NATIONAL HEALTH INSURANCE SCHEME

FEDERAL REPUBLIC OF NIGERIA

STRATEGIC PLAN 2020 – 2030

Financial Access to Quality Healthcare for All Nigerians

2020

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
BOD	Burden of Diseases
CBSHIP	Community-Based Social Health Insurance Programme
CHAI	Clinton Health Access Initiative
CMD	Contribution Management Department
COVID-19	Coronavirus Disease 2019
CRF	Consolidated Revenue Fund
CSF	Critical Success Factor
CSO	Civil Society Organisation
CU5	Children Under Five
DP	Development Partners
DPRM	Department of Planning Research and Monitoring
DPRS	Department of Planning Research and Statistics
DQA	Data Quality Assurance
DRG	Debt Relief Grants
DRPC	Development Research and Project Centre
DSF	Demand-Side Financing
EDMS	Electronic Document Management System
EMR	Electronic Medical Records
ERP	Enterprise Resource Planning
ESO	Executive Secretary's Office
FAD	Finance and Accounts Department
FBO	Faith Based Organisations
FCT	Federal Capital Territory
FIRS	Federal Inland Revenue Service
FMoF	Federal Ministry of Finance
FMoJ	Federal Ministry of Justice
FMoH	Federal Ministry of Health
FMoLP	Federal Ministry of Labour and Productivity
FSD	Formal Sector Department
GDP	Gross Domestic Product
GFF	Global Financing Facility
GM	General Manager
HCF	Health Care Facility
HCP	Health Care Provider
HERFON	Health Reform Foundation of Nigeria
HHE	Household Health Expenditure
HIBPA	Health Insurance Business Process Automation
HIMS	Health Information Management System
HIPAA	Health Insurance Portability and Accountability Act
HIPF	Health Insurance Partners Forum
HIUOR	Health Insurance Under One Roof
HMO	Health Maintenance Organisation
HP+	Health Policy Plus
HRAD	Human Resource and Administration Department
HRH	Human Resource for Health
HTA	Health Technology Assessment
IAD	Internal Audit Department
ICT	Information and Communication Technology

ICTD	Information and Communication Technology Department
IDPs	Internally Displaced Persons
IGR	Internally Generated Revenue
IHSA Ltd	Integrated Health Strategy and Analytics Limited
ILO	International Labour Organisation
IPT	Intermittent Preventive Therapy
ISC	Implementation Steering Committee
ISD	Informal Sector Department
ISS	Integrated Supportive Supervision
JLN	Joint Learning Network
KPI	Key Performance Indicators
LGA	Local Government Area
LMG	Leadership Management and Governance
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MFL	Master Facility List
MHAs	Mutual Health Associations
MSH	Management Sciences for Health
MTSS	Medium Term Sector Strategy
NASCP	National AIDS and STDs Control Programme
NASS	National Assembly
NBS	National Bureau of Statistics
NCDC	Nigeria Centre for Disease Control
NCH	National Council on Health
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NHIS-SP	National Health Insurance Scheme-Strategic Plan
NHMIS	National Health Management Information System
NHP	National Health Policy
NHRHIS	National Health Resources for Health Information System
NIGComSAT	Nigeria Communication Satellite Limited
NIMC	National Identity Management Commission
NITDA	National Information Technology Development Agency
NMEP	National Malaria Elimination Programme
NP	National Planning
NPH	National Partnership on Health
NPHCDA	National Primary Health Care Development Agency
NPI	National Provider Identifiers
NSHDP	National Strategic Health Development Plan
NSHIP	Nigerian State Health Investment Project
NTLCP	National Tuberculosis and Leprosy Control Programme
OAGF	Office of Accountant-General of the Federation
OAuGF	Office of Auditor-General of the Federation
ODA	Official Development Assistance
ODK	Open Data Kit
OHCSF	Office of the Head of Civil Service of the Federation
OOPE	Out of Pocket Expenditure
OPS	Organised Private Sector
PBF	Performance Based Financing
PEMS	Public Expenditure Management System

PERs	Public Expenditure Reviews
PETS	Public Expenditure Tracking Studies
PFM	Public Finance Management
PHC	Primary Health Care
PHI	Private Health Insurance
PIFFP	Presidential Independent Fact-Finding Panel
PPMs	Provider Payment Mechanisms
PPMVs	Patent and Proprietary Medicine Vendors
PRM	Planning, Research and Monitoring
PRMD	Planning, Research and Monitoring Department
PROC	Procurement Department
QALYS	Quality Adjusted Life Years
R4D	Results for Development
RBF	Result Based Financing
RbM&E	Results-based Monitoring and Evaluation
RMNCAH+N	Reproductive, Maternal, New-born, Child, and Adolescent Health
SDGs	Sustainable Development Goals
SDI	Service Delivery Indicator
SGA	Skill Gap Analysis
SGHE	State Government Health Expenditure
SHIA	State Health Insurance Agency
SHIP	Social Health Insurance Programme
SMoH	State Ministry of Health
SOMLPforR	Save One Million Lives Program-for-Results
SOPs	Standard Operating of Procedures
SPA	Self-Paying Agencies
SPHCDA	State Primary Health Care Development Agency
SQAD	Standards and Quality Assurance Department
SSF	Supply Side Financing
SSHIA	State Social Health Insurance Agency
SSHIS	State Social Health Insurance Scheme
STIs	Sexually Transmitted Infections
SYNDANI	Sydani Initiative for International Development
TA	Technical Assistance
TB	Tuberculosis
THE	Total Health Expenditure
TMC	Top Management Committee
TOR	Terms of Reference
TISHIP	Tertiary Institutions Social Health Insurance Programmes
UHC	Universal Health Coverage
UNGA	United Nations General Assembly
USD	United States Dollar
VCSHIP	Voluntary Contributors Social Health Insurance Programme
WHA	World Health Assembly
WHO	World Health Organisation
ZSOD	Zonal and State Offices Department

ACKNOWLEDGEMENT

The path to the development of this plan was paved by the Presidential Independent Fact-Finding Committee, which recommended the development of this all-important document that will serve as a guide to the NHIS and its various stakeholders towards the attainment of UHC in Nigeria. The invaluable contributions of several stakeholders led to the development of the 10-year strategic plan for the Scheme.

The Honourable Minister of Health Dr. Osagie Ehanire, and his team provided the enabling environment necessary for this work. We are grateful for this critical role.

Our gratitude also goes to the Executive Secretary of the NHIS, Prof Mohammed Nasir Sambo, for his unique leadership and guidance throughout this project. The Management Staff of NHIS collectively set the strategic direction upon which the Plan was anchored. I also want to thank all staff of the NHIS who contributed in one way or the other towards the development of this document, especially the selected members of NHIS Task Team under the coordination of Dr Kurfi Abubakar and the members of the Secretariat for their tireless commitment to the project.

I also want to appreciate the management of Integrated Healthcare Services Analytics, the consultants on this project. They demonstrated great commitment and dedication to the whole process. I will also want to thank the Development Partners that fully supported and participated in the project, for their unwavering financial and technical support. Worthy of mention in this regard are BMGF and its implementing Partners, The Lafiya project, WHO, to mention but a few.

To all I say thank you for your support.

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General Manager

{Planning Research and Monitoring Department, NHIS}

PREFACE

National Health Insurance Scheme (NHIS) was established to provide easy access to healthcare for all Nigerians at an affordable cost through various prepayment mechanisms. It became operational in the year 2005 with a presidential mandate to achieve Universal Health Coverage (UHC). However, as at today the NHIS covers less than 10% of the Nigerian population leaving the most vulnerable population at the mercy of healthcare services that are not affordable, this for me, is totally unacceptable.

Upon my appointment as the Executive Secretary of the NHIS, I was given the presidential directive to develop a comprehensive 10-year strategic plan for the organization. The importance of this plan cannot be over emphasized, as it will articulate the vision, mission, as well as the strategic direction of the NHIS for the next 10 years.

This Strategic Plan is an important document in the revitalization and expansion of health insurance in Nigeria. It was developed in line with my 3-point agenda of value reorientation, engendering transparency and accountability in all the operations of the NHIS as well as accelerating the drive towards UHC.

I believe, this document will guide policy formulation, utilization, and health insurance implementation in Nigeria. It will serve as an exceptionally good tool in serving as a milestone for measuring the progress of my intended reforms in the Scheme.

I therefore, urge every stakeholder in the health sector in Nigeria to utilize this document in improving health care delivery in Nigeria.

Prof. Mohammed Nasir Sambo

Executive Secretary/CEO

FOREWORD

National Health Insurance Scheme (NHIS) is a body corporate with a perpetual succession and a common seal. It was originally established under a military Decree No. 35 of 1999, now an Act of the National Assembly contained in Cap N42 LFN, 2004 with the sole aim of mobilizing resources to provide easy access to healthcare for all Nigerians at an affordable cost. It became operational in the year 2005 with a presidential mandate to achieve Universal Health Coverage (UHC).

However, as at today, the NHIS covers less than 10% of the Nigerian population leaving the most vulnerable population at the mercy of healthcare services that are not affordable. Simply put, the informal sector which constitutes more than 70% of the Nigerian population lack access to any form of social health insurance, therefore exposing them to financial hardship when accessing healthcare.

The importance of the development of the 10-Year Strategic Plan cannot be over emphasized in the sense that broadly speaking, NHIS has one goal and one goal alone which is the attainment UHC. And to achieve UHC in Nigeria, there must be a strategic plan to guide and help the Scheme towards achieving that goal.

It is my strong belief that this Strategic Plan will help NHIS to better realize its mission and to move towards its vision.

While appreciating all those who provided support in the development of this Plan, I urge every stakeholder in the health insurance sector to use this plan for the overall good of the health sector in Nigeria.

Dr. Osagie Ehanire

Honourable Minister of Health

EXECUTIVE SUMMARY

Background:

The Federal Government set up a presidential Independent Fact-Finding Panel (IFFP) on the NHIS to examine its activities, amongst other things, the Panel recommended the development of a 10-Year Strategic Plan to reposition NHIS and accelerate progress towards UHC.

Considering the above, the Management of the NHIS under the leadership of Prof Mohammed Nasir Sambo is pleased to present this 10 Year Strategic Plan for the NHIS. The purpose of the strategic plan is to define the future direction for repositioning NHIS for efficiency and better performance and outline measurable goals for achieving UHC and how to achieve these goals.

The Specific Objectives of the Strategic Plan include:

1. Accelerating the attainment of Universal Health Coverage through 90% coverage of the populace with health insurance by 2030.
2. Ensuring substantial pooling of resources to guarantee adequate financial risk protection from catastrophic health expenditure for all enrollees.
3. Enshrining good governance, strategic communication, transparency, and accountability within the National Health Insurance scheme with strategic communication.
4. Ensuring that equity remains a priority in the programmes of the National Health Insurance Scheme and that vulnerable groups have financial protections while accessing healthcare services.
5. Fostering Strategic purchasing of healthcare goods and services with a focus on increasing provider efficiency.

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The Strategic plan will therefore aid the NHIS in the following:

- **Agenda Setting**: to set direction and establish priorities towards achieving Universal Health Coverage, over the next decade.
- **Result-focused**: Strengthening programmes, operations, quality assurance, administration, and all Departments, to achieve NHIS's goals.
- **Streamline decision making**: Identify priority activities necessary for success.
- **Aligning resources with priorities**: Mobilisation of resources for better alignment to maximise NHIS strategic success.
- **Strategic communication**: Communicating NHIS vision and mission to all stakeholders.

Strategic Pillars

> The NHIS-SP consists of Five (5) Strategic Pillars, Nine (9) Priority Areas, Ten (10) Goals, Thirty (30) Strategic Objectives and Forty-Three (43) Indicators. It also contains Sixty-Six (66) Implementation Strategies and Two Hundred and Forty-Seven (247) Key Activities aimed at catalysing the achievement of universal health coverage in Nigeria

The Strategic Plan has been carefully articulated to reinforce the determination of the government to achieve Strategic Objectives for Health Financing identified in NSHDP II, by providing a common strategic framework and plan for improving financial access, quality and affordable healthcare for all Nigerians, during the period 2020 – 2030.

The Strategic Plan has five (5) pillars:

I. Improving Organisational Capacity and Culture
II. Promoting Good Governance and Accountability
III. Expanding Coverage
IV. Integration of ICT
V. Promoting Research and Innovation.

The Development Process

Following the directive on the IFFP report, the Management of NHIS made provision in its 2020 budget and solicited support from the Development Partners to produce the Strategic Plan. The Scheme engaged a consultant Integrated Health Strategy and Analytics Limited (IHSA), to facilitate the process in conjunction with an in-house Task Team. The process included retreats and discussions among internal and external stakeholders. The final draft was validated at a meeting of the Top Management Committee (TMC) of the NHIS. Technical Support for costing the Strategic Plan were provided by the DFID Funded Lafiya Project.

Implementation of the Plan

The over-arching framework for implementing the plan is Health Insurance Under One Roof (HIUOR) which allows NHIS to coordinate and integrate various activities and stakeholders in the health insurance ecosystem. The five pillars have Monitoring and Evaluation (M&E) strategies as a cross-cutting concern.

Costs

1. **Program Cost**: The cost of program management activities and investments is estimated at N91.6 billion over the 10-year period 2021-2030. Program management and investment costs of N16.3 billion in the first year of the plan (2021) represents 17.8% of the total 10-year cost. Investments in integrated information and communication technology (ICT) in the first year valued at N6.9 billion include N4.0 billion in automation of NHIS end-to-end business processes and N1.7 billion in network interconnectivity for NHIS HQ, Zonal and State Offices. A total of N6.0 billion is also expected to be spent on repositioning the NHIS through improvements in organizational capacity and readiness for service excellence. Major

investments in this priority areas in the first year include N1.4 billion on staff training and development, N1.3 billion on deployment of qualified officers to zones and states in line with the decentralization plan, and N1.0 billion on procurement of project vehicles for effective service delivery. These are major catalytic investments needed to be made upfront in order to create the enabling environment for achievement of the goals and objectives of the plan.

Over the 10-year period, organizational capacity and culture is the leading cost driver, accounting for a total of N46.0 billion equivalent to 50.2% of total costs. Leading cost elements are staff training and development – N13.9 billion, construction of HQ and State Office buildings – N12.5 billion, project vehicles – N5.0 billion and corporate social responsibility (CSR) – N3.5 billion. Other major cost drivers over the 10-year horizon are investments of N19.9 billion, equivalent to 21.7% of total costs, in Integrated ICT and expenditures estimated at N11.3 billion, equivalent to 12.4% of total costs, on strategic purchasing at 12.4%. Leading cost elements in the strategic purchasing priority area include N4.9 billion on biennial nationwide re-accreditation of existing and accreditation of new healthcare providers, HMOs and MHAs; and N2.7 billion on quality assurance and compliance visits to healthcare providers and HMOs.

2. Population Estimates

The population of Nigeria is projected at 211.5 million in 2021 and is projected to grow at an annual rate of 2.6% per year to reach 266.1 million by 2030. The formal sector (comprising the public sector and organized private sector) constitutes approximately 12.8% of the population, while the non-vulnerable informal sector constitutes 36.6%. The vulnerable population groups account for the remaining 50.6% comprising informal pregnant women – 4%; children under5 – 15.0%; the elderly (above 64 years) – 3.0%; and the indigents – 28.6%.

3. Coverage and Benefit Package Cost

Currently, only about 4.2% of Nigerians are covered under the social health insurance. However, by virtue of expansion of state-supported health insurance schemes, this rate is projected to reach 8.8% by 2021 and 70% by 2030. Coverage growth of different population groups differ; the vulnerable and non-vulnerable groups' coverage are expected to begin at 5% in 2021 and increase to 70% by 2030 while the non-vulnerable informal group has a slower coverage rate and reaches only 59% by 2030. The public sector and their dependents have coverage rate set at 68% by 2021 and is expected to increase rapidly to cover the whole public sector by 2025. With only 3% coverage rate by 2021, the private sector and their dependents have the lowest start-up coverage rate, however, their coverage is expected to grow rapidly to 80% by 2030. Benefits package costs are N14,994 for current and retired federal government workers, civil and armed services, N12,000 for state employees and the vulnerable groups (except for prison inmates) and N2,000 for students of tertiary institutions

Results and Analysis

Projected resource needs for vulnerable population groups on a current basis will increase rapidly from N64 billion in 2021 to N1.2 trillion by 2030. The pool of BHCPF NHIS Gateway and States' and LGA equity funds as well as donor program funds, airline and airtime levies are sufficient to cover only 20% of the vulnerable population groups by 2023 in the baseline scenario, while coverage will extend to 48% by 2027 in the second scenario due to an increase in projected revenue pool.

Projected needs for total population on current basis are projected to increase from N236.8 billion in 2021 to N2.5 trillion by 2030 when 70% of the population will be covered. Projected revenues from contributions and baseline scenarios for government equity funds and BHCPF, donor programs and innovative financing (airline and telecom levies) sum up to N328.5 billion in 2021 and is projected to increase to N1.6 trillion by 2030. In the first scenario where potential funds available are set against the population coverage, the combined pool of funds is sufficient to pay for coverage in the first two years of the plan and achieve coverage of 16.2% in 2022 before running out of reserves; whereas in the second scenario, the pooled funds are sufficient to cover only up to 43.9% of the population by 2026.

Increasing the Fiscal Space

The management of NHIS and SHIAs will collaborate with all the stakeholders including Ministries, Departments and Agencies implementing social protection programs with the aim to mobilize a portion of disbursements into the social insurance schemes to finance healthcare coverage for the recipients. Other non-traditional sources of revenues that the NHIS can explore include but are not limited to Philanthropies, Sin tax (on alcohol and tobacco), Looted funds returned to state treasuries, Legislative actions (tax on medical tourism, investment of looted funds), and Value-Added Tax (VAT) on luxury services among others.

Investment Case for the NHIS Strategic Plan

Investing in health insurance expansion in Nigeria will significantly lead to a reduction in maternal, neonatal and child morbidity and mortality as shown in this plan. It will also improve the social and economic conditions of Nigerians. It is therefore imperative for all stakeholders to support the NHIS to ensure the full implementation of this plan towards the overall health, economic and social progress of Nigeria.

CHAPTER 1

INTRODUCTION

1.1 Background

Country and Health System Context

Nigeria is located in the West Africa and shares boundaries with Benin, Niger, Cameroon, and Chad. Administratively, the country operates a federal system of governance comprising a Federal Government, 36 State Governments , a Federal Capital Territory (FCT), and 774 Local Government Areas (LGAs). The LGAs are further divided into 9,565 political wards. Nigeria is a multi-ethnic and multi-lingual country that stands out as the most populous country in Africa and one of the top 10 most populous countries in the World with an estimated population of 206 million as at 2020.

The Health System in Nigeria is quite complex, and this complexity is partly as a result of the shared responsibility of providing healthcare services by the three tiers of Government as well as the multi-ethnic and multilingual nature of the country. The Federal Government is mainly responsible for supporting the provision of tertiary care through Federal Teaching Hospital and Federal Medical Centres while the State Governments are primarily responsible for providing secondary care which they provide through State General Hospitals and Comprehensive Healthcare Centres. The local governments are expected to spearhead the provision of primary healthcare services through primary healthcare centres with requisite support from the Federal Government and State Governments. (Babayemi Olakunde, 2012)

There have been different challenges within the health system such as the suboptimal delivery of healthcare services, dwindling funding for healthcare amid rising costs, high dependence on government-owned healthcare facilities and poor integration of private healthcare facilities into the nations health system. These challenges were further accentuated by high out-of-pocket payment by the populace without any tangible financial protection from catastrophic healthcare expenditure. This necessitated the need for a statutory organization that would help to pool resources, purchase healthcare goods and services actively and protect the populace from catastrophic healthcare expenditure.

Establishment and Mandate of the NHIS:

Over the years, there have been considerable efforts aimed at strengthening the health system to ensure delivery of effective, affordable and efficient services at all levels without financial hardship and

achieve better health outcomes. To advance this goal, the National Health Insurance Scheme (NHIS) was established as a corporate body in 1999, by virtue of Decree 35 of 1999 (now cited as NHIS Act Cap 42 LFN, 2004). However, the NHIS became operational in 2005 and since then has remained functional, striving to meet its mandate.

The mandate of the NHIS is to provide social health insurance to Nigerians, ensure Nigerians have access to qualitative and affordable healthcare; regulate and manage all stakeholders of the Scheme including providers of private health insurance. This mandate is reinforced by the existence of relevant legislative and policy instruments with appropriate provisions and clearly set objectives and targets including the National Health Act, the National Health Policy and the National Health Financing Policy and Strategy . [2]

Consequently, the National Health Insurance Scheme, through its various programmes designed to cover different segments of the society, had sought to establish a substantial resource pool that has the capacity to meet the health system goals of improving the health status of Nigerians; ensuring financial risk protection for citizens against cost of healthcare and further strengthen the NHIS to advance strategic purchasing of healthcare services. [3]

Over the past decade, health insurance has expanded slowly in Nigeria but with a potential to exponentially rise. Available health insurance programmes cut across different groups that can be broadly categorized into:

I. Formal Sector Groups

II. Informal Sector Groups

III. Vulnerable Groups

The insurance programmes of these groups are funded through three distinct mechanisms:

(1) Formal Sector Groups comprises the Public sector, organized private sector and the Armed Forces, Police and other Uniformed and Para-military Services. These Formal sector groups are funded through employer-employee funds based on legislation that mandates employers of labour and employees to finance health insurance.

(2) Informal Sector Groups consist of members of the informal sector engaged in non-formal economic activities. These informal sector groups are funded by contributions involving some form of risk-sharing between members/contributors within the informal sector that are related through a common organization such as professional groups, cooperative societies etc.

(3) Vulnerable Groups are groups of persons who due to unavoidable circumstances (including age) cannot engage in any meaningful economic activity. These vulnerable groups are funded through social protection interventions such as the , the BHCPF, equity funds, constituency projects programmes, the defunct MDGs MCH etc.

The different health insurance programmes that are available under the National Health Insurance Scheme are highlighted in Figure 1 and classified based on if they are contributory or non-contributory.

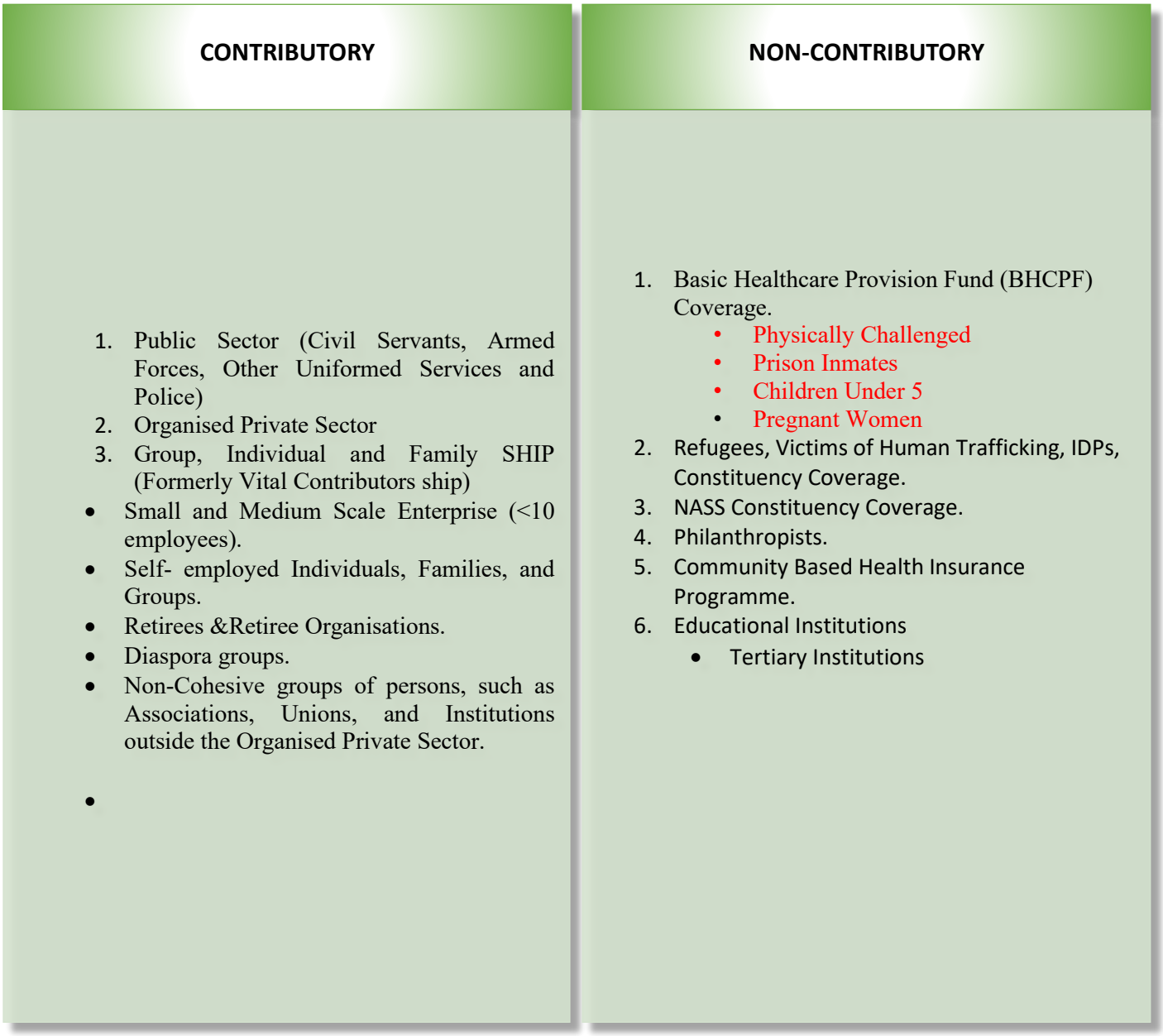


Figure 1: NHIS Programmes

However, in spite of several strategic efforts made by the national government and the Scheme, achieving equitable financing continues to pose a serious problem for health systems at all levels.

Based on available reports, the population coverage has remained dismally low and stuck at about 5% and the OOPE remains considerably high at 76.6% [(4), (5)]. Meanwhile, current administrative data indicates that there is significant increase in the population coverage to about 10% due to progress made in the SSHIS expansion. In the same vain, the country is not making significant progress on the Global UHC Tracking Indicators. These developments are primarily due to considerable limitations that have constrained the Scheme from performing its functions and achieving the desired result of improvements in population health outcomes, towards attaining UHC.

In order to reverse the ugly trend, the country has shown greater commitment to the implementation of both the United Nations General Assembly (UNGA) and World Health Assembly (WHA)

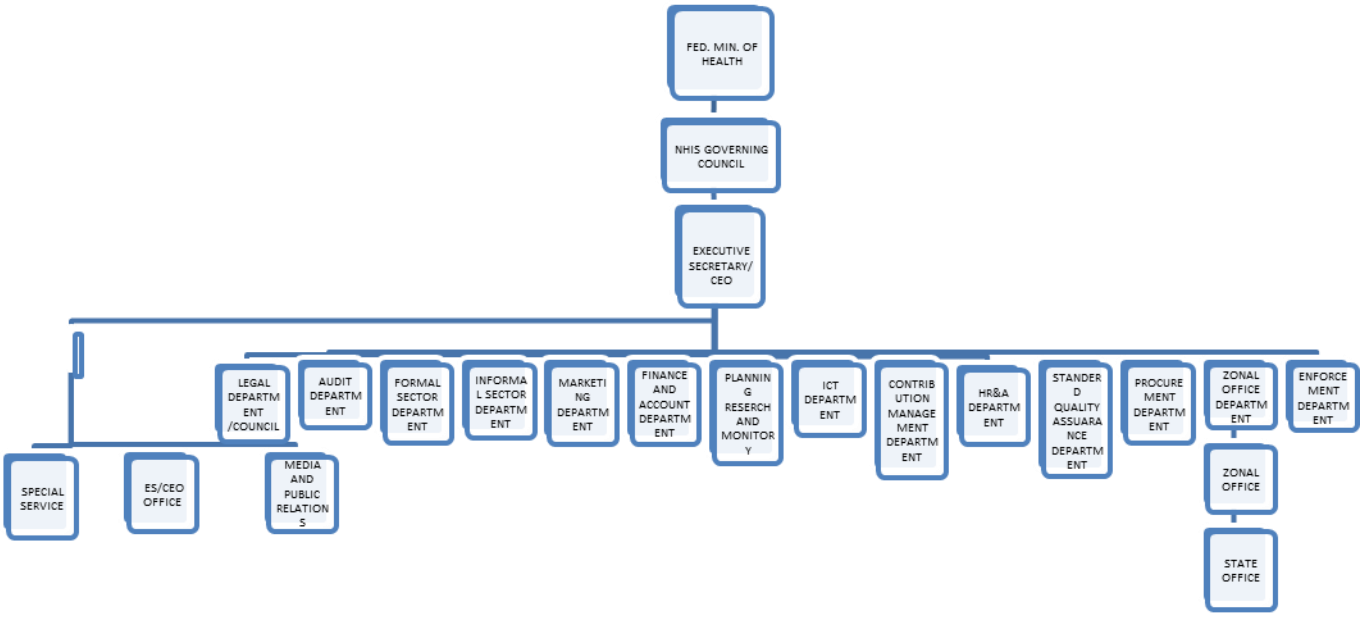
resolutions on Universal Health Coverage. So far, a number of policy *commitments and actions* have been taken in this regard. These include the revision of the National Health Policy in 2016, the development of the National Health Financing Policy in 2017 and the strengthening of Primary Health Care Governance through the implementation of Primary Health Care Under One Roof initiative. [(1), (6)]

Other related actions include the *Presidential Summit on UHC in 2014 with multiple declarations* that re-enforces the UHC agenda as a National Priority of all tiers of Government, the setting up of the Presidential Independent Fact-Finding Panel (PIFFP) on the NHIS in 2019, to examine its activities. The PIFFP recommended the development of a 10-Year Strategic Plan to reposition NHIS and accelerate progress towards UHC. [(7), (8)]

As an organisation, NHIS has experienced a high turn-over of Chief Executives, which has impacted on its ability to follow through with reforms and expand financial risk protection to Nigerians outside the federal public sector. To bring stability and renewed focus, the current ES/CEO has introduced a 3-point Reform Agenda. [(9)] This is anchored on *Value Re-orientation, Engendering Transparency and Accountability in NHIS operations and Accelerating the drive towards UHC*, with 18 elements.

The agenda on *accelerating the drive towards UHC* identified two (2) core elements - to Consolidate existing programmes and to Innovate by creating mechanisms to cover those currently not covered by Health Insurance.

Figure 2: Organogram of the NHIS



Universal Health Coverage (UHC) is one of the targets of the sustainable development goals and aims to ensure that all persons have access to quality healthcare services at a cost that does not cause them to face financial hardship. UHC is closely tied to the Health Financing function in the health system which involves resource mobilization, pooling, purchasing of healthcare services and goods, as well as to setting the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000). UHC can be achieved only with the right mix of healthcare financing sources and the efficient utilization of financial resources for health.

Health Financing can be a lever to UHC as the attainment of UHC requires mobilization and pooling of financial resources as well as the strategic purchasing of healthcare from providers. Key recommended health financing reforms to accelerate UHC include the move towards predominant public funding and compulsory health insurance, reduced fragmentation in pooling to enhance the re-distributional capacity of prepaid funds and strategic purchasing of healthcare with appropriate provider incentives (WHO 2017). The NHIS has sought to advance these health financing priorities through its programmes and activities and will continue to do so towards meeting its mandate.

Health Insurance and Universal Health Coverage

Health insurance is a major health financing mechanism that is essential for the attainment of UHC. Through the NHIS, Nigeria utilizes a mix of social health insurance and tax-based health insurance to advance its quest for UHC. Health insurance fosters the healthcare financing function which involves resources mobilization, risk pooling, and strategic purchasing of healthcare services. The NHIS has been at the forefront of advancing UHC in Nigeria and has continued to work assiduously to expand health insurance coverage for all Nigerians.

However, in spite of several strategic efforts made by the national government and the Scheme, achieving the rapid expansion of health insurance and equitable financial risk protection for the Nigerian populace continues to pose a serious problem for the health system at all levels. This challenge is more evident for the informal sector, which although is the largest sector remains the least covered by health insurance in Nigeria.

Based on available reports, the population coverage has remained dismally low and stuck at about 5% and the OOPE remains considerably high at 76.6% [4), (5)]. Meanwhile, current administrative data indicates that there is significant increase in the population coverage to about 10% due to progress made in the SSHIS expansion. In the same vein , the country is not making significant progress on the Global UHC Tracking Indicators. These developments are primarily due to considerable limitations that have constrained the Scheme from performing its functions and achieving the desired result of improvements in population health outcomes, towards attaining UHC.

To ensure that the attainment of UHC is fast-tracked in Nigeria, the Government has remained committed to the implementation of both the United Nations General Assembly (UNGA) and World Health Assembly (WHA) resolutions on Universal Health Coverage and has formulated and implemented requisite policies to that effect. These include the revision of the National Health Policy in 2016, the development of the National Health Financing Policy and Strategy in 2017, the development of the National Strategic Health Development Plan II and the strengthening of Primary Health Care Governance through the implementation of Primary Health Care Under One Roof initiative. [(1), (6)]

Other related actions include convening the *Presidential Summit on UHC in 2014 with multiple declarations* that re-enforced the UHC agenda as a National Priority of all tiers of Government, the setting up of the Presidential Independent Fact-Finding Panel (PIFFP) on the NHIS in 2019, to review the activities of the scheme . The PIFFP recommended the development of a 10-Year Strategic Plan to reposition NHIS and accelerate progress towards UHC. [7], [8]

As an organisation, NHIS has experienced a high turn-over of Chief Executives, which has impacted on its ability to follow through with reforms and expand financial risk protection to Nigerians outside the federal public sector. In a bid to renew the focus of the NHIS, the current ES/CEO introduced a 3-point Reform Agenda with 18 elements. [9] This reform agenda is anchored on *Value Re-orientation, Enshrining Transparency and Accountability in NHIS operations and Accelerating the drive towards UHC.* w .

Foremost among the elements in the agenda on *accelerating the drive towards UHC* identified two (2) core elements - to Consolidate existing programmes and to Innovate by creating mechanisms to cover those currently not covered by Health Insurance.

Rationale for the Strategic Plan

Since the establishment of the NHIS in 1999, it has not been able to develop a Strategic Plan to outline its policy directions, priorities and strategic objectives until now. In 2019, the Federal Government set up a Presidential Independent Fact-Finding Panel (IFFP) on the NHIS to examine its activities. The IFFP recommended the development of a 10-Year Strategic Plan to reposition NHIS and accelerate progress towards UHC. The 10-Year Strategic Plan is part of broader efforts to define the blueprint for reshaping the health insurance landscape and improve access to quality, affordable and equitable health care for all Nigerians.

This Strategic Plan focuses explicitly on proposing sound policy options and seeks to coalesce new initiatives into clear outcomes and results that fit into a coherent plan, with clear strategies and action steps that will lead to a new, result-oriented NHIS.

