Assessment of the Progress of the Implementation of the Basic Health Care Provision Fund in South East States of Nigeria

Edwin Nwobodo[1], *Francis Ukwuije*[2], *Ucheoma Egwuatu*[3], *Frank O. Ezugwu*[4], *Nkoli Nwobodo*[5], *Amamihechineke Ojiakor*[6] *and David Chibuike Ikwuka*[1]

[1] *Nnamdi Azikiwe University, Nnewi, Nigeria,* [2] *World Health Organisation, Abuja,* [3] *DFID-PERL Program, SE, Enugu,* [4] *Enugu State University College of Medicine, Enugu,* [5] *PPD, North Carolina, USA,* [6] *University of Nigeria Teaching Hospital, Enugu, Nigeria.*

ABSTRACT

Background: The Basic Health Care Provision Fund (BHCPF) is expected to fund delivery of minimum package of healthcare service to Nigerians especially the poor and vulnerable. **Objectives:** This study was designed to commence the assessment of the progress of the processes of the implementation of the fund, and the challenges encountered by operators of the Primary Health Care (PHC) system in Southeast. **Materials and Methods:** This survey conducted between February-August, 2020 entailed recruitment, training of independent investigators and deployment of tracking survey tools to independent monitors and managers of the BHCPF of the States including the PHC Agencies and Facility Managers. Results were collated and validated in a virtual meeting of public and independent monitors. The study focused on the PHC Facilities in the Southeast States of Nigeria. **Results:** The findings indicate a shaky and delayed start of implementation of the BHCPF in five surveyed States, mainly due to a collection of reasons including: non-compliance to processes of the operational guideline; inadequate number and mix crop of Human Resource for Health (HRH); Inadequate management capacity of supervising agencies to ensure adherence to the guidelines; poor management capacities of Officers in Charge (OICs); conflicts between Ward Development Committees (WDCs) and OICs; extremely low level awareness of the availability of BHCPF in the communities of the States surveyed **Conclusion:** These issues arising from the take-off and implementation of BHCPF warrant continuing capacity building and supervision of the programme. Certain States are at lower readiness to access the fund due to the alluded complicated processes.

Keywords: Primary Health Care; Basic Health Care Provision Fund; Civil society organization; Southeast.

INTRODUCTION

The National Basic Health Care Provision Fund (BHCPF) was established by the National Health Act of 2014. At least, one percent of the consolidated revenue fund to the country is to be dedicated to this Fund among other expected domestic and foreign funds. The BHCPF is expected to fund the delivery of a minimum package of health care service to Nigerians and is expected to benefit especially the poor and vulnerable at the third tier of the

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***Correspondence:**
David Chibuike Ikwuka, Department of Human Physiology, Nnamdi Azikiwe University, Nnewi Campus Nnewi, Nigeria.
***Tel**: +2348037147603.*
Email:
dc.ikwuka@unizik.edu.ng

Specialty Section:
This article was submitted to Basic Medical, a section of TJMR.

***Received:** 3 March, 2022*
***Accepted:** 9 May, 2022*
***Published:** 16 July, 2022*

Citation:
Nwobodo E, Ukwuije F, Egwuatu U, Ezugwu FO, Nwobodo N, Ojiakor A. et al,. Assessment of the Progress of the Implementation of the Basic Health Care Provision Fund in South East States of Nigeria. Trop J Med Res 2022;21(1):75-85. DOI: 10.5281/zenodo.6954870

Access Code

http://tjmr.org.ng

national health system. The implementation of this laudable programme started effectively in July 2019. The Nigerian health system is reportedly underfunded and plagued by significant corruption and poor management which translate to inadequate and poor quality of services at service delivery windows, especially in the primary healthcare facilities [1, 2]. The PHC tier of the health system happens to be where the poorest and most vulnerable groups of Nigerians reside and access healthcare. Despite consistent efforts by Government and its development partners, Nigeria continues to record minimal gains in health indicators, majority of which continue to fall short of national and international targets [1]. More dismal is the fact that the highest contributors to morbidity and mortality particularly amongst the most vulnerable groups are health conditions that are either preventable or can be effectively managed at the Primary Health Care (PHC) level [3]. The objective of the BHCPF remains to ensure the bridging of any gaps in funding of health service delivery and quality of service available to the poor and rural citizenry across the country especially at the PHC level.

