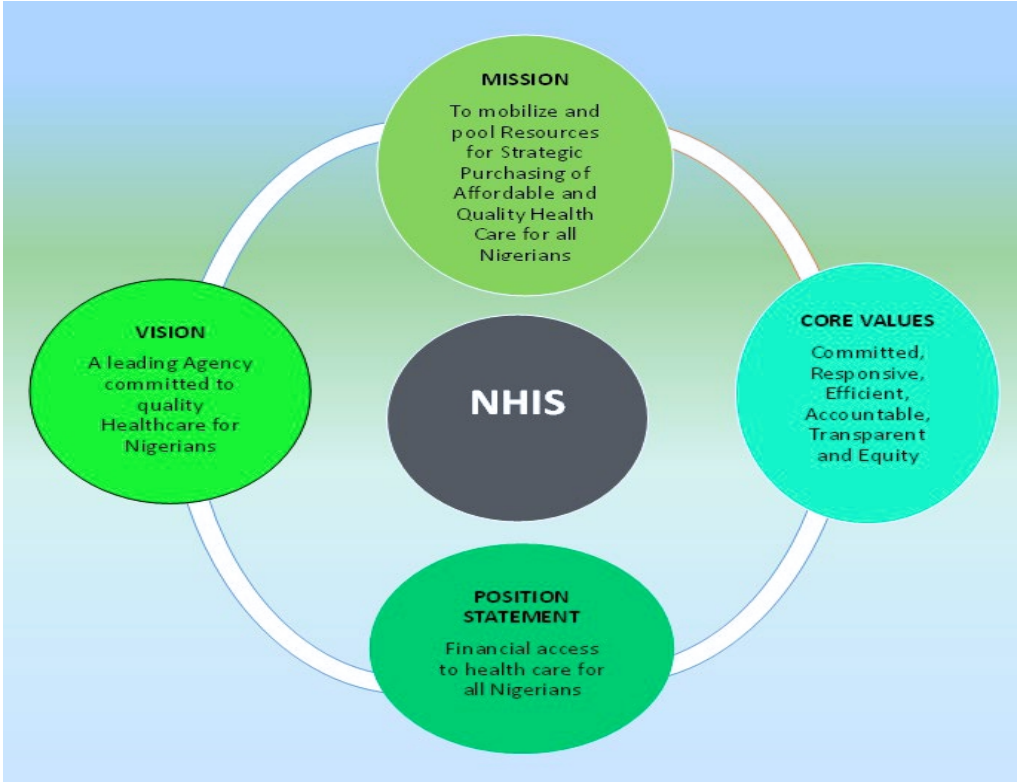


Figure 1 showing the mission, vision, position statement and the core values of NHIS

Functions of the Scheme

In its functions, the Scheme shall:

a) Determine the overall policies of the Scheme, including its financial and operative procedures;
b) Ensure effective implementation of the policies and procedures of the Scheme;
c) Assess, from time to time, the research, consultancy and training programmes relative to the Scheme;
d) Arrange for the financial and medical audit of the Scheme;
e) Set guidelines for effective co-operation with other organizations to promote the objectives of the Scheme;

f) Ensure public awareness about the Scheme;
g) Coordinate manpower training under the Scheme;
h) Carry out such other activities as are necessary and expedient for the purpose of achieving the objectives of the Scheme as set out in the NHIS Act.

Objectives of the Scheme:

a) Ensure that every Nigerian has access to good healthcare services
b) Protect families from the financial hardship of huge medical bills
c) Limit the rise in the cost of healthcare services
d) Ensure equitable distribution of healthcare costs among different income groups
e) Maintain high standard of healthcare delivery services within the Scheme
f) Ensure efficiency in healthcare services
g) Improve and harness private sector participation in the provision of healthcare services
h) Ensure adequate distribution of health facilities within the Federation
I) Ensure equitable patronage of all levels of healthcare
j) Ensure the availability of funds to the health sector for improved services.

Responsibilities of the Scheme

a) Registering of Health Maintenance Organizations (HMOs) and healthcare facilities under the Scheme
b) Issuing appropriate guidelines to maintain the viability of the Scheme
c) Approving format of contracts proposed by the HMOs for all health care providers
d) Determining, after negotiation, capitation and other payments due to healthcare facilities, by the HMOs
e) Advising the relevant bodies on inter-relationship of the Scheme with other social security services
f) The research and statistics of matters relating to the Scheme
g) Advising on the continuous improvement of quality of services provided under the Scheme through guidelines issued by the Standard Committee
h) Determining the remuneration and allowances of all staff of the Scheme
I) Exchanging information and data with the National Health Management Information System (NHMIS), Nigerian Social Insurance Trust Fund, the Federal Office of Statistics, the Central Bank of Nigeria (CBN), banks and other financial institutions, the Federal Inland Revenue Service (FIRS), the State Internal Revenue Services (SIRS) and other relevant bodies
j) Doing such other things as are necessary or expedient for the purpose of achieving the objectives of the Scheme under the Act.

CHAPTER TWO

BASIC HEALTH CARE PROVISION FUND (BHCPF)

2.0 PREAMBLE

The National Health Act (NHAct) 2014 is a milestone in the national momentum to strengthen Nigeria's health system, achieve Universal Health Coverage (UHC), and improve the nation's Health indices with the consequential improvement in economic productivity.

The NHAct 2014 was enacted to ensure improved health outcomes, by providing a legal framework for the provision of health care services and establish an organizational and management structure for the health system in Nigeria. To achieve the important objective of providing quality healthcare services to all Nigerians, the Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS). The BMPHS is a set of preventive, protective, promotive, curative, and rehabilitative health services to be developed and reviewed from time to time by the Minister of Health, after consultation with the National Council on Health (NCH).

The Basic Health Care Provision Fund (BHCPF or "The Fund") was established under Section 11 of the Act, as the principal funding vehicle for the BMPHS, whilst at the same time, serving to increase the fiscal space and overall financing to the health sector. It is expected that the attendant service upscale arising from application of this funding, would assist Nigeria achieve UHC. Funding of the BHCPF would be derived, as stipulated in the Act, from (a) an annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF); (b) grants by international donor partners; (c) funds from any other sources, inclusive of the private sector.

The Purpose of the BHCPF is Threefold:

(1) Ensuring the provision of a Basic Minimum Package of Health Services to all Nigerians, by applying 48.75% of the funds towards purchase of the BMPHS to be managed by the National Health Insurance Scheme (NHIS)

(2) Strengthening the Primary Health Care (PHC) system - With 45% of BHCPF, to be disbursed b the National Primary Health Care Development Agency (NPHCDA) for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (i.e. 20% of BHCPF), the provision and maintenance of facilities, laboratory, equipment and transport for eligible primary healthcare facilities (15% of BHCPF) and the development of Human Resources for Primary Health Care (10% of BHCPF)

(3) Providing Emergency Medical Treatment – with 5% of the BHCPF to be administered by the National Emergency Medical Treatment Committee (NEMTC) as appointed by the National Council on Health (NCH) and

(4) Strengthening Public Health Security with 1.25% of the BHCPF to be administered by National Centre for Disease Control (NCDC).

Aim of the BHCPF

The overall aim is to significantly move Nigeria towards achieving Universal Health Coverage (UHC) based both on the current National Strategic Health Development Plan II (2018 – 2022) in the medium term; and the long-term goals for UHC including the health-related SDG Goals.

Objectives of the BHCPF

The specific objectives of implementing the BHCPF as contained in the 2020 implementation Guidelines are:

1. To have in place at least one (1) fully functional public or private PHC facility in at least 30% of wards in next 3 years, 70% within 5 years and in all wards within 7 years.

2. To achieve at least three (3) fully functional public/private secondary healthcare facilities, benefitting from the BHCPF in at least 50% of states in the federation within the next 3 years and all within the next 5 years.

3. To establish effective emerge ncy medical response services in 36 states and FCT in 5 years including a national ambulance service for Nigeria.

4. To reduce out of pocket expenditure by 30% in 5 years and increase financial risk protection for all Nigerians through health insurance.

5. To increase life expectancy to at least 60 years for males and females over the next decade.

This Protocol shall be subject to review after 2 years of its use in implementation in the first instance and every 3 years subsequently.

Figure 2 showing funds distribution as contained in the NHAct

CHAPTER THREE

GOVERNANCE AND ADMINISTRATION

3.0 GOVERNANCE STRUCTURES

In accordance with the provisions of the BHCPF 2020 implementation Guidelines, the three-payment and implementation Gateways shall be responsible for management of the funds, under the supervision of the Honourable Minister of Health and Honourable Commissioners for Health at federal and state levels, respectively.

The NHIS gateway is responsible for the provision of the Basic Minimum Package of Healthcare Services (BMPHS) to all Nigerians through various state social health insurance/contributory agencies.

Governance and Oversight Functions

1. Ministerial Oversight Committee (MOC)

i. Ministerial Oversight Committee shall be chaired by the HMH

ii. The Secretary of the MOC shall be a Director of the FMoH in the Honourable Minister of Health's office and a non-voting member (refer to the appendix for membership)

2. State Oversight Committee (SOC)

i. HCH, supported by the SOC shall approve all state proposals and reports prior to official transmission to Gateways.

ii. HCH to lead effort to mobilize 25% counterpart funding in cash or kind

3. The BHCPF Gateway Forum

This is a forum to ensure effective synergy and coordination of routine implementation activities of the Gateways at national and subnational levels.

Operational Cost

i. Not more than 5% of funds accruing to Gateways would be utilized for administering the Gateway's operations in line with their annual work plans

ii. MOC to receive 5% of gateways operational cost at National level

iii. SOC to receive 5% of gateways operational cost at State level

iv. SSHIAs operational/administrative cost integrated into the premium from NHIS

On-boarding of States and the FCT:

All states and the FCT shall be eligible for on-boarding onto the various Gateways on condition they fulfill the eligibility criteria for each Gateway as contained in the BHCPF's Guidelines.

Institutional and Administrative Framework (Governance)

i. The NHIS shall coordinate the implementation of the NHIS Gateway.

ii. As a prerequisite to benefit from the Fund, the Honourable Commissioner for Health shall ensure the establishment of a functional health insurance scheme administered by a State Social Health Insurance Agency backed by law.

iii. Each State Commissioner for Health shall ensure the creation of an Equity fund within the SSHIAs and show evidence of budgetary release before participating.

iv. For sustenance of the fund and expansion of the coverage depth, every state shall make a 'counterpart fund' of 25% of the total requirements for coverage of the defined population based on the determined enrolment figure for that state, in line with the NHAct 2014. This counterpart funding may be sourced from the Equity fund of the state. The NHIS will then provide the complementary fund from the BHCPF to the state based on the defined benefit package.

v. The State Health Insurance Agency shall purchase health care services from eligible heath care providers based on agreed rates from the fund. These rates shall be determined actuarially and be subject to periodic reviews (every 2 years) by an NHIS accredited actuary. For primary health care providers, this shall be by capitation and for secondary healthcare facilities, by fee- for- service. The rates for capitation and fee- for - service shall be based on a tariff structure as defined and published periodically by the NHIS.

vi. All payments to HCPs shall be to their accounts domiciled in commercial banks. All funds to the HCPs shall be for the provision of the contents of the Basic Minimum Package of Health Services, as defined.

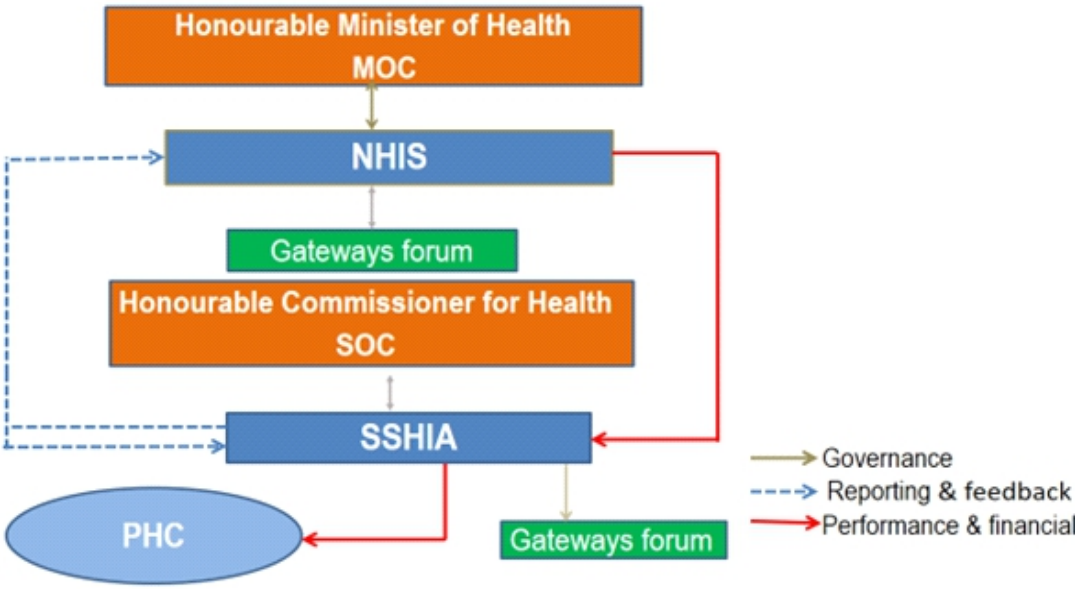


Figure 3: Institutional and governance structure of BHCPF

KEY STAKEHOLDERS UNDER THE BHCPF

1. Federal Government of Nigeria (FGN)
2. Federal Ministry of Health (FMoH)
3. National Council on Health (NCH)
4. Ministerial Oversight Committee (MOC)
5. National Health Insurance Scheme (NHIS)
6. National Primary Health Care Development Agency (NPHCDA)
7. National Emergency Medical Treatment Committee (NEMTC)
8. Nigeria Centre for Disease Control (NCDC)
9. State Oversight Committee (SOC)
10. State Ministries of Health (SMOH)
11. State Social Health Insurance Agencies (SSHIAs)
12. Primary Health Care Facilities (PHCF)
13. Secondary Health Care Providers (SHCPs)
14. Donor Agencies
15. Beneficiaries

Table 1: Roles and Responsibilities of Stakeholders under the NHIS Gateway

Key stakeholders Roles and Responsibilities	
FGN	• Provision of not less than 1% of Consolidated Revenue Fund
FMOH	• Serves as secretariat of the MOC • Provides strategic focus • Coordinates the activities of the Gateways • Monitors and evaluates the implementation of the fund
NCH	• Policy formulation • Protection, promotion, improvement and maintenance of the healthcare system in Nigeria
MOC	• Function as a national oversight group promoting robust collaboration among implementing agencies (NPHCDA, NHIS and NEMTC) in the evolution and implementation of the BHCPF • Coordinate the operations of the stakeholders to ensure alignment with the objectives of the NHAct for the BHCPF • Review annual work plans and budgets of federal and state implementing entities, as presented by implementing agencies, for endorsement • Review updates on flow of funds, performance management and verification of results, as presented by the implementing agencies for guidance and feedback • Evaluate periodic programme reports presented by the implementing agencies • Ensure compliance of all participating agencies and entities with this guideline • Review performance of the implementing entities based on a clear set of agreed upon Key Performance Indicators (KPIs) across the BHCPF • Ensure that funds are disbursed, managed, and accounted for in a transparent manner and in accordance with this guideline • Advocate for and ensure the provision of the required resources for planning and delivery of the BHCPF • Facilitate implementation of financial audits by external auditors. • In exceptional circumstances, at the discretion of the Honourable Minister of Health or Chair of the MOC, the MOC may direct the engagement of an independent entity to review implementation on a case-by-case basis • Prepare progress reports for the National Council on Health (NCH), the National Economic Council (NEC), the National Assembly (NASS), and other stakeholders as may be required from time to time