1.**2 Purpose and Objectives**

The purpose of the Strategic Plan is to define a blueprint to reposition the NHIS for increased efficiency and better performance and outline measurable goals for achieving UHC between 2020 and 2030.

The Specific Objectives of the Strategic Plan include:

1. Accelerating the attainment of Universal Health Coverage through 90% coverage of the populace with health insurance by 2030.
2. Ensuring substantial pooling of resources to guarantee adequate financial risk protection from catastrophic health expenditure for all enrollees.
3. Enshrining good governance, strategic communication, transparency and accountability within the National Health Insurance scheme with strategic communication.
4. Ensuring that equity remains a priority in the programmes of the National Health Insurance Scheme and that vulnerable groups have financial protections while accessing healthcare services.

5. Fostering Strategic purchasing of Healthcare goods and services with a focus on increasing provider efficiency.
6. Providing guidelines and regulations of private health insurance companies operating in Nigeria in line with the objectives of the National Health Insurance Scheme.

1.3 **National Health Context**

Globally, health is regarded as a basic human right which everyone should enjoy to the highest level to live a socially and economically productive life. Health is also widely acknowledged as a major contributor to socio-economic development and has been the focus of several development-oriented programmes around the globe. This has led in the development of a wide range of laws, conventions and policies that underpin the commitment of the Nigerian Government to health such as the Constitution of the Federal Republic of Nigeria.

The 1999 Nigerian Constitution (as amended), places responsibility for healthcare delivery and its management on the three tiers of government – Federal, State and LGA. The National Health Act (NHAct 2014) provides the overall legal framework for the development and implementation of the National Health Policy, defines the organisation of the health care system, the service providers, the relationship between various tiers, and provides the framework for standards and regulation of health services. The NHAct also recommends a minimum service package for all, through the implementation of the Basic Health Care Provision Fund (BHCPF). [10]

Over the years, in spite of a wide range of laws, conventions and policies, the health system remains weak, nowhere close to attaining UHC and with marked inequity in access to healthcare care services. To further position the health system to attain UHC and address the equity gaps with the Health system, the National Health Financing Policy 2017 and the National Strategic Health Development Plan II (NSHDP II 2018 - 2022) were developed. . [1], [11]

. [12]

NSHDP II provides the Health Sector Medium Term roadmap to move the country towards the accomplishment of National Health Policy goals and objectives. Some of the key objectives of the NSHDP II which align to the objectives of the NHIS Strategic Plan (2020 -2030) include: Strengthened governance and coordination for actualising stewardship and ownership of health financing reforms.

i) Increased sustainable and predictable funding for health.

ii) Enhanced financial risk protection through pooled funds at federal and state levels.

iii) Enhanced transparency and accountability in strategic purchasing of Health Services.

The NHIS Strategic Plan (2020 - 2030) has been tactically developed to align with the health system goals and priorities as outlined in the National Health Act, the National Health Policy, the National Healthcare Financing Policy and Strategy and the NSHDP II and aims at improving financial access, to quality and affordable healthcare for all Nigerians between 2020 and 2030.

1.4 Health Care Financing Landscape in Nigeria

In Nigeria, the healthcare system is financed through different mechanisms. These healthcare financing mechanisms include government budget using general tax revenue, direct out-of-pocket payments, social health insurance and donor funding. (Onwujekwe et al, 2019). Other mechanisms that have contributed to healthcare financing in Nigeria include private insurance schemes and community based health insurance schemes. Based on the provision of the National Health Act, the Basic Health Care Provision Fund was established and is to be mainly funded annually by at least 1% of the Consolidated Revenue Fund of the Federal Republic of Nigeria as well as contributions from donor organizations and development partners.

The healthcare financing landscape in Nigeria has not been clearly aligned to the attainment of UHC as out-of-pocket expenditure has remained the predominant health care financing mechanism accounting for as high as 77.5% of Current Health Expenditure in 2017. This level of OOPE is a far cry away from the 30-40% of CHE which is recommended for countries to remain on track to UHC. Additionally, the GGHE/GGE ratio as at 2017 was barely 6.6%; slightly below half of the 15% benchmarked in the 2001 Abuja Declaration. (NHA Technical Report, 2017). The country's demographics, characterised by a huge population size, its high population growth rate and structure, majorly composed of young dependents and females of child bearing age, will require innovative financing mechanisms to mobilise and pool sufficient funds to expand financial risk protection for the populace.

The Health care financing outlook for the Nigerian Health system has also remained bleak as a result of the limited ability of the local governments to independently administer their funds which is statutorily combined with allocations to the State Governments in the State Joint Local Government Account; leaving the local governments bereft of financial resources to meet their statutory mandate of financing primary health care (Jude Okafor, 2010). However, with the recent reinforcement of Government's commitment to increasing financing for the health sector, the slow expansion of health insurance coverage for Nigerians, the establishments of programmes like the BHCPF, and the gradual switch to strategic purchasing in the health system, it can be predicted that the health financing landscape is on track to improve significantly within the next decade.

1.4 Political Economy and UHC

Political, economic, social and governance systems and associated factors can significantly constitute either Critical Success Factors (CSF) or barriers to accessing healthcare. [13]

Like many countries, Nigeria is presently committed to achieving Universal Health Coverage (UHC). This commitment is reflected in the National Health Policy (NHP) 2016, the NSHDP II of 2018 and the National Health Financing Policy and Plan of 2017. Financing UHC will require the distribution of responsibilities and resources across the tiers of government, the health sector and beyond and involve stakeholders and factors within and outside the health sector. In addition, structural changes towards UHC will affect a range of stakeholders and institutions in ways that create political obstacles and tensions. Therefore, moving to UHC should be recognised as a political process that requires managing change in healthcare. [14]

Political economy is a critical determinant of both the design and implementation of efforts to improve access and financial risk protection. Political economy analysis can therefore be helpful in explaining the broader political and economic forces that affect the distribution of health and resources within and across populations. It can also assist health policy makers and leaders in managing the required change that directly affects adoption and implementation processes. [15]

Also, of considerable importance is the effect of socio-economic factors which include poor economic indices occasioned by slowing economic growth, low productivity, and high levels of unemployment, poverty and the burden of external debts.

Equally significant, is the country's political context of constitutional democracy, where federal and decentralised administrative systems at the state and LGA levels have responsibility for health service delivery. Political leaders, both at the executive and the legislative levels may not necessarily see UHC as a priority relative to other national issues, and this may significantly affect budget allocation and passage of relevant legislations. Additionally, political issues also affect the establishment of State Social Health Insurance Scheme (SSHIS) and equity funds at the State level. The advancement of UHC is also negatively impacted by party politics, the ideological leaning of the political party in power and electoral cycles. . [14], [15]

Beyond the ministries of health at the federal and state levels, several stakeholders are involved in health care delivery. They include other Ministries, Departments and agencies (MDAs), the Healthcare Providers and their unions, Industry groups, Insurers , employer groups and specific consumer groups. Quite often, some of these groups contest reforms to protect or expand authority, interests, budgets, personnel, or influence. There are also external players, such as bi-lateral and multilateral agencies, international financial institutions, NGOs, private companies and foundations with considerable influence, that if unchecked can significantly distort priorities and goals and undermine the performance and overall country ownership.

Therefore, a good understanding of political economy can be of great importance in informing strategic responses and sequencing of intervention activities. [16]

1.5 Health System Governance and Service Delivery Structure

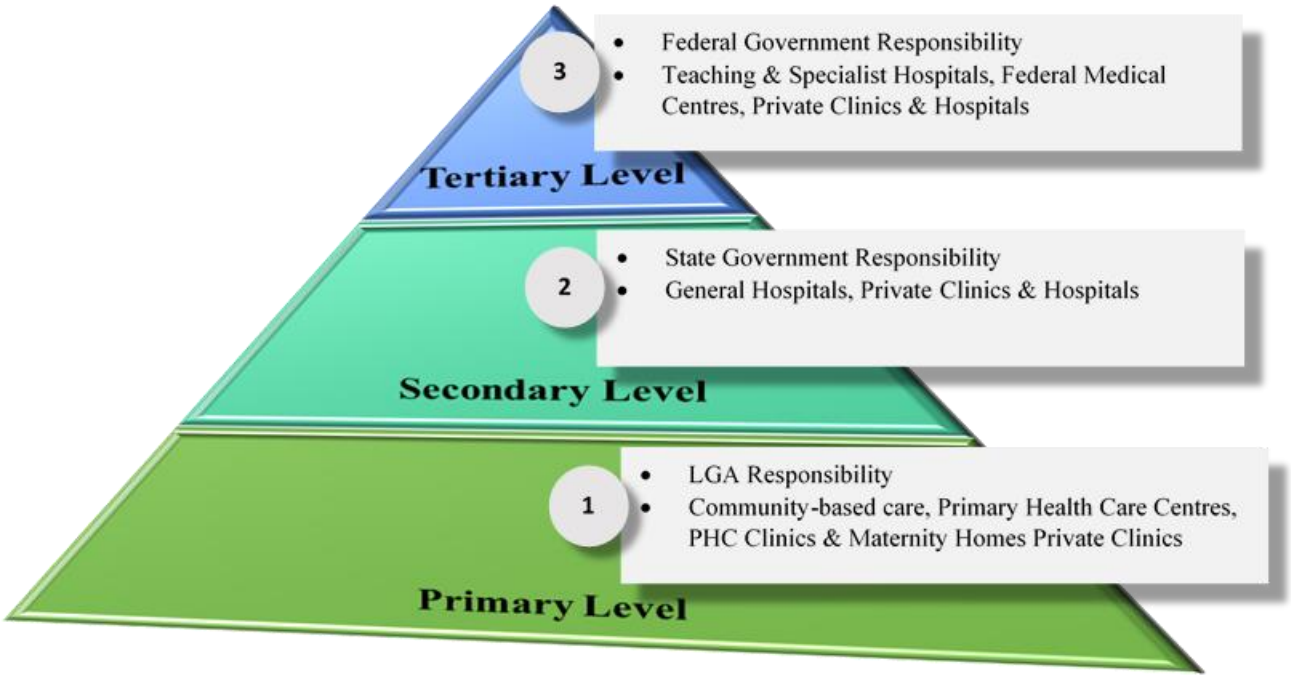


Figure 3: Nigeria Health System Governance and Service Delivery Structure

The Governance of the Nigerian Health system is multi-tiered with governance structures presnet at the Federal, State and Local Government levels. At the level of the Federal Government, the Minister of Health provides overall stewardship of the Health system through the Federal Ministry of Health while in the States, the Commissioners of Health oversee the governance of the health system though the State Ministry of Health. The Governance system for the health system at the local government is anchored by an appointee of the Local Government Chairman, tasked with the responsibility of overseeing the health system at that level. The health system governance structures at these different levels of Government are responsible for formulating and implementing policies and programmes to meet the national and state health system goals and priorities and oversee other health system pillars namely; Healthcare Financing, Medical and Pharmaceutical Products, Health Information and Communication, Human Resources for Health and Service delivery. Additionally, there are also Health MDAs such as NHIS, NPHCDA, SMoH, SPHCDA and SSHIA that manage the implementation of programmes and interventions at the federal and state levels.

Nigeria runs a mixed health service delivery system with public and private sectors, conventional, traditional, Complementary and Alternative Health Care Delivery facilities providing health care in formal and informal settings. The public sector healthcare provides 40% of healthcare services while the private health sector provides the remaining 60% of the services. Public sector healthcare is concurrently the responsibility of the three tiers of government. The LGAs have responsibility for Primary Health Care (PHC) services; State Governments provide secondary level care while the Federal Government provides tertiary level care. [1]

In addition to tertiary healthcare provision, the FMoH leads the development and implementation of specific health programmes operationalized at the levels of Departments, and Agencies likewise at the subnational levels Nigeria has a *network of widely distributed service delivery facilities* at all levels of care detailed in the Master Facility List (MFL) in the National Health Facility Registry. [17] As at 2019,the MFL contains 40,668 health facilities which have all been issued with unique identifiers called, National Provider Identifiers (NPIs). These consist of 35,057 (86.2%); 5,449 (13.4%); and 162 (0.4%) primary, secondary, and tertiary health facilities, respectively. On the basis of ownership, public facilities constitute only 23.6%, while privately owned facilities constitute 76.4%. The private health sector consists of conventional health facilities of various categories, which include not-for-profit services i.e. faith-based and non-governmental organisations, private-for-profit providers, traditional , comple mentary and alternative medicine providers, patent and proprietary medicine vendors (PPMVs) and dispensaries .

The dominance of PHC facilities represents a remarkable effort to ensure equitable geographical access in rural areas, but the quality standards of most of these PHC facilities remain poor with challenges related to human resource for health, availability of medicines and health related supplies, referral linkages and mechanisms and ultimately leadership remaining sub-optimal

Of great significance is the number of NHIS accredited facilities, which constitute only 19.5% of the facilities listed on the MFL. This is dismally low, compared with the number of existing health facilities in the country. [17, 18]

Many of the accredited facilities have multiple provider status and are provider of primary, secondary and tertiary services at the same time. This has brought distortions within the referral system, and tends to limit the achievement of the objective of equitable patronage at all levels

1.6 Process and Methodology

Development of Concept Note	• Presentation of Concept Note and the proposed timeframe to the Top Management Committee (TMC) of the NHIS. • Review and subsequent adoption of Concept Note.
Constitution and Inauguration of a Task Team	• Technical Officers were selected from relevant Departments of NHIS with specific ToR. • They worked with the Consultants in developing the Strategic Plan.
Conduct of the Situation Analysis	• Successful with the assistance of a Consultant, resource persons and facilitators recruited to support the process.
Multiple physical and virtual strategy sessions and group works.	• Participants included members of the Top Management Committee, senior and middle level officers of NHIS and representatives of Strategic Stakeholders to develop and review the strategic elements
Costing of the Strategic Plan	• Key Activities were costed based on a valued baseline expenditure (cost) per year and a marked incremental annual rate of 10% over a 10 Year period
Validation of the Strategic Plan	• The strategic plan was thereafter validated by stakeholders in a 2- Day stakeholders meeting.
Communication and Dissemination of the Strategic Plan	• Implement communication plan and disseminate the strategy using appropriate vehicles.
Execution and Implementation	• Set up Implementation Steering Committee (ISC); and develop & implement execution plan

Figure 3: Process and Methodology

The National Health Insurance Strategic Plan development was participatory and based on available evidence through an inclusive process, which aimed to promote collective ownership, transparency and accountability, optimal performance and better health for all Nigerians.

A team of experts drawn from the National Health Insurance Scheme, Results for Development (R4D) and a private consulting firm, Integrated Healthcare Strategies and Analytics Ltd was constituted by the Executive Secretary, under the Chairmanship of the General Manager, Planning, Research and Monitoring (GM PRM) of the NHIS, with the mandate to develop the Concept Note.

The Concept Note and the proposed time frame were presented to the Top Management Committee (TMC) of the NHIS, comprising all the General Managers and the Heads of relevant Divisions and

Units. The TMC approved the Concept Note after reviewing and making inputs. It was also resolved that the TMC would undertake the development of the NHIS-SP.

The Executive Secretary also constituted and inaugurated a Task Team comprising of select technical officers drawn from relevant Departments of NHIS with the following ToRs:

1. Work with the Consultants in developing the guidelines for strategic planning and implementation.
2. Identify and gather the necessary resource materials and information that will be useful in the development of the strategic plan.
3. Work with the Consultants in conducting Situation Analysis and identifying challenges and potential strategies
4. Advise or recommend on the logistics (locations, date, and times) for the planning sessions.
5. Update status of Action Plans to ensure that NHIS is doing what is to be done.
6. Meet quarterly and review status of strategies and progress on objectives.
7. Meet annually and review progress for the year, identify new barriers and critical success factors, change objectives, and re-establish priorities and action plans.
8. Undertake any other relevant task assigned by the Executive Secretary or relevant officer that will be useful in the development of the Strategic Plan.

Subsequently, resource persons and facilitators were appointed to support NHIS to carry out Situation Analysis. Following the successful conduct of the Situation Analysis, a Consultant was appointed to provide technical assistance for developing the strategic planning.

Multiple strategy sessions, comprising of physical workshops complemented by virtual workshops in adherence to the NCDC advisory on COVID-19 were held for members of the Executive Management, Senior and Middle level officers of NHIS and Partners, leading to the development of the Strategic Plan 2020 – 2030 Framework, with its accompanying vision, mission, values and guiding principles, and priority areas. The participants also developed the goals, strategic objectives, targets, interventions, and proposed actions for each of the priority areas.

Subsequently, a costing exercise was conducted based on valued baseline cost per year and marked incremental annual rate over a 10-Year period.

The draft plan was shared with all key stakeholders, including the SSHIAs and the development partners for input, before a 2 – Day national stakeholders' validation meeting.

In order to further consolidate collaboration with the states under the "Health Insurance Under One Roof" Initiative, the SSHIAs will be encouraged to adapt and domesticate the Strategic Plan.

Subsequently, a 2-Day Management Retreat on the National Health Insurance Strategic Plan and Alignment will be organised for the Top Management of NHIS.

Further technical assistance to support development of execution ability, though capacity building and mentoring execution and the monitoring of the strategic plan implementation, will be commissioned.

Implementation Steering Committee (ISC) will be established and mandated to provide oversight over the execution/implementation of the Strategic Plan.

CHAPTER 2

SITUATION ANALYSIS

SITUATION ANALYSIS

2.1 Health Care Financing and Health Insurance in Nigeria

The optimal utilisation of healthcare services is influenced by investment in the health system, which limits physical and financial barriers to access. Unfortunately, gaps in physical and financial access still exist, due largely to inadequate health investment and sustainable health care financing at all levels of healthcare service delivery in Nigeria.

The National Health Insurance Scheme (NHIS) was established as a corporate body in 1999, by virtue of Decree 35 of 1999 (now cited as NHIS Act Cap 42 LFN, 2004) with the aim of increasing access to healthcare and reducing the financial burden of out-of-pocket payment for health care services. The National Health Act 2014 (NHAct) also provides for the allocation of at least 1% of the Consolidated Revenue Fund (CRF) to deliver a Basic Minimum Package of Health Services through the Basic Health Care Provision Fund. In addition, the federal government developed the National Health Care Financing Policy and Strategy, and developed guidelines for its implementation in 2017. [2], [6], [10]

Despite several efforts over the years, funding of the health sector in general has been considerably suboptimal and the government investment in health financing has been generally poor. [6] Specifically, NHIS has witnessed systemic weaknesses that have limited its capacity. Its leadership, management and governance system have been largely ineffective, and the institutional structure has been inconsistent with policy implementation.

Significantly, accountability deficits have been reported in the operations of the Scheme, leading to loss of confidence by some stakeholders, hence limiting the capacity of the Scheme to provide comprehensive, equitable and qualitative healthcare to all Nigerians. The inability of the NHIS to effectively regulate and coordinate the activities of its various stakeholders like HMOs and HCFs has also affected the overall perception of the Scheme by Nigerians. In addition, the voluntary nature of health insurance as prescribed in the NHIS Act, has also impeded the ability of the NHIS to mobilise and pool resources across all sectors, especially the informal sector. Furthermore, the poor utilization of strategic purchasing mechanisms by the NHIS has also limited its capacity to increase the efficiency of healthcare providers with Allocative inefficiency being prevalent at all levels of the health system.

The proportionately low funding for PHC compared to secondary and tertiary care does not align with the National Health Policy 2016, which aims to strengthen PHC towards attainment of UHC. A few successful innovative pilots have been conducted to improve efficiency, transparency and accountability in health financing. Notable are two World Bank supported Performance-Based Financing (PBF) schemes - SOMLPforR and NSHIP.

Though limited in scale and largely donor-funded, there have also been other approaches to increase utilization of Health care services such as conditional cash transfers, deferrals and exemption schemes for pregnant women and children under five years and other vulnerable groups. [19]

2.2 Current Status of Key Healthcare Financing Indicators.

While Nigeria has continued to strive to advance UHC, several key indicators can show the level of progress that is being made in that regard. Some of these indicators are outlined below:

2.2.1 Health Spending

I. Current Health Expenditure Per Capita (USD) [20]

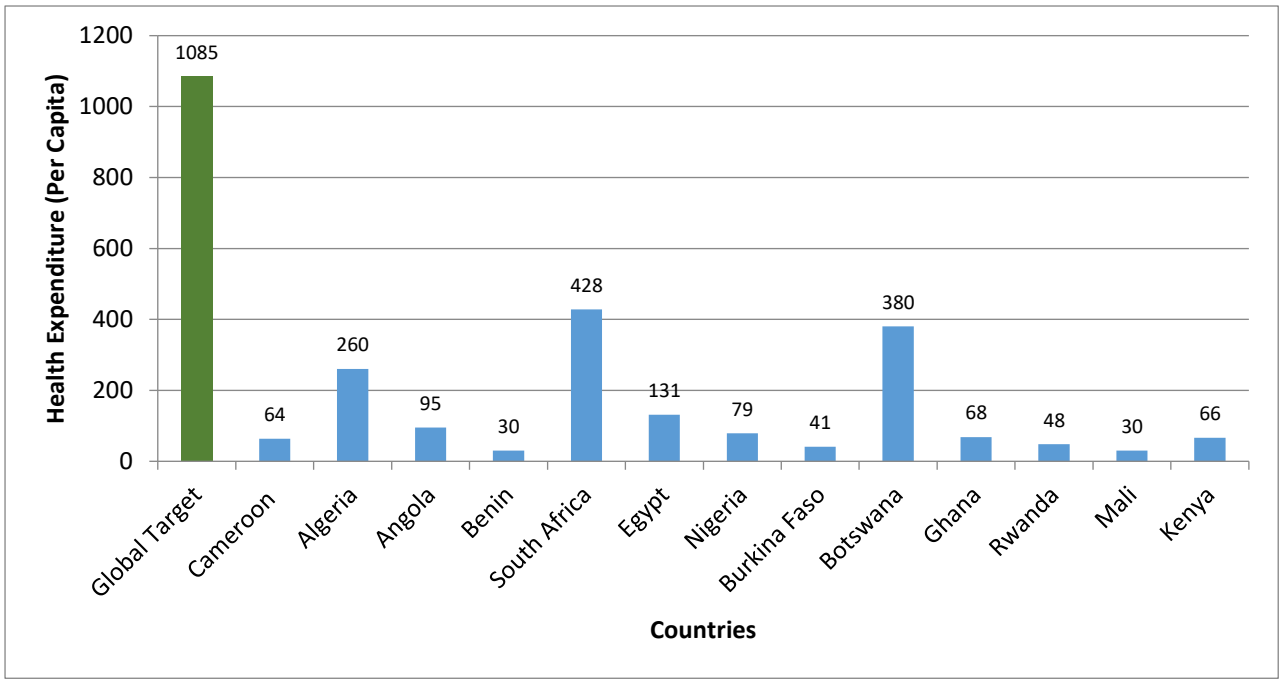


Figure 4: Current Health Expenditure Per Capita 2016 (USD)

Current Health expenditure per capita refers to health spending per person or per head and is a function of the total population and the total expenditure on healthcare in the country. This includes spending by both public and private sources on medical services and goods, public health and prevention programmes and administration, but excludes spending on capital formation (investments). In Africa, Nigeria ranks significantly low on this scale.

II. Current Health Expenditure as % of GDP [20]

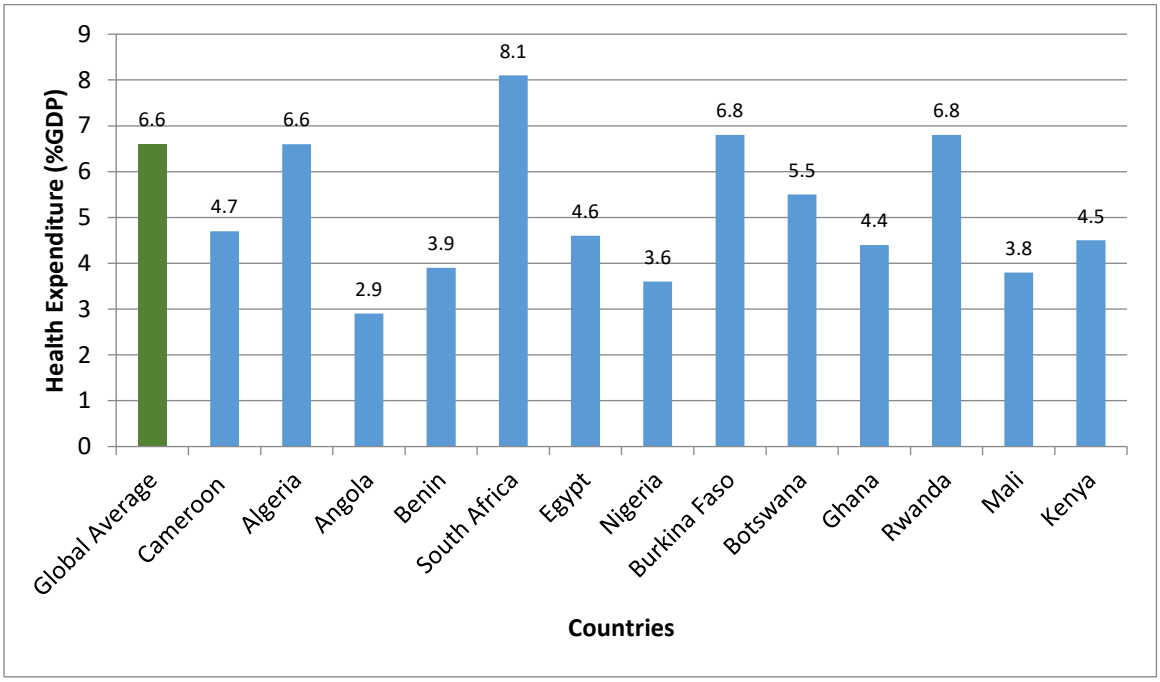


Figure 5: Current Health Expenditure as % of GDP (2016)

Current Health Expenditure as a percentage of GDP is total expenditure on healthcare (public and private expenditures excluding capital formations) as a percentage of GDP (Gross Domestic Product) of a nation, which is the percentage of GDP spent on health care by a country. The figure above shows the Current Health Expenditure as percentages of GDP for some African nations.

Nigeria is performing very poorly compared to the other African countries and the Global Average.

III. Out of Pocket Expenditure (% of Current Health Expenditure) (2017) [5]

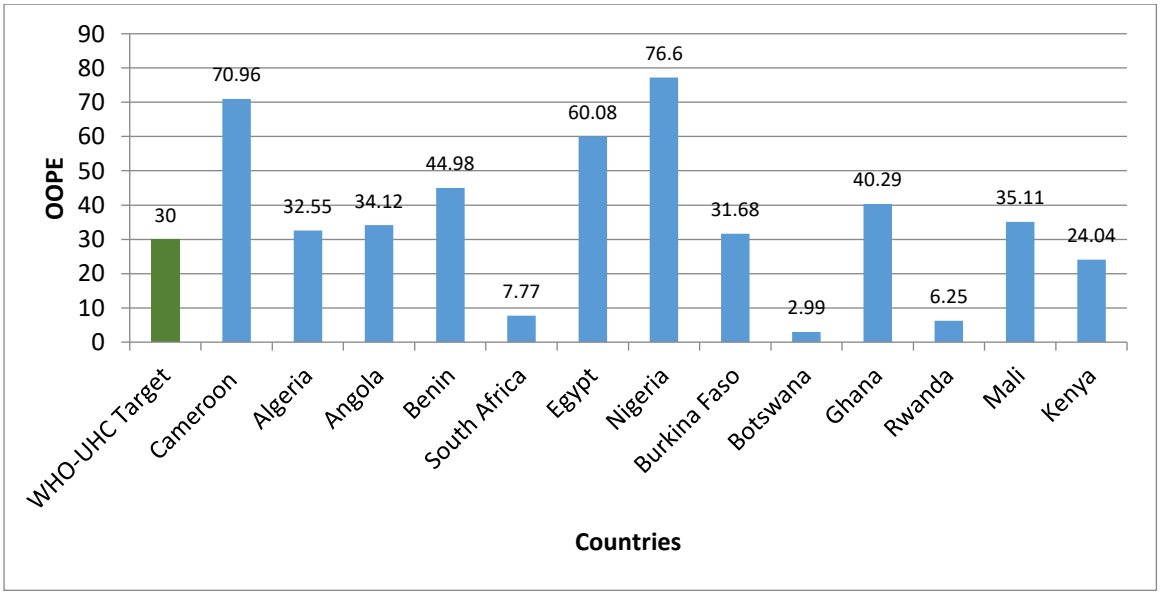


Figure 6: Out of Pocket Expenditure (% of Current Health Expenditure) (2017)

Out-of-pocket payments are defined as direct payments made by individuals or households to healthcare providers at the time of service use. There is a strong correlation between the level of OOPE and the incidence of catastrophic and impoverishing health expenditure, which are indicators currently used to monitor how well a health system is performing in terms of financial protection.

The WHO-UHC target for OOPE is 30-40%. Almost all the African countries shown in the figure above are yet to meet the target. However, South Africa, Botswana and Rwanda are doing remarkably well in this regard.

IV. Annual Health Budget Allocation 2008 – 2020 (21)

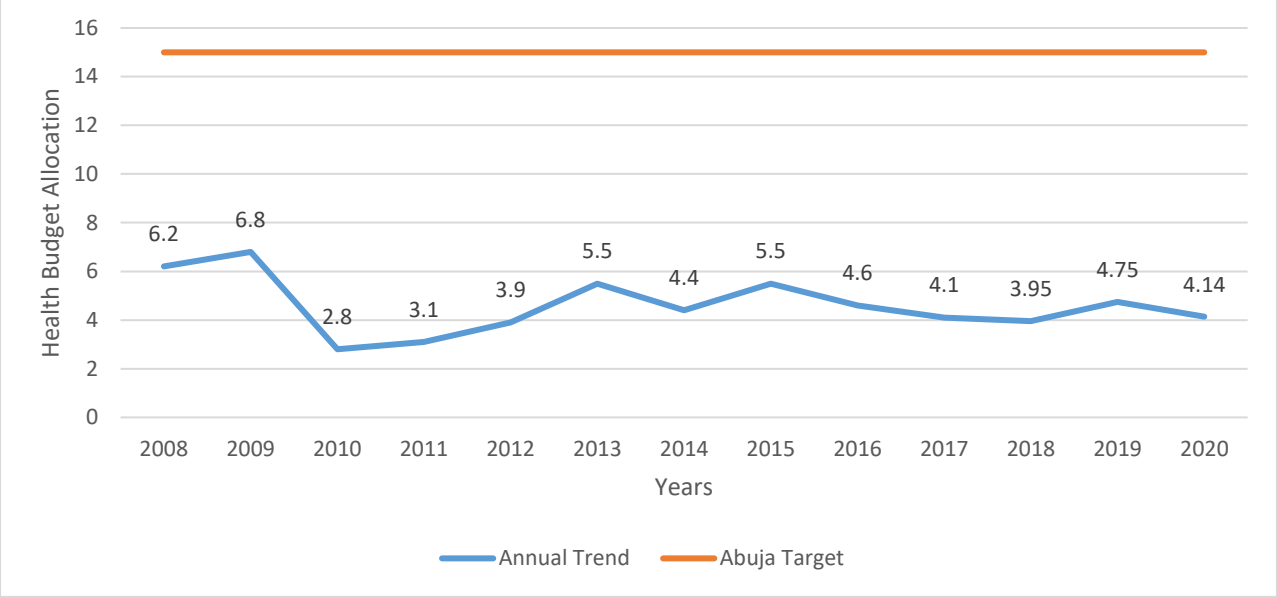


Figure 7: Trend of Health Budget Allocation

Over the years, Nigeria's health budget allocation has remained below the recommended benchmark by the Abuja Declaration, 2001 which recommends that at least 15% of Government's total budget should be allocated to the Health Sector. (21), (22)The figure above shows the trend in Budget allocation for Health by the Federal Government in Nigeria between 2008 and 2020.

I. Resource Allocation

There is a lack of allocative efficiency with disproportionately low funding for PHC compared to secondary and tertiary care. (19). PHC, being the foundation of the health system, is the fulcrum of the different dimensions of equity and requires more investment to strengthen primary healthcare systems, improve the quality of care and enhance public confidence.

Figure 8: Resource allocation to the 3 levels of healthcare

2.2.2 Health Service Coverage

UHC Service Coverage Index (2017)

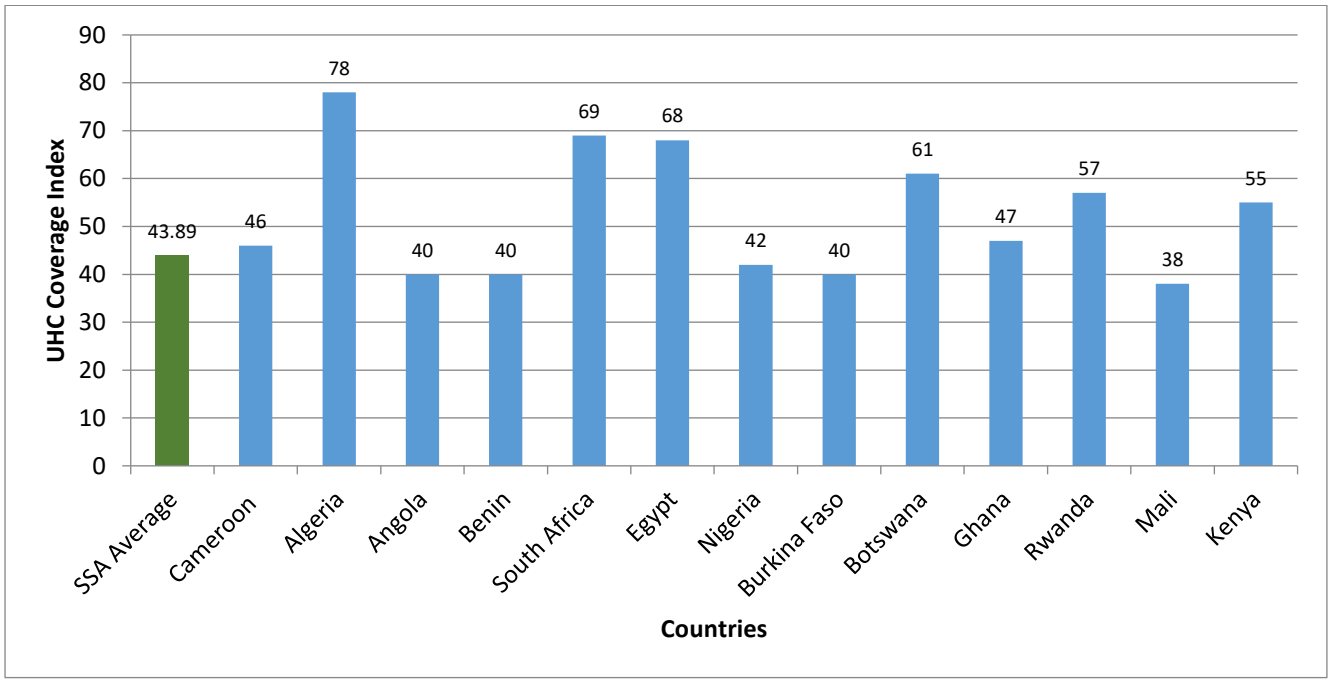


Figure 9: UHC Service Coverage Index of some African countries

UHC Service Coverage Index refers to coverage index for essential health services (based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access).