National Health Law 2014 provided for the Basic Health Care Provision Fund (BHCPF). Section 11 of the Act established the Basic Health Care Provision Fund (BHCPF), as a vehicle for supporting the effective delivery of primary healthcare services, provision of a Basic Minimum Package of Health Services (BMPHS) and emergency medical treatment for all Nigerians [4]. The BHCPF is funded through the Federal Government annual revenue (at least 1% of the Consolidated Revenue Fund), grants by international donor and funds from other sources [5]. It is expected that the application of this fund will stimulate activities in the health sector especially the crucial primary health care tier of the Nigeria Health system. The purpose of the BHCPF are: (1) ensure the provision of a basic minimum package of health services to all Nigerians - with 50% of the BHCPF to be used for the provision of a BMHSP by the National Health Insurance Scheme (NHIS); (2) strengthen the PHC system - with 45% of BHCPF to be disbursed by the National Primary Health Care Development Agency (NPHCDA) for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (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 PHC (10% of BHCPF); (3) provide 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) [6].

Primary Health Care (PHC) is the foundational basis for the provision of healthcare services in Nigeria and this fundamental role is recognized by the Act in a series of sections designed to strengthen PHC [4]. This study centred on the NPHCDA gateway. The real implementation started in 2019 effectively with the actual guideline finally getting the required approvals only in 2020. This was two years after the actual appropriation of the funds. In effect, a substantial one percent of the consolidated revenue of the federation plus additions of other tiers and those from partners and donors funded the BHCPF. This was quite a substantial funding for the health system. The Minimum Service Package was developed to ensure that the Fund provides an essential healthcare for every Nigerian. This is supposed to be augmented by the spreading of the universal health insurance coverage by health insurance schemes and development of emergency medical responses, all provided for in the BHCPF provisions. At the PHC facilities, enrolment in BHCPF will qualify one to receive antenatal care, delivery, and postnatal care for pregnant women; immunizations and treatment for malaria, pneumonia, measles, and dysentery for children under five years ; hypertension and diabetes mellitus screenings, and family planning for adults [7]. Thus, the Fund is expected to be disbursed through three key gates namely, the NPHCDA, NHIS and EMT gates in different ratios.

The key requirement for states to qualify included the establishment of a State Primary Health Care

Board/Agency and Local Government Health Authorities (LGHAs) in accordance with the Primary Health Care Under One Roof (PHCUOR) policy, open a Treasury Single Account (TSA)with the Central Bank titled 'SPHCB/A BHCPF, evidence of contribution of the State and LGHA 25% counter-part funding paid into the SPHCB/A BHCPF treasury account, identify at least one (1) functional health facility in each ward for assessment and subsequent accreditation to enable its participation under the BHCPF, compliance with prevailing health policies as communicated by the NPHCDA, and the NH Act 2014 as well as make initial investments prior to fund receipt to ensure selected facilities conform to minimum standards for PHC (Human Resources, Infrastructure and Equipment). As it is, this was a tall order but most Nigerian States managed to qualify. However, it was not clarified what institutional and organisational capacity the said State Primary Health Care Development Agencies (SPHCDA)or Boards needed to have in place being the overarching managers of the processes in their respective States as in the PHCUOR policy. This study sought to establish the readiness of the States Agencies or Boards to access the funds under the stipulated conditions for qualification. We had earlier undertaken the institutional review of the Boards/Agencies in five Nigerian States [8]. We further assessed the readiness of the States to access the Fund in this paper based on the stipulated eligibility requirements. This is because the readiness to access the fund determines abinitio progress towards implementation process having qualified for disbursement of the funds.