	• Resolve any disputes, discrepancies or issues arising from implementation of the BHCPF
NHIS	• Provision of the BMPHS to all Nigerians/eligible target groups of Nigerians, through accredited public and private PHC and SHC facilities • Definition, publication and review of BMPHS Tariff Structure • Provision of technical support to the SSHIAs • Timely payments to the SSHIAs • Tracking of all disbursed funds to ensure that they are expended appropriately for the provision of health care services to beneficiaries • SSHIA will conduct the accreditation of PHCF in conjunction with NHIS state offices • Validation of enrolment data • Capacity building for SSHIA and other stakeholders • Development of quality assurance tools and validation of SSHIA quality assurance exercises • Development of appropriate ICT infrastructure for efficient implementation of the BHCPF • Monitoring and evaluation of NHIS Gateway funds and activities • Submission of quarterly reports to the MOC on the NHIS Gateway activities • Other functions as delegated by the Minister of Health
NPHCDA	• Implementation of the BHCPF supply side readiness • Collaboration with NHIS for seamless operation of the gateway
NEMTC	• Provide medical emergency treatment with 5% of the BHCPF
NCDC	• Strengthening Public Health Security with 1.25%
SOC	• The Honourable Commissioner for Health, supported by the State Oversight Committee (SOC), shall conduct advocacy, and ensure budgetary appropriation and release of state and local government 25% counterpart funding and any additional funding from other sources pursuant to the NHAct 2014 • Ensure that all onboarding criteria, as required by the gateways, are met and in a timely manner • Ensure that implementation and use of funds within the state comply with this guideline, in a transparent and accountable manner • Receive and review annual workplans and budgets from implementing gateways • Receive quarterly briefing from all gateways, at the state level, on programme performance, fund utilisation, programme implementation and coverage

	• Provide feedback to gateways for strengthening implementation • Coordinate operations of different stakeholders and resolve disputes or issues arising from implementation of the BHCPF • Ensure compliance, conduct periodic performance management, monitoring and supervision of activities within the state
SMOH	• As a prerequisite to benefit from the Fund, the Honourable Commissioner for Health shall ensure the establishment of a functional health insurance scheme administered by a State Social Health Insurance Agency backed by law • Each State Commissioner for Health shall ensure the creation of an Equity fund within the SSHIAs and show evidence of budgetary release before participating. For sustenance of the fund and expansion of the coverage depth, every state shall make a counterpart of 25% of the total requirements for coverage of the defined population based on enrolled figure for that state, in line with the NHAct 2014. This counterpart funding may be sourced from the Equity fund of the state
SSHIAs	In the States, the NHIS gateway will be implemented through SSHIA set up in line with guidelines and support from the NHIS. The functions assigned to the SSHIAs include: • Contracting of Healthcare Providers for programme implementation • Provider Management • Liaison with NHIS State Offices • Enrolment • Monitoring and evaluation • Conduct of the accreditation of PHCF in conjunction with NHIS state offices • Payment to Health Care Providers • Mobilization/Sensitization of Health Care Providers, Enrolees and the General Public • Quality Assurance • Claims Management for secondary care • Routinely furnish the NHIS with designated financial and programmatic data/reports • Other functions designated by NHIS

PHCF	• PHCF shall be the first point of contact for patients, providing the BMPHS and serving as gatekeepers for the initiative • Only designated public PHC facilities, which meet the accreditation criteria shall be enlisted into the NHIS gateway • The designated public PHCs shall have functional bank accounts and signatories shall include the Officer In Charge (OIC) and the Chairman of the Ward Development Committee (WDC) • Private facilities may be contracted by the SSHIA to complement the activities of the public PHCs • Utilize funds received through the NHIS Gateway for the provision of quality PHC services at the facility and community levels • Ensure adequate display of relevant signage to create public awareness of the facility's participation in the BHCPF and the BMPHS available to the community • Ensure prompt referral of all beneficiaries in need of secondary care
SHCPs	• The States shall designate identified Secondary Health Care Providers (SHCPs) to serve as referral Centres for the PHC facilities, which shall provide specialized care to referred beneficiaries • Ensure 2-way referral of beneficiaries from the secondary level back to the primary level after treatment • Public and private SHCPs shall provide specialist services to patients on referral from the participating public and private PHCs • SHCPs , which meet the accreditation criteria set out by the NHIS shall be paid retrospectively, following claims processing • Other functions of the SHC Providers (SHCPs) under the BHCPF are as stated in the NHIS Gateway section of this implementation protocol

Health Care Provider Rights and Responsibilities

I. To be eligible and receive payment in this initiative, each healthcare provider shall be empaneled by the NHIS/SSHIA.

ii. To ensure a consistent level of quality, each facility shall meet the minimum criteria as established by the NHIS.

iii. Selection and continued participation in the initiative is contingent on the healthcare provider maintaining adequate quality standards of care.

Rights and Privileges of Beneficiaries

The target beneficiaries have a right to:

I. Be treated with respect, dignity, and privacy.

ii. Receive information about the BMPHS, its benefits, policies, and participating providers.

iii. Access care, at no additional cost, for covered services from participating public or private providers after proper identification at the care facility without any discrimination or prejudice.

iv. Receive complete course of treatment and generic medications for covered services.

v. Change primary health care provider/receive services from any designated PHC in the event of relocation.

vi. Voice complaints and grievances about the health plan or care provided, and receive timely response.

vii. Participate in decision-making regarding their health care through the Village and Ward Development Committees.

viii. Confidential treatment of their medical information.

ix. Access their medical records in accordance with the NHAct 2014.

CHAPTER FOUR

4.0 OPERATIONS

Financial Management

Criteria for Disbursement to State Agencies (SSHIAs)

The BHCPFs funds will be shared to states using national poverty index and equity considerations. The agencies are expected to fulfil the following conditions to benefit:

I. Setting up of SSHIA in line with approved NHIS criteria
ii. Must be functional with relevant departments and personnel as stipulated by NHIS
iii. Release of Equity Fund to the SSHIA.
iv. Release of 25% of total cost of population coverage
v. Must have commenced some form of health insurance coverage
vi. Must have a basic ICT infrastructure as stipulated in the protocol
vii. Open designated Treasury Single Account (TSA) with CBN through OAGF
viii. Signing of a participative contractual agreement with accredited healthcare providers to provide the BMPHS
ix. Disbursement to the SSHIAs shall be based on the submission of an annual work plan

Funds Flow from NHIS to SSHIA

Following the advice of the MOC, the BHCPF NHIS Gateway funds will be transferred to states within 7 working days of the receipt of funds from CRF.

The following are basic requirements from SSHIA:

I. Submission of the quarterly financial reports;
ii. Submission of the quarterly enrolment records.
iii. Compliance with quarterly service delivery data reporting requirements; and
iv. Resolution of all outstanding reconciliation/audit or ad-hoc financial review findings biannually.

Use of Disbursed Funds in the NHIS Gateway

The fund shall be utilised primarily for the purpose of:

i. The provision of the Basic Minimum Package of Health Services (BMPHS) as contained in the benefit package.
ii. Cost of administration of SSHIAs and NHIS

Financial Records

I. All recipients of BHCPF shall maintain proper books of accounts that show the amount of funds received and how the funds were utilised using cash basis of accounting.
ii. NHIS will conduct a quarterly reconciliation exercise of all funds disbursed to SSHIAs.

The NHIS Financial Reporting:

i. Fund received by NHIS are operational cost and service cost from the CBN
ii. The funds expended are contributions of expected enrolled population disbursed to the states.
iii. NHIS shall prepare statement of account based on funds received and expended to the Ministerial Oversight Committee on a quarterly basis.

The SSHIAS Financial Reporting:

I. The SSHIAs should maintain proper books of account as stipulated by NHIS.
ii. All reports should include date prepared; the period of report covered, the descriptive label and title that will be understandable to any user.
iii. SSHIAs should develop and submit financial reports on yearly basis.
iv. The audited accounts are to be submitted to NHIS

PHCPs and SHCPs

I. Public HCPs shall maintain a database register and records of funds received as well as usage
ii. The SSHIA payment to PHCPs & SHCPs must never be used for any other purpose other than to provide quality care for enrollees.

Signatories to BHCPF Accounts

Table 2: Signatories to the various BHCPF accounts

Entity	Approvals	Authorized Signatories
NHIS	ES, NHIS	NHIS signatory authority (initiator, reviewer and final approver)
SSHIA	ES, SSHIA	SSHIA signatory authority (initiator, reviewer and final approver)
Public SHCs	HHMB	MO in charge/Authorized Signatories
Public PHCs	PHC Coordinator	OIC and Ward Development Committee Chairman / Authorized Signatories
Private PHCs		Not applicable

QUALITY MANAGEMENT SYSTEM (QMS) for BHCPF

The NHIS will design a Quality Management System (QMS) to monitor, assess and improve the quality of service delivery under the gateway with SSHIAs. The QMS will include, accreditation as external assessment, quality assurance, and internally focused quality improvement (HCF/SSHIA self-assessment) to ensure patient safety under the BHCPF.

The quality management system for the NHIS gateway of the BHCPF will be implemented at 3 levels; National (the NHIS), State (the SSHIAs) and the provider level (PHCP/SHCP).

The stakeholders include the following;

1. National Health Insurance Scheme
2. State Social Health Insurance Agencies
3. Ward Development Committees
4. Participating Health Care Providers (Primary and Secondary)
5. BHCPF Beneficiaries

The Roles and Responsibilities of Stakeholders

The NHIS

a. Shall be responsible for the establishment of the regulations governing quality management systems especially accreditation, quality assurance and quality improvement.

b. Support SSHIAs for the conduct of accreditation exercises and all processes leading to accreditation of HCPs.

c. The NHIS may collaborate with NPHCDA to ensure full implementation of quality management systems.

d. The NHIS will provide technical support to the SSHIAs and the HCPs (PHCPs and SHCPs) to develop QIP including collation and analysis of data and interpreting the results.

e. The NHIS shall receive reports of quality assurance exercises carried out by the SSHIA every quarter.

f. The NHIS shall perform validation exercises to reinforce the quality reporting from the SSHIA. These exercises are to be carried out at least twice a year for each State.

g. These validation exercises shall also be used to ascertain the status of HCPs reported for delisting by the SSHIA.

h. The NHIS shall analyze performance indicators and quality monitoring systems. This differs from the validation exercise and may form the basis for the delisting; and contribute to the total score for reaccreditation of HCPs.

I. The NHIS shall carry out periodic audit of SSHIA QMS at least once a year.

j. Utilization data and data generated from quality monitoring will be analyzed at regular intervals. Feedback to SSHIAs and HCPs for performance management and quality improvement will be sent at regular intervals.

k. Data generated from the analysis of quality management systems will be published at regular intervals as determined by the Scheme.

The SSHIA

The roles of SSHIAs in the QMS under the NHIS BHCPF Gateway shall be as follows:

a. Conduct of facility accreditation in collaboration with NHIS

b. Establishment of State level Quality Assurance Systems with detailed approach to HCF monitoring, data collection and analysis.

c. Monitoring of quality of health services at PHCPs and SHCPs using tools developed by the NHIS.

d. Carrying out quality assurance activities in HCPs at least once a year. This implies that QA will be conducted every quarter in 25% of participating facilities in the state.

e. Assisting all PHCPs and SHCPs to develop and implement internally focused quality improvement systems.

f. Conduct of bi-annual review of Quality Improvement Plans of PHCPs and SHCPs

g. Identification of facilities with poor quality indicators/outcomes from the QIP for possible intervention.

h. Liaising with the State Commissioner for Health, SMOH and SPHCB/A for intervention and immediate redress, with clear recommendations and opportunity for improvement.

I. Submission of bi-annual QA reports to NHIS.

j. Duly notify the relevant stakeholders in the State of all updates.

The Ward Development Committee (WDC):

The Roles and Responsibilities of the WDC shall include

a. Collaboration with the PHCP leadership in identification of health and social needs of the ward.

b. Developing a plan for the improvement of health services rendered at the PHCPs.

c. Nomination of one member of the WDC to serve on the PHC Quality Improvement Committee.

The Participating Healthcare Provider:

The role of PHCP/SHCP participating in the BHCPF shall include:

a. Institution of a provider-based Quality Improvement Committee (PHCP/SHCP QIC)

b. Provider QIC shall comprise of the officer-in-charge (as chairperson), one nurse/midwife/CHEW, one member of the WDC, one Pharmacy personnel, one laboratory personnel, one non-medical worker from the provider and one beneficiary from the community. If these categories of health personnel are absent, the PHCP can appoint a key quality officer for the committee.

c. Design and implementation of an annual QIP.

d. Use indicators developed by NHIS and NPHCDA for self-assessment and monitoring of internal processes, outputs and resulting health outcomes.

e. Establish mechanisms to receive feedback from BHCPF beneficiaries (e.g. suggestion boxes, user satisfaction surveys).

f. Comply with BHCPF Guidelines and other guidelines provided by NHIS.

g. Provide returns on utilization of services and other data under the NHIS gateway to NHIS through SSHIAs.

h. Designate the OIC or any other officer to act as desk officer for grievance redressal under supervision of SSHIA.

The Beneficiaries:

The role of beneficiaries of the BHCPF shall include:

a. Being aware of their rights
b. Provision of feedback to the provider and SSHIA.
c. Partaking in user satisfaction surveys.
d. Seeking redress where necessary.

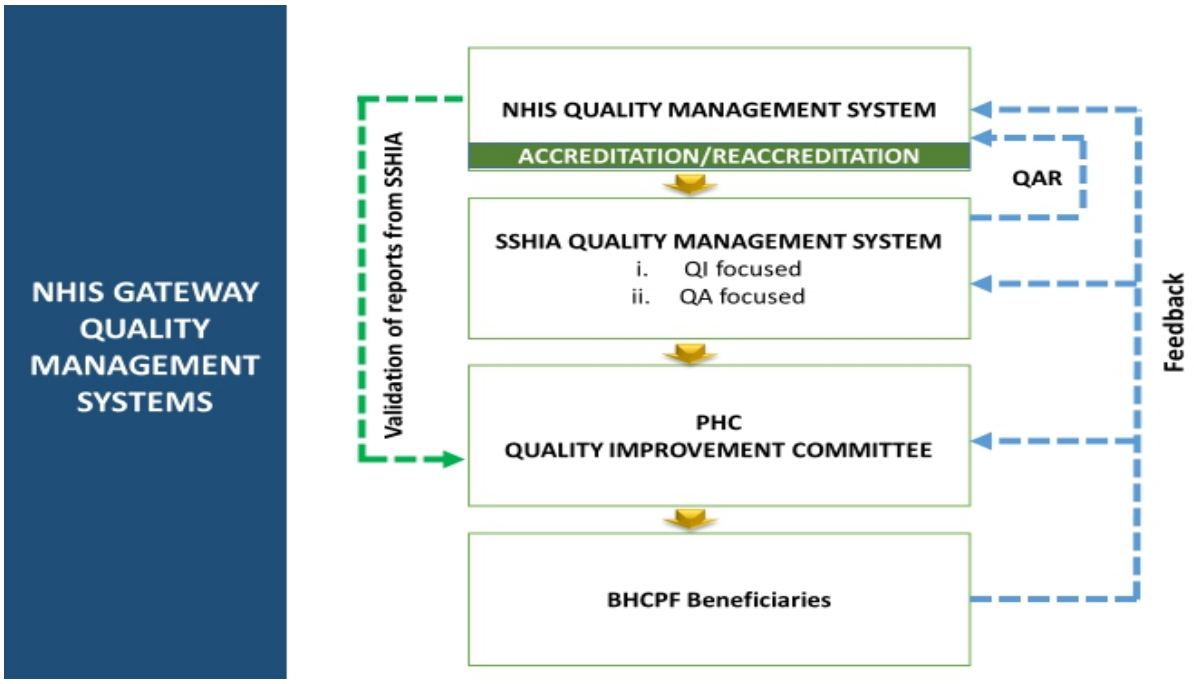


Figure 4: NHIS Gateway quality management systems

ACCREDITATION

Definition of Accreditation

Accreditation is the process of assessing healthcare providers using commonly accepted standards. Accreditation is usually performed for the following purposes:

a. To ensure accessibility and availability of healthcare services to enrollees
b. To promote and improve the quality of healthcare delivery
c. To ensure continuous improvement of the quality of services provided
d. To improve public confidence in the healthcare delivery system.