. Most of the African countries shown in the figure are above average, but Nigeria is performing below average. [20]

I. Essential Services Coverage

Access to High Impact and Cost-Effective Interventions remain poor, with wide geographical disparity across the country.

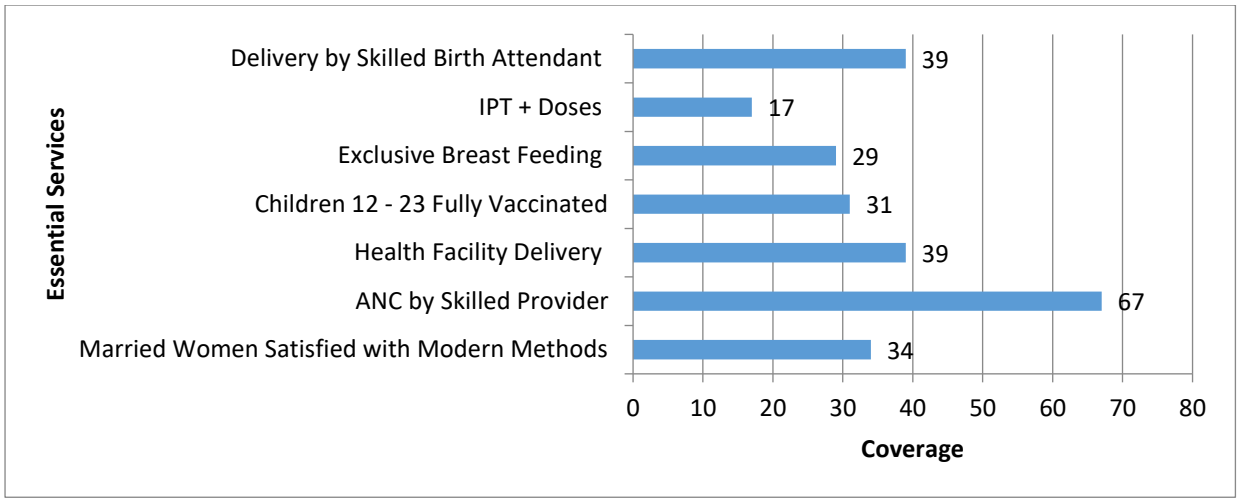


Figure 10: Essential Services Coverage [23]

The coverage rates on essential lifesaving packages such as family planning, immunization, ANC attendance, institutional delivery, use of IPT, among others, remain suboptimal and insufficient to significantly improve maternal and child health outcomes. [5, 12, 23]

Financial access remains a significant challenge and expanding health insurance coverage will accelerate improvements in service coverage and health outcomes. [24, 25]

II. Enrolment into the NHIS

Total enrolment into NHIS is considerably low and significantly driven by the formal sector and organised private sector. This has a significant impact on widening the equity gap as the informal sector is largely left without health insurance coverage. This low enrolment rate is partly attributable to the fact that health insurance is not mandatory. Other factors that are likely responsible for the low enrolment rate into the NHIS include the relatively low awareness about the need and function of health insurance, unwillingness to pay for health insurance and concerns about the quality of care provided by NHIS-engaged healthcare facilities.

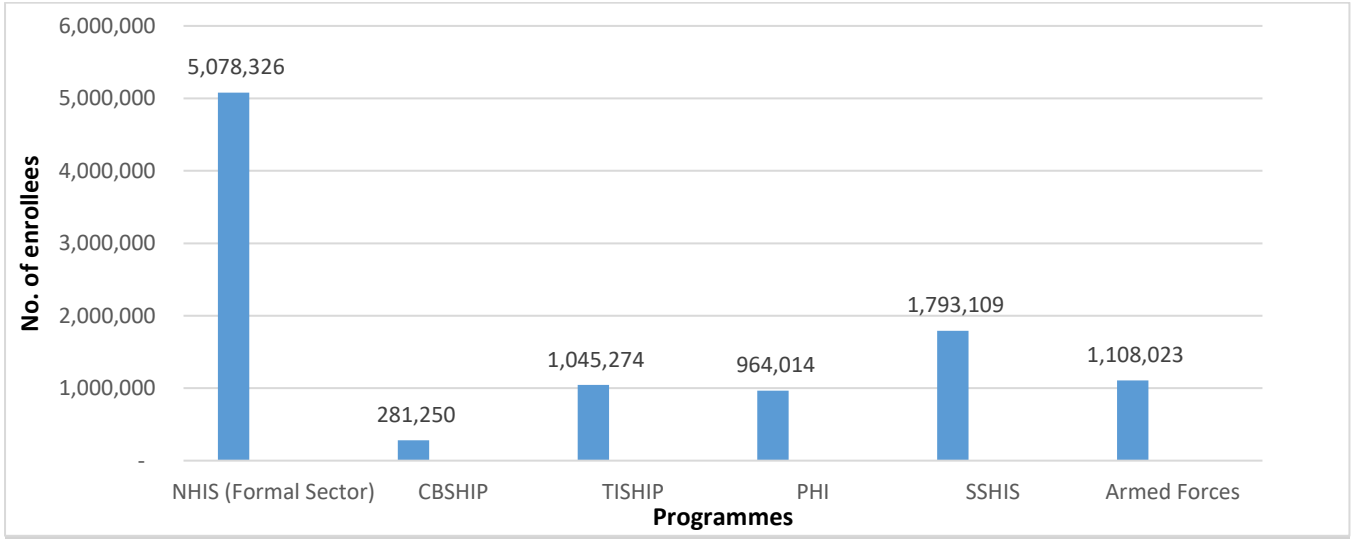


Figure 11: Number of Enrollees Under NHIS Programmes. [26]

2.2.3 Availability of accredited healthcare facilities

Physical access to quality health services that meet set standards and criteria is key to improving health outcomes Physical or geographical access still constitutes a significant barrier to healthcare in Nigeria.

I. General Service Availability

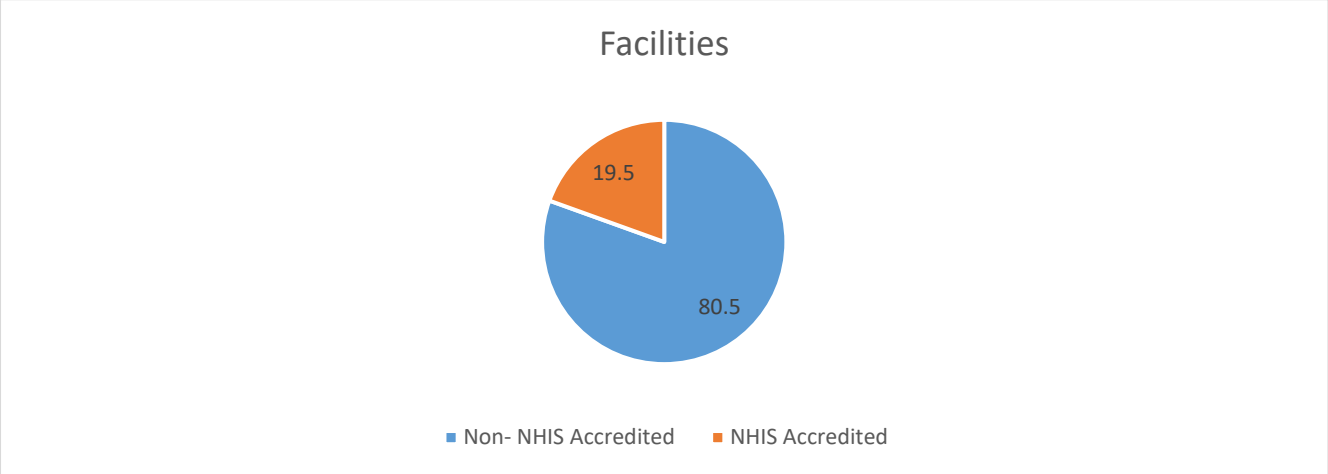


Figure 12: Service availability in NHIS Accredited HCPs

Only 19.5% of the facilities listed on the National Health Facility Registry of the Federal Ministry of Health are accredited by NHIS. This is notably low, against the number of existing health facilities in the country. [17, 18] In addition, many of the facilities concurrently provide primary, secondary and tertiary services. The general availability of services is also affected by unclear referral pathways between different levels of healthcare service delivery among others

Service-Specific Availability

The availability of specialized healthcare services remains low and directly related to the availability of healthcare workers with specialized skills.

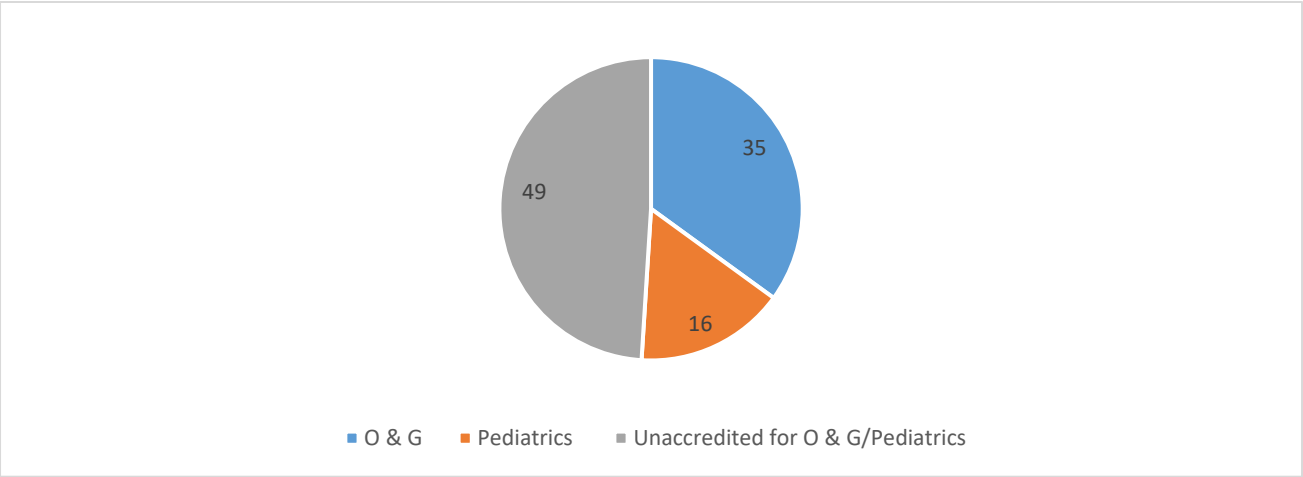


Figure 13: Secondary and Tertiary Facilities Accredited for Provision of Obstetrics/Gynaecology and Paediatric services

Nearly, half of the secondary and tertiary facilities *do not meet accreditation criteria to provide Obstetrics/Gynaecology and Paediatric service.* Yet, a considerable number of women and children may require specialist care following referral from the primary care level. [18]

2.2.4 Financial Access to healthcare

i. Government Health Expenditure on Health

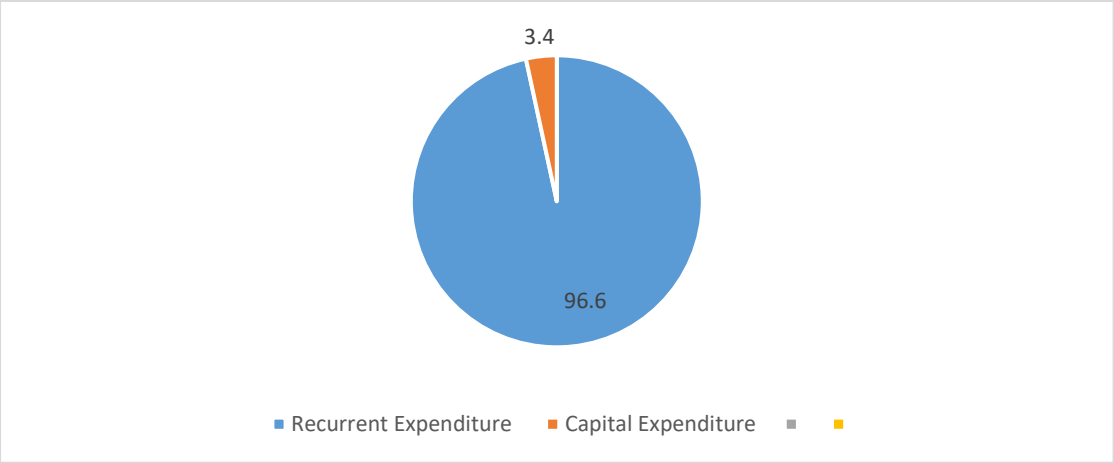
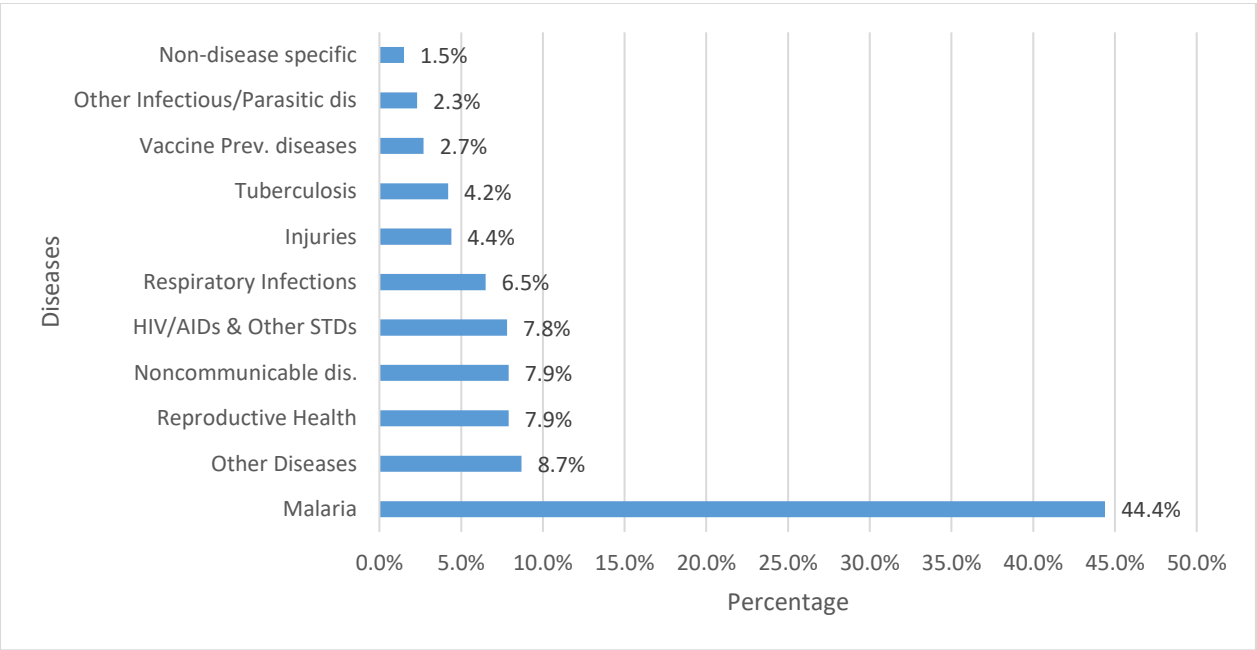


Figure 14: Government Health Expenditure 2017 [5]

Health Expenditure by Government is mostly on recurrent expenditure leaving less than 5% for capital investment on infrastructure, equipment, commodities and supplies. The result is the continuing deterioration in the functional status of many public facilities at all levels making it difficult for many to meet NHIS accreditation criteria.

Health Expenditure on Major Disease Areas



Information on Burden of Disease (BoD) is important in understanding the the expenditure on different disease areas and in defining the benefit package. Malaria is the

ii. Institutional Financing Sources

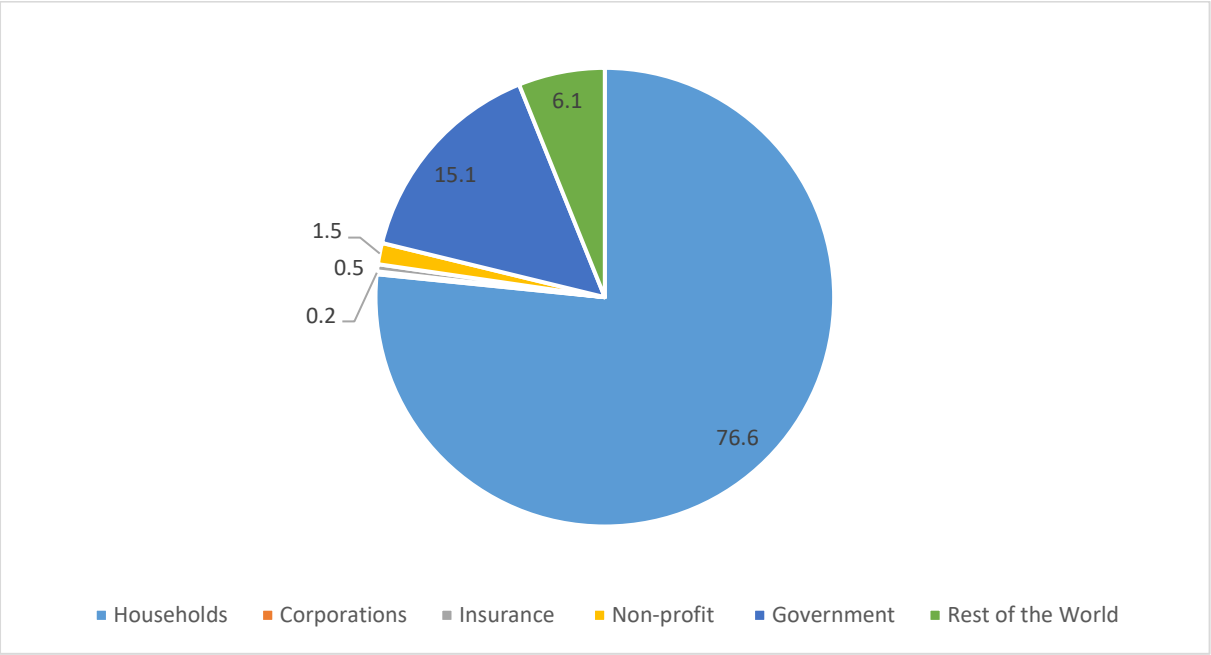


Figure 15: Institutional Funding Sources [5]

Available data on funding sources indicate that the major funding source is household through out of pocket expenditure (76.6%). This figure is significantly more than OOPE of 30-40% of total health expenditure (THE) recommended for UHC tracking by WHO.

Health insurance, for which NHIS has the mandate and regulatory responsibility contributed only 0.5% of the Total Health Expenditure. This means currently, health insurance is playing a relatively minor role towards financing health in Nigeria.

iii. Performance Indicators on Prepayment, Social Security Coverage

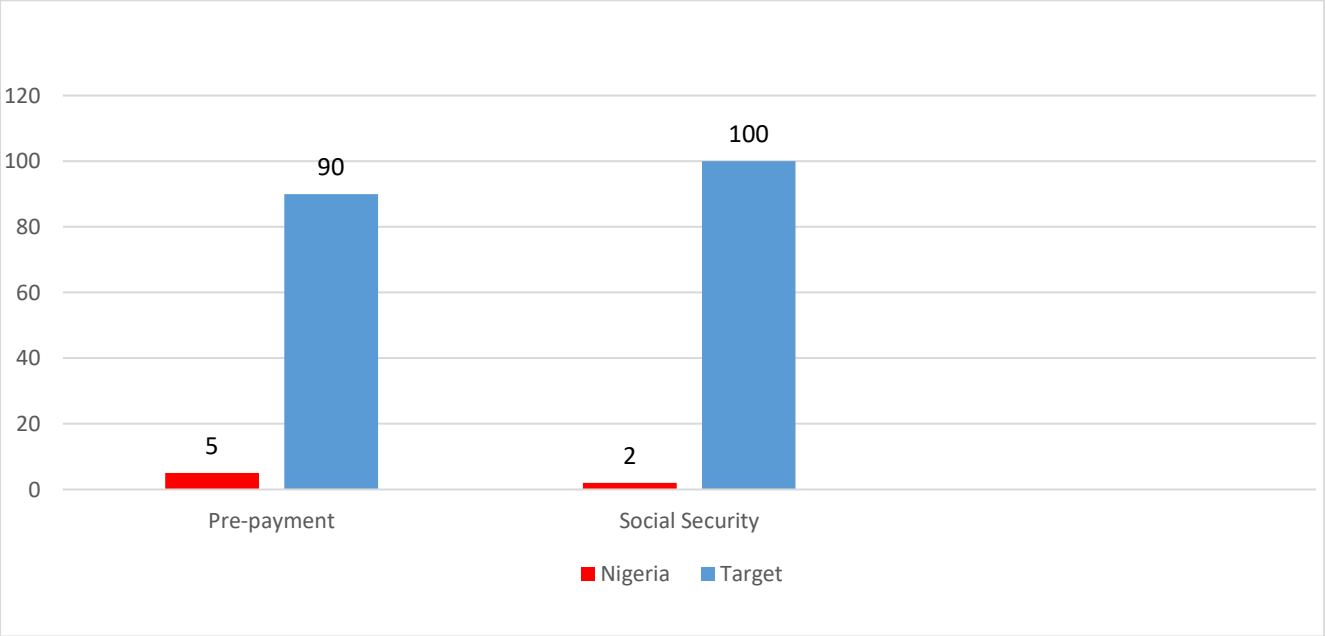


Figure 16: Pre-payment and Social Security Coverage [5]

Nigeria has not achieved the recommended 90% coverage with any form of prepayment mechanism and 100% coverage with social security. As at 2017, a majority of Nigeria's 198 million do not have any prepayment mechanism nor are they covered with a safety net that guarantees social security.

iv. Health Care Providers (Where do Nigerians seek healthcare?)

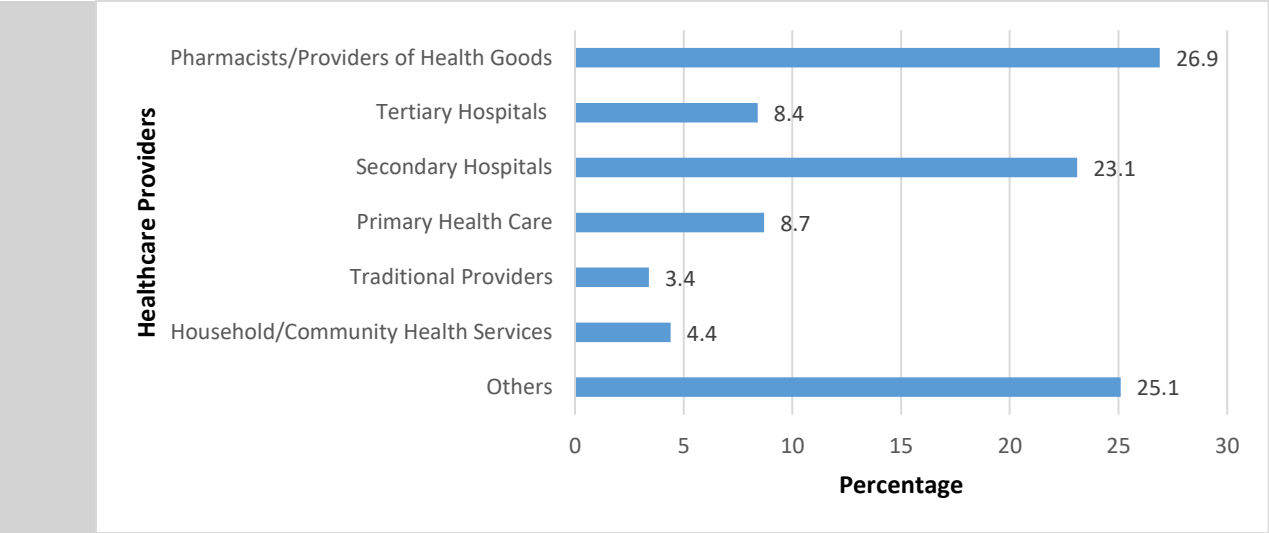


Figure 17: Health Care Providers [5]

Primary Health Care (PHC)is the foundation and the entry point into the health system. PHC facilities are widely distributed to ensure equitable access to quality health care for all Nigerians. However, recent National health Account (NHA) reports indicate that PHCs are grossly underfunded in Nigeria.

v. Revenue Generation

The diagram below indicates contributions received from 2010 – 2018 from contributors

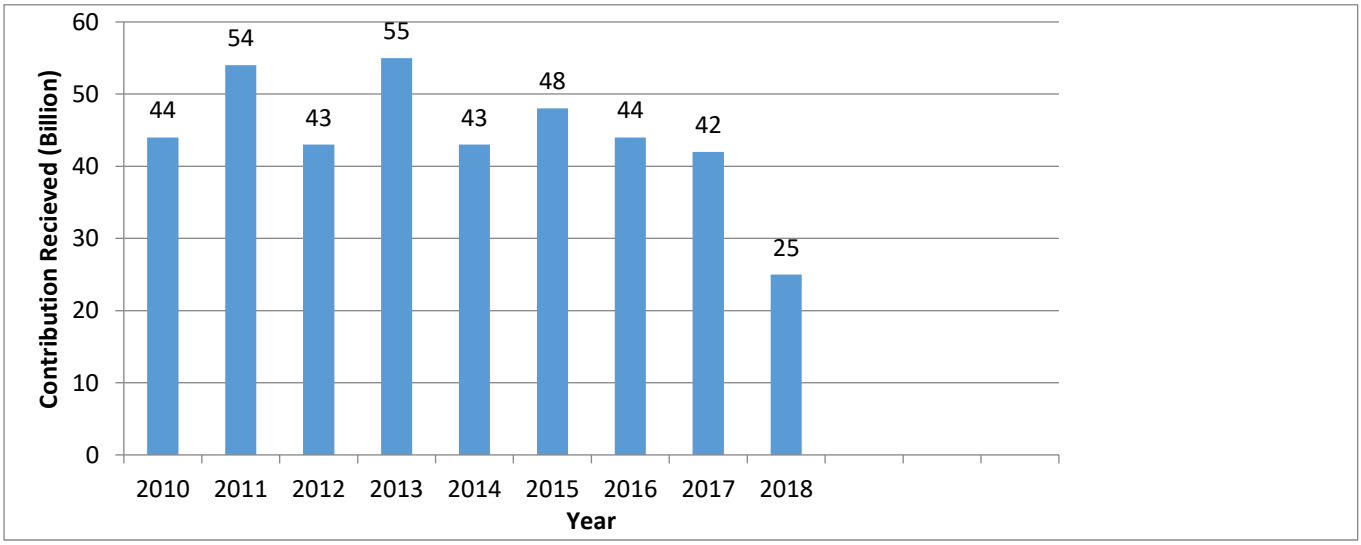


Figure 18: Profile of Contributions Received by NHIS. [27]

NHIS's revenue comes mainly from sector contributions, which include Public Servants, Military and Uniformed Services, Organised Private Sector (OPS). Voluntary Contributors Social Health Insurance Program (VCSHIP), Extra Dependents, and in the past, interest from investment of residual funds and Debt Relief Grant (DRG) from the MDGs.

There is no evidence that there has been routine and regular reconciliation over the years between NHIS, Budget Office in the Federal Ministry of Finance and the Office of the Accountant General of the Federation (AGF)

NHIS also earns 1% commission on the private health insurance plans mobilised by the HMO's. However, there seems to be *no clear evidence of the process of reconciliation as required by the NHIS guidelines.*

The funds from CBSHIP and TISHIP are managed by Trustees of Mutual Health Associations (MHAs) and TISHIP Committees in tertiary institutions, respectively. It is not clear if NHIS has a complete database of existing CBSHIPs and TSHIPs, their population coverage and financial (pool) values.

vi. Basic Health Care Provision Fund (BHCPF)

The National Health Act provides for the establishment of the Basic Health Care Provision Fund (BHCPF), financed with not less than 1% of the Consolidated Revenue Fund (CRF); grants from international donor partners, and funds from other sources. (10)

NHIS is responsible for managing 50% of the fund for provision of *Basic Minimum Package of Health Services* (BMPHS) to all citizens, in accredited PHC facilities.

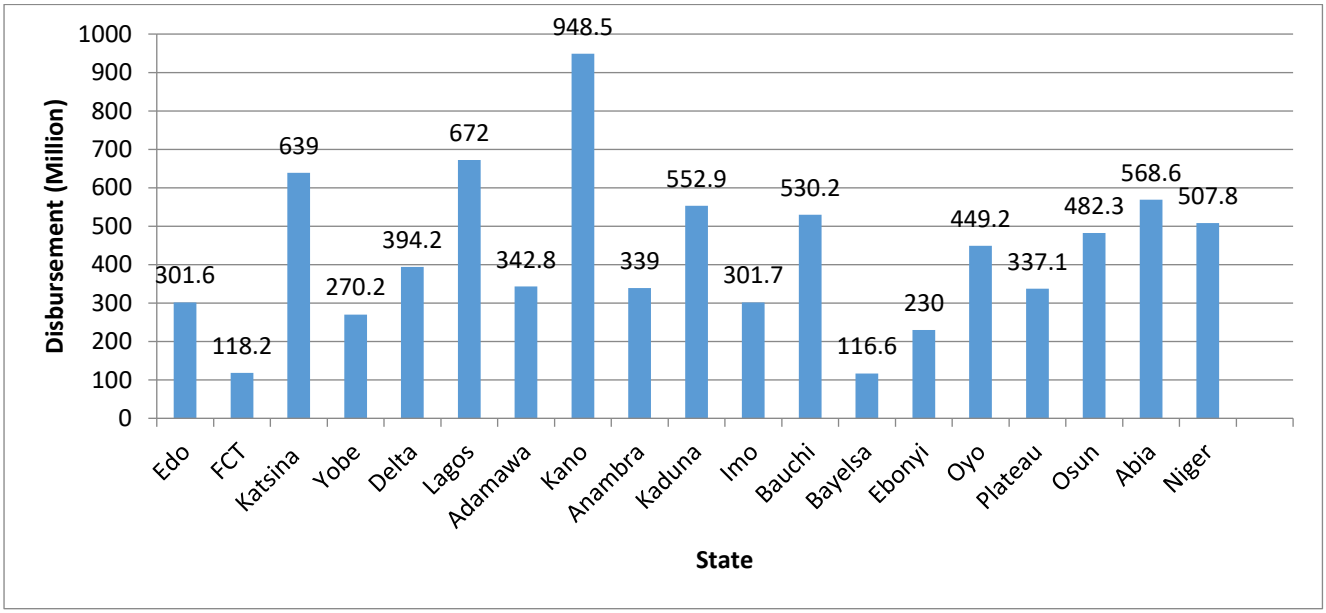


Figure 19: NHIS BHCPF Disbursement to States

In 2018 appropriation, the FGN earmarked N55.1 billion and released 50% of the funds. NHIS disbursed the first tranche of about N8.1 billion to nineteen (19) eligible states through the State Social Health Insurance Agencies as at September 2019.

One of the he main criteria for disbursement was based on poverty index, which is per capita multiplied by the number of estimated poor people in the states (28).

Other criteria included Expression of Interest (EO I), designation of hundred million naira (N100m) for the take-off of State Health Insurance Agencies and well equipped/staffed Primary Healthcare Centres (PHC).

2.2.5 Governance Decentralisation

NHIS cannot accomplish the Demand-Side Financing (DSF) coverage required to achieve UHC alone. Consequently, there has been widespread movement among the states towards establishing State Social Health Insurance Agencies (SSHIAs) to pool risks and fund service delivery.

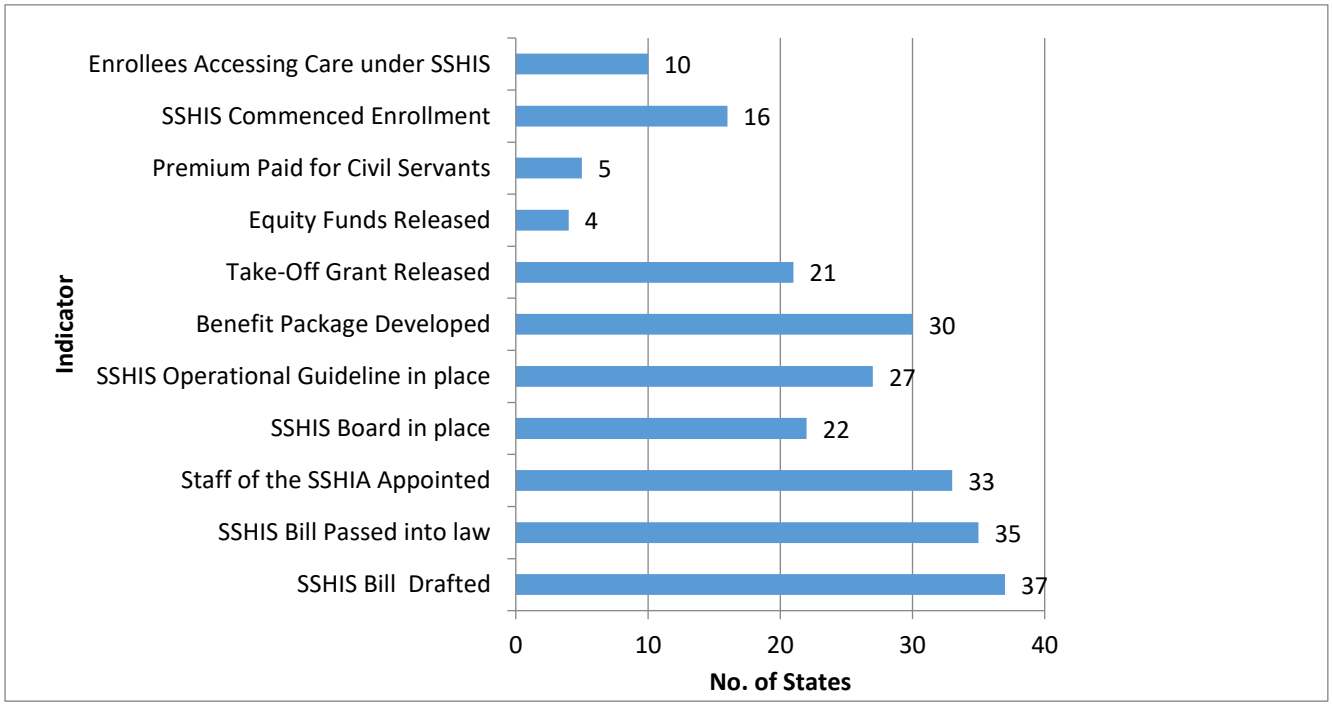


Figure 20: Status of SSHIS Design and Implementation. [29]

Furthermore, the implementation guidelines for BHCPF provide for the establishment of SSHIAs as a precondition to access the fund.

Considerable progress is being made across the 36 states and FCT towards the ultimate goal of improving access to health care services under SSHIS.

Significantly, enrollees are accessing healthcare under SSHIS in only 10 states as at baseline year of 2020.

2.3 Strengths, Weaknesses, Opportunities and Threats

Strengths, Weaknesses, Opportunities and Threats were examined holistically across the health sector.