The overall objective of this study was to track and document the progress of the implementation of this national programme after a full cycle of disbursement of the BHCPF. The goal is to identify early policy and programmatic issues in the implementation as well as assess and document the policy benefits or otherwise of the programme. An additional rationale for this study included to position to track the level of compliance to the approved guidelines of the BHCPF, to ascertain progress and identify relevant bottlenecks/challenges for the attention of South East Governors Forum (SEGF). It is expected that findings can generate evidence for evolution of germane health sector policies to tackle these bottlenecks. There was no mention of readiness to axxess funds already disbursed.

METHODS

Study design

The study adopted an exploratory survey research design. We deployed two tools namely a structured questionnaire for Executive Secretaries of the State Primary Health Agencies and a tracking tool adapted from the monitoring indicators of the basic health care provision fund operational guidelines.

Study area

This is a 2-part survey of a) the readiness of the primary health care development agencies of five states in southeast of Nigeria to access the BHCPF and b) the PHC facilities where we tracked the progress and problems of their implementation of the BHCPF. The second round of survey covered over 100 PHC facilities across selected five States in the region. For the purpose of avoiding naming and shaming, we have coded these five states as States A-E, but we retain actual data for each state as well as the corresponding agencies of the States who are involved in the management of the BHCPF programme. This study was conducted in the first and second quarters of 2020.

Recruitment of survey officers

The respondents to the first survey were exclusively the Executive Secretaries of the State Primary Health Care Boards or Agencies. These officers were directly interviewed at a survey meeting by some of the authors using a structured interview sheet that was thoroughly explained. For the second part of the study the survey officers were members of a consortium of Civil Society Organisations (CSO) operating at the health sectors of the participating States. The selected officers were trained on the principles of the monitoring and evaluation (M&E) framework of the operational guideline for BHCPF implementation of 2020.

Several briefing sessions with these survey officers were held in collaboration with a regional committee on health in the region. The initial meetings were virtual and focused on agreeing and clarifying the purpose and process of the study. The part-2 survey derived its questions from the M&E and accountability framework of the BHCPF Operational Guidelines developed to guide and streamline the operations of the Fund. In all, the tool selected 15 indicators to track at four different levels of the operations of the Fund to include a) the SPHCDA, b) the Local Government Health Authority (LGHA), c) the PHC facility, and d) the Ward Development Committee. There was only a time lag of three months between the two phases of this study.

Assessment of the capacity to implement at the level of the State's Primary Health Care Agencies

The initial part of the study utilized a structured and interviewer administered questionnaires on the Executive Secretaries and Directors of the five PHCDAs. Essentially, the interview interrogated the statutes of the five States Agencies on the five requirements from States before they could be eligible to apply to access and obtain funds from the BHCPF. The questionnaire also explored two recurring challenges of such agencies that could impact their capacity to implement the funds. In all, seven questions were asked, evidence sought and scores ranging from 0-5 were awarded for each domain to indicate the statuses of the states for the domain.

Development and administration of the survey instrument for PHC Facilities and structures

The survey applied a qualitative research method using the narrative approach. The responses obtained were analysed, triangulated, validated and scores for compliance were assigned to statuses of implementation or progress at the four levels. The scores were weighed against 1) presence of compliance, 2) absences of compliance, 3) evidence for compliance and expressed on scale 1-5. The development and consultation on a survey instrument (Tracking Tools) essentially derived from the M&E framework of the National BHCPF Implementation Guidelines as amended [6]. The instruments were shared to potential survey officers and explained to each officer before, during and after the trial runs. The utilization of the BHCPF Guidelines and Tracking tools to guide the surveys to obtain a balanced perspective was shared with both the clients and managers of the States' Primary Health Care Development Agencies.