Accreditation is done to provide standards of excellence that would encourage health institutions to improve their quality of service. Consequently, the NHIS accreditation process is one of the considerations used to determine which health institutions would be eligible to participate in NHIS (related) programmes.

Accreditation of Healthcare Providers

Accreditation for the NHIS Gateway is to be conducted jointly by NHIS State Office and SSHIA. At the primary health care level, providers would be expected to have fulfilled the minimum standards for PHC in Nigeria as published by the NPHCDA in line with sections 12 and 13 of the

NHAct 2014. They would also have to satisfy NHIS accreditation criteria. Public PHC facilities, that require to be accredited would be identified by the SPHCB/A, following baseline assessment processes conducted by the NPHCDA/SPHCB/A. They shall be approved by the state commissioner for health before forwarding to the SSHIA and NHIS for accreditation.

Requirements for public and private PHCPs

All NPHCDA gateway designated public PHCPs, other PHCPs and any rural provider (public or private) will be eligible for accreditation as Primary Care Providers.

Inspection of NPHCDA gateway designated public PHCPs for accreditation purpose, will be based on the list of PHCPs received by NHIS State Office. All other prospective participants will be required to apply to the NHIS State Office through the SSHIAs for accreditation.

All application letters received will be screened to determine suitability for possible physical inspection of provider

a. All public PHCPs expected to benefit from this programme will be expected to meet requirements for accreditation under the BHCPF as set by the NHIS to enable them to qualify for the NHIS gateway.

b. All private PHCPs will be expected to meet requirements for accreditation for PHCPs as set by the NHIS.

c. In addition, all PHCPs whether public or private must meet applicable state registration/licensing requirements. Such registration would be a prerequisite to accreditation for participation in the BHCPF.

d. Health Care Providers who do not meet the accreditation requirements shall be informed formally by documented communication. Such providers will be given 3 months to make amends, following which a re-assessment will be done to determine their qualification.

e. All public PHCPs which meet with requirements for accreditation under the BHCPF will be issued provisional accreditation and will be required to progress to full accreditation status within one year.

f. To progress to full accreditation status, all public PHCPs with provisional accreditation will be required to comply with NHIS accreditation requirements for PHCPs as provided in the NHIS Operational Guidelines.

g. The pass mark for any accreditation exercise shall be 60%. Human resource component for each stage of accreditation shall be deemed to be critical irreducible minimums, and non-scoreable.

h. Such assessment shall apply to all public and private SHCPs desirous of administering the BMPHS under the NHIS gateway.

Requirements for public and private SHCPs

All public or private SHCPs desirous of providing secondary level of care shall be required to apply to the NHIS State Office for accreditation and pay all applicable fees. All application letters received will be screened to determine suitability for possible physical inspection of the provider

a. The accreditation requirements shall consist of general and specialty specific personnel, infrastructure, equipment and process requirements for providing secondary care as contained in the BMPHS

b. An accreditation requirement for Secondary Care Providers is as contained in the NHIS Operational Guidelines.

c. Services for which interested SHCPs can apply for are: Surgery, Obstetrics & Gynaecology, Internal Medicine, ENT, Physiotherapy, Ophthalmology, Paediatrics, Radiology, Dentistry, Laboratory Services and Pharmacy.

d. Critical for successful accreditation of any of the services at SHCP is the presence of requisite human resource.

e. All accredited SHCPs will also be subjected to all other periodic regulatory oversight as obtainable under the formal sector social health insurance program (FSSHIP).

f. All other NHIS accredited providers under the FSSHIP need not undergo another accreditation but will be required to indicate its willingness to provide services under the BHCPF through the SSHIAs to NHIS.

Process of Accreditation

a. Inspection for accreditation by teams of Healthcare professionals to perform an in-depth evaluation to determine whether the facilities meet the established standards shall be conducted jointly by NHIS/SSHIA.

b. Public PHCPs shall be accredited provisionally for one year in the first instance if they meet the limited accreditation requirements set under the BHCPF; they will then be reassessed for full accreditation after one year. This is to ensure compliance with the NHIS accreditation requirements for PHCPs as set under the NHIS Operational Guidelines. Full accreditation shall be for two years.

c. All non-compliant public PHCPs will be given a 3 months grace period to remedy all deficiencies. Failure to do so will result in the withdrawal of such providers from the accreditation process.

d. All private PHCPs and SHCPs shall also be accredited for two years.

e. All accredited providers shall be issued a unique identifier by the NHIS.

f. At the expiration of two years of full accreditation, all accredited PHCPs and SHCPs shall be assessed for reaccreditation.

g. NHIS shall maintain a list of accredited providers in any of its official organs of communication or databases.

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

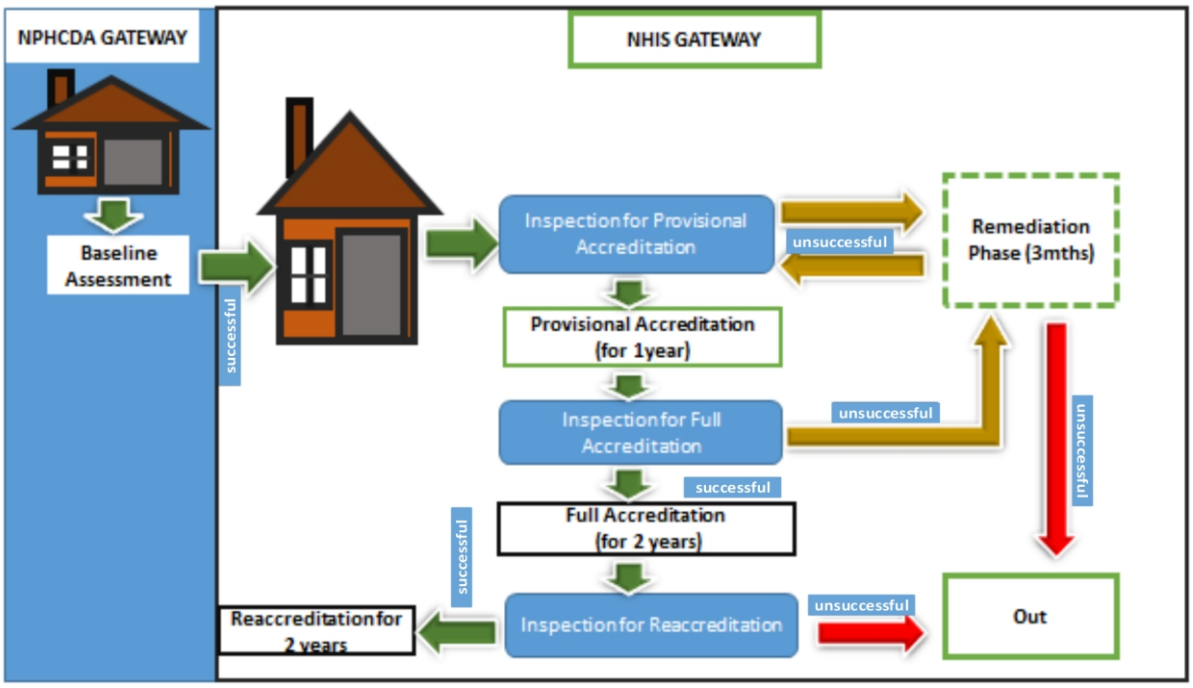


Figure 5: Process of Accreditation for public PHCP

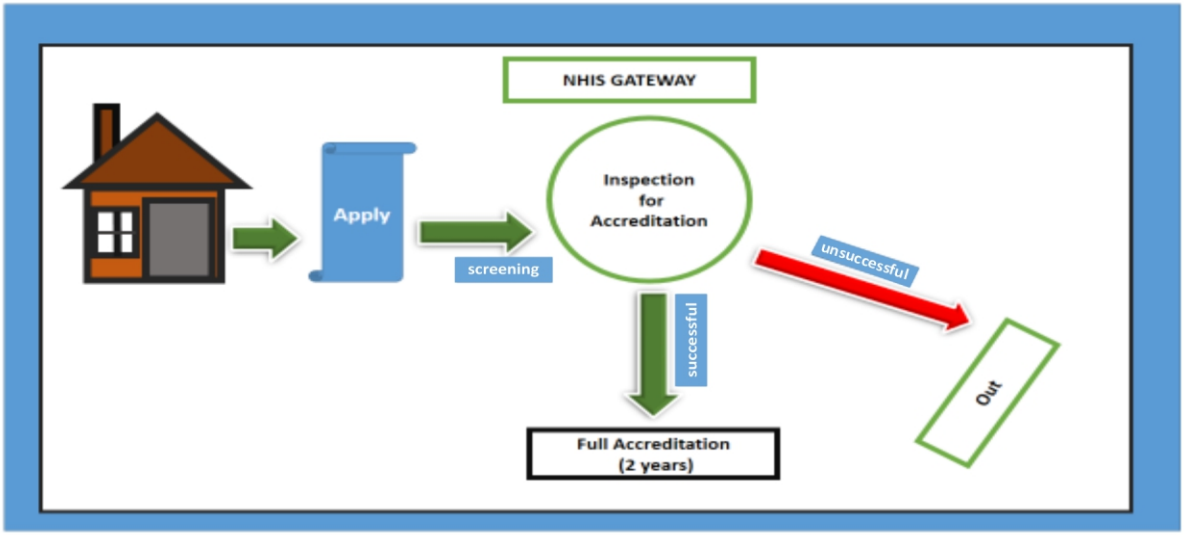


Figure 6: Process of Accreditation for private PHCPs and SHCPs

Remediation Process

Public PHCPs which do not meet requirements for accreditation shall be informed formally. Such PHCPs will be given three (3) months to make amend and then reassessed to determine their qualification for provisional accreditation. The grant of the three (3) months period for remediation will be on a case-by-case basis as determined by the NHIS State Office/SSHIA.

Conditions for Renewal of Accreditation

Accreditation of every Health Care Provider shall be renewable every two (2) years. Notification for renewal shall be provided by the NHIS State Office/SSHIA. Some of the criteria for renewal shall include:

1. Current provider licensure by the respective State Ministry of Health or other prescribed State entity, as applicable.
2. Continued compliance with conditions for initial accreditation or as updated by the NHIS.
3. All necessary returns due to the Local Government M&E unit, SSHIA and NHIS made.
4. Possession of valid current licenses by health personnel.
5. Evidence of internal quality management system and incremental quality improvement.
6. Compliance with the BHCPF Guidelines.
7. Availability of necessary ICT infrastructure as prescribed by NHIS.
8. Other criteria as may be announced by NHIS.

Withdrawal of Accreditation

All healthcare facilities which fail to comply with the requirements for reaccreditation will be delisted from the NHIS gateway. Such providers will be informed via formal communication and publication on the NHIS/SSHIA website.

Beneficiaries in such affected PHCPs will be assigned to the nearest Primary Health Care Provider in the interim. They can subsequently be assigned to providers of their choice.

Delisted SHCPs will no longer be able to provide services to NHIS beneficiaries under any of its programs. They can however upgrade and reapply to NHIS for accreditation.

Provider (voluntary) Exit from the NHIS Gateway

The requirements for provider's voluntarily exiting will be in a manner as prescribed by the NHIS Operational Guidelines.

Provider Relocation

The requirements for providers relocating to another site will be in a manner as prescribed by the NHIS Operational Guidelines.

Change of Name/ownership

The requirements for change of name or ownership will be in a manner as prescribed by the NHIS Operational Guidelines.

Quality Assurance for BHCPF

Quality Assurance involves setting quality standards, assessing performance of professionals or institutions with respect to the standards, and informs corrective action to be taken when the divergence of the set standards exceeds acceptable limits.

After the initial provisional accreditation, every participating PHCP/SHCP will be required to establish Quality Improvement Plan(s) (QIP) coordinated by a Quality Improvement Committee (QIC). SSHIAs will also be required to establish Quality Monitoring Systems to effectively ascertain quality of care and service provision and develop QIP.

These measures are to be implemented to ensure that the PHCPs/SHCPs continue to meet the NHIS standards for reaccreditation.

The BHCPF Quality Assurance Assessment Tool

The NHIS shall be responsible for the design and pilot of the QA assessment tool. The Scheme shall thereafter train staff of SSHIAs on the application of this tool and reporting processes. The QA assessment tool to be used at the provider level shall focus on the 6 domains of quality as follows:

1. Patient's safety.
2. Effectiveness of services provided in the BMPHS under the BHCPF.
3. Responsiveness of HCP to the needs of BHCPF beneficiaries.
4. Timely provision of care by the HCP and remittance of funds by the SSHIA.
5. Efficient use of resources in the provision of health services.
6. Equitable access to health services.

Quality Improvement Plan (QIP)

The NHIS Gateway shall also direct the implementation of Internally Focused Quality Improvement Plans for all stakeholders under the BHCPF.

QIP at the PHC level will be incorporated as:

I. A prerequisite for renewal of accreditation.
ii. A tool for assessing healthcare outcomes at PHC level.
iii. Ensuring provision of quality healthcare services to BHCPF beneficiaries.
iv. An important tool for ensuring patients' satisfaction.

QIP at the SSHIA level will be used as:

I. An assessment of the local health system responsiveness.
ii. A tool to assess effectiveness of health care purchasing and payment mechanisms.
iii. An important tool for ensuring patients' satisfaction.

Implementation of QIP under the NHIS Gateway

This shall include**:**

1. Establishment of HCP Quality Improvement Committee (PHCP/SHCP) -
   All participating HCPs will be required to establish quality improvement committees.
2. Appointment of Quality Officer - SSHIA -
   The supervising SSHIA shall be required to designate a quality officer. This officer will be responsible for the collation of data from participating HCPs, supervision of the implementation of the QIP at the provider and submission of quarterly reports on HCP QIP and Intervention outcomes to NHIS.
3. Framework for Quality Improvement Plan - The plan shall consist of the following steps:

1. Identification of the problem
a. Clearly define the aim for improvement.
b. Determine the process/ system that yields this goal for improvement.
c. Decide who should be on the team that will solve the problem.
d. Achieve a consensus on the problem by the team.

2. Analysis of the problem

a. Understand the process(es)/system that yields this goal for improvement
b. Determine the indicators which enable the implementers to know that the improvement is needed.
c. Analyze the available data and information
d. Collect additional data (as needed)

3. Development of possible changes or interventions

a. Determine possible changes (interventions) which may yield improvement.
b. Organize changes according to importance and practicality
c. Test changes (if possible, one change at a time)

4. Application of the Plan-Do-Study-Act (PDSA) cycle

a. Plan: objectives of the cycle, make predications and develop plan to carry out cycle (who, what, where and when).
b. Do: carry out, test, document problems and unexpected outcomes and begin analysis of data.
c. Study: complete the analysis of the data, compare data to predictions and summarize what was learnt.
d. Act: what changes are to be made? What will be the next cycle?

5. Testing and Implementing changes, including collection and analysis of data to answer the questions

a. Plot a time-series chart
b. Develop flow charts describing the intervention processes
c. Monitor results and

Enrolment

The BHCPF fund shall be used to provide the Basic Minimum Package for Health Services(BMPHS) for all Nigerians. The unit of coverage shall be based on individuals.

Criteria for Enrolment

- The potential beneficiaries must be captured in any database adopted by NHIS, such as

(i) National Social Register
(ii) National Bureau of Statistics
(iii) State sponsored means of targeting

- Validation will be done at the point of data entry/enrolment

- Enrolment will be done by SSHIAs at the community, facility, and state levels using any suitable enrolment device while validation will be done by NHIS.
- Beneficiaries must be registered with NIMC and present their National Identification Number (NIN) to be eligible for enrolment
- Validated beneficiaries shall be empanelled after fulfilling all enrolment requirements.