2.3.1 SWOT Analysis for Leadership and Governance

STRENGTHS

- ✓ Existing National policies, supports, effective leadership and governance in the health sector.
- ✓ Existence of relevant legislations – National Health Act 2014, NHIS Act CAP N42 LFN 2004 and others
- ✓ NHIS Presence in the 36 + 1 States
- ✓ Commitment of the new leadership
- ✓ Existence of a broad Executive Management Structure that accommodates relevant Departments, Divisions and Units, Zones and States.

WEAKNESSES

- ✓ Inadequate vision sharing from leadership to team members
- ✓ High leadership turnover leading to policy summersaults and poor planning
- ✓ Over centralisation of policies and implementation
- ✓ Inadequate communication of policies and activities

OPPORTUNITIES

- ✓ Global and National momentum on Universal Health Coverage.
- ✓ Decentralisation of health insurance to the States
- ✓ Strong National drive for anticorruption.
- ✓ Existence of Public Procurement (BPP) Act 2007 to enhance transparency and accountability in procurement processes.
- ✓ Compliance with the National Chart of Accounts
- ✓ The proposed National Health Insurance Authority (NHIA) Act

THREATS

- ✓ Political Instability and frequent changes in leadership.
- ✓ Poor health system performance.

Figure 21: SWOT Analysis for Leadership and Governance

2.3.2 SWOT Analysis of Service Delivery in the NHIS

STRENGTHS

- ✓ The Federal Constitution recognises the three-tier health system and health as a fundamental human right.
- ✓ The NHIS enabling Act - providing the legal Framework for operation of Health Insurance in Nigeria.
- ✓ The National Health Act 2014 provision for additional funds through BHCPF.
- ✓ The renewed commitment of the leadership and management under the new Executive Secretary.

WEAKNESSES

- ✓ Centralisation and Concentration of activities at the Headquarters.
- ✓ Weak health system.
- ✓ Poor staff orientation on service delivery.
- ✓ Poor implementation of statutory regulatory provisions – including record keeping and retrieval system, poor information dissemination and feedback system.
- ✓ Lack of enforcement and sanctions on defaulting stakeholders.
- ✓ Over dependence on manual and semi-automated platforms for operations.
- ✓ Poor synergy between Departments, State and Zonal Offices in the implementation of activities – sometimes leading to conflict of functions.

OPPORTUNITIES

- ✓ The National Health Act 2014 provision for additional fund through BHCPF.
- ✓ Strategic collaborations with donors and technical partners.
- ✓ Federal and emerging State governments will and commitment.

THREATS

- ✓ General Health System performance.
- ✓ Barriers to uptake of Health Insurance.
- ✓ General political instability.

Figure 22: SWOT Analysis of Service Delivery in the NHIS

2.3.3 SWOT Analysis for Health Financing

STRENGTHS

- ✓ Existence of Health Care Financing (HCF) governance structures including the HCF Unit of the FMoH and NHIS.
- ✓ A detailed National Health Care Financing Policy and implementation plan in place.
- ✓ Provision of BHCPF in the NHAct is a catalyst for UHC
- ✓ Development and Implementing Partner commitment and support for key public health programmes: RMNCAH+N, Malaria, TB, HIV.
- ✓ Most States have established SSHIAs to reduce financial hardship at points of healthcare
- ✓ Strong coverage of the formal sector programme at the NHIS.
- ✓ Recognition of NHIS as a vehicle for achieving UHC in Nigeria.
- ✓ Existing technical capacity and operational experience to drive UHC.

WEAKNESSES

- ✓ Very low budget allocation to health and poor release of budgeted funding to the health sector at all levels.
- ✓ Very high OOPE: a risk to catastrophic health expenditure.
- ✓ Poor national health insurance coverage and nascent SSHIS.
- ✓ Weak health care financing implementation and tracking systems e.g. no sub-national health accounts.
- ✓ Weak overall regulatory mechanisms for healthcare financing actors and Schemes including HMOs, CBHIS, SSHIAs)
- ✓ Donor dependence at all levels for key public health programme funding.
- ✓ Lack of transparency and accountability in financial management.

OPPORTUNITIES

- ✓ Federal commitment to UHC – Presidential Summit on UHC
- ✓ Committed new NHIS leadership
- ✓ Strategic collaborations with donors and technical partners
- ✓ Decentralisation of health insurance in Nigeria has led to pooling of resources being integrated at state levels with enabling state laws.

THREATS

- ✓ Unpredictable and unsustainable healthcare financing.
- ✓ As Nigeria moves to middle income country status, donor funding is decreasing.
- ✓ Fragility, civil unrest and emergence of public health disasters.
- ✓ Changes in political leadership at all levels may affect policy consistency.
- ✓ Weak multi-sectoral coordination limits effectiveness of response to health-related SDGs

Figure 23: SWOT Analysis for Health Financing

2.3.4 SWOT Analysis for Human Resource for Health

STRENGTHS

- ✓ National HRH policy and strategic plan available and domesticated by some states
- ✓ Infrastructure for National Human Resources for Health Information System (NHRHIS) available
- ✓ National task shifting and sharing policy for which SOPs have been developed and rolled out
- ✓ Variable capacity for HRH production exists in all states
- ✓ Existing regulatory bodies for HRH production, practice control and accreditation.
- ✓ Existence of a Department dedicated to Human Resource Management.
- ✓ Large pool of trained and experienced staff in health insurance.
- ✓ Opportunities for Capacity Building.

WEAKNESSES

- ✓ Poor implementation of HRH policy and strategy at all levels
- ✓ Mal-distribution of HRH leading to inequities in the health system
- ✓ Acute shortage of skilled workers especially at the PHC level.
- ✓ Lack of reliable information for HRH planning and management
- ✓ Embargo on employment across many states worsens HRH availability
- ✓ Poor motivation, remuneration, discrepancies in salaries, allowances, incentives and other conditions of service leading to recurrent strikes and high attrition rates
- ✓ Tremendous tension among health professions hindering collaboration and synergy in the health system
- ✓ Lack of Scheme/standards of practice for some health cadres
- ✓ Weak systems for integrated supportive supervision (ISS)
- ✓ Limited continuing education opportunities
- ✓ Absence of formalized HR training plans for the health sector
- ✓ Lack of consistency in implementation of career development plans and programmes.
- ✓ Lack of comprehensive HR plan including workforce assessment, Scheme of service/job description, training plan, workforce projections
- ✓ Most of the HR are centralised at the HQ
- ✓ Lack of performance systems for staff

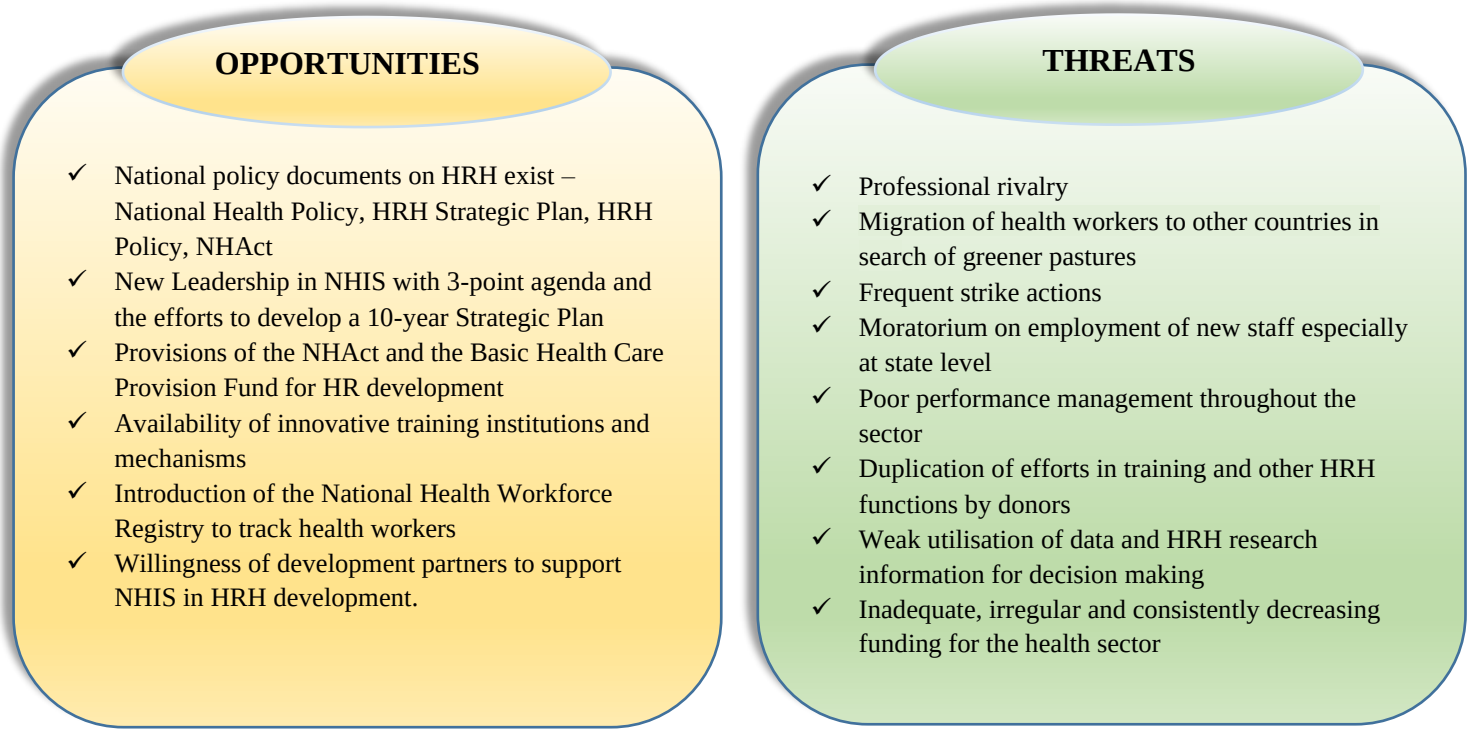


Figure 24: SWOT Analysis for Human Resource for Health

2.3.5 SWOT Analysis for Health Management Information System

STRENGTHS

- ✓ Committed Management
- ✓ Geographical spread of NHIS Offices
- ✓ Availability of Data
- ✓ Legislation – There is provision in the National Health Act, that promotes improvement in the HMIS.
- ✓ Budgetary provisions for ICT infrastructure in the Scheme's budget.
- ✓ Management's recognition of ICT as an indispensable tool for achievement of UHC
- ✓ Partnership with NIGComSAT for the development and deployment of e-NHIS

WEAKNESSES

- ✓ Lack of clarity in roles/responsibilities in data collection & processing, between State offices, Zonal Office & Headquarters
- ✓ Non-Automation of Analytical reports
- ✓ Lack of Standard Dashboard for real time reporting
- ✓ Obsolete ICT Software and Hardware
- ✓ Non-Routine Reporting of data
- ✓ Inability to implement ICT budget for infrastructure which has been rolled over since 2015.
- ✓ Inability to implement Scheme-wide network and connectivity project having secured relevant approval
- ✓ Inability to develop in-house capacity for software development

OPPORTUNITIES

- ✓ Availability of emerging new technology
- ✓ Support from Partners
- ✓ Existing NHMIS platform
- ✓ Provision of funds for ICT infrastructure in BHCPF.

THREATS

- ✓ High cost of purchasing, management & maintaining ICT infrastructure and software solutions.
- ✓ Obsolescence risk.
- ✓ Limited Resources.
- ✓ Cumbersome bureaucratic procurement process of ICT infrastructure and solutions.
- ✓ Lack of locally developed software solution for the automation of health insurance business processes.

Figure 25: SWOT Analysis for Health Management Information System

CHAPTER 3

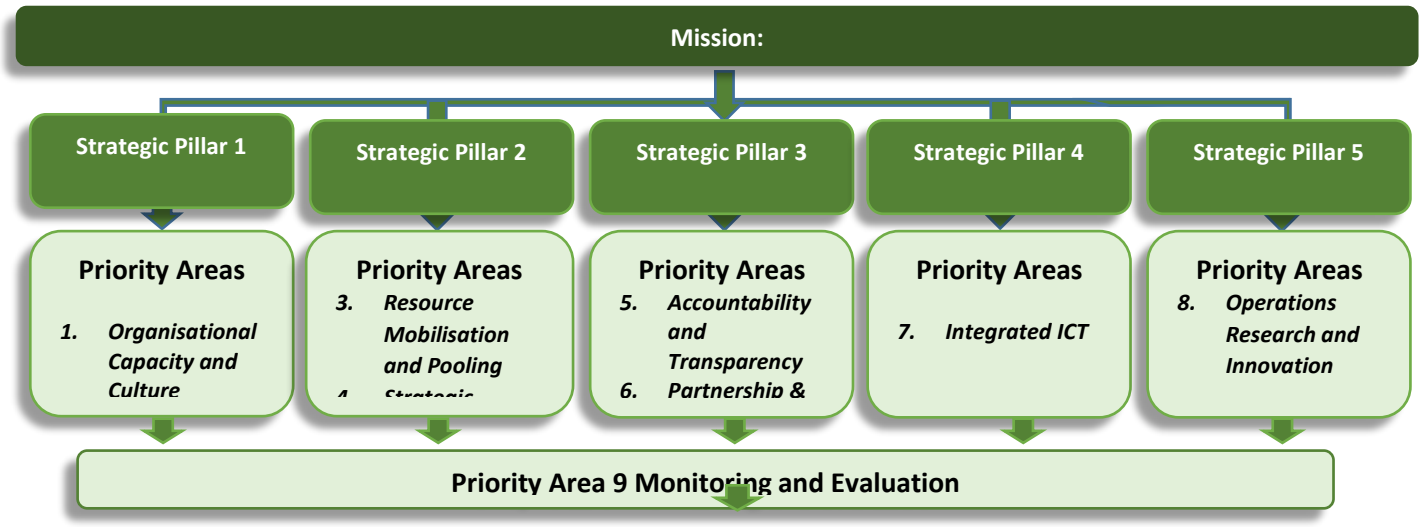
STRATEGIC FRAMEWORK

The development of the NHIS Strategic framework was guided by the NHIS mandate, Pillar Five (5) of the NSHDP II *"Predictable Financing and Risk Protection*" and priority area 15 *of the NSHDP II "ensuring all Nigerians have access to health services without any financial barriers or impediment at the point of accessing health care".*

The NSHDP II identified the following strategic objectives which are relevant to the mandate of the NHIS:

I. *Strengthen Governance and Coordination for actualising stewardship and ownership of health financing reforms.*
II. *Increase sustainable and predictable funding for health.*
III. *Enhance financial risk protection through pooled funds at the federal and state levels.*
IV. *Enhance transparency and accountability in strategic purchasing of health services.*

Accordingly, the Vision, Mission, Core Values, Guiding Principles, Strategic Objectives, Implementation Strategies and Key Activities detailed in this plan have been carefully articulated. This is to ensure the achievement of the mandate of NHIS and considerable alignment with the highlighted NSHDP II strategic objectives.

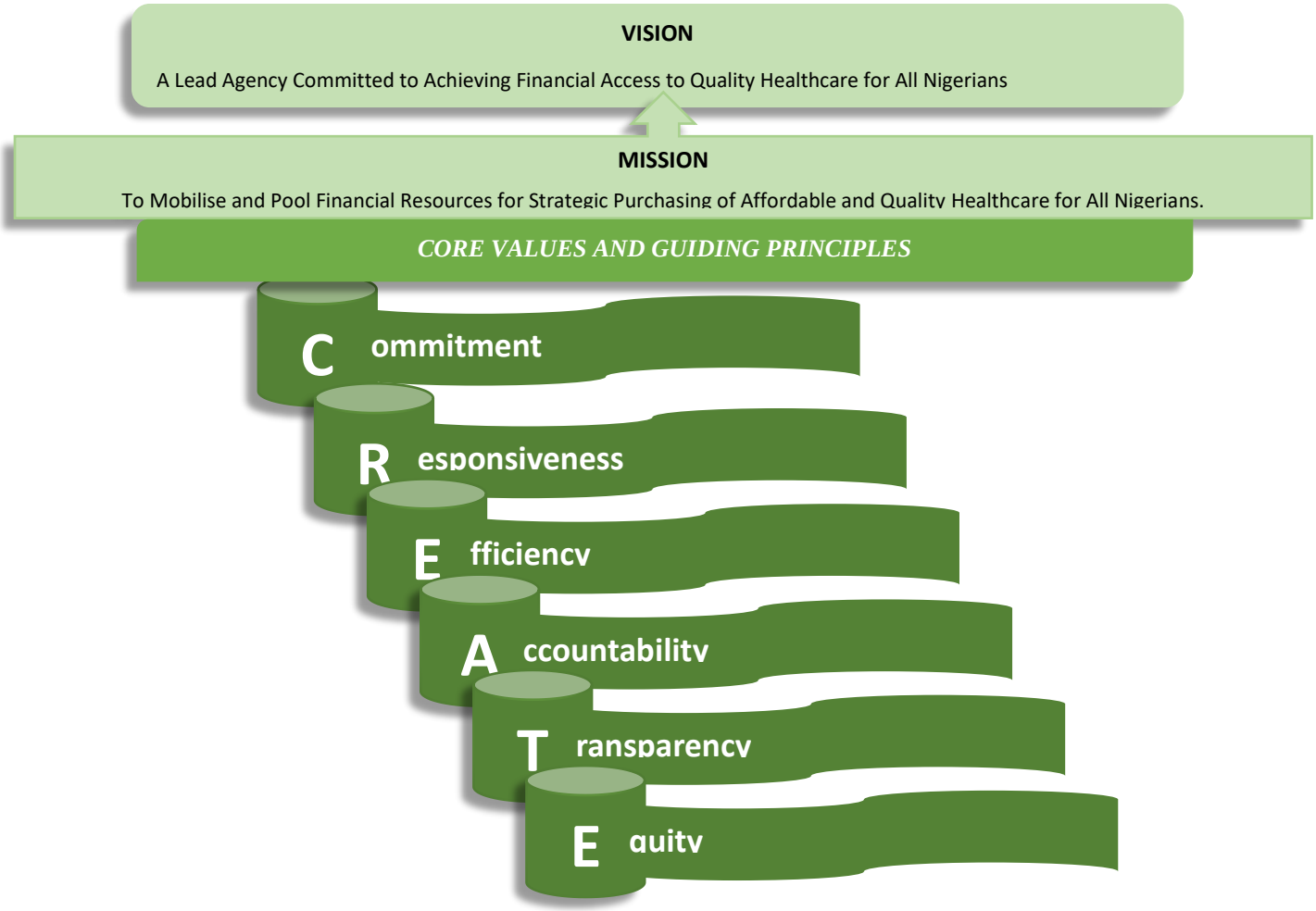


3.3 Goals of the Strategic Plan

Goals (10)
1. To promote Organisational and service excellence using best management practices
2. To improve visibility and acceptability of NHIS operations, business processes and practices
3. To increase revenue generation for financing health insurance programmes to provide financial risk protection for all Nigerians.
4. To achieve value for money and increase efficiency in the provision of healthcare through strategic purchasing mechanisms
5. To promote equity, quality, safety, and responsiveness in the delivery of health services
6. To promote accountability and transparency in NHIS operations, financial transactions, and procurement.
7. To promote effective collaboration and coordination of strategic partners and stakeholders
8. To promote ICT integration of NHIS processes to maximise efficiency and enable innovation to advance NHIS goals.
9. To promote and sustain excellence in operational research on health insurance and related activities of the NHIS
10. To ensure robust monitoring and evaluation of programmes and activities and periodic assessment of the performance of all NHIS operations

This Strategic Plan is designed to cover a 10-year period and is aligned with the SDG target of UHC. It is segmented into 3 phases consisting of a Short Term (2020-2022), Medium-Term (2023-2025), and Long-Term phase (2026-2030). All its phases are designed to be continuous in order to achieve its specific objectives, with annual or biennial review of the targets, projections and allocations in line with contemporary economic, demographic and political realities.

3.1 Strategic Direction: Vision, Mission, Core Values, and the Guiding Principles



POSITIONING STATEMENT

Financial access to quality healthcare for all

Core Values	
1. Commitment	We are committed to promoting excellence and professionalism in our business processes and healthcare delivery.
2. Responsiveness	We understand your healthcare needs and will ensure your rights and expectations are met.
3. Efficiency	We believe in delivery of highest level of health care standards and will ensure speedy and cost-effective services.
4. Accountability	We value high standards of accountability and will hold ourselves and other stakeholders accountable for any inadequacies.
5. Transparency	We build open and honest relationships with all stakeholders.
6. Equity	We treat all healthcare providers, consumers, and other stakeholders at all levels with courtesy, respect, dignity and impartiality.

3.3The Structure of the Strategic Plan

Figure 26: NHIS Strategic Direction and Strategic Plan Structure

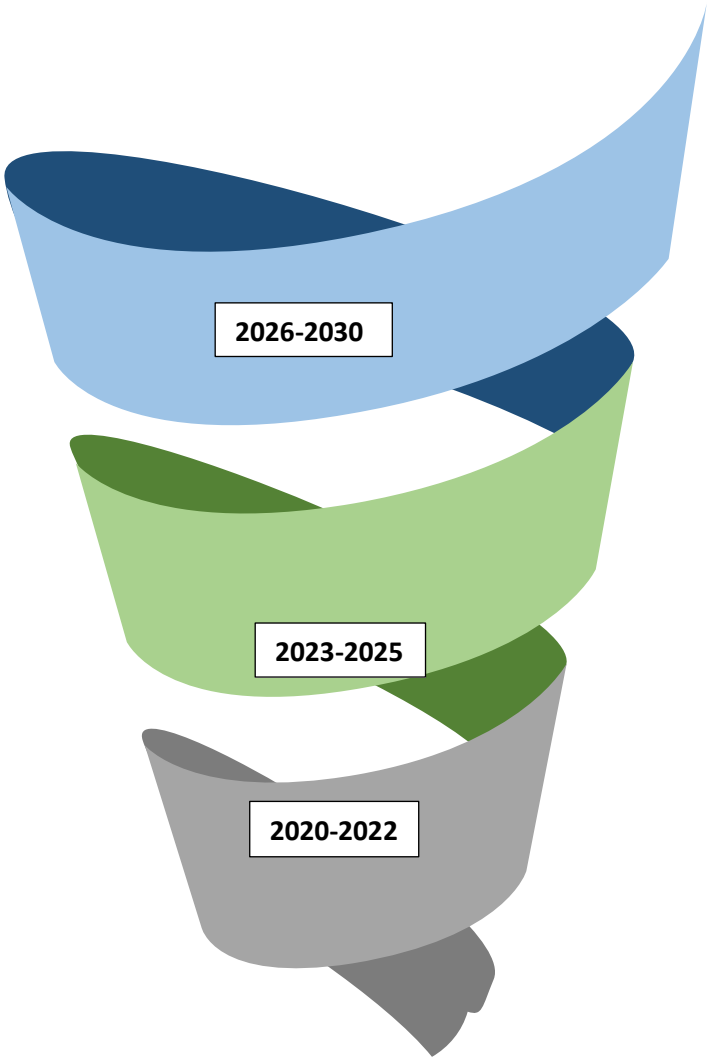
Goals (10)
1. To promote Organisational and service excellence using best management practices
2. To improve visibility and approval of NHIS operations and business processes and practices
3. To improve revenue generation for financing healthcare services to protect Nigerians against financial hardship of paying for healthcare
4. To achieve value for money for healthcare at minimum supply chain risk in strategic purchasing of health services
5. To promote equity, quality, safety, and responsiveness in the delivery of health services
6. To promote accountability and transparency in NHIS operations, financial transactions, and procurement.
7. To promote effective collaboration and coordination of strategic partners and stakeholders
8. To promote ICT integration of NHIS processes to maximise efficiency and enable innovation to advance NHIS goals.
9. To promote, utilise and sustain excellence in research in health financing and UHC and innovation for improved health outcomes
10. To ensure systematic tracking of programmes and activities and the performance of all NHIS operations

Figure 27: Structure of Strategic Plan

The Plan is a "Ten (10) Year Rolling Plan" designed to continue over a period and is subject to regular review and updating. It will run and terminate with the SDGs (UHC) target of 2030.

It is segmented into 3 phases comprising of the first phase of Short Term (2020-2022), second phase of Medium-Term (2023-2025), and a third phase of Long-Term consolidation (2026-2030), all with the possibility of rolling over.

The advantage is that it will be flexible and allow for revision and adjustments of targets, projections, and allocations as per the changing conditions in the political economy.


2026-2030
2023-2025
2020-2022

CHAPTER 4

PILLAR 1: ORGANISATIONAL CAPACITY AND CULTURE

Priority Area 1 – Organisational Capacity and Culture

Goal:

1. To Promote Organisational and Service Excellence Using Best Management Practices.

4.1.1 Strategic Objectives

Table 1: Strategic Objectives and Key Performance Indicators and targets for Organisational Capacity and Culture

Strategic Objectives	Key Performance Indicators and Targets	
	Indicators	**Targets**
▪ To achieve organisational excellence through effective stewardship and efficient delivery of services required to maintain the integrity and optimal functioning of NHIS.	% of zones and states that have trained personnel on implementation of public service extant regulations, best management practices and Code of Conduct	100%
	% of states and zones that develop and implement work plans using best practices.	100%
	% of national and sub-national personnel acquainted with NHIS operations, processes, and practices.	100%
▪ To achieve 100% alignment of administrative and operational roles with National priorities .	% alignment of administrative and operational roles with the National priorities t	100%
▪ To decentralize decision making in operations and business processes to the Zones and States	% of zones and states making independent decisions in operations and business processes.	100%
▪ To ensure availability of human and material resources required for effective management and service delivery annually.	% of zones and states that have available human and material resource requirements for effective management and service delivery.	100 %
▪ To ensure that the workforce has the required skills and competencies for organizational and service excellence.	% of staff trained on core competencies and skills required for organizational and service excellence.	100 %

4.1.2 Implementation and Action Plan

Table 2: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Organisational Capacity and Culture

Strategic Objective 1: To achieve organisational excellence through effective stewardship and efficient delivery of services required to maintain the integrity and optimal functioning of NHIS.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
1.1 Institute effective and efficient stewardship and management.	1.1.1 Develop and disseminate Guidelines on public service extant regulations, best management practices and Code of Conduct	12 months	HRAD, PRMD
	1.1.2 Organise workshops/retreat for NHIS managers on public service extant regulations, best management practices and Code of Conduct	Annually	HRAD, PRMD
	1.1.3 Hold Sensitisation meetings/workshops on public service extant regulations, best management practices and Code of Conduct for staff at headquarters (HQ) and zonal levels	Annually	HRAD, PRMD
	1.1.4 Strengthen NHIS capacity for developing, operationalizing and monitoring strategic and operational plans.	12 months	HRAD, PRMD
1.2 Institute incentives and reward system to enhance employee's performance.	1.2.1 Organise regular "productivity achievement awards" to honour employees and stakeholders for outstanding performance.	Annually	HRAD, PRMD
1.3 Promote effective internal (intra-agency) communication	1.3.1Regular circularisation of official information on business processes and practices within and outside with strategic stakeholders	12 months	HRAD, ICTD
	1.3.2 Digitalise internal communication processes including use of intranet	12 months	HRAD, ICTD

	1.3.3 Hold regular meetings with internal stakeholders to improve internal communication	Quarterly	HRAD, TMC
Strategic Objective 2: To achieve 100% alignment of administrative and operational roles with National priorities.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
2.1 Develop and Implement Alignment Plan to ensure that the structure, process, roles, and persons align with the Strategic Plan	2.1.1 Set up Committee to align NHIS structure, processes, roles, and persons with the Strategic Plan	12 months	HRAD
	2.1.2 Conduct sensitisation/orientation/re-orientation meetings/workshops on alignment of the Strategic Plan	Annually	HRAD, PRMD
Strategic Objective 3: To decentralize decision making in operations and business processes to the Zones and States			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
III.1 Develop and implement framework for decentralisation of decision making	3.1.1 Implement decentralisation plan - identify and deploy qualified officers to Zones and States	12 months	HRAD
	3.1.2 Conduct Capacity Building in Leadership, Management and Governance (LMG) at HQ, Zonal and State levels	Annually	HRAD
Strategic Objective 4: To ensure availability of human and material resources requirement for effective management and service delivery annually.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
4.1 Improve the capacity of NHIS workforce for effective management and service delivery.	4.1.1 Conduct HR Needs/Gap Analysis	Annually	HRAD
	4.1.2 Conduct recruitment exercise to fill critical HR Needs	Every 2 years	HRAD
4.2 Improve the capacity of NHIS infrastructure to provide	4.2.1 Conduct Infrastructure and Material Needs Assessment	Annually	HRAD

adequate office space and working tools	4.2.2 Develop Infrastructure and Material Development/ Renewal Plan	Annually	HRAD, PRMD
	4.2.3 Provide Infrastructure and Material Needs Based on the Renewal Plan	Annually	HRAD, PRMD
Strategic Objective 5: To ensure that the workforce have the required skills and competencies for organizational and service excellence.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
a. Training Needs Assessment to identify competencies and skills gaps	5.1.1 Conduct Training Need Assessment (TNA)/ Skills and Competency Gaps Analysis	Every 2 years	HRAD, PRMD
	5.1.2 Develop Capacity/Training Plan on the TNA	Annually	HRAD, TMC, PRMD
	5.1.3 Conduct Capacity Buildings/Training workshops based on the TNA	Quarterly	HRAD, TMC, PRMD
b. Implement knowledge management program for creating, sharing, using, and managing knowledge and information to achieve organisational objectives of NHIS	5.2.1 Create a Learning Network on improving access of workforce for continuous learning and adoption of best practices	12 months	HRAD, PRMD

4.2 Priority Area 2 – Communication and Marketing

Goal:

2. To Improve visibility, acceptance and Public perception of NHIS operations and business processes and practices.

4.2.1 Strategic Direction

Table 3: Strategic Objective and Key Result Area for Communication and Marketing

Strategic Objectives	Key Result Area	
	Indicators	**Targets**

▪ To achieve 100% engagement with key sectors and partners such as FMoF/National Planning, FMoH, FMoL and Development Partners to influence discourse on UHC	% of stakeholders (sectors, partners etc) engaged on UHC	100%
▪ To increase public awareness on health Insurance	% of States and zones that have Health insurance sensitization workshops conducted annually	100%

4.2.2 Implementation and Action Plan

Table 4: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Communication and Marketing

Strategic Objective 6: To achieve 100% engagement with key sectors and partners such as FMoF/National Planning, FMoH, FMoL and Development Partners to influence discourse on UHC			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
I.1 Support institutionalisation of structured multi-sectoral and partners' fora	6.1.1 Facilitate/Convene regular multi-sectoral and partners' dialogue between NHIS\SSHIS and other key sectors like FMOH, the National Assembly, CSOs, Patient Rights Groups, FMoF/NP, FMoL to influence national discourse on UHC and other relevant stakeholders	Annually	Media Unit, PRMD
Strategic Objective 7: To increase public awareness on health Insurance			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
7.1 Develop and Implement Strategic Marketing and Communication Plan to increase public awareness	7.1.1 Develop Strategic Marketing and Communication Plan	12 months	Media Unit, Marketing Department, PRMD, Consultant
	7.1.2 Conduct training on strategic marketing and communication to increase public awareness of health insurance	Quarterly	Media Unit, Marketing Department, PRMD, Consultant
	7.1.3 Conduct advocacy, sensitisation meetings and public enlightenment campaigns on increasing public awareness of health insurance through multiple communication channels in all States and Zones	Quarterly	Media Unit, Consultant
	7.1.4 Facilitate development/review of advocacy kits, IEC materials.	Annually	Media Unit Marketing Department

	7.1.5 Conduct regular social marketing of the NHIS and its programmes	Quarterly	Media Unit Marketing Department
7.2 Promote effective engagement with media stakeholders	7.2.1 Conduct regular media dialogue sessions and sensitisation meeting/workshops with media and other interest groups	Quarterly	Media Unit

CHAPTER 5

PILLAR 2: EXPANDING COVERAGE

5.1 Priority Area 3 – Resource Mobilisation and Pooling

Goal:

3. To improve revenue generation for financing health insurance, to provide Nigerians with financial risk protection in accessing healthcare services

5.1.1 Strategic Direction

Table 5: Strategic Objectives and Key Result Areas for Resource Mobilisation and Pooling

Strategic Objectives	Key Performance Indicators	
	Indicators	**Targets**
▪ To achieve sustainable annual increase in health financing through **public and *private* spending.	% of national budget allocated to health (GGHE/GGE%)	At least 15%
	% contribution to Health Financing from innovative healthcare financing instruments eg Sin Tax	20%
	% reduction in household out-of-pocket expenditure on health	30%
	% contribution of private sector investments in the health sector	30%
	% Increase in Health Insurance contribution to Current Health Expenditure (Health Insurance/CHE %)	50%
▪ To achieve 20% annual increase in health insurance (population) coverage	% of annual increase in population coverage	20% per annum (2030 Target - 90%)
▪ To ensure allocation and release of equity funds by all the States annually.	% of States with equity fund allocation in the annual budget	100%
	% of SSHIA that achieve 100% release of earmarked equity funds annually.	100%

▪ To achieve 100% release of BHCPF to NHIS and SSHIS.	% release of BHCPF to NHIS and SSHIAs.	100%
▪ To achieve 100% investment of residual funds	% of NHIS residual funds invested annually	100%
▪ To achieve full integration of all existing pools at the State level	% of SSHIAs that achieve full integration of all existing pools.	100%
▪ To achieve reduction of Out of Pocket Expenditure by 10% annually	% annual reduction of OOP based on State and National Health Accounts	10% per annum
	% population of Nigerians with at least one prepayment mechanism	90%

5.1.2 Implementation and Action Plan

Table 6: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Resource Mobilisation and Pooling

Strategic Objective 8: To achieve sustainable annual increase in health financing through public and private spending.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
8.1 Advocate for increase in Government annual budget and spending on health by all levels of Government	8.1.1 Conduct advocacy visits for increase in Government annual budget and spending on health by all levels of Government	Annually	FSD, ISD, Media, ESO
	8.1.2 Conduct sensitisation campaigns and advocacy visits on increasing health financing through Government earmarked funds.	Annually	FSD, ISD, Media, ESO
8.1 Develop Framework and implementation Guidelines on innovative financing	8.2.1 Develop and implement a Framework and implementation Guidelines on innovative financing .	12 months	FSD, ISD, PRMD
	8.2.2 Conduct capacity building workshops for SSHIAs on innovative financing of healthcare	12 months	FSD, ISD, PRMD
Strategic Objective 9: To achieve 20% annual increase in health insurance (population) coverage.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
9.1 Targeted advocacy and sensitisation at Federal and State Levels	9.1.1 Conduct advocacy visits and sensitisation campaigns to Strategic Partners and Stakeholders (includes Executive and Legislative arms, , Professional Groups, CSOs, Traditional and Religious leaders etc) to increase health insurance uptake and coverage	Annually	FSD, ISD, Media, ESO
9.2 Develop communication and social marketing strategy.	9.2.1 Develop and Implement communication and social marketing strategy	12 months	Marketing Department, Media, PRMD