Collation and Analysis of the reports

The results were collated by survey reports and virtual presentation and explanation of the reports involving all survey officers and practitioners including public managers of the PHC system and the UHC agencies of the region subsequently referred to as the stakeholders. The results were triangulated and confirmed. At these meetings, and based on the submission of the stakeholders as well as the survey including consortium of CSOs, the authors developed a brief. This study discusses this potential policy brief (action points), highlighting identified bottlenecks/challenges for leadership of the regional health sector to consider for policy shifts and adjustment. The virtual learning event was attended by a cross section of stakeholders from the government and citizens sides and facilitated by the authors with support from PERL. The event was an interactive session and provided a platform for the commencement of full operationalization of the partnership accountability framework. The consultant walked the participants through the various monitoring indicators which were adapted from the latest version of the BHCPF guideline [6] with the aim of improving their understanding of what should be monitored at each level of interaction.

Data Analysis

Validated findings were analysed using the narrative typology of qualitative research. The responses were subsequently noted and rated against the indicators among the States. The results of the ratings of the 7-domain assessments States' PHCDA are expressed as figures on a scale of 5.

RESULTS

1. Readiness of the SPHCB to access the Basic Health Care Fund

The result of the survey of the readiness to access the fund showed varying degrees of readiness with respect to the criteria for States to access the Fund. Table 1 summarizes the scores pooled by respective State Agencies in each of the domains of the 7-part questionnaire. For domain 1 namely 'what is your key service delivery target for 2020', the 5 Agencies were yet to do more than three of the following requisite actions namely, a) identified service delivery gaps; b) defined the targets; c) developed the plans; d) shared the plans; or e) implementing the plans. This five-scoring guide for this domain earned a score of *1* on a scale of *5 for each of the 5 stages of progress as listed above*. On the domain to have institutional focused training and mentorship of PHCDA staff and staff retention programme, again all States have done not more than two of the following requirements, a) list of trained staff and their new competences; b) timetable of training; c) database of trainings attended; d) On-the-job-capacity-building (OJCB) curriculum; or e) retention mechanism /approval of same. Similarly, on the criterion for having collateral agencies and coordination mechanisms for all the BHCPF gateways (NHIS, PHCDA, EMT), States were also not above 50% mark for readiness. However, on all other readiness to access Fund, ratings, such as 1) letter of intent; 2) payment of Government Counterpart Cash Contribution; 3) implementation of Ward Facility mapping and assessment, the States had appreciable rankings. The scores for each of the 7-domains interview is as in table 1.

2. Progress of implementation of the BHCPF at the PHC facilities and structures

The findings of the survey on the progress of implementation based on 15 tracking indicators as contained in the Operational Guidelines for the Fund is as shown in Table 2. The table shows that:

a) Two of the five States are yet to get or draw down on their disbursements at all.
b) Only one of five States rendered a timely financial report at 80% level.
c) All the States have some sort of capacity building around funds management and application.
d) Only 60% of the States have had the required business plans of facilities approved.
e) Facility utilisation has remained at less than 50% across the facilities.
f) Client awareness of the program is still zero in two of the surveyed States.
g) The ward development committees (WDCs) are either functioning at about 50% level or non-existent in the States.
h) Across board, less than 50% of intended beneficiaries access services at the facilities

In a nutshell, it is yet to be demonstrated that the implementation of the BHCPF in the surveyed States is achieving the expected, planned service improvements. It is also clear that a transparent and compliant use of BHCPF at the PHC facilities is still far from satisfactory. At the moment, only a small fraction of the intended beneficiaries could be said to be obtaining services, namely the Basic Minimum Package of Health Services (BMPHS). It is uncertain hitherto if there is due process in the application of funds which is deployed in the provision of quality health service for community members that should result in improved access to care, improved facility infrastructure/utilities and readiness to deliver PHC services with improved community participation.

State by State analysis

Some of the major findings from a collation of the reports are as summarized in Table 2. State B was able to complete its first and second quarters' implementation on a timely basis because disbursement was done directly to the PHC facilities through REMITA which is a Central Bank of Nigeria (CBN) accounting platform causing some level of bureaucratic delays in the regulated flow of funds to service delivery windows. We have deliberately concealed the actual names of these States for political reasons and opted for the A-E codes in this report.