Process of Enrolment

1. Potential beneficiary reports at SSHIA designated venue /Agent with necessary credentials e.g. community
2. Enrolment officer checks credentials against NIN
3. Beneficiary details are captured and thus, enrolled
4. An identification slip is issued to the enrollee
5. The SSHIAs should generate monthly register while NHIS pays quarterly/ as the funds are received
6. ID card shall be provided to all enrollees
7. SSHIA and HCF retain electronic copy of enrolment register
8. Electronic copies of the register shall be synchronized to NHIS database

Required Fields for Enrolment

1. National Identification Number (NIN) – Unique Identifier
2. Name (First name, middle name, surname)
3. Date of Birth: (DD-MM-YYYY)
4. Location (State, LGA, Ward)
5. Phone number
6. E-mail (optional)
7. Marital Status (Married, Widow, Single, Widower, Single Parent, Divorced)
8. Gender (M/F)
9. Special needs? (Physically Challenged, Pregnant Woman, CU5, Aged , NA)
10. Facility Code
11. Facility Name

Roles and Responsibilities of Key Stakeholders NHIS

1. Provision of Guidelines on criteria for beneficiary eligibility
2. Validation of enrollee records
3. Provision of technical support during enrolment
4. Ensuring compliance with NIMC enrolment standards
5. Provision of guideline on basic minimum ICT infrastructure requirements for SSHIAs and HCFs and ensure interoperability with NHIS/NIMC
6. Provision of guidelines on enrollee fields to be captured for enrolment
7. Sharing of enrolment information with relevant stakeholders
8. Provision of central enrolment platform including software solution for effective management and aggregation of enrollee register and support for registration of enrollees into BHCPF for SSHIAs

SSHIAs

1. Sensitization and Mobilization of HCFs, WDCs and enrollees for enrolment
2. Enrolment of beneficiaries
3. Provision of enrollee register on a monthly basis to HCP
4. Provision of at least monthly update on enrollee records to NHIS
5. Provision of basic minimum ICT infrastructure for enrolment
6. Procurement and installation of enrolment software solution for registration of enrollees into SSHIA
7. End-to-end automation of SSHIA's Enrolment Processes.
8. Training of SSHIA enrolment officers

HCPs

1. Provide the platform for Enrolment and verification
2. Keep enrollees' register for verification during access to healthcare as received from SSHIA
3. Regular update of enrollee records in case of death, exit from community, etc.

Ward Development Committee

1. Sensitization and Mobilization of potential enrollees
2. Support the SSHIA in validating enrollee information
3. Help in providing enrollee information on deaths, relocation, etc.

Beneficiaries

1. Ensure NIMC enrolment
2. Enroll into the programme

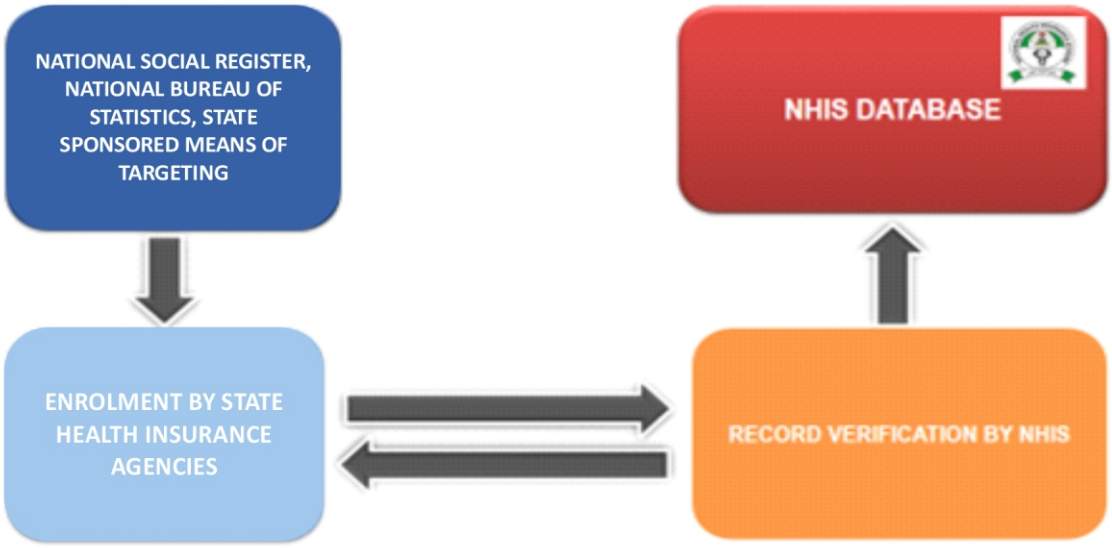


Figure 7: Enrolment flow

Benefit Package

The Basic Minimum Package of Health Services (BMPHS) as defined by NHIS and approved by the Honourable Minister of Health will be implemented. This consists of a package consisting of preventive, promotive, curative and rehabilitative services for all Nigerians (see Table 3). Provision of the BMPHS shall be by Primary Health Care (PHC, secondary facilities registered by the SMOH and accredited by NHIS and SSHIA as in the NHIS operational Guidelines. Both public and private primary healthcare facilities shall be used as service delivery points. Secondary health care services will be provided by both public and private health care services following referral from the PHCs.

Table 3: Basic Minimum Package of Health Services (BMPHS)

S/No	Minimum Package
	Primary Level Care
1	General consultation with prescribed drugs from accredited PHC facilities
2	**Health education for prevention of diseases**
	Family planning education (use of Safe period, pills, condoms, etc.) ii. Dental health iii. HIV/AIDS/Tuberculosis/Malaria iv. Immunization v. Vitamin A supplementation vi. Promotion of essential nutrients for children and pregnant women vii. Promotion of personal, domestic and environmental hygiene, etc.
3	**Primary Care Surgery**
	Minor Surgical Procedures: incision & drainage, suturing of lacerations, minor burns, simple abrasions, ii. Minor wound debridement iii. Circumcision of male infants iv. Evacuation of impacted faeces v. Relief of urinary retention vi. Primary eye care including treatment of: – Conjunctivitis – Parasitic and allergic ailments Simple contusion, abrasions etc.

4	**Primary Care Paediatrics**
	Child Welfare Services - Growth monitoring, routine immunization as defined by the NPHCDA, Vitamin A supplementation, Nutritional advice and health education, etc. ii. Management of uncomplicated malnutrition iii. Treatment for Helminthiasis iv. Treatment of common childhood illnesses such as malaria, diarrheal disease, schistosomiasis, upper respiratory tract infections and uncomplicated pneumonia, v. Urinary Tract Infections (uncomplicated), vi. Simple otitis media, pharyngitis, vii. Childhood exanthemas, simple skin diseases/infestations and other viral illnesses such as mumps viii. Treatment of anemia not requiring blood transfusion.
5	**Primary Care Internal Medicine (Adult)**
	Management of simple infections/infestations – Malaria – Respiratory tract infections – Urinary tract infections – Gastroenteritis – Primary ear, nose, and throat infections – Diarrheal diseases – Enteritis/ typhoid fever – Schistosomiasis – Helminthiasis – Skin infections/infestations such as chicken pox and fungal diseases e.g. tinea versicolor, Malassezia furfur, Tinea Capitis etc. – Emergency management of bites and stings e.g. snakes, scorpions, bees, spiders etc. (Minus serum) Management of simple anemia (not requiring blood transfusion)

	iii. Screening & referral for diabetes mellitus, hypertension and other chronic diseases iv. Treatment of simple arthritis and other minor musculoskeletal diseases v. Routine management of sickle cell disease vi. Allergies
6	**HIV/AIDS/Sexual Transmitted Diseases**
	Voluntary Counseling and Testing (VCT)
7	**Primary Care Mental Health Management**
	Anxiety neurosis ii. Psychosomatic illnesses iii. Insomnia iv. Identification of drug abuse
8	**Primary Care Maternal, Neonatal and Child Health (MNCH) Services**
	Provision of basic Family Planning Commodities ii. Antenatal care - Routine antenatal clinic - Routine drugs to cover duration of pregnancy - Routine urine and blood tests - Referral services for complicated cases iii.Postnatal services - All eligible livebirths up to 6 weeks from date of birth. (Cord care, Eye care, Management of simple neonatal infections) iv. Delivery services - Spontaneous Vaginal Delivery by skilled attendant including repair of birth injuries and episiotomy - Essential drugs for Emergency Obstetric care (EmOC)

9	**Primary Care Emergency Services**
	I. Airway assessment and use of airway adjuncts ii. Use of basic means of airway aspiration and clearance iii. Breathing assessment and use of simple equipment to aid and monitor breathing like ambu-bags iv. Pulse oximetry v. Control of bleeding using compression dressing vi. Assessment of hemodynamic stability vii. Establishment of intravenous line and venous cut down viii. Fluid resuscitation ix. Basic cardiopulmonary resuscitation x. Assessment and basic management of the unconscious patient xi. Suturing of small lacerations where no resuscitation is required xii. Immobilization of fractures and cervical spine using pre - provided splints
10	**Basic laboratory investigations**
	Malaria Parasite ii. Urinalysis iii. HB/PCV iv. Stool microscopy v. Urine microscopy vi. Pregnancy Test vii. Blood Glucose Test

	Secondary Level Care
1	Consultation with prescribed drugs from accredited Secondary Health Care facility.
2	Emergencies occurring outside the usual residence or accredited HCP
3	Admission for maximum of 15 days cumulative per year for medical admission and 20 days cumulative per year for surgical admissions.
4	Treatment and procedures that cannot be handled at primary level but covered with the BMPHS.
5	**HIV/AIDS** Treatment of pportunistic infections as defined in the HIV Treatment Protocol.
6	**Paediatrics**
	i.Treatment of Severe infections/infestations - Respiratory tract infections, Urinary Tract Infections, diarrhoea disease with moderate to severe dehydration, enteric fever, severe malaria, septicemia, meningitis, severe measles ii. Management of childhood noncommunicable diseases iii. Management of severe anaemia requiring blood transfusion iv. Management of neonatal infectiɵns Neonatal sepsis v. Neonatal conditions such as birth asphyxia, neonatal jaundice, management of child from diabetic mothers
7	**Internal medicine (Adult)**
	i. Treatment of moderate to severe infections and infestations – Management of severe malaria – Management of meningitis, septicemia – Management of complicated Respiratory Tract Infections – Management of complicated typhoid fever ii. Management of non communicable diseases – Management of diabetes and hypertension

	– Management of sickle cell disease – Treatment of severe musculoskeletal conditions – Treatment of cardiovascular conditions, renal diseases (such nephritis, nephrotic syndrome), Liver diseases (hepatitis, amoebic liver abscess). – Management of severe anemia iii. Treatment of snake bites (inclusive of serum)
8	**Obstetrics and Gynaecology**
	Basic and Comprehensive Emergency Obstetric Care – Management of preterm/pre-labor Rupture of Membrane (P/PROM) – Detection and management of hypertensive diseases in pregnancy – Management of bleeding in pregnancy – Management of postpartum hemorrhage – Eclampsia – Caesarian section – Operative management for ectopic gestation – Management of intrauterine fetal death – Management of puerperal sepsis – Instrumental deliveries – High risk deliveries- 1st deliveries, Beyond 4th deliveries, multiple deliveries, malpositioning/malpresentation and other complications, ii. Gynecological Intervention – Hysterectomy for uncontrollable Postpartum Haemorrhage
9	**Surgery**
	i. Appendicectomy ii. Herniorrhaphy

	iii. Hydrocelectomy iv. Management of Testicular Torsion v. Management of Fractures
10	**Dental care**
	Simple and surgical tooth extraction for medical reasons without complications
11	**Ophthalmology**
	i. Eye problems, e.g. major trauma, pterygium, glaucoma, cataract extraction and other simple ophthalmological surgical procedures ii. Removal of foreign bodies iii. Refraction, including provision of spectacles not exceeding N5000
12	**Ear, Nose & Throat**
	i. Antral wash-out ii. Foreign body removal from Ear, Nose and Throat iii. Tonsillectomy iv. Nasal Polypectomy v. Tracheostomy vi. Adenoidectomy vii. Myringotomy
13	**Physiotherapy**
	i. Post-traumatic rehabilitation ii. Management of palsies within 15 days after initial treatment with a maximum of 5 sessions. iii. Post-cerebrovascular accident therapy within 15 days with a maximum of 5 sessions.

14	**Laboratory investigations**
	i. Genotype ii. Lumbar puncture iii. Urea/electrolyte/creatinine iv. Liver Function Test v. Ketone bodies vi. Microscopy/culture/sensitivity - urine, blood, stool, sputum, wound, urethral, ear, eye, throat, aspirate, cerebrovascular spinal fluid, endoscopy cervical swab, high vaginal swab. vii. Occult blood in stool viii. Skin snip for microfilaria ix. Acid fast bacillus for Tuberculous Bacillus (sputum, blood) x. Gram stain xi. Mantoux test xii. Blood groupings/Cross matching xiii. Hepatitis B surface antibody screening xiv. Confirmatory test for HIV xv. Full Blood Count xvi. Erythrocite Sedimentation Rate xvii. PCR, IGRA xviii. Platelets/ Reticulocyte count xiv. Platelets concentration xx. Blood transfusion services for up to 3 pints of safe whole blood or blood xxi. Radiology-X-ray of chest, abdomen, skull & extremities, dental X-rays, xxii. Abdominopelvic & obstetric scan

Provider Payment Mechanism (PPM)

Purchaser - National Health Insurance Scheme

Provider - Accredited Public and Private Primary Health Care Centers (PHCs) and other Secondary Providers

Payer - State Social Health Insurance/Contributory Agencies on behalf of NHIS

Capitation

1. The NHIS will pay premium for the expected population under the BHCPF to the SSHIAs/Contributory Agencies per person per annum.
2. An accredited PHC under the BHCPF program shall be paid capitation per enrollee per month by SSHIA for all enrollees using the facility.
3. SSHIAs/Contributory Agencies shall pay capitation in advance for enrolled population in the facility not later than 5 days to the commencement of the month paid for.
4. As stipulated in the BHCPF Guidelines, Administrative charge of 5% of the premium (N12, 000.00 per person per annum), which translates to N600.00 per person per month will be paid to SSHIAs/Contributory Agencies. This payment shall be effected for the enrolled population up to the state enrolment limit, quarterly and prorated.
5. The balance of the premium (N11, 400.00 per enrollee per annum) will be dedicated strictly for service delivery.
6. 57% of the premium (N6, 840.00) shall be the capitation payable per enrollee per annum by NHIS, and this amount to N570.00 per enrollee per month.
7. The capitation of N570.00 per enrollee per month will be paid to the PHC assigned/selected by enrollees through the designated Commercial Bank Account of the PHC, monthly in advance.

Note: the amount for capitation is derived from rating against 10 "must use" services capitated in the benefit package.

Fee-For-Service

1. SSHIAs shall designate not more than 11.25% of Premium paid by NHIS for Fee-for-service only. This amounts to N1, 350.00 per enrollee per annum/N112.50 per enrollee per month.
2. The BHCPF Claims form shall be the format of claims presentation
3. Fee-for-service will be paid by SSHIA to an accredited Secondary Provider upon submission of claims using the Claims Form from the facility.
4. Claims from an accredited Secondary Provider will be submitted monthly to SSHIA for processing, verifications and payment. .
5. All claims from a HCP shall reach the SSHIA/Contributory Agencies within 30 days of being incurred.
6. Submitted claims must be adjudicated, verified, and processed for payment to the Secondary Provider within 30 days of submission to SSHIAs.
7. All HCP incurred claims but not received by SSHIA after 90 days shall not be reimbursed.
8. All claims submitted by a Secondary Provider will be acknowledged by SSHIA/Contributory Agencies stamp with date and time.
9. NHIS will conduct periodic claims audit

ICT Fund

1. There shall be ICT fund, which is 9.75% of premium which amounts to N1,170.00 only, per person per annum/N97.50.per person per month.
2. The ICT fund is for integration and uniformity of data collection from SSHIAs.
3. ID card production, development and integration of BHCPF claims management software with SSHIAs and HCPs shall be funded from this pool.
4. This fund shall be pooled at the SSHIAs

Quality Assurance/Monitoring & Evaluation

1. This fund shall be reserved for the conduct of Quality Assurance (QA) and Monitoring & Evaluation (M&E) by the various SSHIAs
2. The QA/ME fund will be 5% of the premium. This amounts to N600.00 per person per year/N50.00 per person, per month.
3. QA will be conducted in at least 25% of facilities per Quarter
4. Monitoring will be conducted routinely and Evaluation at least once a year

Reserve Fund

1. There shall be a reserve fund which will be domiciled in SSHIA Reserve Pool Account.
2. The reserve fund shall serve strictly as a safety net to fund more coverage and excess fee-for-service utilization, which will vary among SSHIAs as a result of differing states' disease burden.
3. The reserve fund will be 12% of the premium. This amounts to N1, 440.00 per person per year/N120.00 per person, per month.
4. This fund shall be pooled in SSHIA. 80% of it will be used strictly for coverage of additional beneficiaries under the BHCPF programme at the end of each year, after utilization review and verification of SSHIA expenses on Fee-For-Service which will be done by NHIS.
5. In the event a SSHIA exhausts its Fee-For-Service funds, such states may use funds from the reserve pool for Fee-For-Service exceeded.