	9.2.2 Conduct training on social marketing	12 months	Marketing Department, Media, PRMD
	9.2.3 Support public education and enlightenment for raising awareness on Health Insurance and contributory scheme	Annually	Marketing Department, Media, PRMD
9.3 Provide technical support to SSHIA in design and implementation of State Social Health Insurance Scheme	9.3.1 Develop guidelines for design, implementation and monitoring for SSHIS expansion.	12 months	FSD, ISD, PRMD
	9.3.2 Organise workshops, trainings, and mentoring programmes for SSHIS expansion	Annually	FSD, ISD
9.4 Facilitate enactment of revised law to make health insurance mandatory.	9.4.1 Advocacy visits to NASS, FMOF, FMOJ, Federal Ministry of Labour etc. on enactment of revised law to make health insurance mandatory	Annually	Legal Dept. FSD, ISD, ESO, Media, PRMD
	9.4.2 Facilitate the repeal of current NHIS law	12 months	Legal Dept. FSD, ISD, ESO
9.5 Develop Framework and Guidelines to Strengthen the Role of NHIS in Health Emergencies in partnership with relevant stakeholders	9.5.1 Implement in partnership with relevant stakeholders the Framework and Guidelines on the role of NHIS in Emergency Medical Services under the BHCPF	Annually	SQAD, Enforcement, FSD, ISD, CMD, FAD, PRMD
	9.5.2 Implement in partnership with relevant stakeholders the Framework and Guidelines on the role of NHIS in Public Health Emergency	Annually	SQAD, Enforcement, FSD, ISD, CMD, FAD, PRMD
9.6 Promote linkage with Social Protection Programmes (SPPs) provided by other Sectors and Ministries.	9.6.1 Develop Framework and Guidelines for linkage of Health Insurance with SPPs	12 months	SQAD, ENF, FSD, ISD, CMD, FAD, PRMD
	9.6.2 Implement Guidelines for linkage of Health Insurance with SPPs	Annually	SQAD, ENF, FSD, ISD, CMD, FAD, PRMD
	9.6.3 Participate in regular consultative meetings with Social Protection Stakeholders	Annually	SQAD, ENF, FSD, ISD, CMD, FAD, PRMD

Strategic Objective 10: To ensure allocation and release of equity funds by all the States annually			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
10.1 Ensure institutionalisation of equity funds in States annual budgets.	10.1.1 Develop framework and guideline on management of equity funds.	12 months	FSD, ISD, PRMD, SQAD, CMD
	10.1 2 Collaborate with the FMOH for the creation/strengthening of health financing equity and investment units in the States	12 months	FSD, ISD, Legal, ESO, FAD
	10.1.3 Conduct advocacy visits on allocation and release of earmarked equity funds to State Executives and Legislators, Ministry of Finance etc.	24 months	FSD, ISD, Legal, FAD, CMD, ESO
10.2 Facilitate re-programming of BHCPF for risk equalization across states and population through National Health Act amendment.	10.2.1 Advocacy visits to NASS, FMOF, FMOH on re-programming of BHCPF for risk equalisation across states and population through National Health Act amendment.	Annually	Legal, FSD, ISD, Media, PRMD, ESO
	10.2.2 Develop guidelines on risk equalisation across states and population	12 months	Legal, FSD, ISD, PRMD, SQAD
Strategic Objective 11: To achieve 100% release of BHCPF to NHIS and SSHIS.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
11.1 Ensure 100% release of BHCPF to NHIS and SSHIS	11.1.1 Advocacy visits to NASS, FMOF, OAGF etc	Annually	ISD, PRMD, ESO, CMD, FAD, Media
	11.1.2 Monitor release and utilisation of BHCPF through a functional system for expenditure tracking, including National and State Health Accounts.	Quarterly	FAD, ISD, PRMD, ESO, CSO
Strategic Objective 12: To achieve 100% investment of residual funds			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**

12.1 Develop and implement investment plan for residual NHIS funds.	12.1.1 Develop and implement guidelines for investment of residual NHIS funds.	12 months	CMD, PRMD, FAD
	12.1.2 Develop and implement investment plan for NHIS	12 months	CMD, PRMD, FAD
Strategic Objective 13: To achieve full integration of all existing pools at State level			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
13.1 Develop guidelines for integration of existing pools by SSHIS	13.1.1 Advocacy visits on achieving integration of all existing pools at all levels to State Executives and Legislators, Ministry of Finance etc.	12 months	ISD, FSD, ESO, FAD, CMD, Media
Strategic Objective 14: To achieve reduction of Out of Pocket Expenditure by 10% annually			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
14.1 Promotion of expansion of Social Health Insurance Scheme towards reduction of Out of Pocket Expenditure	14.1.1 Conduct advocacy visits, policy dialogues, public enlightenment campaigns and social marketing to enhance enabling environment for expansion of health insurance and reduction of Out of Pocket Expenditure.	Annually	FSD, ISD, ESO, Media
	Support the FMOH to facilitate the conduct of National and State Health Accounts (SHA)	Annually	FAD, PRMD, ESO, CSO

5.2 Priority Area 4 – Strategic Purchasing

Goals:

4. To maximize efficiency in the purchase of healthcare services and goods through strategic purchasing mechanisms
5. To promote equity, quality, safety, and responsiveness in the delivery of health services

5.2.1 Strategic Direction

Table 7: Strategic Objective and Key Result Areas for Strategic Purchasing

Strategic Objectives	Key Result Area	
	Indicators	**Targets**
▪ To ensure the utilization of Strategic Purchasing mechanisms for the purchase of all healthcare goods and services in all States	% of State Health Insurance Schemes that utilize strategic purchasing mechanisms	**100%**
▪ To ensure that providers are given incentives to increase efficiency and service quality.	% of providers in each state that respond to incentives and increase efficiency and quality.	**`100%**
▪ To strengthen provider payment and commodity pricing systems in all States.	% of States that biennaily review their provider payment mechanisms and commodity pricing systems.	**100%**
▪ To achieve full implementation of defined benefit packages by all providers	% of providers rendering services in each State in line with defined benefit packages	100%
▪ To ensure full compliance of providers and HMOs with established service quality standards and contractual agreements	% of providers in each State complying with minimum established service quality standards and contractual agreements	100%
▪ To ensure synergy between Providers, HMOs and the NHIS on professional and ethical standards	% of providers and HMOs that attend the annual Provider-HMO-NHIS meeting in each State.	100%
▪ To increase the responsiveness to the health needs and demands of health consumers annually by healthcare providers and HMOs	% of providers and HMOs have clearly defined pathways for enrollees to channel complaints about service quality and efficiency in each State. t	50%
▪ To achieve full provider payment by HMOs within 30 days of payment claims request due to improved efficiency in Provider Payment Mechanisms (PPMs) .	% of providers reporting full payment of claims within 30 days in each State.	100%
▪ To ensure that all enrollees- are aware of their rights and benefit package and understand the processes for holding providers, HMOs and other stakeholders accountable	% of States where planned consultations/sensitisation meetings, media campaigns, Health Consumers' Forum carried out for enrollees	100%
	% of HCP that display Patients' Bill of Rights, and Grievances/Redress Policy, Guidelines or Procedure	100%
	% of reported enrollee complaints resolved within 48 hours.	100%

5.2.2 Implementation and Action Plan

Table 8: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Strategic Purchasing

Strategic Objective 15: To ensure the utilization of Strategic Purchasing mechanisms for the purchase of all healthcare goods and services in all States			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
15.1 Develop the capacity of SSHIAs to utilize Strategic Purchasing mechanisms	**15.1.1 Develop and Disseminate a Training Manual on Strategic Purchasing for developing the capacity of Officers of the State Insurance Schemes.**	**12 months**	**FSD, ISD, ESO**
	15.1.2 Conduct capacity building workshops for SSHIAs on Strategic Health Purchasing	**Continuous**	**FSD, ISD, ESO**
	15.1.3 Conduct advocacy visits to SSHIAs to promote the utilization of Strategic Purchasing mechanisms	**Continuous**	**FSD, ISD, ESO**
15.2 **Ensure the utilization of Strategic Purchasing mechanisms by all HMOs at National and State levels**	**1 Develop and Disseminate a Strategic Purchasing manual for utilization by all HMOs**	**12 months**	**FSD, ISD, ESO**
	2 Organize a Workshop on Strategic Purchasing for HMOs, SSHIAs and other Stakeholders to advocate for the utilization of Strategic Purchasing mechanisms	**Annually**	**FSD, ISD, ESO**

To ensure that Providers are given incentives to increase efficiency and service delivery			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
15.3 Increase the capacity of SSHIAs and HMOs to provide incentives to Providers	Develop a framework for incentivizing Providers in line with Strategic Purchasing mechanisms	12 months	FSD, ISD, ESO
	Organize a workshop for SSHIAs and HMOs to access review the effect of Provider Incentives on efficiency and service quality	Annually	FSD, ISD, ESO
15.4 Ensure that Providers are positioned to appropriately respond to Strategic Purchasing incentives	Support the SSHIAs to organize a workshop for Providers to improve their capacity to respond appropriately to Strategic Purchasing Incentives	Annually	FSD, ISD, ESO

To strengthen provider payment and commodity pricing systems in all States.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
15.5 To ensure that providers payment systems are linked with Quality improvement in all States	Develop a National framework for linking provider payment mechanisms with Quality improvement and efficiency	12 months	FSD, ISD, ESO
	Conduct training for SSHIAs to link provider payment mechanisms with Quality improvement and Efficiency	Annually	FSD, ISD, ESO

	Advocate for the Biennial review of provider payment mechanism	**Continuous**	**FSD, ISD, ESO**
15.6 **To ensure that Commodity Pricing systems are robust and focused on Quality and efficiency in all States**	**Develop a National Commodity Pricing framework focused on Quality and Efficiency**	**12 months**	**FSD, ISD, ESO**
	Conduct training for SSHIAs on Commodity Pricing for Quality and Efficiency	**Annually**	**FSD, ISD, ESO**
	Advocate for the Biennial review of Commodity Prices by all SSHIAs	**Continuous**	**FSD, ISD, ESO**

Strategic Objective 15: To achieve full implementation of defined benefit packages by all providers			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
15.7 Conduct harmonisation of NHIS and State Benefit Packages into not more than three categories of National Standard Benefit Packages	15.1.1 Develop/Review defined Benefit Packages	12 months	FSD, ISD, SQAD
	15.1.2 Routine monitoring of benefits package utilisation across states	Quarterly	SQAD, CMD, PRMD, Zonal and State offices
	15.1.3 Conduct dialogues meetings with SSHIA, HMOs, HCPs, Enrollees on benefit packages	Quarterly	SQAD, ENF, Zonal and State offices, FSD, ISD
Strategic Objective 16: To ensure full compliance by Providers and HMOs with established service standards and contractual agreements			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
16.1 Promote compliance by Stakeholders with established	16.1.1 Conduct regular and unscheduled visits to Healthcare Providers and HMOs	Continuous	SQAD, Zonal and State offices, ENF, Legal

service standards and contractual agreements			
	16.1.2 Conduct nationwide reaccreditation of healthcare providers and HMOs	Annually	SQAD, Zonal and State offices, Legal
Strategic Objective 17: To ensure synergy between Providers, HMOs and the NHIS on ensuring professional and ethical standards			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
17.1 Provide framework for professional and ethical standards	17.1.1 Conduct regular review of Operational Guidelines	Every 2 Years	SQAD, ENF, FSD, ISD, PRMD, Legal
17.2 Implement enforcement of routine quality assurance guidelines to ensure compliance.	17.2.1 Conduct scheduled/unscheduled quality assurance visits	Continuous	SQAD, ENF, Zonal and State offices, PRMD
17.3 Implement sanctions and rewards based on operational guidelines and standards.	17.3.1 Conduct enforcement of sanctions	Yearly	ENF, ZSOD, Zonal and State Offices
	17.3.2 Organise awards and recognition for stakeholders with high compliance and quality standards	Yearly	ESO, SQAD, ENF
17.4 Establish NHIS Health Technology Assessment unit (HTA) to follow HTA guidelines as provided by the FMOH	17.4.1 Implement NHIS Quality Review & HTA Systems to determine which health interventions are cost effective in accordance with National HTA guidelines	24 months	SQAD, ISD, FSD, PRMD, ICTD
Strategic Objective 18: To increase the responsiveness to the health needs and demands of health consumers annually by Healthcare Providers and HMOs			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**

18.1 Develop and Implement effective accountability approaches to improve service delivery	18.1.1 Conduct routine Client Satisfaction, Citizens Report Cards and Community Score Cards surveys for effective accountability and improvement in service delivery	Continuous	PRMD, SQAD, ZSOD, Zonal and State Offices

Strategic Objective 19: To achieve full provider payment by HMOs within 30 days of payment claims request due to improved efficiency in the Provider Payment Mechanisms (PPMs).

Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
19.1 Reform and strengthen PPM to improve efficiency and management of NHIS funds	19.1.1 Carry out regular provider payment workshops for eligible stakeholders	Annually	SQAD, ENF, FSD, CMD, FAD
	19.1.2 Conduct analysis to identify challenges in PPM	12 months	FSD, ISD, SQAD, CMD, FAD, PRMD
	19.1.3 Organise stakeholder's forum on PPM reform	12 months	FSD, ISD, SQAD, CMD, FAD
	19.1.4 Develop and Implement timely coordinated data systems to monitor PPM	12 months	PRMD, FSD, ISD, SQAD, ICTD, CMD, FAD, ZSOD, Zonal and State Offices
	19.1.5 Conduct routine monitoring of provider payment system	Annually	FSD, ISD, SQAD, PRMD, CMD, FAD
	19.1.6 Facilitate implementation of PBF as a results-based provider payment mechanism	Annually	FSD, ISD, SQAD, PRMD, FAD, CMD
19.2 Initiate dialogue with stakeholders on review of provider payment rates.	19.2.1 Implement reviewed provider payment rate	12 months	CMD, FAD, PRMD

Strategic Objective 20: To ensure that all enrollees are aware of their rights and benefit package and understand the processes for holding providers, HMOs and other stakeholders accountable

Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**

20.1 Implement Patients' Bill of Rights	20.1.1 Carry out sensitisation meetings, enrolee fora and media campaigns for increasing awareness of patients' rights	Continuous	Media, SQAD, FSD, ISD, ENF
20.2 Establish an effective grievance redress system	20.2.1. Develop, implement, and monitor grievances resolution processes	Continuous	ENF, SQAD

CHAPTER 6:

PILLAR 3: GOOD GOVERNANCE AND ACCOUNTABILITY

6.1 Priority Area 5 – Accountability and Transparency

Goal:

6. To promote accountability and transparency in NHIS operations, financial transactions and procurement.

6.1.1 Strategic Direction

Table 9: Strategic Objective and key result area for Accountability and Transparency

Strategic Objective	Key Result Areas	
	Indicator	**Target**
▪ To achieve 100% compliance with extant financial and procurement regulations, guidelines and processes for efficiency, cost effectiveness and value for money.	% compliance with extant financial and procurement regulations, guidelines, and processes	100%
	% of accounts and procurement officers trained on PEMS and internal control systems	100%
	% of planned reconciliations between NHIS, FMoF, OAGF, OAuGF and other stakeholders	100%
▪ To ensure full involvement of Independent Health Insurance Advocacy groups and "Watchdogs" in NHIS operations.	% of NHIS operations in which Independent Health Insurance Advocacy groups and "Watch dogs" are involved	100%

6.1.2 Implementation and Action plan

Table 10: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Accountability and Transparency

Strategic Objective 21: To achieve 100% compliance with extant financial and procurement regulations, guidelines and processes for efficiency, cost effectiveness and value for money			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
21.1 Develop and Implement Accountability Framework and Integrity Plan to promote	21.1.1 Develop Accountability Framework and Integrity Plan	2 months	PRMD, CMD, FAD

efficiency, cost effectiveness and value for money in financial and procurement processes and strategic purchasing.	21.1.2 Implement accountability initiatives to strengthen accountability linkages and provide reasonable assurance regarding achievement of operational compliance and reporting objectives based on figure-31 (Conceptual Framework) in section 13.3	12 months	FAD, IAD, CMD, PROC
21.2 Institute functional Public Finance Management (PFM) to ensure effective and efficient financial management system	21.2.1 Conduct training of accounts officers on PFM and other internal control systems	Biannually	FAD, IAD, HRAD, CMD, PROC
	21.2.2 Conduct external audit	Annually	FAD, IAD, ESO, PROC
	21.2.3 Conduct regular financial reconciliation and verification between NHIS, FMOF, OAGF, OAuGF etc.	Annually	FAD, IAD, CMD
	21.2.4 Conduct regular financial reconciliation and verification between NHIS, SSHIS, HMOs & HCPs	Quarterly	CMD, ISD, ENF, FAD, IAD
	21.2.5 Produce and distribute financial management guidelines and tools	12 months	FAD, IAD, PROC
21.3 Institute functional Public Procurement System to ensure effective and efficient procurement of goods and services.	21.3.1 Develop and implement procurement plan	Annually	PROC, PRMD
	21.3.2 Conduct training of procurement officers on Public Procurement Guidelines	Biannually	PROC, PRMD
Strategic Objective 22: To ensure involvement of Independent Health Insurance Advocacy groups and "Watchdogs" in 20% of NHIS operations.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
20.3 Facilitate creation of coalition of Health Insurance Advocacy groups	22.1.1 Facilitate bi-annual meetings and feedback forum	Bi-annually	ZSOD, FSD, ISD, Media

	of Independent Health Insurance Advocacy groups.		

6.2 Priority Area 6 – Partnership and Stakeholder Coordination

Goal:

7. To promote effective collaboration and coordination of strategic partnerships and stakeholders.

6.2.1 Strategic Direction

Table 3: Strategic Objectives and Key Result Areas for Partnership and Stakeholder Coordination

Strategic Objectives	Key Result Areas	
	Indicators	**Targets**
▪ To promote 100% implementation of Health Insurance Under One Roof (HIUOR) in 2020 - 2021.	% of SSHIAs operating based on the HIUOR Guidelines	100%
	% of SSHIAs that have been trained on the HIUOR Guidelines	100%
▪ To ensure 100% alignment of development partners' mandate and other stakeholders' activities with NHIS priorities.	% of Partners and other stakeholders whose mandate and activities align with NHIS Activities and Programmes	100%

6.2.2 Implementation and Action Plan

Table 4: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Partnership and Stakeholder Coordination

Strategic Objective 23: To promote 100% implementation of Health Insurance Under One Roof (HIUOR) in 2020 - 2021.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
23.1 Implement HIUOR to create greater coherence and enhance synergy in Social Health Insurance Programme with NHIS leadership	23.1.1 Develop and Implement HIUOR Framework and Guidelines to ensure effective coordination of SSHIS	3rd - 4th Quarter 2020	TMC, FSD, ESO, `PRMD
	23.1.2 Conduct advocacy visits on HIUOR to relevant stakeholders- Executives, Legislatures, MDAs and CSOs etc. to secure buy-in	Quarterly	TMC, ZSOD Zonal and State offices
	23.1.3 Support development, implementation and monitoring of SSHIA Strategic Plans including Accountability Framework and Integrity Plan	12 months	TMC, PRMD, ZSOD, Zonal and State offices

	23.1.4 Organise periodic (quarterly) meetings with SSHIA leadership to share information and feedback on progress of HIUOR	Quarterly	TMC, ZSOD, Zonal and State offices
	23.1.5 Organise capacity building workshops/conferences on relevant operational areas to strengthen institutional and operational capacity of SSHIAs	Bi-annually	TMC, ZSOD, Zonal and State offices
23.2 Implement Knowledge Management Program (creating, sharing, using, and managing knowledge and information) to support SSHIAs achieve their operational objectives.	23.2.1 Strengthen NHIS/SSHIAs Learning Network	Continuous	FSD, ISD, ZSOD and State Offices
	23.2.2 Facilitate study Tours of successful SSHIP	Quarterly	TMC, ZSOD, Zonal and State offices
	23.2.3 Conduct Joint Monitoring and Evaluation of programmes and activities of SSHIS	Continuous	FSD, ZSOD, PRMD, Zonal and State offices
	23.2.4 Conduct Joint Annual Reviews	Annually	FSD, ISD, PRMD, Zonal and State offices
Strategic Objective 24: To ensure 100% alignment of development partners' mandate and other stakeholders' activities with NHIS priorities			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
24.1 Establish Health Insurance Partners Forum (HIPF) for coordination of development Partners	24.1.1 Develop and Implement Guidelines for Health Insurance Partners Forum to enhance alignment of Partners' mandate with NHIS	3 months	TMC, PRMD
	24.1.2 Develop National Registry of Health Insurance Partners to provide database and information on mandates	December 2020	PRMD, FSD, ICTD
	24.1.3 Organise periodic (quarterly) meetings with Development Partners in Health Financing.	Quarterly	PRMD, FSD

CHAPTER 7:

PILLAR 4: INTEGRATED INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) INFRASTRUCTURE

7.1 Priority Area 7 – Integrated ICT

Goal:

8. To promote ICT integration of NHIS processes towards maximising efficiency and enabling innovation to advance NHIS goals.

7.1.1 Strategic Direction

Table 13: Strategic Objectives and Key Result Areas for Integrated ICT

Strategic Objectives	Key Result Areas	
	Indicators	**Targets**
▪ To achieve deployment of ICT infrastructure that meet established standards including data security, integration, and interoperability in 70% of NHIS Zones and States, SSHIAs, accredited HMOs and Providers.	% of States and Zones with ICT infrastructure that meet established standard in data security, integration, and interoperability	70%
▪ To Achieve 70% reduction in lead time for carrying out key internal NHIS processes, such as accreditation, claims management, access to enrolee register and referral management.	% of key internal business processes that achieve 70% reduction in lead time.	70%

7.1.2 Implementation and Action Plan

Table 14: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Integrated ICT

Strategic Objective 25: To achieve deployment of ICT infrastructure that meet established standards including data security, integration, and interoperability in 70% of NHIS Zones and States, SSHIAs, accredited HMOs and Providers.			
Implementation Strategies	Key Activities	Time Frame	Responsibility
25.1 Support the implementation of the National e-Health Strategic framework that will accelerate data information exchange,	25.1.1 Support the development and updating of standards for integrated modern ICT infrastructure for NHIS and the SSHIAs	12 months	ICTD, PRMD
	25.1.2 Acquire and deploy modern ICT infrastructure, including Health Insurance	24 months	ICTD, PRMD, PROC

interoperability, security, data analytics and adoption of new technology.	Business Process Automation (HIBPA), HIE, ERP, etc.		
25.2 Facilitate Implementation of global standards for managing health information system	25.2.1 Facilitate Production of high-level requirements and design for foundational ICT services	12 months	ICTD, PRMD, SQAD, FSD, ISD, CMD
25.3 Develop and update NHIS ICT policy to include e-health standards, rules and protocols for information exchange and protection.	25.3.1 Facilitate adoption of e-health standards, rules and protocols for information exchange and protection	12 months	ICTD, PRMD, HRAD
	25.3.2 Promote compliance with ICT policy on adoption of e-health standards, rules and protocols for information exchange and protection	12 months	ICTD, PRMD, HRAD
25.4			
25.5 Establish ICT continuing education and other related training programs to improve access to continuous professional development	25.5.1 Provide e-learning and digital resources for NHIS Personnel	12 months	ICTD, PRMD, HRAD, PROC
25.6 Deploy e-archiving system	25.6.1 Implement Electronic Document Management System (EDMS)	12 months	ICTD, PRMD
25.7 Establish standardised data security for managing enrolee data,	25.7.1 Formulate data security policy for managing enrolee data.	12 months	ICTD, PRMD
	25.7.2 Implement a robust data privacy and ICT security policy in the Scheme	24 months	ICTD, TMC
25.8 Comply with extant NIMC regulations and guidelines on Data Creation and capturing modalities	25.8.1 Setup NHIS -NIMC Technical Committee on Data Creation and capturing modalities	6 months	ICTD, PRMD
	25.8.2 Procure and install NIMC approved enrolment data devices	24 months	ICTD, PROC, PRMD

25.9 Ensure mandatory verification of enrolee's records through NIMC database	25.9.1 Harmonise NHIS database with that of NIMC	24 months	ICTD, PROC, PRMD
25.10			
25.11			

Strategic Objective 26: To Achieve 70% reduction in lead time for carrying out key internal NHIS processes, such as accreditation, claims management, access to enrolee register and referral management.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
26.1 Develop and Implement a data driven approach to key internal business processes.	26.1.1 Setting up Project Implementation Committee	18 months	ICTD, PRMD, HRAD
	26.1.2 Collect and analyse users' requirements and specification	18 months	ICTD, PRMD, HRAD
	26.1.3 System Analysis, Design and Development of the proposed automation	18 months	ICTD, PRMD, HRAD
	26.1.4 Procure relevant digital and automation tools/applications	18 months	ICTD, PRMD, HRAD
	26.1.5 Addressing Pre-Installation Prerequisites	18 months	ICTD, PRMD, HRAD
	26.1.6 Installation of digital and automation tools/applications	18 months	ICTD, PRMD, HRAD
	26.1.7 Application development control mechanism	18 months	ICTD, PRMD, HRAD
	26.1.8 Testing and Debugging of e NHIS equipment	18 months	ICTD, PRMD, HRAD
	26.1.9 Change management	18 months	ICTD, PRMD, HRAD

	26.1.10 Deployment of new automated solution	18 months	ICTD, PRMD, HRAD
	26.1.11 Project Commissioning	18 months	ICTD, PRMD, HRAD

CHAPTER 8

PILLAR 5: RESEARCH AND INNOVATION

8.1 Priority Area 8 – Operations Research and Innovation

Goal:

9. To promote, utilise and sustain excellence in research on health insurance for UHC

8.1.1 Strategic Direction

Table 15: Strategic Objective and key result area for Operations Research and Innovation

Strategic Objectives	Key Result Areas	
	Indicators	**Target**
▪ To strengthen the capacity of the NHIS to conduct Health insurance research.	% of NHIS budget allocated to research on health insurance annually	10%
	% of stakeholders utilising NHIS research findings to inform policy and decision making, and as a guide to implement health insurance programmes	70%
▪ To build institutional capacity to promote, undertake and utilise research for improved decision making	% of research related capacity building programmes and activities conducted by NHIS that are research related per annum	10%
	% of research officers trained to improve skills and competencies in research design and methodology annually.	20%

8.1.2 Implementation and Action Plan

Table 16: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Operations Research and Innovation

Strategic Objective 27: To strengthen the capacity of the NHIS to conduct Health insurance research			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
27.1 Ensure sustainable funding of research activities at NHIS	27.1.1 Allocate 10% of NHIS annual budget to research and innovation	Annually	ESO, PRMD, FAD
27.2 Create linkages with partners and stakeholders for effective collaboration.	27.2.1 Establish and operationalise coordinating mechanism for health insurance partners and stakeholders to align operational research priorities with NHIS.	Continuous	PRMD

	27.2.2 Collaborate with partners to commission research on relevant areas of health insurance to generate evidence to inform operations and programmes	Continuous	PRMD
	27.2.3 Provide technical support to SSHIAs in design and implementing research programs.	Annually	PRMD, FSD, ISD
	27.2.4 Collaborate to establish a Health Insurance Training and Research Centre.	36 months	TMC
27.3 Create Learning Network to enhance capacity for operations research and innovations	27.3.1 Develop and implement knowledge management strategies in health insurance	Annually	PRMD
	27.3.2 Participate in joint research activities with other Learning Network Member Countries	Continuous	PRMD
Strategic Objective 28: To build institutional capacity to promote, undertake and utilise research for improved decision making			
Implementation Strategies	Key Activities	Time Frame	Responsibility
28.1 Build capacity for research and networking	28.1.1 Conduct gap analysis for agenda setting to promote evidence-based priority setting in the health insurance sector	12 months	PRMD, ESO
	28.1.2 Develop a research agenda for the NHIS.	Annually	PRMD, ESO
	28.1.3 Train Key NHIS staff members in research methodology.	Annually	PRMD, ESO
	28.1.4 Establish/Strengthen system for routine health insurance evidence generation and management, including regular health insurance expenditure tracking surveys, and supporting FMOH in conduct of Annual National/State Health Accounts.	Annually	PRMD, ESO
	28.1.5 Develop and implement innovative research grant schemes in collaboration with partners for health insurance research.	Annually	PRMD, ESO
28.2 Establish process documentation systems to facilitate	28.2.1 Collaborate with the FMOH to build institutional strength on Health Technology Assessment in line	Annually	PRMD, ICTD, SQAD, ESO

development of journal articles and research papers.	with existing structures and policy frameworks.		
	28.2.2 Facilitate participation in international conferences and symposia	Annually	PRMD, ESO
	28.2.3 Secure Registration or affiliation with relevant professional associations locally and internationally.	Annually	PRMD, ESO
	28.2.4 Strengthen the Research and M&E Divisions of the NHIS.	Annually	PRMD, ESO

CHAPTER 9

MONITORING AND EVALUATION

9.1 Priority Area 9 – Results-based Monitoring and Evaluation

Goal:

10. To ensure systematic tracking of programmes and activities and the performance of all NHIS operations

9.1.1 Setting Strategic Direction

Table 17: Strategic Objective and key result area for Monitoring and Evaluation

Strategic Objective	Key Result Areas	
	Indicator	**Target**
▪ To achieve total tracking of operations and programme performance using available data.	% operations and programme performance tracked with available data.	100%
	% implementation of annual monitoring plan –monthly, quarterly and annual reviews	100%
• To ensure 70% of health financing policy decisions and implementations are informed by NHIS data	% of health financing policy decisions and implementation activities informed by NHIS	70%
▪		

9.1.2 Implementation and Action Plan

Table 18: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Monitoring and Evaluation

Strategic Objective 29: To achieve total tracking of operations and programmes performance using available data.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
29.1 Develop Annual Operational Plan based on the strategic objectives	29.1.1 Develop and Implement Annual Operational Plan	Annually	PRMD

	29.1.2 Produce Annual Reports and ensure Documentation/archiving of Reports	Annually	PRMD
29.2 Develop and Implement Monitoring and Evaluation Framework and Plan	29.2.1 Develop and Implement M & E Framework and Plan	12 months	PRMD
	29.2.2 Create and publish Web Version of the Strategic Plan	12 months	PRMD, ICTD
	29.2.3 Create and Operate Monitoring Dashboard	Continuous	PRMD, ICTD
	29.2.4 Conduct periodic Monitoring and Evaluation based on the Monitoring Plan	Continuous	PRMD
29.3 Improve health insurance related Data Management (collection, collation, analysis, storage, and quality assurance)	29.3.1 Design and implement electronic data management system	12 months	PRMD, ICTD
	29.3.2 Acquire Data Equipment and Tools (data forms, ODK, etc)	12 months	PRMD, ICTD
	29.3.3 Conduct Capacity Building/Training on Monitoring and Evaluation	Continuous	PRMD, HRAD
29.4 Adapt and domesticate National Data Quality Assurance (DQA) Policy	29.4.1 Adapt Data Quality Assurance (DQA) Policy.	Continuous	PRMD, ICTD
	29.4.2 Implement Data Quality Assurance (DQA) Policy.	12 months	PRMD, ICTD
Strategic Objective 30: To ensure 70% of health financing policy decisions and implementation activities are informed by NHIS data.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
30.1 Implement Health Insurance Management	30.1.1 Conduct HMIS Stakeholder Analysis	12 months	PRMD

Information System (HMIS).	30.1.2 Implement HMIS Change management activities	12 months	ICTD, PRMD, FSD, ISD
	30.1.3 Conduct Analysis of user requirements for HMIS.	12 months	ICTD, PRMD
	30.1.4 Design and deploy relevant modules of HMIS	12 months	ICTD, PROC, PRMD
	30.1.5 Carry out Documentation of all system and user processes.	12 months	ICTD, PRMD
	30.1.6 Conduct User training on HMIS	12 months	ICTD, PRMD
	30.1.7 Documentation of lessons learnt.	12 months	ICTD, PRMD
	30.1.8 Incorporate feedback mechanism on existing NHIS website.	12 months	ICTD, PRMD
	30.1.9 Create dashboard to show HCPs, HMOs and SSHIAs ratings and performance	12 months	ICTD, PRMD, SQAD

CHAPTER 9

MONITORING AND EVALUATION

9.1 Priority Area 9 – Results-based Monitoring and Evaluation

Goal:

10. To ensure systematic tracking of programmes and activities and the performance of all NHIS operations

9.1.1 Setting Strategic Direction

Table 17: Strategic Objective and key result area for Monitoring and Evaluation

Strategic Objective	Key Result Areas	
	Indicator	**Target**
▪ To achieve 100% tracking of operations and programme performance using available data.	% operations and programme performance tracked with available data.	100%
	% implementation of annual monitoring plan –monthly, quarterly and annual reviews	100%
▪ To ensure 70% of health financing policy decisions and implementation activities are informed by NHIS data.	% health financing policy decisions and implementation activities informed by NHIS data.	70%

9.1.2 Implementation and Action Plan

Table 18: Implementation Strategies, Key Activities, Time Frame, Responsibility and Cost for Monitoring and Evaluation

Strategic Objective 29: To achieve 100% tracking of operations and programmes performance using available data.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
29.1 Develop Annual Operational Plan based on the strategic objectives	29.1.1 Develop and Implement Annual Operational Plan	12 months	PRMD
	29.1.2 Produce Annual Reports and ensure Documentation/archiving of Reports	Annually	PRMD
29.2 Develop and Implement Monitoring and Evaluation Framework and Plan	29.2.1 Implement M & E Framework and Plan	12 months	PRMD
	29.2.2 Create and publish Web Version of the Strategic Plan	12 months	PRMD, ICTD
	29.2.3 Create and Operate Monitoring Dashboard	Continuous	PRMD, ICTD
	29.2.4 Conduct periodic Monitoring and Evaluation based on the Monitoring Plan	Continuous	PRMD
29.3 Improve Data Management (collection, collation, analysis, storage, and quality assurance)	29.3.1 Design and implement electronic data management system	12 months	PRMD, ICTD
	29.3.2 Acquire Data Equipment and Tools (data forms, ODK, etc)	12 months	PRMD, ICTD
	29.3.3 Conduct Capacity Building/Training on Monitoring and Evaluation	Continuous	PRMD, HRAD

29.4Develop and Implement Data Quality Assurance (DQA) Policy	29.4.1 Formulate Data Quality Assurance (DQA) Policy.	12 months	PRMD, ICTD
	29.4.2 Implement Data Quality Assurance (DQA) Policy.	12 months	PRMD, ICTD
Strategic Objective 30: To ensure 70% of health financing policy decisions and implementation activities are informed by NHIS data.			
Implementation Strategies	**Key Activities**	**Time Frame**	**Responsibility**
30.1Implement Health Management Information System (HMIS).	30.1.1 Conduct HMIS Stakeholder Analysis	12 months	PRMD
	30.1.2 Implement HMIS Change management activities	12 months	ICTD, PRMD, FSD, ISD
	30.1.3 Conduct Analysis of user requirements for HMIS.	12 months	ICTD, PRMD
	30.1.4 Design and deploy relevant modules of HMIS	12 months	ICTD, PROC, PRMD
	30.1.5 Carry out Documentation of all system and user processes.	12 months	ICTD, PRMD
	30.1.6 Conduct User training on HMIS	12 months	ICTD, PRMD
	30.1.7 Documentation of lessons learnt.	12 months	ICTD, PRMD
	30.1.8 Incorporate feedback mechanism on existing NHIS website.	12 months	ICTD, PRMD
	30.1.9 Create dashboard to show HCPs, HMOs and SSHIAs ratings and performance	12 months	ICTD, PRMD, SQAD

Result based Monitoring and Evaluation Framework

Accomplishing the goals, strategic objectives and targets are critical to achieving UHC. Therefore, instituting a result-based monitoring and evaluation system will allow for the setting out of the results and measures. This will also enable partners and stakeholders to monitor achievements, learn lessons and hold the organisation accountable, in order to ensure evidence-based planning, decision making and improved knowledge management.