There was delayed implementation in States A and C

despite the availability of an average of three hundred million naira in their respective CBN accounts. This is because of some level of non-compliance with some of the BHCPF Guidelines on requirements for training of health workers.
Some States are experiencing delays reportedly due to conflicts with their States' Health Insurance Scheme. There were implementational challenges in State E because of inadequate Human Resource for Health (HRH) to provide services as stipulated by the NPHCDA accreditation requirements to qualify to commence implementation.
There is an apparent lack of the required synergy between the SPHCDAs and the Universal Health Coverage (UHC) agencies of the States. There are wide variations in the number of lives being provided for in the States Health Insurance Scheme (SHIS) NHIS- gateway for various States; for instance, there is a possible 160 in State B whereas State E has a provision for 80 lives only, and this is without recourse to their population. The NHIS-gateway is reportedly not yet complementing the PHCDA gateway as required.
In any case, there is relatively low level of Civil Society Organization (CSO) involvement in the implementation process. This impact negatively on

Table 1: Self assessed readiness to commence implementation of the Basic Health Care Provision Fund Programme by Chief Executives of State Primary Health Care Agencies

	Domain	5 Criteria scale	State C	State B	State A	State D	State E
1.	What in your organisational structure constrains your mandate delivery?	Duplicity in reporting lines; incomplete desks; dearth of senior staff; MoH interference	3	4	2	2	4
2.	Letter of intent	Letter: Governor's approvals, dispatched and acknowledged receipt	5	5	5	5	5
3.	Government Counterpart Cash Contribution	Cash payment, PHCDA account; access to fund, draw down; compliance to guidelines (probe understanding)	5	5	5	5	5
4.	What is your key service delivery target for 2020?	Identified service delivery gaps; defined the targets; developed the plans, shared the plans, implementing the plans	2	2	2	2	2
5.	Implementation of Ward Facility mapping and assessment	Map, Assessment; Report; GIS; functional WDC/FHC	5	5	5	5	5
6.	Institutional focused training and mentorship of PHCDA staff, staff retention programme	List of trained staff and their new competences; timetable of training; database of trainings attended; OJCB curriculum; retention mechanism /approval.	3	3	3	3	3
7.	Collateral agencies and coordination mechanisms for all the BHCPF gateways (NHIS, PHCDA, EMT)	Existence of agency; platform for sharing and cooperation; understanding of roles; staff know and use the guidelines; guidelines availability at the PHCDA	2	2	2	2	2

Table 2: Findings from reports and structured questionnaire survey clients and operators of BHCPF -PHC facilities

Level of Tracking		Tracked Indicators	State A	State B	State C	State D	State E
PHCDA	1.	Timeliness of Disbursement to Facilities	0%	50%	0%	100%	50%
	2.	Timely Financial report	0%	0%	0%	88%	0%
	3.	Approval of plans and budgets	0%	100%	0%	100%	100%
	4.	Capacity building of Facility managers	0%	100%	100%	100%	100%
LGHA or Department	5.	Approval of plans	0%	100%	100%	100%	100%
PHC Facility	6.	Procurement process compliance	0%	80%	0%	>70%	>80%
	7.	Spending structure compliance	0%	100%	0%	>70%	>50%
	8.	Statement of bank accounts	0%	>70%	0%	>50%	>80%
	9.	Bookkeeping and financial reports	0%	>70%	0%	>70%	>80%
	10.	Facility utilisation and Clients' throughput	0%	X	0%	X	>50%
Community and Ward Development Committees (WDCs) Or Facility Health Committees (FHC)	11.	Client awareness of service availability	0%	>80%	0%	>80%	>80%
	12.	Community Participation in facility procurements	0%	>80%	0%	>80%	>80%
	13.	WDCs Signatory to the account	0%	<50%	0%	<50%	>50%
	14.	Integrity of the WDC	0%	<50%	0%	<50%	0%
	15.	Outputs of expenditures	No PHC facility is yet participatin g in the BHCPF (0%)	Only 292 of over 722 facilities participating in the BHCPF. (40%)	About 305 of 518 facilities participating (59%)	Only about 160 PHCs are participating ()	176 qualified to participate instead of the 339 PHCs that are selected to participate. (52%)
	16. 17. 18.	Outcomes Impacts [1] Number of persons accessing services	About 0 %	Less than 50%	Less than 50%	Less than 50%	Less than 50%