The governance structure shall be the following;

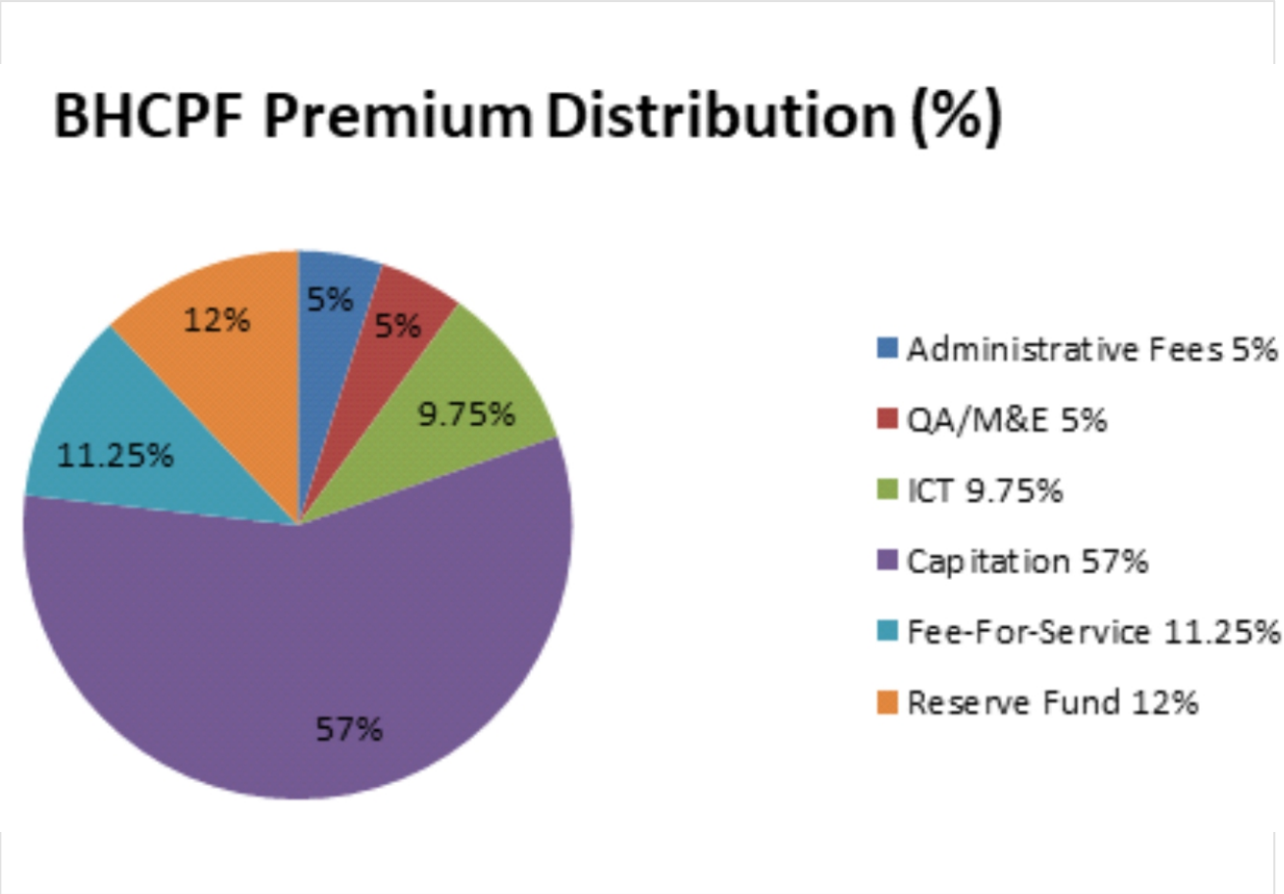
a) The State Oversight Committee (SOC) will make recommendation for the use of the reserved funds.

b) NHIS will give final approval for the use of the reserve funds.

Table 4: BHCPF Premium Distribution

BHCPF PREMIUM DISTRIBUTION					
Portion Of Premium (N12,000.00)	**Purpose**	**Percentage (%)**	**Amount Per Person Per Month**	**Amount Per Person Per Annum**	**Beneficiary**
Administrative Fees	Administration only	5%	N50.00	N600.00	SSHIAs
QA/M&E	To carry out Quality Assurance and Monitoring & Evaluation	5%	N50.00	N600.00	SSHIAs
ICT	Production of ID cards and integrated Software for claims etc.	9.75%	N97.50	N1, 170.00	SSHIAs
Capitation	Primary care Services	57%	N570.00	N6,840.00	PHCs (Through SSHIAs)
Fee-For-Service	Secondary Care Services	11.25%	N112.50	N1,350.00	SHCs (Through SSHIAs)
Reserve Fund	80% for more coverage of beneficiaries and excess FFS	12%	N120.00	N1,440.00	SSHIAs
TOTAL		**100%**	**N1,000.00**	**N12,000.00**	

Figure 8: BHCPF Premium Distribution (%)



CHAPTER FIVE

5.0 MONITORING AND EVALUATION

Monitoring and Evaluation

The performance of the NHIS gateway will be monitored in accordance with the gateway's theory of change and M&E framework.

Purpose and Objectives:

The overall purpose of the BHCPF Monitoring and Evaluation is to assess the implementation of the NHIS Gateway in detail and determine whether intended results are being achieved in addition to applying rigorous evaluations in assessing program efficiency, effectiveness and performance.

The specific objectives are to:

- Monitor BHCPF activities by measuring key input, output, and outcome indicators at both National and State levels;
- Promote learning, feedback and knowledge sharing based on the results achieved.
- Ensure transparency and accountability.
- Produce evidence for operational reviews and informed decision making.
- Outline the data management Plan for the BHCPF operations and establish the roles of each stakeholder.

Theory of change

The theory of change which highlights key operations towards achieving the NHIS Gateway's goal is shown in figure 9.

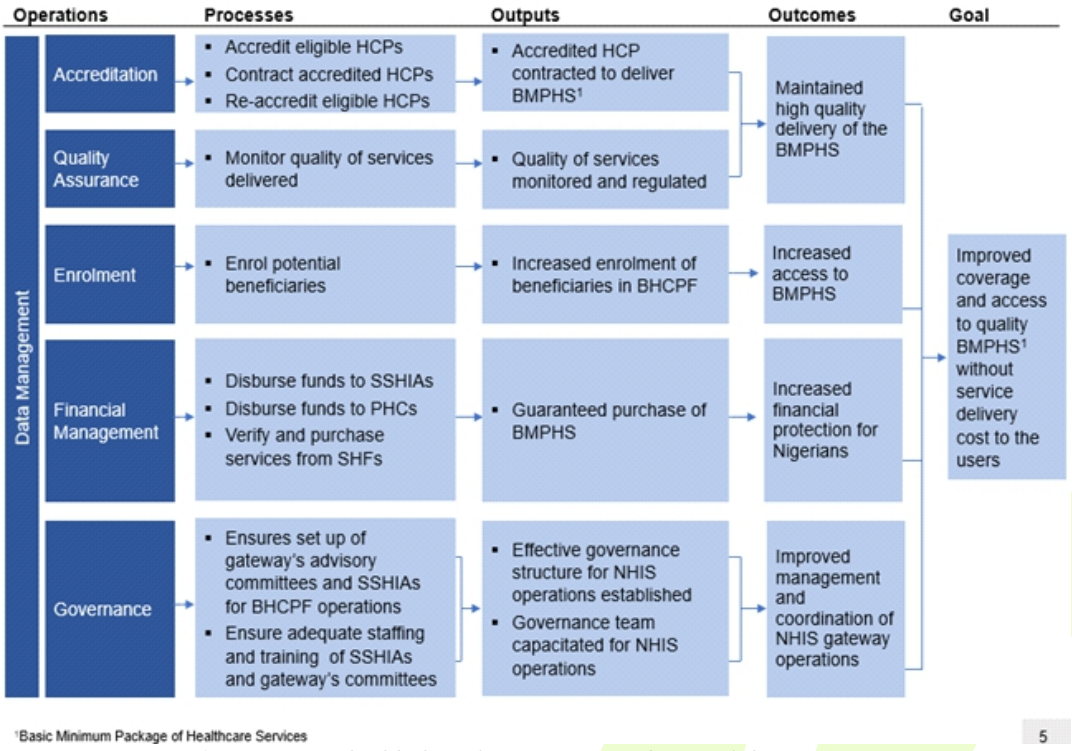


Figure 9: Key highlights of NHIS GatwayTheory of change

M&E Framework

The M&E framework will facilitate the institutionalization of M&E principles and practices to support decision making and adaptive learning, planning and management across the gateway. It will also serve as a vital tool for timely and systematic data collection, analysis and reporting thereby improving overall performance and accountability to all stakeholders and beneficiaries.

NHIS Gateway Indicators

The specific indicators to be tracked across the operations of the gateway are as presented in table 5.

Table 5: NHIS Gateway specific indicators

Operation	Indicators	Frequency of collection	Ownership
Accreditation	Proportion of PHCPs per state where accreditation has been conducted	Quarterly	NHIS
	Proportion of PHCPs per state that meet the requirements for full accreditation	Quarterly	NHIS
	Number of private PHCPs per state enlisted into the BHCPF	Quarterly	NHIS
	Number of SHCPs per state enlisted into the BHCPF	Quarterly	NHIS
	Proportion of PHCPs/SHCPs per state where re-accreditation has been conducted	Every 2 Years	NHIS
	Proportion of PHCPs/SHCPs per state that meet the requirements for re accreditation	Every 2 Years	NHIS
Enrolment	Proportion of states that have compiled the list of target beneficiaries	Quarterly	NHIS
	Proportion of states where enrolment processes have commenced	Quarterly	NHIS
	Proportion of target beneficiaries enrolled per state	Quarterly	NHIS/SSHIA
	Proportion of states that have enrolled at least 80% of their target beneficiaries	Annual	NHIS
	Proportion of SSHIAs that have shared enrolment data with NHIS	Quarterly	NHIS

	Proportion of total population covered under the BHCPF	Every 2 Years	NHIS
	Percentage of enrolees that accessed the BMPHS[1]	Quarterly	NHIS/SSHIA
Financial Management	Proportion of PHCPs that have opened current accounts for BHCPF	Quarterly	SSHIA
	Proportion of SSHIAs that received funds for BHCPF operations from NHIS	Quarterly	NHIS
	Proportion of allocated amount received by SSHIAs	Quarterly	NHIS
	Proportion of PHCs that received funds not later than 5 days to the commencement of the next month	Quarterly	SSHIA
	Proportion of SHCPs that submitted claims to SSHIA	Quarterly	SSHIA
	Proportion of SSHIA whose claims have been verified	Quarterly	NHIS
	Proportion of SHCPs whose vetted claims were reimbursed not later than 90 days from when the claims were submitted	Quarterly	SSHIA
	Proportion of claimed amount disbursed to SHCPs by SSHIA	Quarterly	SSHIA
	Proportion of Funds set aside as Re-insurance fund	Quarterly	SSHIA
	Proportion of Funds set aside as ICT fund	Quarterly	SSHIA
Quality Assurance	Proportion of PHCPs and SHCPs per state where quality assessment has been conducted	Quarterly	SSHIA
	Proportion of states that their BHCPF facilities made up to an average quality assessment score of 60%	Quarterly	NHIS
	Number of periodic checks conducted	Quarterly	NHIS
	Proportion of PHCPs delisted	Quarterly	NHIS
	Proportion of client complaints redressed	Quarterly	NHIS

	Proportion of enrolled beneficiaries under the BHCPF who pay out of pocket for the BMPHS	Every 2 Years	NHIS
Data Management	Proportion of SSHIAs submitting timely data	Quarterly	nhis
	Proportion of stakeholders who have received analysis report	Quarterly	NHIS
	Proportion of states where M&E validation exercises have been conducted	Quarterly	NHIS
Governance	Proportion of states with their state oversight committees set up	Quarterly	NHIS
	Proportion of SSHIAs that have been trained on operations of NHIS gateway	Quarterly	NHIS
	Proportion of facilities whose staff have been trained on operations of NHIS gateway	Quarterly	SSHIA
	Proportion of States whose state oversight committees held at least 2 meetings in the quarter	Quarterly	NHIS

Essential services under the BMPHS (Treatment of Malaria, Typhoid, Gastroenteritis, Respiratory tract infections, Urinary tract infections, Diarrhea, Hypertension, Diabetes, Laboratory investigations and Normal delivery)

The specific details of the various task, outputs and outcomes of the indicators listed above are contained in the NHIS Gateway's M&E framework

Data reporting

Data report for M&E purposes will follow the system indicated below

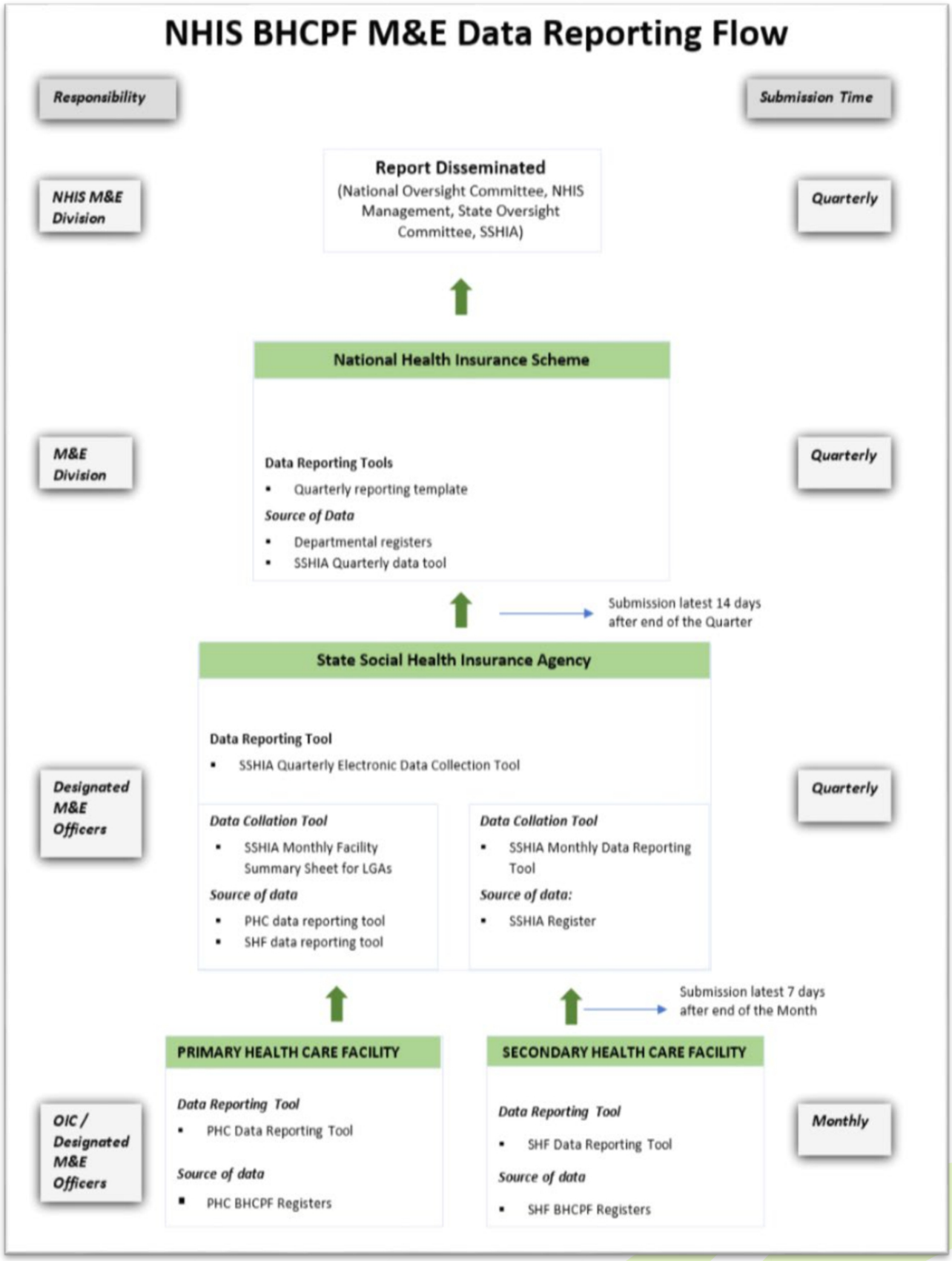


Figure 10: Data reporting for M&E

The SSHIAs are responsible for collating all identified data elements including service utilization (encounter), financial, morbidity and mortality and sending to the NHIS on a quarterly basis, while the NHIS will analyze the data and provide feedback to the Honorable Minister of Health quarterly.