Results-based Monitoring and Evaluation (RbM&E) is a systematic approach for tracking results and performance, based on a transparent and reflective logical and results framework approach. It also measures impact through evaluation.

The main purpose is to provide accurate, reliable and timely information on progress made by the NHIS-SP, and provide regular reporting on the Key performance indicators.

Key performance indicators define a set of values against which to measure. Currently, NHIS does not have clear Key Performance Indicators (KPIs) for tracking results.

KPIs have been developed for monitoring progress of each of the Strategic Objectives and will be applied as shown in the results matrix table. It is important that the M&E process meets the important reporting requirements and ensures that the under listed core principles of a standard M&E system are addressed:

1. Provide data with adequate disaggregation to meet the reporting requirements of the Strategic Plan and the stakeholders.
2. Identify vulnerable groups that are consistently left out of health insurance coverage, to promote equitable access;
3. Use independent assessments for evaluation to ensure objectivity
4. Have clearly defined roles and responsibilities for M&E data collection, analysis and use, to ensure accountability
5. Identify appropriate tools and methods covering both supply and demand side issues for providing accurate data.
6. Disseminate M&E results widely using approaches such as report cards, to enable better informed program decisions

Apart from the above, it is also necessary that statutory reporting to the NCH as well as annual reviews by the NHIS, development partners and other stakeholders are adhered to, for monitoring implementation progress. Best practice from other settings indicates that the annual reviews have a number of components. Firstly, there will be quarterly field-level joint monitoring by stakeholders to get a good feel of field reality. This will be done using a standard monitoring checklist, which will be targeted at each of the States, to ensure comparison.

This checklist will be both qualitative and quantitative in scope. The second component will be a mid-year review, which will use information from both the M&E system and the joint field monitoring exercises. The purpose of the mid-year review is to ensure that mid-course corrections are undertaken in the annual work plans and that the programme will not have to wait for a full year to make such corrections.

Finally is the annual programme review, which will take place every year end (preferably at the end of November or early December). This is for annual stock-taking, to ensure that important programme decisions are made. It also provides a platform for the presentation and agreement on the next annual plans in draft.

9.2.1 Data Management

Data Management deals with collection, storage, usage, quality, flow, processing, compilation, analysis, integration, sharing and security of data. Under the current dispensation, it is the responsibility of the relevant Departments, Divisions and Units at the NHIS and all NHIS accredited facilities to provide returns on the utilisation of services and other related data to NHIS. [3]

With automation of Health Insurance business processes, it is expected that data will be entered at the facility, sub-national levels of NHIS and SSHIAs. NHIS, SSHIAs and other relevant stakeholders, can access the data, analyse and use it for informed policy and decision making. [30]

9.2.2 Results Matrix

The NHIS-SP results matrix provides an excellent summary of Key Performance Indicators to assess the progress of the plan. It has a total of forty-three (43) indicators, covering an essential combination of indicators on impact, output, process and inputs. Some of these indicators require population-based data while others require facility-based information collected by surveys, quantifiable supervision checklists, Health Management Information System (HMIS) and data from published reports and records. All indicators included in the Results Matrix are clearly defined and baselines are available for most of them.

The performance targets for the indicators have been established in this plan. The figure below presents logical flow of the inputs, activities, outputs, outcomes and impacts.

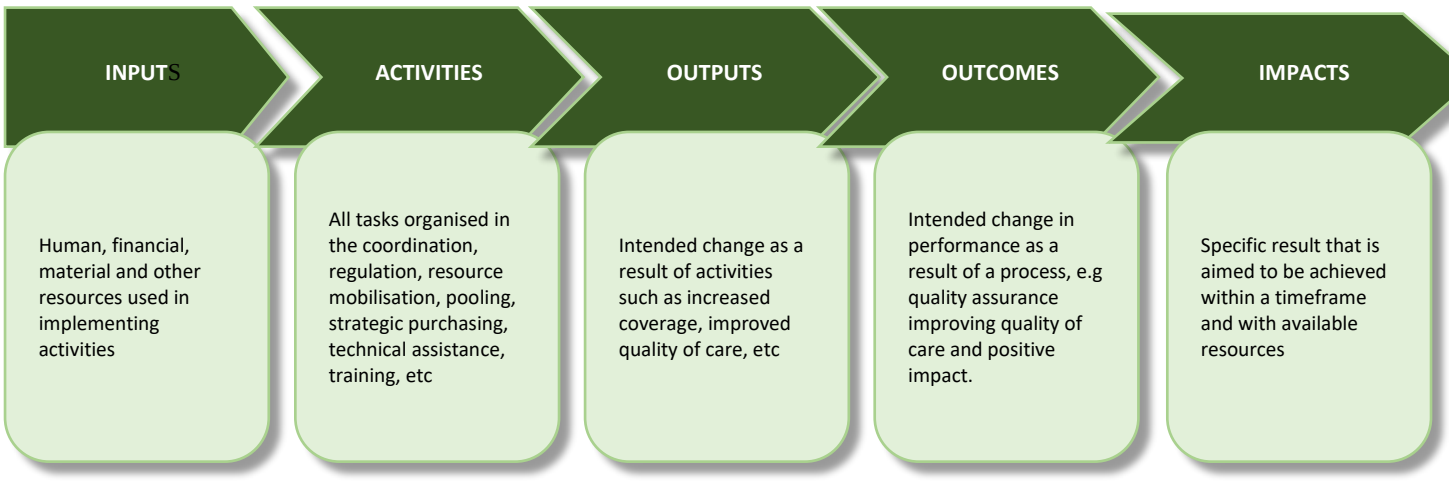


Figure 28: Logical Framework

: Results Matrix

Key Elements of the Results Matrix include:

1. Every result matrix needs **indicators** that are specific, measurable, and relevant. These must focus on what should be measured. The **output** dimension entails services delivered or facilities accredited, and the **outcome** dimension encompasses changes in population coverage. A last indicator dimension is the **impact**, which covers long term goals such as reduction in morbidity and mortality. Also, indicators are either quantitative (e.g. number of people trained) or qualitative (e.g. level of satisfaction with health service).
2. **Targets** represent the desired value and the direction of intended progress an indicator should reach by a defined time.
3. **Baselines** consist of the information gathered at the starting point, against which all variations are to be measured.
4. **Data sources and collection methods** must be indicated, to ensure transparency and intersubjective understanding of results, meet the requirements of being reliable, valid, available, and relevant.
5. **Assumptions** are external influences on reaching the targets.

9.2.3 Approaches for Data Collection:

The focus of the proposed M&E system will be on collecting accurate, reliable and timely data on the NHIS-SP results, at prescribed intervals, using appropriate tools and providing data both from population and health facilities. A combination of approaches is proposed to implement the system, to update the results matrix accurately at the required periodicity. The proposed system will ensure adequate objectivity in the information provided. It will also focus on building capacities for data collection and analysis.

9.2.4 Monitoring Process and Plan

The monitoring process and plan define the process and the timetable that will be used for monitoring monthly, quarterly, and annually.

1. **Plan Monitor**: Naming a *Plan monitor* is important. S/he is the strategic planning czar and responsible for monitoring and reporting on the plan's progress. The person should have passion for tracking and ensuring follow through.
2. **Developing a Monitoring Schedule:** Using *Gantt Chart* to schedule the monthly, quarterly, and annual monitoring.
    i. **Monthly:** During monthly monitoring, the question to ask is, "*Are we doing what we said we were going to do"?* The focus is on whether the action steps are being done.
    ii. **Quarterly:** The quarterly monitoring focuses on results by answering *"Are we achieving the results we said we would achieve"?* At each quarterly review, you are evaluating each objective by asking "What have been the results and at this current rate, where do we expect to be by the end of the year"? The planning team will decide which strategies to stop or continue and which new strategies to start, and adjust objectives as required, based on issues and priorities.
    iii. **Annually:** The planning team will meet to review progress for the year, identify new barriers and CSFs, change objectives, and re-establish priorities and action plans.
3. **Use of a Monitoring Dashboard:** A Monitoring Dashboard may be used by the organisation to monitor the entire progress in the execution of the strategic plan. It is often colour-coded and would show in green those strategies that are 100% complete, in yellow those that are 75% or more complete, and in red those that are less than 75% complete. The entire organisation receives a score and a grade, based on the numeric values shown in the Table 21 below.

Table 21: Monitoring Dashboard

Dashboard Summary		**Current Status of KPIs**				
	100 percent done					
	75-95 percent done					
	0-75 percent done					
S/N	**Key Performance Indicators**	**YR 1**	**YR 2**	**YR 3**	**YR 4**	**YR 5**

4. Developing Web Version of the Strategic Plan

Publish Web Version (document) of the Strategic Plan and regularly provide updates on the priorities, performance measures, accomplishments and next steps, and ensure frequent tracking and updating.

This reinforces the Strategic Plan's function as a living and vital document that serves a genuine management purpose.

CHAPTER 10

RESOURCE REQUIREMENTS

The resources required to accomplish successful implementation of the Strategic Plan is dependent on the magnitude of ambitions to scale up the population coverage during the next 10 years and the efficiency of the healthcare service delivery. In order to achieve UHC, it is important to strive to increase efficiency in the current system.

Resource requirements can be categorised as follows:

I. Human Resources
II. Material Resources: Physical Infrastructure and ICT
III. Financial Resources

Without a comprehensive assessment of the current levels of resources, financial, human and material, and efficiency in health service delivery, it will be difficult to estimate the resource requirements. It is, therefore, important that efforts be made to conduct a comprehensive assessment of the current levels of all resources and efficiency, in order to improve the basis for future analysis.

10.1 Human Resources

Workforce is the heartbeat of service delivery. The workforce in the health system and healthcare organisations determines health outputs and outcomes, drives performance, and commands the largest share of a budget.

NSHDP II provides the benchmark for HRH with the goal "to have in place the right number and skill mix of competent, motivated, productive and equitably distributed health work force, for optimal and quality health service provision"**.**

NHIS does not provide health services but interrelates with stakeholders, including the healthcare providers at different levels, through which enrolees access services.

Available reports indicate that there is inadequate HR requirement for NHIS to discharge its roles and responsibilities. This has contributed to its weak performance outcomes and the resultant deficiencies in work values, attitudes and practices over the past years**.** [31] Consequently, it will be necessary to strengthen policy, planning and management of human resources for attainment of NHIS' organisational mandate.

In order to strengthen HR capacity in NHIS, it will be necessary to focus on the following areas:

a. Costed, prioritised human resources management/development plan.

There is no evidence that NHIS has a workforce diagnostic that determines the HR requirements to enable it discharge its roles and responsibilities, neither is there an HR development plan and estimates of the cost.

HR Skill Gap Analysis (SGA) is key to HR availability, development, and deployment. It is important for NHIS to conduct SGA.

b. HR Availability and Deployment

In any organisation, knowledgeable, skilled and motivated workforce is critical for it to effectively and efficiently discharge its mandate. In order to achieve the Scheme's vision of "A Leading Agency Committed to Achieving Financial Access to Quality Healthcare", officers with relevant qualifications and skills must be in sufficient number at all levels of the organisation; Headquarters, Zones and States.

i. Staff Distribution

Available reports on staff distribution indicate a maldistribution of staff by location and position. This will need to be addressed in alignment with the Strategic Plan. Specifically, there should be deployment of more senior management officers to the Zones and States and ensure equity in the distribution.

Similarly, the senior management level constitutes more than 40% of current staff level. The implication is that the organisation is significantly top heavy, thus calling for urgent development of a succession plan to ensure sustainability of current and future efforts.

ii. Staffing by Specialisation

Health Insurance is a highly specialised area that requires expertise, skills and competencies in many core areas. For NHIS to discharge its roles and responsibilities effectively, it will require experts and specialists in the following disciplines:

- Health Economics
- Health Planning
- Statistics/Data Analytics
- ICT and Data Security
- Public Health
- Actuary/Insurance
- Accounting
- Human Resource Management
- Epidemiology
- Research, Monitoring and Evaluation

There is insufficient information on distribution by specialisation**.** However, considering the expected expansion of responsibility in achieving UHC, more professionals will be expected to be recruited.

iii. HR Management Practices

Like in many MDAs, poor management practices are common accountability and transparency challenges. They include lack of job schedules, usurping of responsibilities, delay in approval of memos for activities, weak staff appraisal system, lack of training on civil service rules relating to value reorientation, field activities driven by material gains, weak loyalty to the organisation, delay in upgrading staff, porous security systems within the organisation and lack of appropriate identification check-in and checkout procedures for all staff and visitors.

For effective HR Management Practices, NHIS will need HR diagnostics that is based on the mandate of the Scheme towards attainment of UHC, the decentralisation to Zonal and offices and possible future roles.

In the absence of workforce diagnostic, the precise requirements of skills and competencies needed to fulfil the mandate of the Scheme cannot be determined.

There is no known benchmark in terms of the skills mix and distribution with which to assess the current staffing.

10.2 Material Resources: Physical Facilities and ICT Infrastructure

10.2.1 Physical Facilities

There exists extensive network of public and private health facilities nationwide. Therefore, in order to improve physical access to healthcare, NHIS does not need investment in health facilities.

There is an existing guideline for accreditation of HCPs and quality assurance, that will need to be reviewed to ensure compliance and quality of care.

10.2.2 ICT Infrastructure

Globally, many nations have adopted ICT infrastructure for easy access to and delivery of quality healthcare. Currently, ICT operations in NHIS is constrained by critical challenges which include the following:

i. Dearth of Hardware
ii. Insufficient Network Connectivity and Internet Penetration
iii. Lack of Data Centre and Security
iv. Lack of System Process automation
v. Poor Health Information System Governance
vi. Lack of integration with critical applications

Following the establishment of State Health Insurance Agencies by many states in Nigeria, NHIS is expected to play a leading role in providing industrial standard ICT infrastructure for effective coordination, regulation and easy plug-in by these State Health Insurance Agencies. This will enable the seamless exchange of information between NHIS, the SSHIAs and other relevant external stakeholders.

Failure to achieve this will embolden the SSHIAs to source for different ICT infrastructure and solutions, which may be difficult for interoperability.

9

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RESOURCE REQUIREMENTS

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Failure to achieve this will embolden the SSHIAs to source for different ICT infrastructure and solutions, which may be difficult for interoperability.

CHAPTER 11

COSTING AND FINANCIAL SUSTAINABILITY PLAN

Background

The National Health Insurance Scheme Strategic Plan (NHIS-SP) 2021-2030 presents a blueprint for repositioning the NHIS for efficiency and better performance and accelerate the achievement of universal health coverage (UHC). This document provides an assessment of the financial sustainability of the NHIS-SP by 1) estimating the program management costs of repositioning NHIS and service delivery costs of expanding social health insurance coverage and accelerating progress toward UHC over the 10-year horizon; 2) assessing the affordability of coverage expansion scenarios using various streams of resource flows identified in the plan; and 3) analyzing the implications of the identified options available to finance the NHIS-SP and recommend – to governments and development partners (including bilateral donors, multilateral agencies), civil society and the private sector – appropriate initiatives that NHIS might take to achieve the national coverage targets.

Methodology

The NHIS-SP cost estimates were determined using a Microsoft Excel based modelling. The total cost of the plan presented in this section is the aggregate of costs of social health insurance coverage for all Nigerians across all 36 states and the FCT, and the program management inputs and activities to be carried out by the NHIS. The estimation of coverage costs takes into account only the demand-side financing of healthcare delivery through the social health insurance system and consigns the burden and risks of supply-side (input) financing to providers and other stakeholders, while the estimation of program management is based on bottom-up ingredient costing approach. The costing adopted 2020 as the base year and set the duration of the strategic plan to 2021-2030 in accordance with the 10-year NHIS-SP.

Program Management Costs

The cost of program management activities and investments is estimated at N91.6 billion over the 10-year period 2021-2030. Program management and investment costs of N16.3 billion in the first year of the plan (2021) represents 17.8% of the total 10-year cost. Investments in integrated information and communication technology (ICT) in the first year valued at N6.9 billion include N4.0 billion in automation of NHIS end-to-end business processes and N1.7 billion in network interconnectivity for NHIS HQ, Zonal and State Offices. A total of N6.0 billion is also expected to be spent on repositioning the NHIS through improvements in organizational capacity and readiness for service excellence. Major investments in this priority areas in the first year include N1.4 billion on staff training and development, N1.3 billion on deployment of qualified officers to zones and states in line with the decentralization plan, and N1.0 billion on procurement of project vehicles for effective service delivery. These are major catalytic investments needed to be made upfront in order to create the enabling environment for achievement of the goals and objectives of the plan.

Over the 10-year period, organizational capacity and culture is the leading cost driver, accounting for a total of N46.0 billion equivalent to 50.2% of total costs. Leading cost elements are staff training and development – N13.9 billion, construction of HQ and State Office buildings – N12.5 billion, project vehicles – N5.0 billion and corporate social responsibility (CSR) – N3.5 billion. Other major cost drivers over the 10-year horizon are investments of N19.9 billion, equivalent to 21.7% of total costs, in Integrated ICT and expenditures estimated at N11.3 billion, equivalent to 12.4% of total costs, on strategic purchasing at 12.4%. Leading cost elements in the strategic purchasing priority area include N4.9 billion on biennial nationwide re-accreditation of existing and accreditation of new healthcare providers, HMOs and MHAs; and N2.7 billion on quality assurance and compliance visits to healthcare providers and HMOs.

Population Estimates

The population of Nigeria is projected at 211.5 million in 2021 and is projected to grow at an annual rate of 2.6% per year to reach 266.1 million by 2030. The formal sector (comprising the public sector and organized private sector) constitutes approximately 12.8% of the population, while the non-vulnerable informal sector constitutes 36.6%. The vulnerable population groups account for the remaining 50.6% comprising informal pregnant women – 4%; children under5 – 15.0%; the elderly (above 64 years) – 3.0%; and the indigents – 28.6%.

Coverage and Benefit Package Cost

Currently, only about 4.2% of Nigerians are covered under the social health insurance. However, by virtue of expansion of state-supported health insurance schemes, this rate is projected to reach 8.8% by 2021 and 70% by 2030. Coverage growth of different population groups differ; the vulnerable and non-vulnerable groups' coverage are expected to begin at 5% in 2021 and increase to 70% by 2030 while the non-vulnerable informal group has a slower coverage rate and reaches only 59% by 2030. The public sector and their dependents have coverage rate set at 68% by 2021 and is expected to increase rapidly to cover the whole public sector by 2025. With only 3% coverage rate by 2021, the private sector and their dependents have the lowest start-up coverage rate, however, their coverage is expected to grow rapidly to 80% by 2030. Benefits package costs are N14,994 for current and retired federal government workers, civil and armed services, N12,000 for state employees and the vulnerable groups (with the exception of prison inmates) and N2,000 for students of tertiary institutions. The packages and pricing are scheduled to be reviewed every two years to reflect prevailing realities.

Contributions and Revenues

Population Group	Revenue/Contributions in baseline scenario	Modelling Input/Additional scenarios:
Formal Sector Programs		
Public sector employees	Employee salary deductions and remittance to NHIS/SHIA	
Private sector employees	Employer - 10% of basic salary; Employee - 5% of basic salary	Self-financing scheme: enrollee contributions finance coverage costs
Students	N2,000 per academic year per person	
Retirees	N14,994 per annum per person	
Informal Sector Programs		
Non-Vulnerable Informal contributors	N14,994 per annum per person	Self-financing scheme: enrollee contributions finance coverage costs
Equity Health Programs		
Vulnerable group health program	BHCPF NHIS Gateway – 0.5% of FG CRF	BHCPF NHIS Gateway – 1% of FG CRF
	State Equity Funds – 1% of State CRF	State Equity Funds – 2% of State CRF
	LGA Equity Funds – 1% of LGA CRF	LGA Equity Funds – 2% of LGA CRF

	Donor – Current commitment and 1% of Program Fund (Start year 2022)	Donor – Current commitment and 2% of Program Fund (Start year 2022)
	Airline Levy: Domestic - $1/$3 on Economy/Business; International - $10/$30 on Economy/Business	Airline Levy: Domestic - $1/$5 on Economy/Business; International - $10/$50 on Economy/Business
	Airtime Levy: 1kobo/s - Domestic & 3kobo/s - International	Airtime Levy: 2kobo/s - Domestic & 5kobo/s - International

Results and Analysis

Projected resource needs for vulnerable population groups on a current basis will increase rapidly from N64 billion in 2021 to N1.2 trillion by 2030. The pool of BHCPF NHIS Gateway and States' and LGA equity funds as well as donor program funds, airline and airtime levies are sufficient to cover only 20% of the vulnerable population groups by 2023 in the baseline scenario, while coverage will extend to 48% by 2027 in the second scenario due to an increase in projected revenue pool.

Projected needs for total population on current basis are projected to increase from N236.8 billion in 2021 to N2.5 trillion by 2030 when 70% of the population will be covered. Projected revenues from contributions and baseline scenarios for government equity funds and BHCPF, donor programs and innovative financing (airline and telecom levies) sum up to N328.5 billion in 2021 and is projected to increase to N1.6 trillion by 2030. In the first scenario where potential funds available are set against the population coverage, the combined pool of funds is sufficient to pay for coverage in the first two years of the plan and achieve coverage of 16.2% in 2022 before running out of reserves; whereas in the second scenario, the pooled funds are sufficient to cover only up to 43.9% of the population by 2026.

Increasing the Fiscal Space

The management of NHIS and SHIAs should collaborate with other ministries and agencies implementing social protection programs with the aim to mobilize a portion of disbursements into the social insurance schemes to finance healthcare coverage for the recipients. Other non-traditional sources of revenues that the NHIS can explore include but are not limited to Philanthropies, Sin tax (on alcohol and tobacco), Looted funds returned to state treasuries, Legislative actions (Ban on medical tourism, investment of looted funds), and Value-Added Tax (VAT) on luxury services.

Under a policy stance where the benefits package is reduced to a level commensurate with pricing of N8,500 for the vulnerable group schemes, available funds under the baseline scenario will cover up to 34% of the vulnerable population by 2025. Under the enlarged resource scenario, the healthcare costs of vulnerable population groups will be fully absorbed and coverage of 70% will be attained by 2030. Similarly, at the overall population level, the aggregate pool of earmarks and contributions will fund costs up to 2024 under baseline scenario while the aggressive scenario potential revenue will fund population coverage target of 70.2% by 2030.

Introduction

Estimates of cost and resources available for implementation of NHIS Strategic Plan (NHIS-SP) are critical to ensuring realistic levels of ambition and ascertaining the level of effort required to achieve the objectives and targets. A modelling of the resource requirements and potential resource availability, and a financial sustainability analysis will support the design of appropriate measures to finance the emerging resource gaps. This section outlines the methodology used in costing the NHIS-SP 2021-2030, and the estimates of available resource commitments within the country over the planning horizon. With both the costs of the plan and resource commitments estimated; recommendations have also been presented to bridge the emerging financing gap.

Objectives

The central objective of the activity is to assess the financial sustainability of the NHIS 10-year Strategic Plan. The sub-objectives are:

- To estimate the program management costs of repositioning NHIS and service delivery costs of expanding social health insurance coverage and accelerating progress toward UHC over the 10-year horizon;
- To assess the affordability of coverage expansion scenarios using various streams of resource flows identified in the plan;
- To analyze the implications of the identified options available to finance the NHIS-SP and recommend – to governments and development partners (including bilateral donors, multilateral agencies), civil society and the private sector – appropriate initiatives that NHIS might take to achieve the national coverage targets.

NHIS-SP Costing Methodology

The NHIS-SP cost estimates were determined using a Microsoft Excel based modelling. The total cost of the plan presented in this section is the aggregate of costs of social health insurance coverage for all Nigerians across all 36 states and the FCT, and the program management inputs and activities to be carried out by the NHIS. The estimation of coverage costs takes into account only the demand-side financing of healthcare delivery through the social health insurance system and consigns the burden and risks of supply-side (input) financing to providers and other stakeholders, while the estimation of program management is based on bottom-up ingredient costing approach. The costing adopted 2020 as the base year and set the duration of the strategic plan to 2021-2030 in accordance with the 10-year NHIS-SP.

The following data sources were consulted in arriving at the total NHIS-SP cost:

- Unit costs of program management activities and investments were sourced from NHIS experience data and accredited vendors;
- The aggregate population estimates are sourced from Central Bank of Nigeria (CBN) publication;
- Public sector and formal private sector employment numbers were obtained from the National Pension Commission;

- The size of vulnerable population groups (pregnant women and children under-5 not covered in the formal sector, the elderly and indigents) were determined based on data from National Population Commission, Federal Ministry of Health Estimate and Nigerian Living Standard Survey (NLSS) 2019.
- The profile of existing plans and nationwide coverage (including insureds and dependency ratio) was provided by NHIS;
- Data on labour market structure and size of informal sector were determined from data sourced from the National Bureau of Statistics (NBS)
- The BHCPF Estimates are sourced from Federal Government Medium Term Expenditure Framework (MTEF) 2021 – 2023 while State and Local Governments Equity Funds were estimated from the published Annual Central Bank of Nigeria (CBN) Reports.
- The outgoing calls traffic of telecom industry are sourced from 2018 Subscriber/Network Data Report and projected based on average GDP growth rate of next three years contained in the MTEF report.
- Revenue Estimates from Capital Market are sourced from the published annual report of Security Exchange Commission (SEC).
- The number of passengers is obtained from Air Transport Statistics published by Federal Airport Authority of Nigeria (FAAN) and projected similarly based on average GDP growth rate of next three years.

Program Management Costs

The NHIS-SP consists of Five (5) Strategic Pillars, Nine (9) Priority Areas, Ten (10) Goals, Thirty (30) Strategic Objectives and Forty-Three (43) Indicators. It also contains Sixty-Six (66) Implementation Strategies and Two Hundred and Forty-Seven (247) Key Activities aimed at catalysing the achievement of universal health coverage in Nigeria.

The cost of programme management activities and investments is estimated at N91.6 billion over the 10-year period 2021-2030. The costs are summarized by priority areas and presented in Table 1.

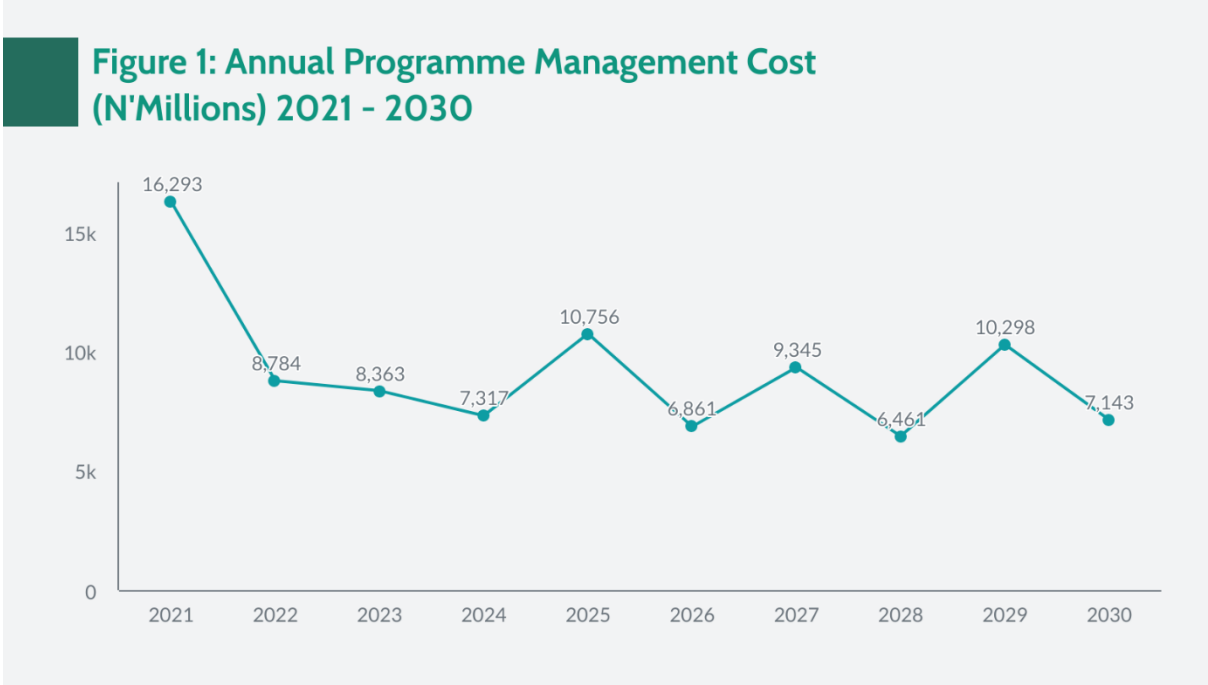
Table 1: Total Programme Management Cost 2021-2030 (N' Millions)

Priority Areas	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**Total**	**%**
Organizational Capacity and Culture	6,048	5,594	4,610	4,334	4,507	3,534	5,549	3,494	4,115	4,188	**45,972**	**50.2**
Communication and Marketing	460	248	249	248	255	453	249	248	249	255	**2,914**	**3.2**
Resource mobilization and pooling	399	330	351	318	351	351	342	328	341	318	**3,429**	**3.7**
Strategic Purchasing	1,648	743	1,432	810	1,442	835	1,507	744	1,432	746	**11,339**	**12.4**
Accountability and transparency	296	407	238	210	241	232	238	210	241	199	**2,512**	**2.7**
Partnerships and Stakeholders' coordination	155	141	139	141	139	158	139	141	139	141	**1,432**	**1.6**
Integrated ICT	6,879	837	961	837	3,423	862	936	862	3,397	862	**19,856**	**21.7**
Operations Research & Innovation	284	295	259	275	259	293	259	275	259	275	**2,731**	**3.0**
Result-based Monitoring and Evaluation	123	189	125	144	141	143	125	159	125	159	**1,433**	**1.6**
TOTAL	**16,293**	**8,784**	**8,363**	**7,317**	**10,756**	**6,861**	**9,345**	**6,461**	**10,298**	**7,143**	***91,620***	**100**
Share of Grand Total	**17.8%**	**9.6%**	**9.1%**	**8.0%**	**11.7%**	**7.5%**	**10.2%**	**7.1%**	**11.2%**	**7.8%**	**100%**	

Programme management and investment costs of N16.3 billion in the first year of the plan (2021) represents 17.8% of the total 10-year cost as shown in Figure 1. Investments in integrated information and communication technology (ICT) in the first year valued at N6.9 billion include N4.0 billion in automation of NHIS end-to-end business processes and N1.7 billion in network interconnectivity for NHIS HQ, Zonal and State Offices. A total of N6.0 billion is also expected to be spent on repositioning the NHIS through improvements in organizational capacity and readiness for service excellence. Major investments in this priority areas in the first year include N1.4 billion on staff training and development, N1.3 billion on deployment of qualified officers to zones and states in line with the decentralization plan, and N1.0 billion on procurement of project vehicles for effective service delivery. These are major catalytic investments needed to be made upfront in order to create the enabling environment for achievement of the goals and objectives of the plan.

Major investments are also planned for the fifth year (2025) and nineth year (2029) when 11.7% and 11.2% of the costs will be incurred respectively.

Figure 1: Annual Programme Management Costs (N' Millions) 2021-2030

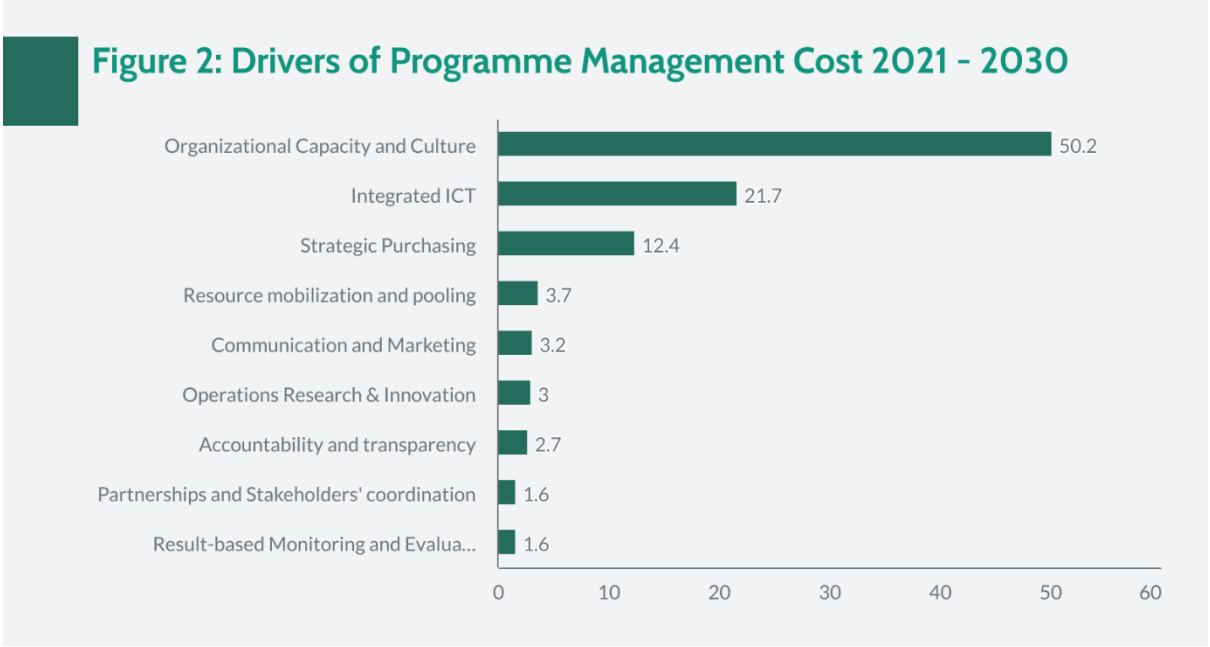


The distribution of the 10-year costs by priority areas in Table 1 (above) and Figure 2 (below) shows that organizational capacity and culture is the leading cost driver, accounting for a total of N46.0 billion equivalent to 50.2% of total costs. Leading cost elements are staff training and development – N13.9 billion, construction of HQ and State Office buildings – N12.5 billion, project vehicles – N5.0 billion and corporate social responsibility (CSR) – N3.5 billion.