the provision of independent tracking of implementation using the approved accountability framework of the BHCPF Implementation Guideline.

A core ingredient of the BHCPF structured expenditure is procurement of medicines and other health commodities and to be able to account for them. There is no public Central Medical Store in some States, such as State D, to facilitate verifiable and transparent procumbent of quality medicines and consumables. This can deprive such States of the benefits of bulk purchase pricing.

The Ward Development Committees (WDC) is key to successful implementation of the BHCPF in so far as the leadership of this committee is one of the lead signatories to the ultimate service window account. It may be necessary for the Town Unions or Ward Councillors to be mandated to facilitate the selection, election and supervision of men and women of integrity into the WDCs of benefitting Wards/PHCs/Communities.

Many PHC facilities still lack basic water and electricity supply. There is need to explore the solar power option, but this clearly requires financing that could come from this Fund. Staff quarters are necessary in these facilities to ensure staff availability. There is need to sensitize the various rural communities on the availability of the BHCPF services and to start to register vulnerable groups that can best benefit from this Fund across the region. The usefulness of the BHCPF in ensuring functionality of the various service delivery windows and health centres appears to be highly promising in some of the States in the region in which the programme has started more effectively.

DISCUSSION

The first part of this study revealed the readiness of the State Primary Health Care Agencies to receive and implement the BHCPF [8]. It indicated the varying state of readiness of the agencies and by extension the States in this region to meet with the requirements to qualify to access the Fund [8]. A more detailed institutional review of the Boards to manage PHC services [9] indicated varying levels of institutional capacity. In other words, the institutional readiness was essential for PHCDAs to ensure effective management of the Fund given the fair correlation of the institutional organisational score and level of progress of BHCPF in the sample States.

The findings showed that there are many gaps in the understanding and implementation of the Basic Health Care Provision Fund (BHCPF) among operators of the PHC facilities, many managers as well as poor awareness about the existence and operation of the BHCPF among potential beneficiaries. There is therefore need for clear and consistent information and education activities among both supply and demand side actors. Two of five States selected for this study were yet to start implementation, while some were only 50% into the process. Of all the reasons listed for no/slow progress, the authors determined that all the issues were largely manageable. The core problems are summarized for specific States in Table 2.Some of the problems included human capacity deficits that can be bridged by the PHCDA of respective States; locational issues such as remote and rural areas that have suppliers that cannot issue receipts for retirement of funds and others are more of internal conflict between the communities/WDCs and managers of the PHC facilities.

Independent citizens and civil society organisations (CSOs) in various communities though clearly recognized and trained for this study, can be crucial for tracking of the BHCPF implementation using the National implementation Guideline. Such demand side actors need financial or logistical support in accessing the approved facilities for implementation of the Basic Health Care Provision Fund; training on the revised BHCPF National Operations Manual in order for them to have a clear understanding of how to independently track and report progress and issues of BHCPF implementation to ensure that the targeted beneficiaries are reached. The States will need to continually train and support their PHC on the BHCPF Guidelines including the spending structure and accountability.

It is uncertain how citizens CSOs reporting can be

coordinated, consolidated and configured for process improvements by managing authorities as in the BHCPF operational guidelines [6]; and how such reports could reach high level managers and policy makers. In any case, the SPHCDA will need to provide more management support to the BHCPF facilities including such basic procedures as book-keeping, plan development and financial reporting. There is a need to clearly mark out BHCPF facilities for identification and referrals.