Table 6: Key performance indicators for NHIS Gateway

S/n	Indicator	Data Frequency	Data source	KPI Target	National Program Target	Ownership
1	Percentage annual release of earmarked equity funds by States to SSHIA	Annual	State reports	100%	100%	SSHIA
2	Percentage annual increase in State Health Expenditure from health insurance	Annual	National Health Account	10% annual increase	70%	NHIS/ SSHIA
3	Percentage of enrolees satisfied with services rendered by participating HCFs	Bi-annually	Survey reports	70%	80%	NHIS
4	Percentage of HCFs paid within specified time frame for services rendered	Quarterly	TSA analysis, State financial reports	90%	100%	SSHIA
5	Percentage annual increase in enrolment of beneficiaries	Quarterly	NHIS Gateway reports	20% annually		SSHIA
6	Percentage annual increase in utilization of essential services by enrolled populations	Quarterly	DHIS, State Programmatic reports	20% annually		NHIS/ SSHIA

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

NHIS will monitor and evaluate the audited financial reports using the KPIs above. This will assess the performance of every SSHIA.

Evaluation

Rigorous Impact Evaluation (IE) shall be designed to assess the impact of the fund. Conduct of the Impact Evaluation shall be the responsibility of the Federal Ministry of Health in collaboration with the National Bureau of Statistics. The Impact Evaluation shall be designed to measure progress in utilization of key BMPHS and will be tied to the objectives of implementing the fund.

NHIS shall design an Outcome Evaluation to assess the performance of the gateway every 2 years.

Roles and Responsibilities for M&E functions

The roles and responsibilities of key agencies/stakeholders at national, state, facility levels are presented in tables 7.8.9 and 10.

Table 7: Roles and responsibilities of National level (NHIS) M&E Division

Key Areas	NHIS M&E functions under the BHCPF
Establishment of a common data architecture	• Define standards for sharing aggregate BHCPF data. • Coordinate the development of data requirements for the BHCPF. • Create and maintain a repository of BHCPF data. • Conduct oversight functions in the management of BHCPF data across levels for informed policy making.
Improve performance and review processes	• Use aggregate data to analyze findings for BHCPF priorities. • Compile reports at the National level to track implementation of the BHCPF. • Verify the quality of data received and follow up for validity and reliability. • Build capacity and provide technical support on BHCPF M&E functions at all (SSHIAs, PHCPs and SHCPs).
Enhance sharing of data and promote use of information for decision making	• Institutionalize data flow to meet BHCPF and MOC reporting obligations. • Prepare national annual and quarterly performance reports. • Disseminate the National and States BHCPF Data (reports) to the MOC/NHIS and SSHIAs respectively.

Table 8: Roles and responsibilities of SSHIA M&E Division

Key Areas	SSHIA M&E functions under the BHCPF
Establishment of a common data architecture	• Establishing data collection and management structures. • Create and maintain a repository of BHCPF data • Collaborate with SMOH M&E Unit in providing data for policy formulation and decision making. • Build capacity and provide technical support to the facility level on use of M&E tools
Improve performance and review processes	• Work within the BHCPF M&E framework and guidelines to meet reporting requirements.
Enhance sharing of data and promote use of information for decision making	• Strengthening M&E Unit operations within the state • Prepare and disseminate the States and Facility BHCPF Data (reports) to the SOC and NHIS.

Table 9: Roles and responsibilities of Healthcare Facility (PHCPs/SHCs) Finance/Record office

Key Areas	SSHIA M&E functions under the BHCPF
Establishment of a common data architecture	• Create and maintain a repository of BHCPF data • Assign a staff responsible for management of BHCPF data • Routinely update the data information system for effective management of BHCPF operations • Protect from unauthorized access to BHCPF data • Build capacity in Record Officers in the Facilities
Improve performance and review processes	• Work within the stipulated BHCPF guidelines to meet reporting requirements.
Enhance sharing of data and promote use of information for decision making	• Fill BHCPF M&E tools appropriately for routine submission to the SSHIAs

Table 10: Roles and responsibilities of National Level Partners (Development Partners (DPs), CSOs NGOs, FBOs)

Key Areas	Partner functions at the national level
Establishment of a common data architecture	• Provide technical, material and financial support to strengthen monitoring and evaluation. • Promote a national integrated health information system for decision making. • Collaborate with NHIS to provide data from health related research for decision making.
Improve performance and review processes	• Work within the existing M&E framework and meet defined reporting requirements.
Enhance sharing of data and promote use of information for decision making	• Strengthening national level M&E operations • Aid in the dissemination of data, research findings and performance reports.

CHAPTER SIX

6.0 INFRACTIONS AND SANCTIONS

The provisions of the Implementation Protocol for the NHIS Gateway require strict compliance by all the stakeholders. Therefore, for the purpose of proper regulation of the Schemes, conducts that would constitute infractions of the Implementation Protocol and the appropriate sanctions have been provided hereunder.

Sources of Reports of Infractions

a) Monitoring and Evaluation reports

b) Report on Quality Assurance and Accreditation/Re-accreditation

c) Aggrieved persons who have complained through the Grievance Redressal Mechanism

Types of Sanctions

I. Warning

ii. Withholding of a percentage from the administrative fund payable to the SSHIAs.

iii. Suspension from further releases by NHIS

iv. Suspension of healthcare providers with the transfer of enrollees

v. Impose Fine

The tables (11, 12, and 13) provide the range of infractions and sanctions. Accordingly, persons, institutions or healthcare facilities found to have breached the Implementation protocol, shall be informed within a reasonable time (not exceeding 7 days) or such period as may be determined by the authority from time to time. The person in breach shall comply forthwith with any sanctions imposed thereon.

Table 11: Summary of offences and sanctions for Target Group: **SSHIAs**

S/No	Offences	Sanctions	Enforcement
1	Delay to remit payment of claims to facilities after receiving same from the Scheme. **Delay in this context means failure to pay within five (5) working days.*	**1st default**- Warning letter and shall remit the appropriate claim to the facility within seven (7) days of receipt of warning. **2nd default** – Withdrawal of 10% of administrative funds due to the SSHIA. **3rd default**–SSHIA is suspended from administrative fees due for the next quarter. **4th default**–The funding by NHIS to the SSHIA shall be suspended.	**NHIS**
2	Refusal to remit payment of claims to providers after receiving the same from the Scheme. **Refusal in this context means failure to comply with the warning to pay within seven (7) days.*	**1st default**– Withdrawal of 20% of administrative funds due to the SSHIA. 2nd **default**– SSHIA is suspended from administrative fees due for the next quarter. **3rd default**- The funding by NHIS to the SSHIA shall be suspended.	**NHIS**
3	Underpayment of capitation and/or Fee -For-Service to healthcare providers	**1st default** - Warning letter and shall remit the appropriate claim to the facility within 7 days. **2nd default**-The officers involved in the fraud shall be handed over for prosecution.	**NHIS**
4	Diversion of BHCPF funds for purposes other than provision of healthcare	**1st default**–Warning letter and refund of the monies back to the account. **2nd default**–Refund of the monies back to the account and withdrawal of 50% of the administrative funds due to the SSHIA in the next quarter release. **3rd default**-The funding by NHIS to the SSHIA shall be suspended.	**NHIS**

5	Fraudulent bill-vetting process and procedure by officers involved in the vetting of submitted bills	**1st default**- Warning letter and shall remit the appropriate claim to the provider within 7 days. **2nd default** The officers involved in the fraud shall be handed over for prosecution.	**NHIS**
6	Failure to provide evidence of audited financial reports	**1st default**-Warning letter **2nd default**– Suspension of BHCPF funds disbursement and NHIS to take over operations pending resolution of outstanding issues with SSHIA	**NHIS**
7	Failure to conduct Quality Assurance visits to all accredited healthcare providers at least Once annually.	**1st default**- Warning letter and shall proceed to conduct inspection of the healthcare facilities within 7 days. **2nd default** - Withdrawal of 5% administrative funds due to the SSHIA in the next quarter's release.	**NHIS**
8	Failure to keep records and/or make quarterly returns of data to the Scheme.	**1st default**– Warning letter and the requisite data shall be forwarded to the Scheme within 7 days. **2nd default** - Withdrawal of 5% administrative funds due to the SSHIA in the next quarter's release.	**NHIS**
9	Failure to enforce any sanction against erring healthcare provider or enrolee as directed by NHIS.	**1st default**–Warning **2nd default**– Pay a fine of N50,000 to NHIS coffers.	**NHIS**
10	Failure to enrol the appropriate number/population paid for by NHIS	No further disbursement to the state till the appropriate number paid is enrolled	NHIS

Table 12: Summary of offences and sanctions for Target Groups: **Primary and Secondary Healthcare Providers**

S/No	Offences	Sanctions	Enforcement
1	Discriminates and/or refuses to treat or manage the enrolees registered with the facility.	**1st default**– Warning letter to the provider and pay the cost incurred according to the programme tariff. **2nd default**– Suspension for not less than three months. **3rd default** – Withdrawal of accreditation of the provider.	**SSHIA**
2	Receives, consults or manages any enrolee as a fee - paying patient for services covered under the programme.	**1st default**– Warning letter to the provider and refund the amount collected. **2nd default**– Suspension for not less than three months. **3rd default** – Withdrawal of accreditation of the provider.	**SSHIA**
3	Failure to refer an enrolee where secondary/tertiary service is required.	**1st default**– Suspension for not less than three months. **2nd default** - Withdrawal of accreditation of the provider.	**SSHIA**
4	Referring an enrolee without clinical justification.	**1st default**– Suspension for not less than three months. **2nd default** – Withdrawal of accreditation of the provider.	**SSHIA**
5	Failure to keep records and make quarterly returns of prescribed data.	**1st default**– Warning letter and the requisite data shall be forwarded within 7 days. **2nd default**- Suspension for not less than three months	**SSHIA**
6	Where a healthcare provider makes false claims for a treatment or procedure not carried out.	**1st default** Payment of the monies collected and suspension for not less than three months.	**SSHIA**

	2nd default Withdrawal of accreditation of the provider and report appropriate regulatory body.		
7	Where a healthcare provider operates against medical ethics and undermanages an enrollee	Report to the appropriate regulatory body	**SSHIA**
8	Diversion of BHCPF funds for purposes other than provision of healthcare	**1st default -** Warning letter and refund of the monies back to the account. **2nd default -** Suspension for not less than 3 months. **3rd default -** Withdrawal of accreditation of the provider and notification of NHIS	**SSHIA**
9	Where the healthcare provider fails to provide the prescribed drugs for the enrolee and the enrolee pays out-of-pocket for drugs covered under the programme	**1st default -** Warning letter to the provider and refund to the enrolee the cost of the medication based on the program tariff. **2nd default -** Refund to the enrolee the cost of the medication based on the program tariff and pay a fine of N20, 000 to SSHIAs coffers.	**SSHIA**
10	Where the facility makes false claims of non - payment by SSHIA for services rendered.	**1st default -** Warning letter to the provider **2nd default -** Pay a fine of N20, 000 to SSHIAs coffers.	**SSHIA**
11	Low Quality Assessment score	**In accordance with the provisions of the accreditation guidelines**	**SSHIA**
12	Failure to formally notify the SSHIA, NHIS, and the enrolees registered with the healthcare provider within three months of its intention to relocate to a new facility.	**Default -** To pay a fine of N20,000 to SSHIAs coffers and notify accordingly	**SSHIA**

13	Failure to formally notify the SSHIA, NHIS, and the enrolees registered with it within three months of its intention to exit from the Program	**Default-**To pay a fine of N20,000 to SSHIAs coffers	**SSHIA**

Table 13: Summary of offences and sanctions for **Target Group: Enrollees/ Beneficiaries**

S/No	Offence	Penalty	Enforcement
1	Allow usage of identity card by unauthorized persons	**1st default** – Warning **2nd default** – Delisting from the programme	SSHIA
2	Making false claim against the healthcare provider or an officer	**1st default** – Warning **2nd default** – Delisting from the programme	SSHIA

Grievance Redressal Mechanism

The NHIS shall set up a grievance redressal mechanism to be responsible for receiving complaints, investigating same and resolving them accordingly.

Infractions Constituting Economic Crime

Notwithstanding the content of the foregoing tables, a person (juristic or otherwise) whether acting alone or otherwise, who commits or omits to carry out a prescribed act under BHCPF, which constitutes a crime under any law, shall be handed over to the appropriate body for prosecution. This includes but not limited to diversion, misappropriation, and embezzlement of the released funds to the SSHIAs.

Consequences of Suspension of Healthcare Providers

Any Healthcare facility that has been suspended due to infraction of the provisions of this Implementation Protocol shall have its lives transferred to the nearest Healthcare facility.

APPENDIX

Appendix 1

ICT Infrastructure Requirement Guidelines

This is to guide states and facilities on ICT infrastructure requirements for efficient interoperability, monitoring, evaluation, and reporting.

State Social Health Insurance Agencies

S/No	DEVICE	RECOMMENDATION
1.	5 units all in one Computer 20 units of Laptop 1 unit of Server	Core I5 8GB RAM 320 HDD with a good screen resolution with 3 or more USB port. USB spec of 2.0 and 3.0. **Recommended OS: Windows 10 pro** Preloaded with Microsoft Office tools Core I5 8GB RAM 320 HDD with a good screen resolution with 3 or more USB port. USB spec of 2.0 and 3.0. **Recommended OS: Windows 10 pro** Preloaded with Microsoft Office tools HPE Proliant DL380 Gen10
2.	2 Units Printer:	Laserjet Pro M402dw or similar printer
3.	Document Scanner	HP Scanjet 300, or HP G4010 or HP Scanjet Pro 2500 f1
4.	Webcam	Logitech c920
5.	Fingerprint Scanner:	1. Suprema real scan g10, or 2. Cross match patrol ID, or 3. Green bit DactyScan 84c, or 4. DermalogLF10, or 5. DermalogZF10, or 6. Kojak IB scan ultimate.