Other major cost drivers over the 10-year horizon are investments of N19.9 billion, equivalent to 21.7% of total costs, in Integrated ICT and expenditures estimated at N11.3 billion, equivalent to 12.4% of total costs, on strategic purchasing at 12.4%. Leading cost elements in the strategic purchasing priority area include N4.9 billion on biennial nationwide re-accreditation of existing and accreditation of new healthcare providers, HMOs and MHAs; and N2.7 billion on quality assurance and compliance visits to healthcare providers and HMOs.

The least programme management cost drivers are Result-based Monitoring and Evaluation (1.6%), and Partnerships and Stakeholders' coordination (1.6%).

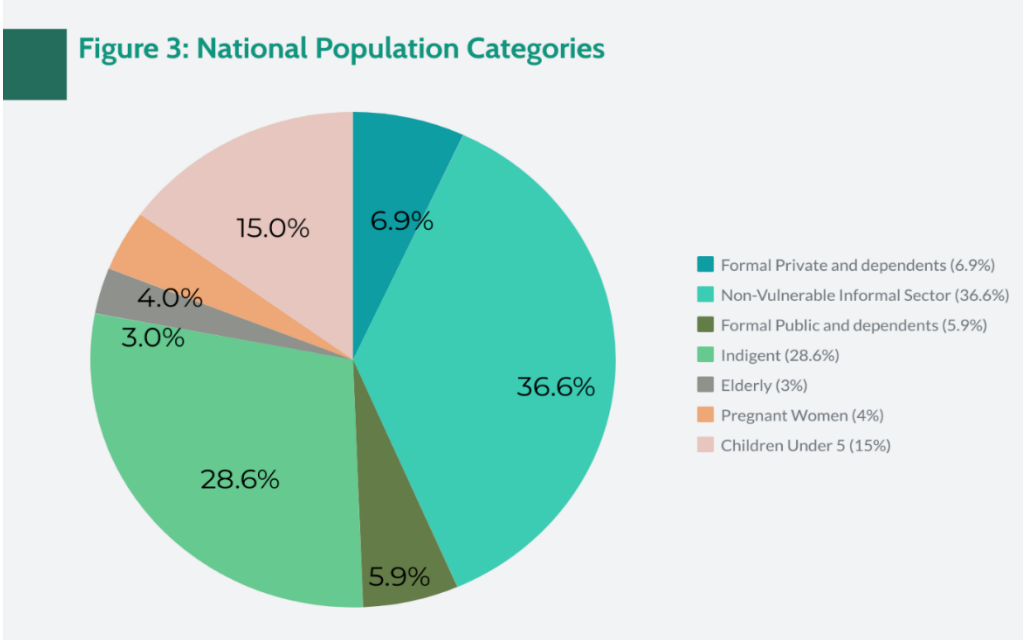
Figure 2: Drivers of Programme Management Cost 2021 - 2030



Healthcare Coverage Costs: Inputs and Assumptions

Population Estimates

The population of Nigeria is projected at 211.5 million in 2021 and is projected to grow at an annual rate of 2.6% per year to reach 266.1 million by 2030 (CBN, 2019). The formal sector (comprising the



public sector and organized private sector) constitutes approximately 12.8% of the population, while the non-vulnerable informal sector constitutes 36.6%. The vulnerable population groups account for the remaining 50.6% and comprise the informal pregnant women – 4%; children under5 – 15.0%; the elderly (above 64 years) – 3.0%; and the indigents – 28.6%. The distribution is illustrated in Figure 3.

Table 2 below shows the projection of the population for the period 2021-2030. Although the projections are based on a static distribution into population groups, which is likely to change during the plan horizon, the implications for the costing exercise is trivial as movements between informal and formal categories are very minimal.

Table 2: Composition of National Population 2021-2030(Millions

)

Population Category	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Formal Public and dependents	12.5	12.9	13.3	13.7	14.1	14.6	15.0	15.5	16.0	16.5
Formal Private and dependents	15.7	17.3	19.0	20.9	23.0	25.3	27.8	30.6	33.7	37.1
Non-Vulnerable Informal	75.9	76.2	76.5	76.5	76.5	76.2	75.8	75.1	74.2	73.1
Vulnerable Group										
Children Under 5	31.8	32.6	33.5	34.3	35.2	36.1	37.0	38.0	39.0	40.0
Pregnant Women	8.5	8.7	9.0	9.2	9.4	9.7	9.9	10.2	10.5	10.7
Elderly	6.3	6.5	6.6	6.8	7.0	7.2	7.4	7.6	7.7	8.0
Indigent	60.8	62.8	64.8	66.9	69.0	71.2	73.5	75.8	78.3	80.8
Total	**211.5**	**217.0**	**222.6**	**228.3**	**234.2**	**240.3**	**246.5**	**252.9**	**259.4**	**266.1**

Population Coverage

The coverage of population categories modelled in the analysis is presented in Table 3. The proportion of total population covered under social health insurance which is currently estimated at 4.2% (2020) is projected to increase to 8.8% by 2021 on account of expansion of state-social health insurance schemes and to reach a target of 70% by 2030 as indicated in the strategic plan.

- Coverage of the vulnerable population groups (informal pregnant women, young children, elderly and indigent) are expected to begin at 5% in 2021 and increase linearly by 6.7% annually to reach 65% by 2030;
- Coverage of the non-vulnerable informal sector is expected to begin at 5% in 2021 but increase faster than the vulnerable groups and reach 70% by 2030;
- Coverage of the public sector and their dependents (Federal, State & LGA) is projected at 68% by 2021 and is expected to increase rapidly to 100% by 2025;
- The formal private sector coverage projected at 3% in 2021. However, the coverage of this group is projected to rise to 80% by 2030.

Table 3: Assumptions of Coverage rates 2021-2030, with 70.5% Population Coverage by 2030

Population Coverage (%)	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Children Under 5	5.0%	12.2%	19.4%	26.7%	33.9%	41.1%	48.3%	55.6%	62.8%	70.0%
Pregnant Women	5.0%	12.2%	19.4%	26.7%	33.9%	41.1%	48.3%	55.6%	62.8%	70.0%
Elderly	5.0%	12.2%	19.4%	26.7%	33.9%	41.1%	48.3%	55.6%	62.8%	70.0%
Indigent	5.0%	12.2%	19.4%	26.7%	33.9%	41.1%	48.3%	55.6%	62.8%	70.0%
Non-Vulnerable informal	5%	11%	17%	23%	29%	35%	41%	47%	53%	59%
Formal Public and dependent	68%	78%	86%	93%	100%	100%	100%	100%	100%	100%
Formal Private and dependent	3%	16%	24%	32%	40%	48%	56%	64%	72%	80%
Total Coverage	**8.8 %**	**16.1 %**	**23.0 %**	**29.9 %**	**36.9 %**	**43.4 %**	**50.1 %**	**56.7 %**	**63.4 %**	**70.2 %**

Contributions and Revenues

The assumptions made in the modelling are detailed in Table 4 below.

Table 4: Assumptions of Coverage rates 2021-2030, with 70.5% Population Coverage by 2030

Population Group	**Revenue/Contributions in baseline scenario**	**Modelling Input/Additional scenarios:**
Formal Sector Programs		
Public sector employees	Employee salary deductions and remittance to NHIS/SHIA	

Private sector employees	Employer - 10% of basic salary; Employee - 5% of basic salary	Self-financing scheme: enrolee contributions finance coverage costs
Students	N2,000 per academic year per person	
Uniformed officers	N14,994 per annum per person	
Retirees	N14,994 per annum per person	
Informal Sector Programs		
Non-Vulnerable Informal contributors	N14,994 per annum per person	Self-financing scheme: enrolee contributions finance coverage costs
Equity Health Programs		
Vulnerable group health program	BHCPF NHIS Gateway – 0.5% of FG CRF	BHCPF NHIS Gateway – 1% of FG CRF
	State Equity Funds – 1% of State CRF	State Equity Funds – 2% of State CRF
	LGA Equity Funds – 1% of LGA CRF	LGA Equity Funds – 2% of LGA CRF
	Donor – Current commitment and 1% of Program Fund (Start year 2022)	Donor – Current commitment and 2% of Program Fund (Start year 2022)
	Airline Levy: Domestic - $1/$3 on Economy/Business; International - $10/$30 on Economy/Business	Airline Levy: Domestic - $1/$5 on Economy/Business; International - $10/$50 on Economy/Business
	Airtime Levy: 1kobo/s - Domestic & 3kobo/s - International	Airtime Levy: 2kobo/s - Domestic & 5kobo/s - International

Coverage Costs

The pricing of benefits packages is summarized in Table 5. The benefits package of the NHIS is priced at N14,994 per year per enrollee for current workers and retirees of federal civil service and uniformed services, armed forces, police force, DSS, and members of the populace under the GIFSHIP of the NHIS when the scheme becomes operational. An exemption applies to students of tertiary institutions whose package is priced at N2,000 per year. The benefit package of state social health insurance/contributory schemes, based on anticipated alignment with the BHCPF package, is priced at N12,000 per year. This implies that this cost will apply to State and LGA employees and the vulnerable population groups. Notably, prison inmates are not included in the vulnerable population category; it is assumed that their coverage will be priced similar to the informal sector (Group, Individual and Family Social Health Insurance Program -GIFSHIP). The model assumed constant unit cost of coverage throughout the plan period due to the limitation of information on when NHIS will adjust the pricing list after considering rising inflation and economics of scale. However, the plan is scheduled to be reviewed every two years to reflect current realities.

The distribution of the service cost includes advance capitation payment to primary healthcare providers, fee-for-service payments to secondary care providers, insurance agency administrative charges, ICT platform charge, third party administrator fees (TPAs) and Reserve fund.

Table 5: Unit Coverage Costs by coverage groups

Population Categories	Cost per enrollee										
	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Formal Sector											
FGN Employees & Uniformed Services	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
FGN Retirees	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
Armed Forces & Retirees	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
Police Force & Retirees	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
DSS Retirees	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
Organized Private Sector	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
Self-Paying Agencies	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
NYSC Members	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*
Federal/State Tertiary Institutions	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*	*2,000*
State/LGAs Employees	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
State LGAs Retirees	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Informal Sector											
Non-vulnerable & dependents	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*

Vulnerable Group											
Children Under Five	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Pregnant Women	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Elderly (65 above)	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Disabled	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Indigents	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*	*12,000*
Prison Inmates	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*	*14,994*

Healthcare Coverage Costs: Results and Analysis

Projected Expenditures and Contributions

Based on population estimates (Table 2) and assumed coverage rates (Table 3), the resource requirements are estimated and summarized by population group for each year from 2021 to 2030.

Vulnerable Population Groups

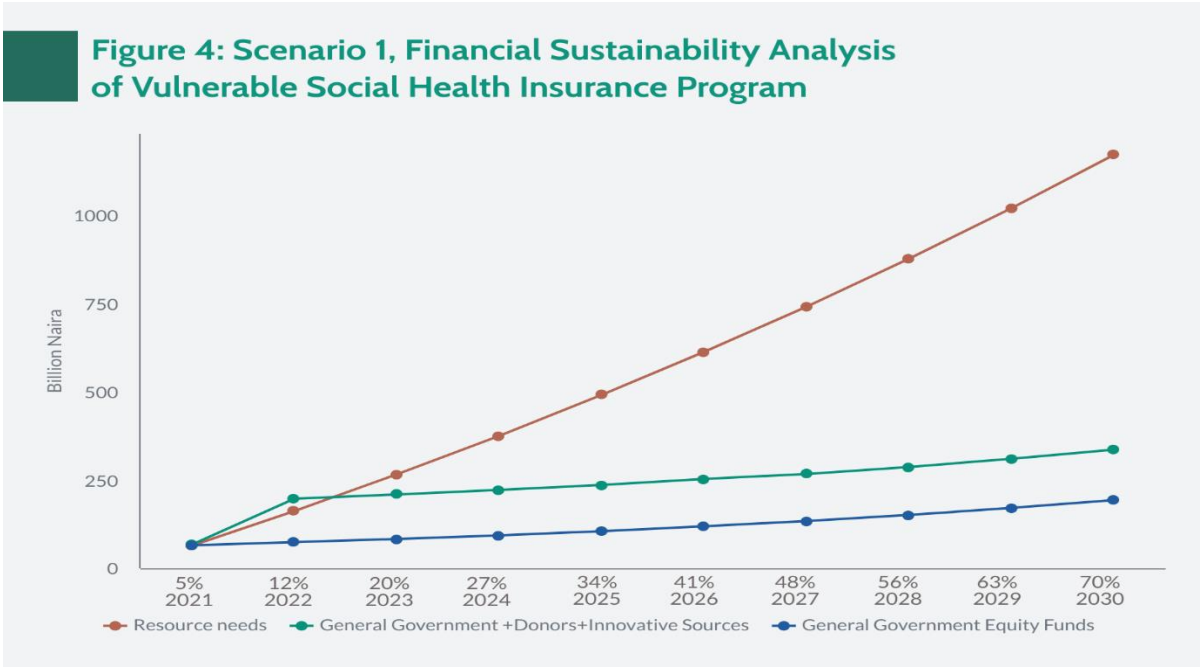
Based on the population estimates for the vulnerable group and their assumed coverage rates, the results presented in Table 6 provide the estimated total resource needs (costs) and the estimated total resources available for coverage of vulnerable population groups nationwide during 2021-2030, at premium level of N12,000.

Table 6: Scenario 1, Resource Needs and Resource Available for Vulnerable Groups (N' Billions 2021-2030)

Scenario 1	5% **2021**	12% **2022**	20% **2023**	27% **2024**	34% **2025**	41% **2026**	48% **2027**	56% **2028**	63% **2029**	70% **2030**
Resource Needs	64	162	266	375	491	613	741	877	1,020	1,171
General Govt Equity Funds (BHCPF + State & LGA Equity Funds)	65.1	74.1	82.9	93.5	105.5	119.0	134.2	151.4	170.8	192.7
General Govt Equity Funds + Donor Prog Funds + Airline & Airtime Levies	66.7	196.7	208.6	222.4	235.9	252.8	266.6	287.4	310.5	336.1

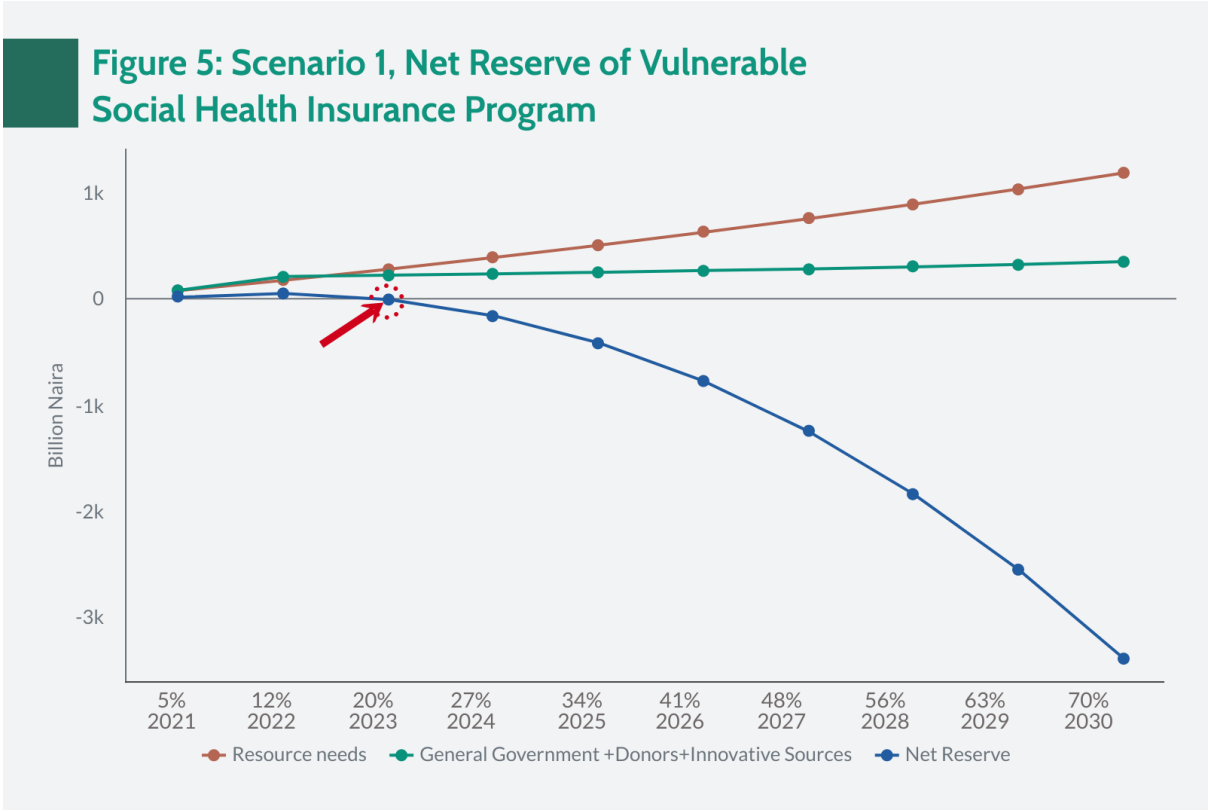
Projected resource needs for coverage of vulnerable population groups on a current basis increased rapidly from N64 billion in 2021 to N1.2 trillion by 2030, increasing by an average of N123 billion per year. The pool of BHCPF NHIS Gateway estimated at N17.5 billion is insufficient to fund the resource needs for coverage of 5% of vulnerable population groups in 2021. However, if States and LGAs contribute their equity funds based on 1% of CRF and allocations respectively, the potential resources available will absorb the cost of 5% target in 2021. Furthermore, if the pool of funds available is enlarged to include 1% of donor program funds, airline and airtime levies from 2022 as outlined in Table 4 (baseline scenario), then coverage of vulnerable population groups can extend only for a limited period up to 2022 by which coverage will reach only 12%. Beyond this point, current revenues will fall short of current resource needs. Thus, the inflows of earmarked funds from government at all levels (% of CRF), Donor funds and innovative sources are only sufficient to finance the vulnerable groups for 2021 and 2022 only. Figure 4 illustrates these scenarios.

Figure 3: Scenario 1: Financial Sustainability Analysis of Vulnerable Social Health Insurance Program



However, when reserves accrued in 2021 and 2022 are taken into consideration, the enlarged resource pool can extend coverage to near 20% by 2023 and run into deficit immediately afterward as illustrated in Figure 5.

Figure 4: Scenario 1: Net Reserve of Vulnerable Social Health Insurance Program



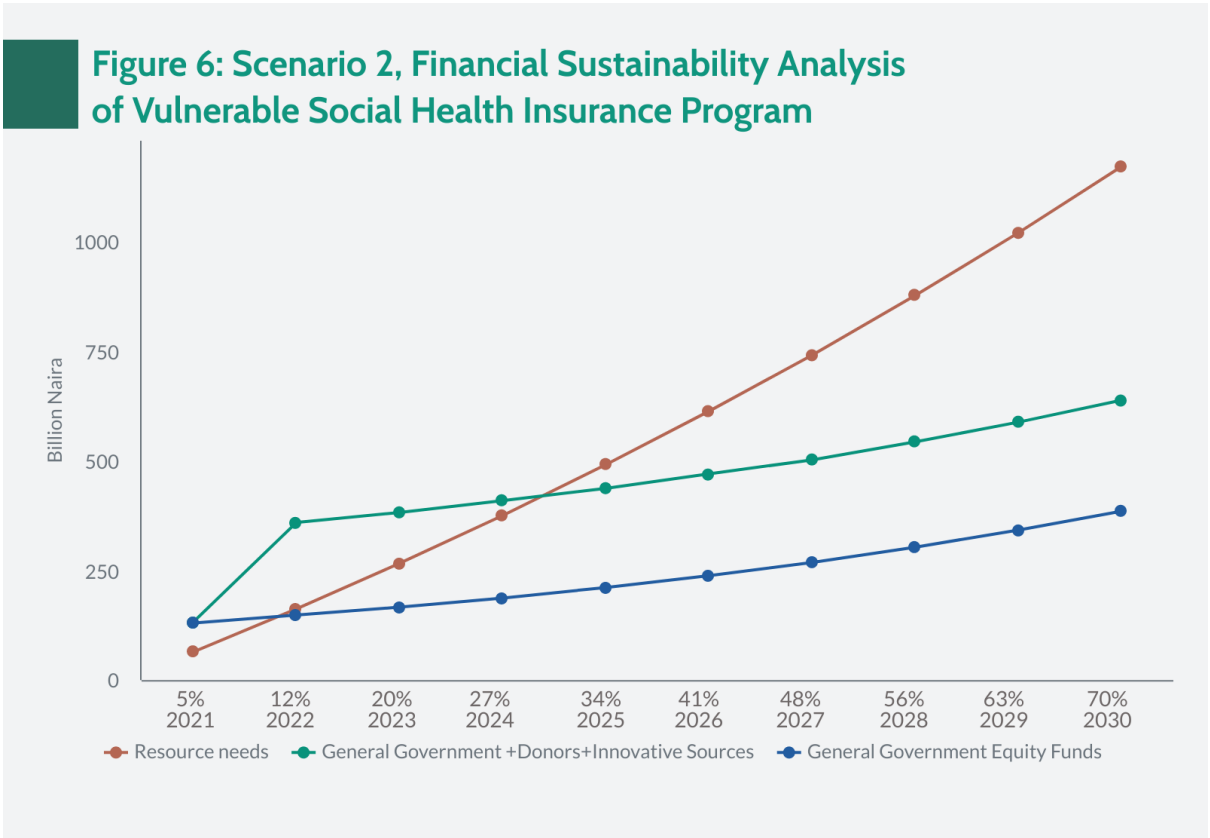
The second scenario is where the Federal Government raises BHCPF NHIS Gateway from 0.5% to 1% of its CRF, all states and LGAs double their earmarks from 1% to 2%, donor contributions, airline and airtime levies also increase as outlined in Table 4 (additional scenario). In this case, from results in Table 7 and Figure 6, a doubling of BHCPF and State and LGA Equity funds are insufficient to

push coverage of vulnerable population groups to 20% by 2023. With the addition of donor funds and innovative sources, coverage of vulnerable population groups can extend only for a limited period up to 2024 by which coverage will reach only 27%.

Table 7: Scenario 2, Resource Needs and Resources Available for Vulnerable SHIP (N' Billions 2021-2030)

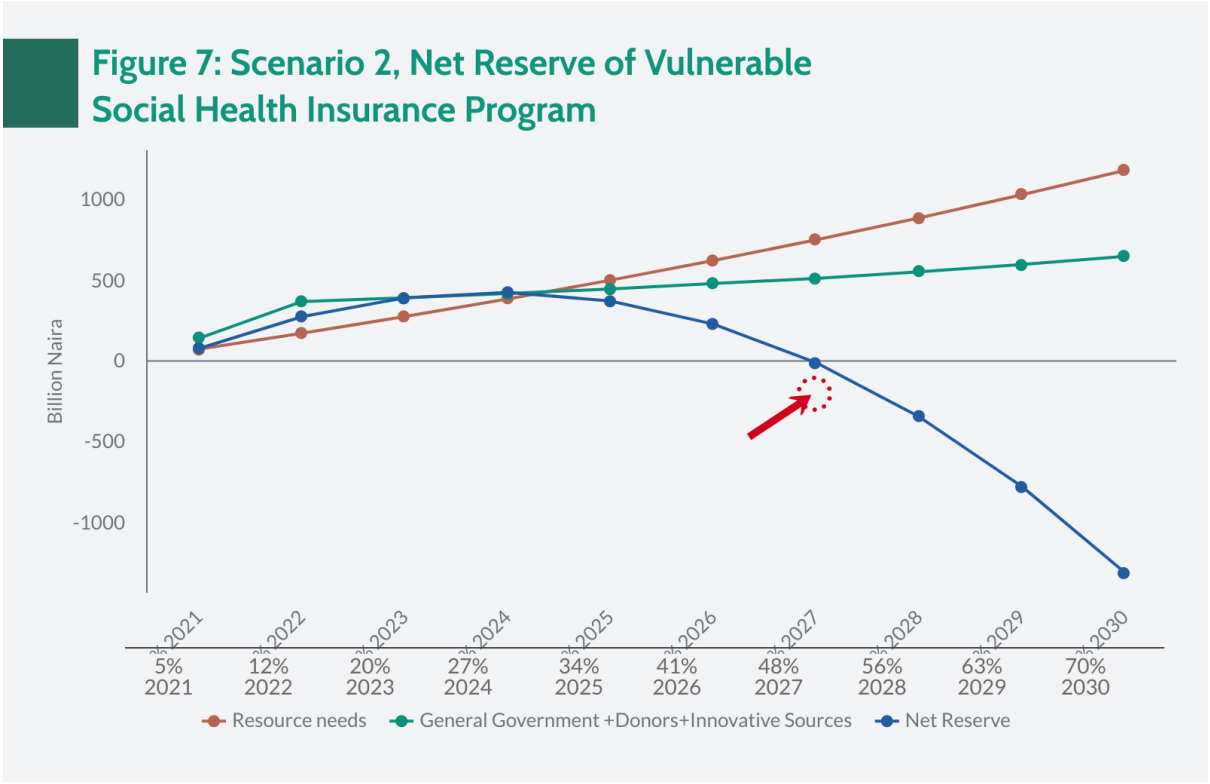
Scenario 2	5% **2021**	12% **2022**	20% **2023**	27% **2024**	34% **2025**	41% **2026**	48% **2027**	56% **2028**	63% **2029**	70% **2030**
Resource Needs	64	162	266	375	491	613	741	877	1,020	1,171
General Govt Equity Funds (BHCPF + Equity Funds)	130.3	148.2	165.8	187.0	210.9	237.9	268.4	302.8	341.6	385.3
General Govt Equity Funds (BHCPF + Equity Funds) + Donor Prog Funds + Airline Levy + Airtime Levy	131.8	359.3	382.4	409.2	437.2	470.2	501.8	542.5	587.8	638.2

Figure 5: Scenario 2, Financial Sustainability Analysis of Vulnerable Social Health Insurance Program



However, as shown in Figure 7, when reserves accrued in the earlier period are taken into consideration, the enlarged resource pool can extend coverage to near 48% by 2027 and run into deficit afterward.

Figure 6: Scenario 2, Net Reserve of Vulnerable Social Health Insurance Program



All Population Groups

The contributions of various segments of the population are summarized against the aggregate coverage cost in Table 8 below. Resource requirement for modelled population coverage rates is projected to increase from N236.8 billion in 2021 to N2.5 trillion by 2030 when 70% of the population will be covered. The extent of cross subsidization from public and private formal sector may not be adequately examined within the larger pool due to the limitation of salary/wages data over the 10-year period. However, the contribution of the formal private sector is set equal to the cost of their coverages. Projected revenues from contributions, government equity funds and BHCPF, Donor program contributions and baseline scenarios for innovative financing (airline and telecom levies) sum up to N328.5 billion in 2021 and is projected to increase to N1.6 trillion by 2030.

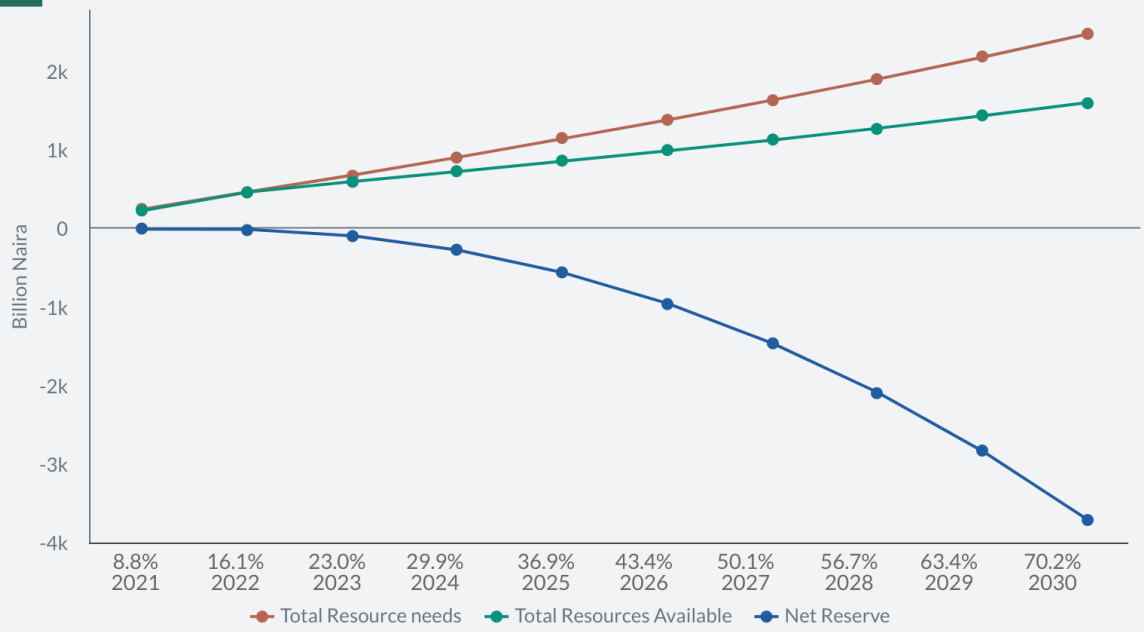
Table 8: Scenario 1, Resource Needs and Potential Resource Available for the Total Population (N' Billions 2021-2030)

Scenario 1	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Resource Needs	**236.8**	**455.5**	**670.4**	**895.9**	**1,132.7**	**1,372.0**	**1,624.0**	**1,889.5**	**2,169.1**	**2,463.7**
Potential Resources Available										
Public Formal Sector	89.5	89.2	116.9	128.3	139.7	144.3	149.1	154.0	159.1	164.4
Organized Private Sector	5.9	41.4	68.3	100.2	137.9	182.1	233.8	294.0	364.0	445.1
Non-Vulnerable Informal	56.9	125.7	194.9	264.0	332.5	400.1	466.0	529.6	590.0	646.5
Government Equity Funds & BHCPF	65.1	74.1	82.9	93.5	105.5	119.0	134.2	151.4	170.8	192.7
Donors & Innovative Sources	1.6	122.6	125.7	129.0	130.5	133.9	132.4	136.0	139.7	143.5
Total Resources Available	**219.0**	**453.0**	**588.7**	**715.0**	**846.0**	**979.3**	**1,115.4**	**1,265.0**	**1,423.6**	**1,592.1**

In this scenario illustrated in Figure 8 where the potential funds available are set against the coverage of all the groups, the pool of funds is sufficient to pay for coverage in the first two years of the plan and achieve coverage of 16.2% in 2022 but the scheme will be unable to extend coverage to 23.3% in 2023 without additional resources**.**

Figure 7: Scenario 1: Financial Sustainability Analysis of the NHIS

Figure 8: Scenario 1, Financial Sustainability Analysis of the NHIS

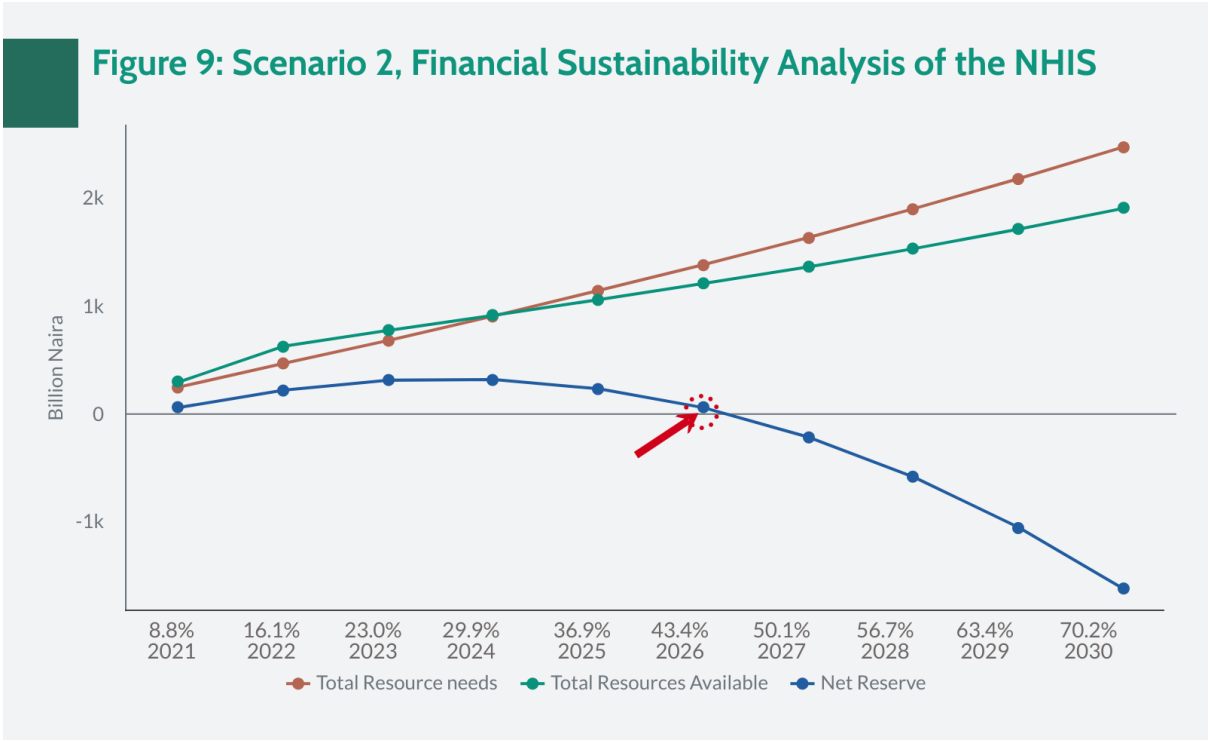


In the second scenario of revenues summarized in Table 9 and Figure 9, the pooled funds and reserves are sufficient to cover only up to 44% of the population by 2026. By 2027, the fund will need to mobilize additional N228 billion in order to achieve the coverage target of 50% of Nigerians.

Table 9: Scenario 2, Resource Needs and Potential Resource Available for the Total Population (N' Billions 2021-2030)

Scenario 2	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Resource Needs	**236.8**	**455.5**	**670.4**	**895.9**	**1,132.7**	**1,372.0**	**1,624.0**	**1,889.5**	**2,169.1**	**2,463.7**
Potential Resources Available										
Public Formal Sector	89.5	89.2	116.9	128.3	139.7	144.3	149.1	154.0	159.1	164.4
Organized Private Sector	5.9	41.4	68.3	100.2	137.9	182.1	233.8	294.0	364.0	445.1
Non-Vulnerable Informal	56.9	125.7	194.9	264.0	332.5	400.1	466.0	529.6	590.0	646.5
Government Equity Funds & BHCPF	130.3	148.2	165.8	187.0	210.9	237.9	268.4	302.8	341.6	385.3
Donors & Innovative Sources	1.6	211.1	216.6	222.3	226.3	232.2	233.4	239.7	246.2	252.9
Total Resources Available	**284.2**	**615.6**	**762.5**	**901.8**	**1,047.3**	**1,196.6**	**1,350.7**	**1,520.1**	**1,700.9**	**1,894.2**

Figure 8: Scenario 2, Financial Sustainability Analysis of the NHIS



Healthcare Coverage Costs: Increasing the Financial Space

Collaboration with welfare and empowerment programs

Owing to the prevailing high level of poverty in the country, several social protection programs are being implemented in the form of conditional and unconditional transfers, empowerment, entrepreneurship, trader monies, and a host of other special interventions targeted at raising the productivity of the poor.