A detailed analysis of the status of implementation, level of compliance and potential outcomes of the Fund in the study States indicated some important challenges and bottlenecks. In summary, two States are yet to commence implementation. One State is yet to start implementation in nearly half of the approved facilities. The other two States are implementing but with some issues that range from a) poor compliance; b) poor reporting; c) poor accounting; d) fraud; e) lack of adequate human capacity and numbers; f) weak monitoring framework; f) lack of synergy between the two key Agencies of the States in this process namely the Universal Health Coverage (UHC) Agency and the State Primary Health Care Development Agency (SPHCDA); and g) absence of key States health infrastructure such as the Central Medical Store that aims to assure verifiable procurement of quality and affordable medicines for the PHC facilities.

The State A Government will be required to provide funds for the training of PHC staffers of the BHCPF PHC facilities for them to undergo final NPHCDA certification and authorization to draw down their BHCPF from the REMITA platform of the CBN. This will mean that the citizenry is yet to start to benefit from the good intentions of the BHCPF and the enabling Health Act.

State C continues to await final verification by the NPHCDA and BHCPF teams; this could be facilitated by the State Government to ensure eventual commencement of implementation.

State E and other States will be required to provide adequate number of Human Resources for Health (HRH) to provide services in these BHCPF facilities.

And to ensure continual availability of the bespoke staff for accreditation to provide BMPHS under the BHCPF, it is recommended that all States should provide housing for staffers of the health facilities within or about the facilities, especially in the rural areas.

There are indications of self-interests and halting quarrels in the operations of WDCs (constituted from members of the respective Communities) who are part of the management of this fund by default. It is therefore, important that Local or State Governments could facilitate organized Town Unions or such Government structures at these levels to sanitize the election or selection of members of the WDCs (or Facility Health Committee in some States). The two Agencies of the States (SPHCDA and Agencies for health insurance schemes) involved in the BHCPF implementation continue to work in apparent cross purposes; Governments are invited to facilitate collaborative working of the Agencies across the States.

This study succeeds in articulating the status and bottlenecks in the implementation of the BHCPF in the Southeast States of Nigeria. The information presented represents the synthesis of the views of managers of the BHCPF agencies in the States as well as persons from the demand side. The issues vary across the States and have been summarized in Table 1. Some issues that are beyond the authority of the agencies of Government could be articulated for the attention of Governments and managers of the BHCPF for remediation and potential adjustments in an eventual revision of requisite policies and programming. In all, the implementation of the BHCPF is off to a shaky start in some Nigerian states and significant support and coordination from all sides will be required. It should, however, be expected that new policies will take time to get steady and consistent results, but that is if and only early warning signs are identified and adequately addressed.

CONCLUSION

In conclusion, these many issues arising from the take-off and implementation of BHCPF warrant continuing capacity building and supervision of the

programme. Adherence to her guidelines, it appears that the stipulated processes are too complicated relative to the capacity of managers at the PHC tier but with continuing handholding, the processes and adherence is expected to improve. Certain States are at lower readiness to access the fund due to the alluded complicated processes.

Acknowledgements
The authors wish to acknowledge the funders of this survey, the DFID-PERL-ARC Programme, Nigeria. And we are immensely grateful to all the CSOs who participated in this active monitoring exercises and reportages.

Author Contributions
E Nwobodo, FN Ukwuije, Ucheoma Egwuatu and F Ezeugwu conceptualized and designed the study. U Egwuatu, N Nwobodo, A Ojiakor and DC Ikwuka contributed to data collection. E Nwobodo, FN Ukwuije and DC Ikwuka contributed to data analysis. All authors contributed to manuscript writing and revision and gave final consent of the version to be published.

Data Availability
The data used to support the findings of this study are available from the site publicly.

Funding
Funding was provided by DFID-PEL ARC Programme for the field work for data collectors and analysis of the data.

Conflict of Interest
There is no conflict of interest.

Ethical Approval
Ethical approval was provided by the five Ministries of Health in the region where the studies were conducted.

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