6.	Additional Screen for applicant	19-inch screen
7.	2D Barcode Scanner for scanning pre-enrolment form	Datalogic Gryphon GD44XX, or Motorola symbol LS2208
8.	Signature Pad: monochrome signature Pad	1. Topaz T-LBK462-HSB-R, or 2. Wacom LCD Signature Tablet STU 300, or 3. Topaz T-LBK460-HSB-R
9.	Energy saving light	LED AC 90-240V 5060 HZ
10.	Finger licence	Neurotech finger licence
11.	Facial license	Aware Preface
12.	Antivirus-Endpoint license	1. ESET Endpoint, or 2. Synmantec Endpoint
13.	UPS	APC 650/750
14.	GPS Device	1. U-Blox GPS /GNSS location sensor (Bluetues USB GPS Receiver BS-708 2. ACELEX GLONASS GPS Tracker VK172 GPS Module
15.	IRIS Scanner	1. IriShield BK 2121IU 2. ICAM T10
16	Power Extension	with surge protector
17.	Backdrop	Grey
18.	Connectivity	VPN over internet: Cisco any connect
19.	Chairs	Swivel Chair
20.	Table:	Official Table
21.	Cooling system	Air conditioner

Appendix 2

Facility Level Ict Infrastructure

S/No	DEVICE	RECOMMENDATION
1.	1. 1unit All in one Computer 2. 1unit of Laptop	Core I5 8GB RAM 320 HDD with a good screen resolution with 3 or more USB port. USB spec of 2.0 and 3.0. **Recommended OS: Windows 10 pro** Preloaded with Microsoft Office tools Core I5 8GB RAM 320 HDD with a good screen resolution with 3 or more USB port. USB spec of 2.0 and 3.0. **Recommended OS: Windows 10 pro** Preloaded with Microsoft Office tools
2.	1 Units Printer:	LaserJet Pro M402dw or similar printer
3.	Document Scanner (Optional)	HP Scanjet 300, or HP G4010 or HP Scanjet Pro 2500 f1
4.	Single finger verifier (Optional)	Digital Personnel or similar
5.	2D Barcode Scanner for scanning pre enrolment form (Optional)	Datalogic Gryphon GD44XX, or Motorola symbol LS2208
6.	Endpoint license Antivirus	1. ESET Endpoint, or 2. Symantec Endpoint
7.	UPS	APC 650/750
8.	Power Extension	with surge protector
9.	Connectivity	internet: Cisco any connect
10.	Chairs	Swivel Chair
11.	Table:	Official Table
12.	Cooling system (Optional)	Air conditioner
13.	Email	Functional Facility email address

Appendix 3

PHC Data Collection Tool

BASIC HEALTH CARE PROVISION FUND
National Health Insurance Scheme Gateway

PHC DATA COLLECTION TOOL

PHC name and NHIS code:	**Month:**
LGA:	**Ward:**

To be filled by the Officer -in-charge

Instructions: Please record findings under the column marked 'Findings'. Please record the numbers in the boxes provided and tick either "YES" or "NO" for questions that apply.

S/No	Questions	Findings
A	**Enrollment**	
1	Did you receive the list of BHCPF enrollees for this facility in the reporting month?	**YES** ☐ **NO** ☐
2	Total number of BHCPF enrollees in your facility	
B	**Financial Management**	
3a	Have you received payment for capitation (money for each BHCPF enrollee) for the reporting month?	**YES** ☐ **NO** ☐
3b	Date you received the payment for capitation (money for each BHCPF enrollee) for the reporting month from the statement of account	DD/MM/YY
3c	Were you notified through a pay advice or other documentary means?	**YES** ☐ **NO** ☐

		4	Amount received for capitation (money for each BHCPF enrollee) for the reporting month								
		C	**Service Utilization**								
		5	Number of BHCPF enrollees that visited your facility during the reporting month								
		6	Number of BHCPF enrollees that were referred from your facility in the reporting month								
		7	Number of BHCPF enrollees that attended ANC in this facility in the reporting month								
		8	Number of BHCPF enrollees that had normal delivery in this facility in the reporting month								
		9	Number of BHCPF enrollees that accessed immunization[1] services in this facility in the reporting month								
		10	Number of BHCPF enrollees that were treated for malaria in this facility in the reporting month		**Adult:**		**Children under 5:**				
		11	Number of BHCPF enrollees that were screened and referred for hypertension in this facility in the reporting month								
		12	Number of BHCPF enrollees that were screened and referred for diabetes in this facility in the reporting month								
		13	Number of BHCPF enrollees that were treated for typhoid fever in this facility in the reporting month								
		14	Number of BHCPF enrollees that were treated for respiratory tract infection in this facility in the reporting month		**Adult:**		**Children**				

		15	Number of BHCPF enrollees that were treated for diarrhoea in this facility in the reporting month		**Adult:**		**Children under 5:**					
		16	Number of BHCPF enrollees that were treated for urinary tract infection in this facility in the reporting month									
		17	Number of BHCPF enrollees that were treated for gastroenteritis in this facility in the reporting month									
		18	Total number of deaths (BHCPF enrollees) that you recorded in this facility in the reporting month									
		19i	Maternal deaths									
		19ii	Neonatal (0-30 days) deaths									
		19iii	Infant (1-12 months) deaths									
		19iv	Children (1-5 years) deaths									
		Name & designation of officer:										
		Phone Number:										
		ANC refers to all ANC visits										
		Immunization refers up to penta 3										

Appendix 4

SHCP Data Collection Tool

		BASIC HEALTH CARE PROVISION FUND **National Health Insurance Scheme Gateway**									
		SHCP DATA COLLECTION TOOL									
		SHCP name:			**NHIS code:**						
		LGA:			**Month:**						
		To be filled by the Medical Director **Instructions:** Please record findings under the column marked 'Findings'. Please record the numbers in the boxes provided.									
		S/No	**Questions**		**Findings**						
		A	**Financial Management**								
		1i	When was the last claim submitted to the SSHIA				DD/MM/YY				
		1ii	Which month did it cover?								
		1iii	Amount requested in the last submitted claim stated above								
		2i	When was the last claim reimbursement received?								
		2ii	Indicate the month for which the reimbursement covers								
		2iii	Reimbursement received								
		B	**Service Utilization**								
		3	Number of BHCPF enrollees that were referred to your facility in the reporting month								

		4	Number of BHCPF enrollees that were referred for caesarean section to your facility in the reporting month									
		5										
		6	Number of BHCPF enrollees that were treated for hypertension in this facility in the reporting month									
		7	Number of BHCPF enrollees that were treated for diabetes in this facility in the reporting month									
		8	Number of BHCPF enrollees that were treated for severe malaria in this facility in the reporting month		**Adult:**		**Children under 5:**					
		9	Number of BHCPF enrollees that were treated for complicated respiratory tract infection in this facility in the reporting month		**Adult:**		**Children under 5:**					
		10	Number of BHCPF enrollees that were treated for severe urinary tract infection in this facility in the reporting month									
		11	Number of BHCPF enrollees that were treated for complicated typhoid fever in this facility in the reporting month									
		12	Total number of deaths (BHCPF enrollees) that you recorded in this facility in the reporting month									
		13i	Maternal deaths									
		13ii	Neonatal (0-30 days) deaths									
		13iii	Infant (1-12 months) deaths									
		13iv	Children (1-5 years) deaths									
		Name & designation of officer:										
		Phone Number:										

Appendix 5

SSHIA Data Collection Tool

BASIC HEALTH CARE PROVISION FUND **National Health Insurance Scheme Gateway**	
SSHIA DATA COLLECTION TOOL	
State:	
Month:	
To be filled by responsible SSHIA officers **Instructions:** Please record findings under the column marked 'Findings'. For questions that findings are needed on a quarterly basis, fill at the end of each month.	

S/No	Questions	Findings
A	**Enrollment**	
1	Total number of target BHCPF beneficiaries in this state based on funds received	
2	Total number of target BHCPF beneficiaries enrolled in this state	
B	**Financial Management**	
3	Amount received from NHIS this quarter	
4	Total amount spent on capitation in the reporting month	
5	Total amount remaining for capitation in your SSHIA account	
6	Total amount spent on fee-for-service in the reporting month	

		7	Total amount remaining for fee-for-service in your SSHIA account								
		8	Total amount spent from the reserve fund pool in the reporting month, if any								
		9	Total amount remaining in the reserve fund pool account								
		10	Total amount spent from the ICT fund in the reporting month								
		11	Total amount remaining for ICT in your SSHIA account								
		C	**Quality Assurance**								
		12	What is the total number of BHCPF PHCs where quality assessment was conducted in the reporting month?								
		13	What is the total number of BHCPF SHCFs where quality assessment was conducted in the reporting month?								
		14	Total number of facilities that made up to an average quality assessment score of 60% in the reporting month?								
		D	**Governance**								
		15	Number of PHCs that their staff have been trained on operations of the NHIS gateway								
		16	Number of SHCFs that their staff have been trained on operations of the NHIS gateway								
		Name & designation of officer:									
		Phone Number:									
		Total number of target BHCPF beneficiaries is amount received by SSHIA or paid to SSHIA divide by N12,000									

Appendix 6

SSHIA Monthly Facility Summary Sheet For LGAs

		BASIC HEALTH CARE PROVISION FUND **National Health Insurance Scheme Gateway**									
		SSHIA MONTHLY FACILITY SUMMARY SHEET FOR LGAs									
		LGA:			**Month:**						
		To be filled by the SSHIA officer assigned to the LGA Instructions: Please record findings under the column marked 'Findings'. Please record the total value calculated for all PHCs and SHCPs in this LGA in the boxes provided									
		S/No	**Questions**		**Findings**						
		A	**Enrollment**								
		1	Number of PHCs in this LGA that received the list of BHCPF enrollees for the reporting month								
		2	Total number of BHCPF enrollees in this LGA								
		B	**Financial Management**								
		3i	Number of PHCs in this LGA that received payment for capitation in the reporting month								
		3ii	Number of PHCs that received payment for capitation within the first 5 days of the reporting month								
		4	Amount in total received by PHCs in this LGA for capitation in the reporting month								

		5i	Number of SHCs in this LGA that submitted claims to SSHIAs for the reporting month									
		5ii	Number of SHCs in this LGA that submitted claims to SSHIAs within 30 days from the end of the reporting month									
		5iii	Total amount requested in the claims submitted for the reporting month									
		6i	Number of SHCs in this LGA whose vetted claims were reimbursed for the reporting month									
		6ii	Number of SHCs in this LGA whose vetted claims were reimbursed not later than 30 days from claims submission for the reporting month									
		6iii	Total amount reimbursed									
		C	**Service Utilization in PHCs**									
		7	Number of visits in total received by PHCs in this LGA from BHCPF enrollees in the reporting month									
		8	Number of BHCPF enrollees in total that were referred from PHCs in this LGA in the reporting month									
		9	Number of BHCPF enrollees in total that were referred to the SHCP in this LGA in the reporting month									
		10	Number of BHCPF enrollees in total that registered for ANC in PHCs in this LGA in the reporting month									

		11	Number of BHCPF enrollees in total that accessed immunization services in PHCs in this LGA in the reporting month								
		12	Number of BHCPF enrollees in total that were treated for malaria in PHCs in this LGA in the reporting month		**Adult:**		**Children:**				
		13	Number of BHCPF enrollees in total that were screened and referred for hypertension in PHCs in this LGA in the reporting month								
		14	Number of BHCPF enrollees in total that were screened and referred for diabetes in PHCs in this LGA in the reporting month								
		15	Number of BHCPF enrollees in total that were treated for typhoid in PHCs in this LGA in the reporting month?								
		16	Number of BHCPF enrollees in total that were treated for respiratory tract infection in PHCs in this LGA in the reporting month		**Adult:**		**Children:**				
		17	Number of BHCPF enrollees in total that were treated for diarrhoea in PHCs in this LGA in the reporting month		-						
		18	Number of BHCPF enrollees in total that were treated for urinary tract infection in PHCs in this LGA in the reporting month								
		19	Number of BHCPF enrollees in total that were treated for gastroenteritis in PHCs in this LGA in the reporting month								
		20	Number of BHCPF enrollees in total that had normal delivery in PHCs in this LGA in the reporting month								
		21	Total number of deaths in total (in relation to BHCPF beneficiaries) that were recorded in PHCs in this LGA in the reporting month								

		21i	Maternal deaths								
		21ii	Neonatal (0-30 days) deaths								
		21iii	Infant (1-12 months) deaths								
		21iv	Children (1-5 years) deaths								
		D	**Service Utilization in SHCPs**								
		22	Number of BHCPF enrollees in total that were referred for caesarean section to the SHCP in this LGA in the reporting month								
		23	Number of BHCPF enrollees in total that were treated for hypertension in the SHCP in this LGA in the reporting month								
		24	Number of BHCPF enrollees in total that were treated for diabetes in the SHCP in this LGA in the reporting month								
		25	Number of BHCPF enrollees that were treated for severe malaria in this facility in the reporting month		**Adult:**		**Children:**				
		26	Number of BHCPF enrollees that were treated for complicated respiratory tract infection in this facility in the reporting month		**Adult:**		**Children:**				
		27	Number of BHCPF enrollees that were treated for severe urinary tract infection in this facility in the reporting month								
		28	Number of BHCPF enrollees that were treated for complicated typhoid fever in this facility in the reporting month								
		29	Total number of deaths in total (in relation to referred BHCPF beneficiaries) that were recorded in the SHCP in this LGA in the reporting month								

		30i	Maternal deaths								
		30ii	Neonatal (0-30 days) deaths								
		30iii	Infant (1-12 months) deaths								
		30iv	Children (1-5 years) deaths								
		E	**Quality Assurance**								
		31	What is the total number of BHCPF PHCs where quality assessment was conducted in the reporting month?								
		32	What is the total number of BHCPF SHCFs where quality assessment was conducted in the reporting month?								
		33	Total number of facilities that made up to an average quality assessment score of 60% in the reporting month?								
		F	**Governance**								
		34	Number of PHCs that their staff have been trained on operations of the NHIS gateway								
		35	Number of SHCFs that their staff have been trained on operations of the NHIS gateway								
		Name & designation of officer:									
		Phone Number:									

Appendix 7

NHIS BHCPF Service Utilization Register

NHIS BHCPF SERVICE UTILIZATION REGISTER														
PHC NAME:														
MONTH/ YEAR:														
							Maternal Health				**Child Health**	**OPD**		
S/N	**Date (DD/MM/YYYY)**	**First Name**	**Surname**	**Date of Birth (DD/MM/YYYY)**	**Sex [F/M]**	**Unique identification No [NIN]**	**ANC visit [1st/2nd/3rd/4th]**	**Care given**	**Delivery**	**Outcome**	**Vaccines administered**	**Diagnosis**	**Care given [1]**	**Referral [Y/N]**

*Care given is referring to drugs administered, admission, type of investigation, counseling, etc

Appendix 8

BASIC HEALTHCARE PROVISION FUND (BHCPF)

NHIS GATEWAY

Quality Assurance Checklist

I. GENERAL INFORMATION

Name of Facility
Address ofacility/location
State
e-mail
Contact Person (i/c)

A	**GOVERNANCE & ADMINISTRATIVE STRUCTURES:**				
1	Do you have a management committee?	Yes (1)	No (0)		
2	Community participation in management: do you involve the	Yes (1)	No (0)		
3	Evidence regular management committee meeting community in the management of your facility?	Yes (1)	No (0)		
4	Present of Ward Development Community	Yes	No (0)		
5	Evidence of regular WDC meeting?	(1) Yes (1)	No (0)		
6	Evidence of well implemented Shift/Call duty roster	Yes (1)	No (0)		
7	Do you have complaint redress system?	Yes	No (0)		
8	Availability of conspicuously displayed complaint/suggestion box	(1) Yes (1)	No (0)		
B	**FINANCIAL MANAGEMENT CAPACITIES (PLANNING, BUDGETING AND EXECUTION):**	Yes (1)	No (0)		
9	Do you have Bank account?	Yes (1)	No (0)		
10	Capacity to generate and submit income and expenditure statements	Yes (1)	No (0)		
11	Operational expenses (cash) by source and frequency				
12	User fee charges displayed (confirm any exemptions)	Yes (1)	No (0)		
13	Designated accountant and/or financial manager (underline which)	Yes (1)	No (0)		
14	Where commodities are obtained from (central medical store vs open market)?				
15	If open market, what is the process informing procurement?				
16	Are there staff with experience with generating and submitting claims?	Yes (1)	No (0)		
17	Supply chain guidelines in place	Yes (1)	No (0)		
18	Contingency stocks available	Yes (1)	No (0)		
19	Data based or self-reported stock-out rates?				
C	**HUMAN RESOURCE MANAGEMENT**				
20	Is the following Staff regularly available in the PHC/Hospital for 24 hours?				
21	Doctor	Yes (1)	No (0)	Number	
22	Nurse/midwife	Yes (1)	No (0)	Number	
23	CHEWs & JCHEWs	Yes (1)	No (0)	Number	
24	Pharmacist /Dispensing staff	Yes (1)	No (0)	Number	
25	Laboratory Staff	Yes (1)	No (0)	Number	
26	Trained Records/Front Desk officer	Yes (1)	No (0)	Number	
27	Others	Yes (1)	No (0)	Number	

28	Mode of payment of staff				
29	How many of the staff are accommodated out of the total	Number			
30	Evidence of staff training	Yes (1)	No (0)		
D	**PATIENT CARE MANAGEMENT**				
31	Check the clerking of beneficiaries (random assessment of 3 folders)				
	a. biodata	Good (1)	Fair (1)	Poor (0)	
	b. history	Good (1)	Fair (1)	Poor (0)	
	c. examination	Good (1)	Fair (1)	Poor (0)	
	d. provisional diagnosis	Good (1)	Fair (1)	Poor (0)	
	e. investigation	Good (1)	Fair (1)	Poor (0)	
	f. treatment	Good (1)	Fair (1)	Poor (0)	
32	Relevance of treatment plan to working/provisional diagnosis	Yes (1)	No (0)		
33	Relevance of laboratory investigations to working/provisional diagnosis	Yes (1)	No (0)		
34	Prescribed drugs (appropriateness, dose & duration)	Yes (1)	No (0)		
35	Are the prices of drugs prescribed consistent with the BHCPF drug price list	Yes (1)	Sometimes (1)	No (0)	
36	Are ward rounds conducted regularly?	Yes (1)	Sometimes	No (0)	
37	Availability and use of protocols and procedures for diagnosis and Patients management e.g. Anaemia, ARI, STI, Diarrhoea, fever, hypertension, diabetes etc	Good (1)	Fair (1)	No (0)	
38	Ease of access to doctors/secondary care during emergencies	Yes (1)	No (0)		
E	**MATERNAL & CHILD HEALTH SERVICES**				
39	Availability of a written protocol for delivery (note: ANC, Birth records, portogram)	Yes (1)	No (0)		
40	Birth record of the beneficiaries *(in last 12 months)*	Total number			
41	Outcome of pregnancies:				
42	a. Live births (assess birth records in the last 12months)	Total number			
43	b. Fresh still births (assess birth records in the last 12months)	Total number			
44	c. Macerated still births (assess birth records in the last 12months)	Total number			
45	Immunization services for neonates	Yes (1)	No (0)		
46	Availability of sterile delivery instruments	Yes (1)	No (0)		
47	Availability of basic equipment/consumables in the labor room	Yes (1)	No (0)		
48	Payment for A.N.C/delivery by enrollees (review 3 antenatal/ case notes)	Yes (1)	No (0)		

F	**DRUG MANAGEMENT SYSTEM**				
49	Is the pharmacy/dispensary adequately stocked with ACT, Antibacterial, Antihypertensive, anti-diabetic drugs etc.	Yes (1)	No (0)		
50	Prescribed drugs (appropriateness, dose & duration)	Yes (1)	No (0)		
51	Is Drug Revolving Fund (DRF) Committee in place and functional?	Yes (1)	No (0)		
52	If no, how do you ensure availability of drugs in the hospital?				
53	Availability of drug counseling	Yes (1)	No (0)		
54	Provision for out of-stock (o/s) for enrollees	Yes (1)	No (0)		
55	If yes, what does facility do?				
56	Adequate drug storage with A/C	Yes (1)	No (0)		
57	Intermittent Prevention Therapy in Pregnancy (Sulphadoxine and Pyrimethamine)	Yes (1)	No (0)		
58	Does the PHC have capacity for PMTCT of HIV/AIDS	Yes (1)	No (0)		
59	Assess the drug store for labelling	Yes (1)	No (0)		
G	**LABORATORY**				
60	Availability of a written standard operating procedure for each investigation in laboratory	Yes (1)	None (0)		
61	Appropriateness of Laboratory tests for e.g. MP, HB, Urine, Stool, FBS, HIV, Genotype etc.	Good (1)	Fair (1)	Poor (0)	
62	Evidence of basic laboratory equipment (in a side lab) :Microscope, Bench centrifuge, Haematocrit centrifuge etc	Yes (1)	No (0)		
63	Availability of rapid diagnostic test kits: malaria widal, urinalysis, Hb etc,	Yes (1)	No (0)		
H	**INFECTION CONTROL**				
64	Availability of a written standard handling procedure of medical wastes/sharps	Yes (1)	No (0)		
65	Availability of a written standard operating procedure for disinfection and sterilization	Yes (1)	No (0)		
66	Availability of sterilization system?	Yes (1)	No (0)		
67	Is there hand washing culture in the hospital?	Yes (1)	No (0)		
68	Clean environment and well-cut grasses	Yes (1)	No (0)		

I	**HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS):**				
69	Is Beneficiary Registration Forms available?	Yes (1)	No (0)		
70	Are patient record forms, patient referral forms available?	Yes (1)	No (0)		
71	Are there designated administrative/data management staff?	Yes (1)	No (0)		
J	**PHYSICAL INFRASTRUCTURE**				
72	Adequate water supply	Yes (1)	No (0)		
73	Efficient power supply	Yes (1)	No (0)		
74	Is the consultation room clean?	Yes (2)	No (0)		
75	Are the wards clean and well ventilated?	Yes (1)	No (0)		
76	Are the wards adequately illuminated?	Yes (1)	No (0)		
77	Are there mosquito screens on the windows or bed nets?	Yes (1)	No (0)		
78	Are the toilets clean?	Yes (1)	No (0)		
79	Is the hospital environment clean/grass well cut?	Yes (1)	No (0)		

GENERAL ASSESSMENT

FINDINGS FOR FOLLOW -UP

NOTED COMMENDATIONS
NOTED CHALLENGES
RECOMMENDATIONS
CORRECTIVE ACTIONS

Name & Signature of Facility Representative

……

Name & Signature of Q A Team Members:

1. ……
2. ……
3. ……
4. ……

Appendix 9

NATIONAL HEALTH INSURANCE SCHEME

QUALITY ASSURANCE CHECKLIST FOR THE NHIS GATEWAY

(Using Process Indicators)

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2. **GENERAL INFORMATION**

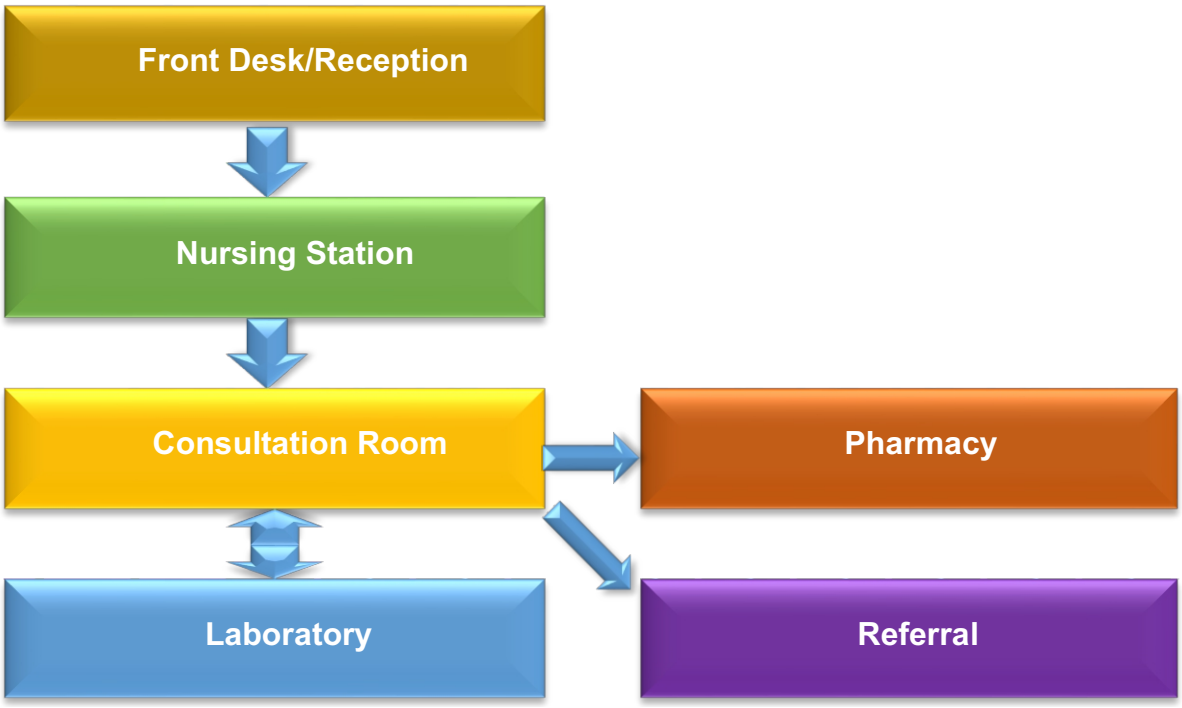
Name of Facility
Code
Address of facility/location
State
e-mail
Contact Person (i/c)

Guideline for the Use of the Checklist

Processes are a series of inter-related activities undertaken to achieve specific objectives which in this case may be any or a mix of components of the spectrum of medical care. 'Process' denotes what the practitioner actually does in giving care, i.e. the practitioner's activities in making a diagnosis, recommending or implementing treatment, or other interaction with the patient.
Process indicators therefore assess what the provider did for the patient and how well it was done. They measure the activities and tasks in patient episodes of care.

For the purpose of this Tool, quality of the processes involved in managing a patient will be assessed from the view point of the various service points the patient goes through in the course of treatment i.e. what the practitioners did at the various service points in the course of providing medical care for beneficiaries.

Different Service Points



The assessor is to observe the management of beneficiaries (patients) from the moment they step into the healthcare facility till when they collect their medications. Subsequently, the exit-interview questionnaires may be deployed for other indicators.
This assessment should be non-intrusive. i.e. done without interference in the normal patient management as much as possible. This tool has been designed to capture information across the basic service points as shown in the chart above. Ensure also, that the beneficiaries consent is sought before commencement

Service Point	Process	Process Indicators	Indicators to observe	Scores
Front Desk / Reception	Patient Record Management	Prompt attention to patients	Was the patient promptly attended to?	Less than 5 Minutes (10 Points)

			(Startsfrom the moment patient enters the HCP building)	5 to 9 Minutes (5 Points) 10 Minutes and above (0 Point)
		Ease of retrieval of patient records/Files	How easy was it to retrieve patient's record? *(Timing starts from the moment patient starts to give particulars to front desk office)*	Less than 5 Minutes (10 Points) 5 to 9 Minutes (5 Points) 10 Minutes and above (0 Point)
		Ease of scheduling patients for appointment/consultation with Doctor	How long did it take to clear the patient to consult with the Doctor *(Timing starts from the moment patient file is found (or opened) to when the patient sits to wait for the prescriber/goes into the consulting room)*	Less than 5 Minutes (10 Points) 5 to 9 Minutes (5 Points)

				10 Minutes and above (0 Point)
			Who contacted the SHIA for referral code? *(If applicable)*	The patient (0 point) The HCP (10 points)
Nursing Station	Assess, observe and record the patient's general health condition.	Record of Vital Signs	Were the vital signs of the patient checked and recorded? *Vitals include:* *Height* *Blood Pressure* *Pulse* *Weight* *Temperature*	Yes (10 Points, <u>All or none basis</u>) No (0)
Consultation Room	Treatment, counseling and referral where necessary.	Consultation	How long was the consultation with the prescriber? *(Timing begins from when the patient sits to when he/she leaves the consulting room)*	Less than 5 minutes (0 point) 5 minutes and above (10 points)

		Patient complaints	Was the patient allowed to fully express himself/herself *(Observe to ensure the prescriber listens while the patient presents complaints without unnecessary interruptions. Accepted interruptions should be clarifications)*	Yes (10 Points) No (0)
		Clerking	Was the patient's complaints and the prescriber's assessments documented? *(Review the patient's folder)*	Yes (10 Points) No (0)
		Diagnosis	Was the Diagnosis reached in line with Best Clinical Practice and/or	Yes (10 Points)

			Laboratory result? *(Review the patient's case note and observe systematic arrival at Diagnosis)*	No (0)
		Prescribing	Was the prescription done in alignment with established/ National protocols	Yes (10 Points) No (0)
		Counselling	Was the patient adequately counseled concerning the medical condition(s) *Information such as:* *(Probable) cause* *Preventive measures* *Treatment Plan*	Yes (10 Points) No (0)

		Patient Rights	Was the patient informed of treatment options (where available)	Yes (10 Points) No (0) NA (10 Points)
			Was the patient's opinion concerning the treatment plan considered (where available)	Yes (10 Points) No (0) NA (10 Points)
Laboratory	Investigations	Sample Collection	Were samples collected as requested by the prescriber *(Sample collected should be matched against laboratory*	Yes (10 Points) No (0)

			request form)	NA (10 Points)
			Were samples collected labelled appropriately? *(Observe the labelling of sample bottles and match against that on laboratory request form)*	Yes (10 Points) No (0) NA (10 Points)
			Are there standard protocols for the standardization of tools/equipment *(Sight them and review record of recent standardization (3months))*	Yes (10 Points) No (0) NA (10

				Points)
		Test Result	Were test results available as at when promised? *(Contact patient to know when it was available)*	Yes (10 Points) No (0) NA (10 Points)
Pharmacy	Dispensing of medications	Dispensing	Were the drugs prescribed made available for the patients? *(Observe that the medications were made available whether through the dispensary or alternate sources?)*	Yes (10 Points) No (0) NA (10 Points)
		Suitability of Medication	Were the drugs prescribed suitable for the patients? *Observe the*	Yes (10 Points)

			following *Right Patient* *Right product* *Right formulation* *Right dosage form* *Right time* *Right condition* ***Right time implies no O/S***	No (0) NA (10 Points)
		Medication Counselling	Was the patient counseled about the drug: *Counselling should include:* *Side effects* *Timing* *Interactions (drug-drug OR drug-food OR drug-herb)*	Yes (10 Points) No (0)

Appendix 10

NATIONAL HEALTH INSURANCE SCHEME

Enrollee Exit Questionnaire

Quality of care assessment tool for NHIS-Accredited Healthcare Facilities

HCF NAME	NHIS CODE

		strongly agree	agree not	sure/not applicable	disagree	strongly disagree
	MEDICAL PERSONNEL					
1	The nurses treated me with courtesy and respect					
2	The nurses listened carefully to everything I said					
3	The nurse explained things in a way that I could understand					
4	The Doctor treated me with courtesy and respect					
5	The Doctor listened carefully as I described my symptoms					
6	The Doctor took time to explain the course of action and the reason behind the treatment plan					
7	The Doctor explained the working diagnosis to me in a way that I clearly understood					

	SERVICE POINTS					
8	The hospital staff treated me with courtesy and respect at all the service points I accessed today					
	The hospital records staff/receptionist ……..					
9	The hospital staff listened carefully as I spoke to them and responded patiently.					
10	The pharmacist/technician treated me with courtesy and respect					
11	The Pharmacist/technician told me what the medicine was for					
12	The Pharmacist/technician described the possible side effects of the medicines I was given					
13	The laboratory receptionist treated me with courtesy and respect					
14	The laboratory Scientist/Technician explained what the tests ordered was for					
15	The Laboratory Scientist/Technician described the procedure for the test in a way I could understand					
16	The Laboratory Scientist/Technician carefully collected samples in a manner that was ……..					
	ACCESS EXPERIENCE					
17	I spent less than an hour waiting to see the doctor					
18	I spent less than 30mins at the laboratory					
19	I spent less than 30 mins at the pharmacy					
20	I spent more than two hours at the hospital					
21	I was given all the drugs prescribed					
22	I was asked to pay the full amount for the drugs prescribed					

	CONFIDENTIALITY					
23	I felt that my medical details were being kept confidential					
24	I felt as if the hospital staff needlessly told others about my medical condition					
	OVERALL HOSPITAL RATING					
25	I would recommend this hospital to family and friends					

26	Rate your overall experience at this facility (please tick)	**1**	**2**	**3**	**4**	**5**
		6	**7**	**8**	**9**	**10**