The management of NHIS and SHIAs should collaborate with other ministries and agencies implementing those programs in order to maximize the benefits of the interventions. The idea is to mobilize a portion of disbursements under the programs into the social insurance schemes to finance healthcare coverage for the recipients. In addition, the collaboration could monitor the productivity of recipients to ensure that those who have become more productive and whose economic conditions have improved enough to raise them sufficiently above the poverty line should be targeted for transition into the non-vulnerable informal sector scheme with full contribution or targeted subsidies.

Exploring other non-traditional sources

Other potential sources of additional revenue to be explored include

- Philanthropies
- Sin tax (on alcohol and tobacco)
- Looted funds returned to national/state treasuries;
- Legislative actions (tax on medical tourism, investment of looted funds)

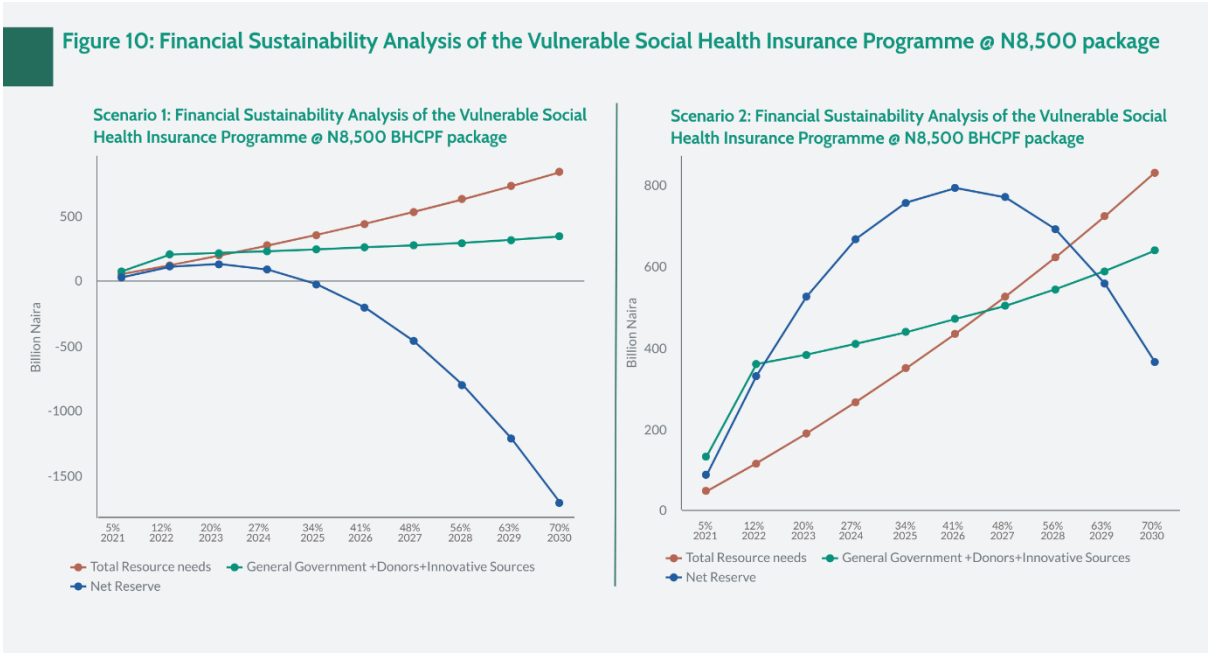
- Value-Added Tax (VAT) on luxury services
- Luxury property tax
- Adoption program
- Diaspora remittance
- Efficiency gains

Scaling Down the BHCPF Benefits Package for the Vulnerable Group

Consider the policy scenario of reduction in the breadth of the BHCPF benefits package. Given that vulnerable population programs will be aligned to the package, scenarios of benefits packages that actuarially cost lower than N12,000 was analyzed.

With a package costed at N8,500 for the vulnerable group, the expenditures for financing coverage of these groups are fully funded by the baseline scenario of government equity funds and BHCPF, donor program funds and the innovative sources (airline and telecom levies) up to 2025 when coverage of the population group will reach 34%. As illustrated in Figure 10 Scenario 1, the vulnerable program will run into deficit afterwards.

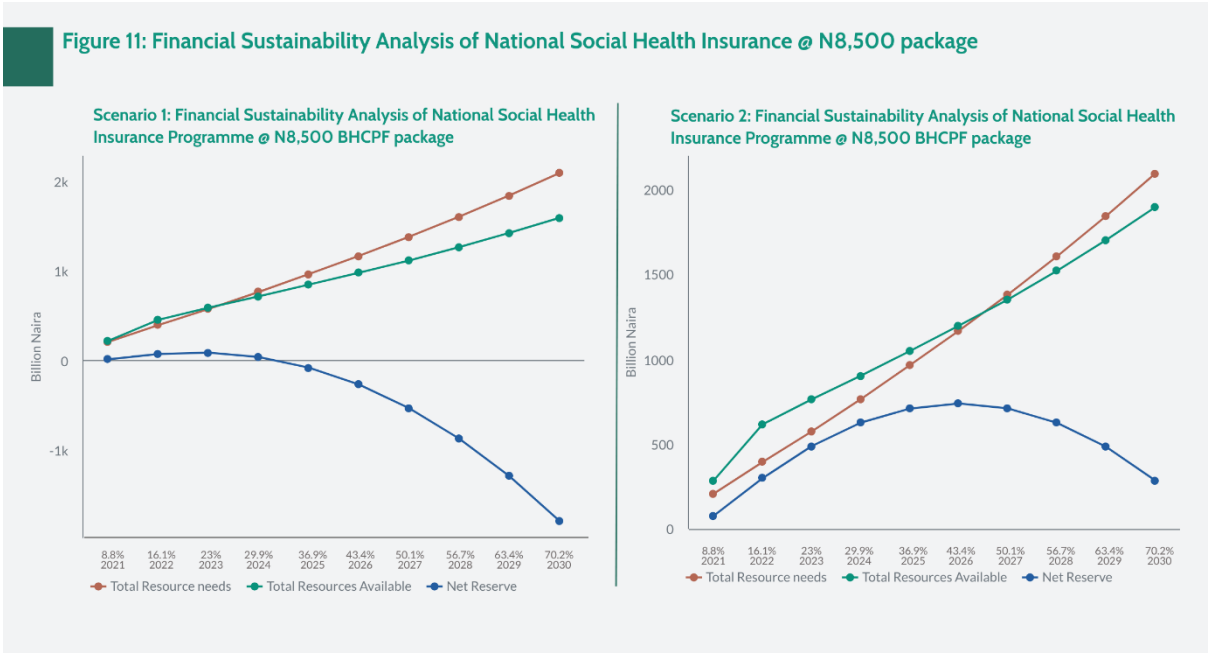
Figure 9: Financial Sustainability Analysis of the Vulnerable Social Health Insurance Program @N8,500 package



Under the more aggressive scenario (Figure 10, scenario 2) involving doubling of BHCPF and equity funds and higher rates of airline and telecoms levies, the expenditures of vulnerable population groups will be fully absorbed by those funds, coverage of 70% will be attained by 2030 with a surplus of N365 billion, if all the funds are applied solely to coverage of vulnerable groups.

Similarly, at the overall population level, the aggregate pool of earmarks and contributions will run into deficit by 2025 under baseline scenario while the aggressive scenario potential revenue will fund population coverage target of 70.2% by 2030 (Figure 11).

Figure 10: Scenario 2, Financial Sustainability Analysis of National Social Health Insurance @N8,500 package



INVESTMENT CASE FOR THE STRATEGIC PLAN

Background

The National Health Insurance Scheme Strategic Plan (NHIS-SP) 2021-2030 presents a blueprint for repositioning the NHIS for efficiency and better performance, and accelerate the achievement of universal health coverage (UHC). The Plan is part of a broader effort to define the direction for reshaping the health insurance landscape and improve access to quality, affordable and equitable health care for all Nigerians. The resource requirements of the plan – including the program management costs of repositioning NHIS and service delivery costs of expanding social health insurance coverage – have been estimated, and a corresponding financial sustainability analysis (FSA) had been conducted.

Subsequent to the FSA, the NHIS is moving forward to develop an investment case for the NHIS-SP to support advocacy efforts toward ensuring adequate funding of the plan. This involves development of a stream of impacts (health outcomes and health financing) and benefits (economy and productivity) of the plan and integration of the costs, impacts and benefits into a single document. This document presents estimated health outcome impacts of the NHIS-SP.

Methodology

The health impacts of NHIS-SP were estimated within the OneHealth Tool (OHT) framework. Priority interventions covered in the benefits packages (BHCPF and Formal Sector) were harmonized with interventions profiled in OHT, baseline and target intervention coverages were determined, and a linear interpolate profile was used to scale up coverages over the 10-year horizon with 2020 as the baseline year. Four policy scenarios were modelled:

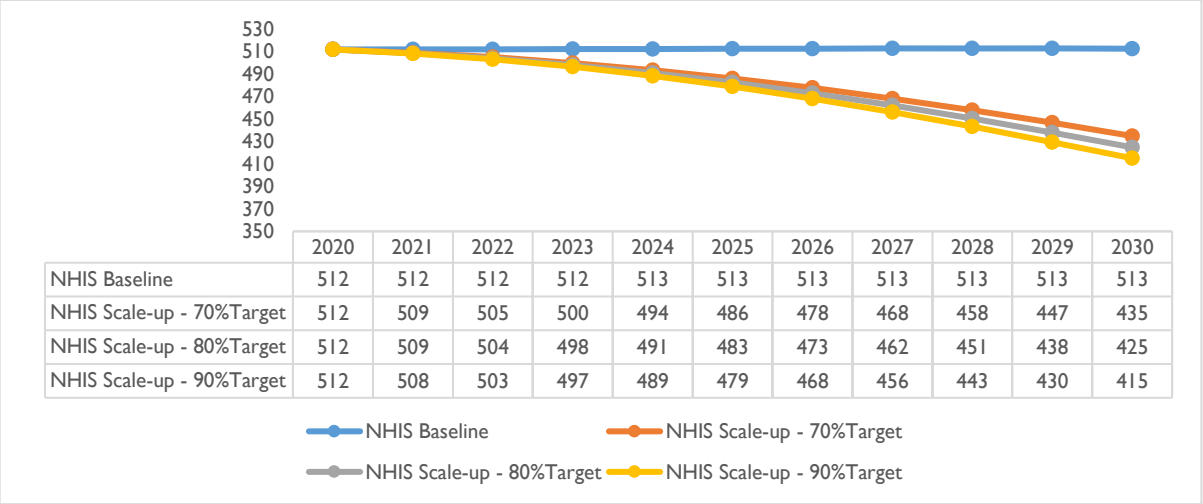
- A baseline scenario with intervention coverages maintained at their 2020 levels
- A scale-up scenario with target 70% population coverage by 2030
- A scale-up scenario with target 80% population coverage by 2030
- A scale-up scenario with target 90% population coverage by 2030

Baseline intervention coverage data were sourced mainly from MICS 16/17 and NDHS 2018

Mortality Impacts

Maternal Mortality Rate (MMR): Measured in deaths per 100,000 live births, MMR remained unchanged from 512 in the baseline scenario in which there was no health insurance coverage scale-up, dropped to 435 in the scenario of 70% coverage by 2030 which reduced further to 425 in the scenario of 80% coverage by 2030 and to 415 in the scenario of 90% coverage by 2030 (Figure 1). These translate to 15%, 17% and 19% declines respectively in MMR over the 10-year horizon. Meanwhile, estimated MMR remains very high compared to the SDG target of 70 by 2030.

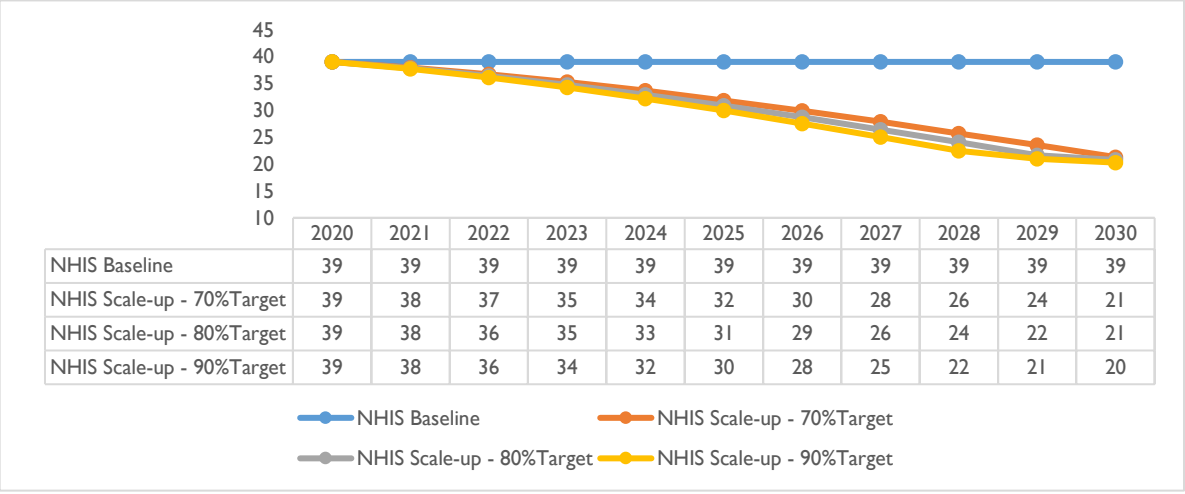
Figure 11: Maternal mortality ratio (deaths per 100,000 live births)



	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
NHIS Baseline	512	512	512	512	513	513	513	513	513	513	513
NHIS Scale-up - 70%Target	512	509	505	500	494	486	478	468	458	447	435
NHIS Scale-up - 80%Target	512	509	504	498	491	483	473	462	451	438	425
NHIS Scale-up - 90%Target	512	508	503	497	489	479	468	456	443	430	415

Neonatal Mortality Rate (NMR): Measured in deaths per 1,000 live births, NMR remained unchanged from 39 in the baseline scenario in which there was no health insurance coverage scale-up, dropped to 21 in the scenarios of 70% and 80% coverage by 2030 and reduced slightly to 20 in the scenario of 90% coverage by 2030 (Figure 2). Meanwhile, estimated NMR remains above the SDG target of 12 1,000 live births by 2030.

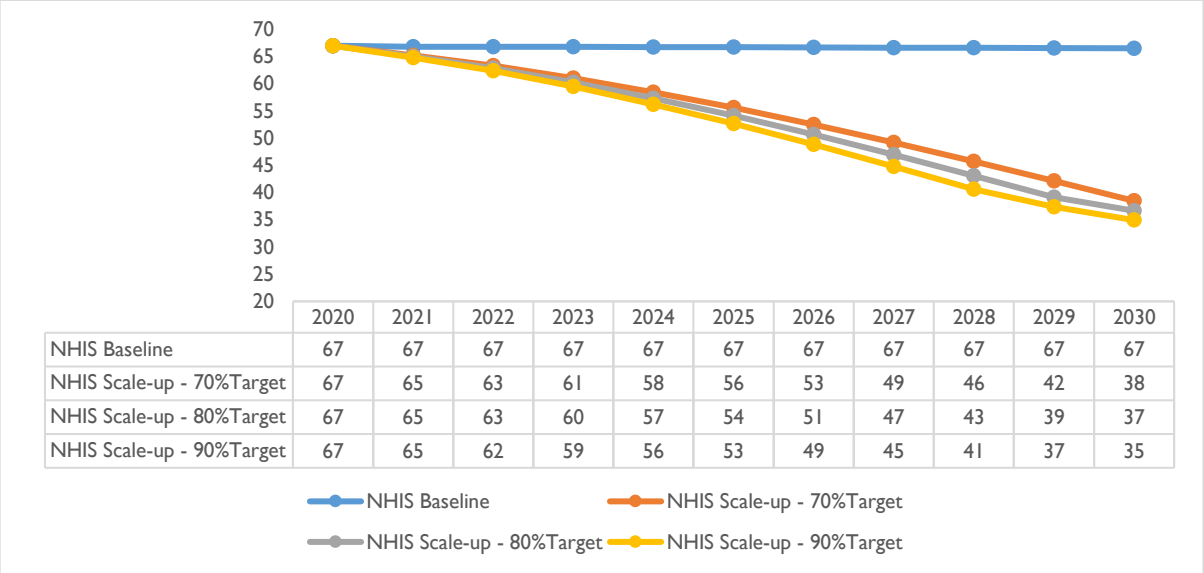
Figure 12: Neonatal mortality rate (deaths per 1,000 live births)



	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
NHIS Baseline	39	39	39	39	39	39	39	39	39	39	39
NHIS Scale-up - 70%Target	39	38	37	35	34	32	30	28	26	24	21
NHIS Scale-up - 80%Target	39	38	36	35	33	31	29	26	24	22	21
NHIS Scale-up - 90%Target	39	38	36	34	32	30	28	25	22	21	20

Infant Mortality Rate (IMR): With 67 deaths per 1,000 live births under the NHIS baseline, a 70% scale-up target reduces the Infant mortality rate to 38 deaths per 1,000 live births over the 10-year period (Fig. 3). The 80% scale-up target of health interventions further reduces the infant mortality rate to 37 deaths per 1,000 live births over the period. Under the 90% scale-up target, the rates reduce slightly to 35 deaths per 1,000 live births.

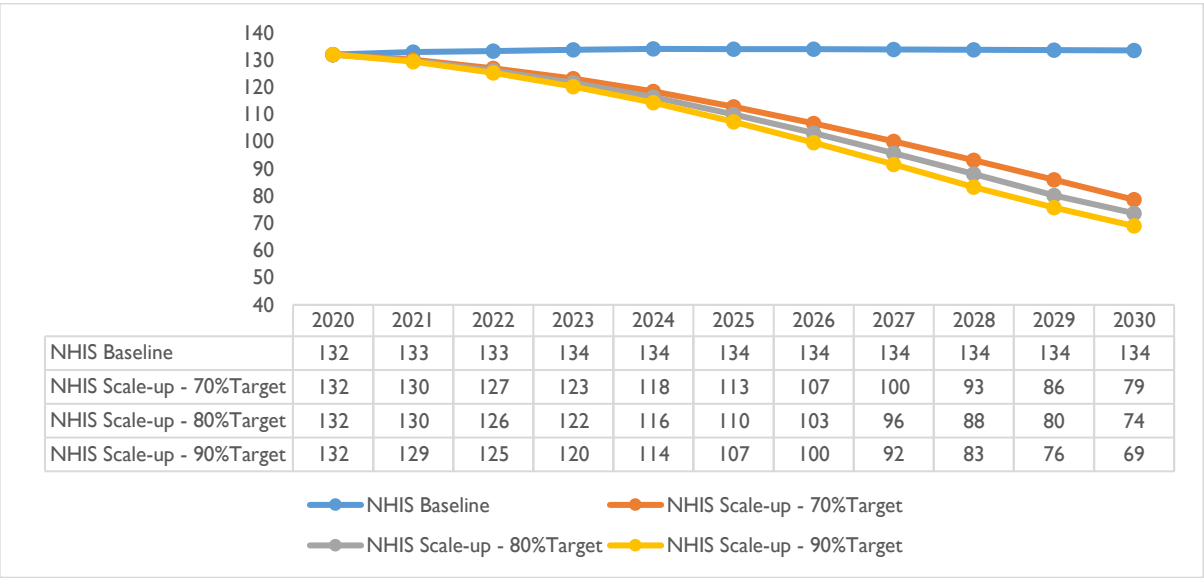
Figure 13: Infant mortality rate (deaths per 1,000 live births)



	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
NHIS Baseline	67	67	67	67	67	67	67	67	67	67	67
NHIS Scale-up - 70%Target	67	65	63	61	58	56	53	49	46	42	38
NHIS Scale-up - 80%Target	67	65	63	60	57	54	51	47	43	39	37
NHIS Scale-up - 90%Target	67	65	62	59	56	53	49	45	41	37	35

Under 5 Mortality Rate (U5MR): In the baseline scenario, U5MR (deaths per 1,000 live births) will climb slightly from 132 in the base year to 134 in 2030. In the scale-up scenarios, U5MR will drop to 79 in the 70% coverage scenario, 74 in the 80% intervention scale-up scenario and further to 69 in the 90% coverage scenario. These translate to 41%, 45% and 49% declines respectively. However, these targets are high relative to the SDG target of 25 by 2030.

Figure 14: Under-five mortality rates (deaths per 1,000 live births)



	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
NHIS Baseline	132	133	133	134	134	134	134	134	134	134	134
NHIS Scale-up - 70%Target	132	130	127	123	118	113	107	100	93	86	79
NHIS Scale-up - 80%Target	132	130	126	122	116	110	103	96	88	80	74
NHIS Scale-up - 90%Target	132	129	125	120	114	107	100	92	83	76	69

Lives Saved

Child Lives: In the baseline scenario, a total of 118,000 children will be lost over 10-years starting from 4,534 in 2021 and increasing to 16,356 in 2030. In comparison, a total of 2.4 million children will be saved alive in the 70% coverage scale-up scenario, rising to 2.8 million children in the 80% coverage scale-up scenario and 3.0 million children in the 90% coverage scale-up scenario (Table 1).

Table 10: Additional child lives saved

	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total

NHIS Baseline											
Total (0-59 months)	-4,534	-5,574	-8,596	-12,285	-12,971	-13,518	-14,067	-14,805	-15,633	-16,356	**-118,339**
<1 month	0	0	0	0	0	0	0	0	0	0	**0**
1-59 months	-4,534	-5,574	-8,596	-12,285	-12,971	-13,518	-14,067	-14,805	-15,633	-16,356	**-118,339**
NHIS Scale-up - 70%Target											
Total (0-59 months)	16,814	45,914	81,889	126,202	181,777	243,805	313,821	391,662	477,193	570,116	**2,449,193**
<1 month	8,398	19,013	31,883	47,060	64,618	84,624	107,117	132,025	159,121	188,044	**841,903**
1-59 months	8,416	26,901	50,006	79,142	117,159	159,181	206,704	259,637	318,072	382,071	**1,607,289**
NHIS Scale-up - 80%Target											
Total (0-59 months)	19,650	52,852	94,070	144,692	207,431	277,125	355,430	441,890	536,294	621,928	**2,751,362**
<1 month	9,566	21,654	36,282	53,479	73,292	95,775	120,949	148,540	178,318	193,718	**931,573**
1-59 months	10,085	31,199	57,788	91,213	134,139	181,350	234,481	293,350	357,975	428,209	**1,819,789**
NHIS Scale-up - 90%Target											
Total (0-59 months)	22,469	59,728	106,095	162,864	232,513	309,588	395,601	490,029	581,323	670,803	**3,031,013**
<1 month	10,720	24,259	40,609	59,767	81,746	106,643	134,242	164,278	185,343	199,041	**1,006,648**
1-59 months	11,749	35,469	65,486	103,097	150,768	202,945	261,359	325,751	395,980	471,762	**2,024,366**

Maternal Lives: A total of 557 maternal lives will be lost in the baseline coverage scenario between 2021 and 2030. In comparison, a total of 33,000 women will be save alive under the 70% scale-up scenario, 38,000 in the 80% coverage scale-up scenario and 42,000 in the 90% coverage scale-up scenario. (Table 2).

Table 11: Additional maternal lives saved

	NHIS Baseline	NHIS Scale-up - 70%Target	NHIS Scale-up - 80%Target	NHIS Scale-up - 90%Target
2021	-4	235	266	297
2022	-17	574	652	730
2023	-30	1,032	1,174	1,317
2024	-44	1,613	1,838	2,061
2025	-59	2,328	2,651	2,972
2026	-73	3,184	3,626	4,070
2027	-84	4,196	4,780	5,354
2028	-90	5,370	6,104	6,824
2029	-86	6,704	7,600	8,475
2030	-70	8,192	9,261	10,296
Total	-557	33,428	37,952	42,396

REFERENCES

1. Federal Ministry of Health, National Health Policy, 2016
2. National Health Insurance Scheme Act (NHIS Act CAP N42 LFN 2004).
3. National Health Insurance Scheme, Operational Guidelines, 2012
4. National Health Insurance Scheme, Report of Management Retreat, 2019
5. Federal Ministry of Health, National Health Account 2017
6. The National Health Financing Policy and Strategy, 2017
7. Report of Presidential Summit on UHC, 2014
8. Presidential Independent Fact-Finding Panel (IFFP) Report
9. National Health Insurance Scheme, 3-Point Rebranding Agenda for New NHIS, 2019
10. The National Health Act, 2014
11. Federal Ministry of Health, National Strategic Health Development Plan I 2010 – 2015
12. Federal Ministry of Health, National Strategic Health Development Plan II 2018 – 2022
13. https://questioneverything.typepad.com/question_everything/political-economy/page/9/
14. David Stuckler et al, The political economy of Universal Health Coverage, 2010
15. Susan P. Sparkes et al, Research Article: Political Economy Analysis for Health Financing Reform, 2019
16. Carolyn Hughes, Tuohy & Sherry Glied, Political Economy of Health Care, 2011
17. Federal Ministry of Health, National Health Facility Registry, December 2019
18. NHIS, HMO and Health Care Provider Data, ICT Department, December 2019
19. NPHCDA, Report of the expert group on revitalization of PHC in Nigeria, 2015
20. Monitoring Health for the SDGs, Annex 2, Table of Health Statistics by country, WHO region and globally; WHO World Health Statistics, 2019
21. Nigeria Health Budget Analysis, Policy Brief, 2013-2020 Approved Budget
22. Abuja Declaration, 2001
23. Nigeria Demographic and Health Survey 2018
24. Darius Erlangga, The impact of public health insurance on health care utilisation, financial protection and health status in low- and middle-income countries: A systematic review, PLos One, 2019
25. Priyanka Saksena et al, Mutual Health Insurance in Rwanda: evidence on access to care and financial protection, Health Policy 2011
26. National Health Insurance Scheme, Formal Sector Department/Informal Sector Department, Data Base, 2019
27. National Health Insurance Scheme, Contribution Management Department, Profile of Contributions Received 2010 – 2018
28. National Bureau of Statistics, 2019
29. Development Governance International (DGI) Consult, SHIS Implementation Scorecard, 2019
30. NHIS Strategic Roadmap Report 2019

31. Comprehensive Report of NHIS Retreat, 2019

ANNEXES

Annex 1

PRESIDENTIAL SUMMIT DECLARATION ON UNIVERSAL HEALTH COVERAGE IN NIGERIA ABUJA, 10TH MARCH, 2014

THE Presidential Summit on Universal Health Coverage in Nigeria held under the theme ***"UHC… a Vehicle for sustainable Growth and Development".***

2**. RE-AFFIRMING** that health is a fundamental human right and the responsibility of the government in assuring the health of its people;
3. **RECOGNISING** that Universal Health Coverage (UHC) holds the key to unlocking the door for equitable, qualitative and universally accessible healthcare for all Nigerians without suffering financial hardship;
4. **AWARE** of the pivotal role of a healthy population as a driver for sustainable, equitable and inclusive economic growth and national development;
5. **DEEPLY CONCERNED** that Nigeria's attainment of the target of 30% health insurance coverage by December, 2015 is threatened by the non-institutionalisation of Universal Health Coverage;
6. **RECOGNISING** that the key challenges for achieving UHC are related to the sub-optimal health system characterised by budgetary constraints, inadequate financial protection for the poor, shortage and mal-distribution of human resources for health, uneven quality of health care services, challenges in the provision of health commodities, poor coordination, and weak referral system and the uneven utilisation of health services;
7. **ACKNOWLEDGING** the progress made towards UHC through initiatives at Federal and State levels, targeted at improving access to and creating demand for health care services;
8. **APPRECIATING** the support of all partners and stakeholders in the Nigerian health sector including Federal, state and local governments, civil society organisations, private sector, traditional and religious institutions, academia, media, communities and multilateral and bilateral organisations;

WE HERBY STRONGLY RECOMMEND TO THE GOVERNMENT OF NIGERIA AT ALL LEVELS (FEDERAL, STATE AND LOCAL GOVERNMENT) TO SIGNIFICANTLY MAKE PROGRESS TOWARDS ACHIEVING UNIVERSAL HEALTH COVERAGE IN NIGERIA BY:

9. **COMMITING** to implementing recommendations of this presidential Summit on Universal Health Coverage;
10. **WORKING TOWARDS** institutional mandatory health insurance in Nigeria, with contributions from all income earners (formal and informal) and special funds to cover the poor;
11. **COMITTING** to increase budgetary allocation to health at Federal, state and local Government with a proportion earmarked for UHC priority interventions;
12. **DEPLOYING** alternative, innovative and sustainable sources of funding for Universal Health Coverage;
13. **ENSURING** that all existing and new funds from 11 and 12 above and all other sources, are pooled into Universal Health Coverage Fund at all levels.

14. **STRENGTHENING** and expanding financial risk protection mechanisms for the poor and vulnerable groups as part of the broader social protection efforts in the country;
15. **DEFINING** a standard benefit package of essential health services that address priority health care needs of Nigerians;
16. **DELIVERING** the standard benefit package through ensuring adequate physical infrastructure, skilled human resource, medicines and other lifesaving commodities and equitable distribution of same.
17. **PROVIDING** policy and regulatory instruments for the institutionalisation of systems and mechanisms that ensure quality of care and satisfaction for consumers of health care services;
18. **EXPLORING** the establishment of an Independent Health Quality Commission to ensure standards and compliance;
19. **DELIBERATELY** building an organised referral system that guarantees each citizen access to functional primary health care facility, which shall be the first point of contact in the national health system;
20. **CONSTITUTING** and inaugurating appropriate committees that will initiate appropriate actions towards the realization of the recommendations of the Presidential Summit;
21. **BUILDING** on existing and gorging new multi-sectoral partnership for coordinated UHC efforts for Nigeria led by Government and supported by non-state (non-governmental) actors;
22. **ESTABLISHING** a joint mechanism to monitor and evaluate progress of Universal Health Coverage efforts in Nigeria;
23.**ENDORSING** the aforementioned this, 10th day of March, 2014.

Annex 2

NHIS THREE (3) POINT REBRANDING AGENDA, 2019

AGENDA	ELEMENTS (THEMATIC AREAS)
Agenda 1 Value reorientation	1. Good work ethics 2. Unity of purpose and direction 3. Synergy/Collaboration 4. Teamwork/ Team spirit 5. Effective Communication and Information Management 6. Excellent work environment 7. Efficiency (result oriented) 8. Proper record keeping 9. Appropriate rewards and sanctions 10. Equity and Fairness
Agenda 2 Transparency and Accountability	1. Openness in the operations of NHIS 2. Working with evidence 3. Adequate information to all stakeholders 4. Stakeholders' engagement in decision making. 5. Effective administration and financial management system 6. ICT Driven NHIS
Agenda 3 Elements for accelerating the drive towards UHC	1. **Consolidate**: expand coverage of existing programmes i.e. public sector, organised private sector, VCSHIP SSHIP 2. **Innovate**: create or revisit programmes designed to cover those currently not covered by NHIS, i.e. Retirees, NYSC, refugees/IDPs, pupil of public primary school, physically challenged, prison inmates, urban self-employed, vulnerable i.e. CU5 whose parents are not covered under any of the programmes, elderly, etc

Annex 3

HEALTH FINANCING INDICATORS AND TARGETS (NSHDP II)

S/N	Indicators and Targets	Current Situation
1	70% of States with functional Healthcare Financing Equity & Investment Units	So far, 32 states have signed their laws on equity funds in the State Health Insurance laws. The equity funds in the states ranges from 0.5% to about 2% of consolidated revenue in states.
2	70 % of States with approved Health Financing Policy & Strategy	Only the few states that have done health accounts actually have health financing policy and strategy.
3	70 % of States that have approved investment cases for UHC priorities	This could not be established in the course of this analysis.
4	70 % of States that have conducted and/or updated State Health Accounts (SHA)	Only Imo, Anambra, Kaduna, Cross River, Sokoto, Lagos, and Niger have done state health accounts
5	35 % of health budget allocated to PHC	There is no data in this regard but the BHCPF funding seems to the main funding source in many states.
6	15 % of national budget allocated to the health sector	This has not been achieved in the past years.
7	30 % of Nigerian population covered by risk protection mechanisms for health financing	Available data indicate that less than 5% of the Nigerian population is insured under the NHIS
8	35% of Out of Pocket Expenditure on health	OOP expenditure as a percentage of total health expenditure is currently at about 76.6%
9	40 % of Health MDAs operating PBF as a results-based provider payment mechanism	Status of this indicator could not be established in the course of this analysis.
10	70 % of States with health financing integrated into functional PFM Systems	This has been achieved as 32 states that have signed their laws, have PFM in the laws integrating the system.

Annex 4

Priority Areas, Goals and Strategic Objectives of the Plan

Goals	Strategic Objectives
Priority Area 1: Organisational Capacity and Culture	
To promote Organisational and service excellence using best management practices	To achieve organisational excellence through effective stewardship and 100% delivery of services required to maintain the integrity and efficient functioning of NHIS.
	To achieve 100% alignment of administrative and operational roles with the structure.
	To achieve decentralisation of 70% of decision making in operations and business processes to the Zones and States
	To achieve 70% human and material resources requirement for effective management and service delivery annually.
	To ensure that 70% of the workforce have the required skills and competencies to meet established performance target annually.
Priority Area 2: Communication and Marketing	
To improve visibility and approval of NHIS operations and business processes and practices	To achieve 100% engagement with key sectors and partners such as FMoF/National Planning, FMoH, FMoL and Development Partners to influence discourse on UHC
	To achieve 50% increase in public awareness on health Insurance annually
Priority Area 3 – Resource Mobilisation and Pooling	
To improve revenue generation for financing healthcare services to protect Nigerians against financial hardship of paying for healthcare	To achieve sustainable annual increase in health financing through public and private spending.
	To achieve 20% annual increase in health insurance (population) coverage
	To ensure allocation and release of equity funds by all the States annually.
	To achieve 100% release of BHCPF to NHIS and SSHIS.
	To achieve 100% investment of residual funds
	To achieve 100% integration of all existing pools at the State level over 2 years
	To achieve reduction of Out of Pocket Expenditure by 10% annually
Priority Area 4 – Strategic Purchasing	
To achieve value for money for healthcare at minimum supply chain risk in strategic purchasing of health services	To achieve 100% implementation of defined benefit packages
	To ensure 100% compliance by Stakeholders with established service standards and contractual agreements

	To achieve 100% provider payment within 30 days due to improved efficiency in the Provider Payment Mechanisms (PPMs).
To promote equity, quality, safety and responsiveness in the delivery of health services	To achieve 50% improvement in responsiveness to the health needs and demands of health consumers annually
	To ensure 100% adherence to professional and ethical standards
	To ensure that 100% of enrolees are aware of their rights and understand the processes for holding providers, HMOs and other stakeholders accountable
Priority Area 5 – Accountability and Transparency	
To promote accountability and transparency in NHIS operations, financial transactions, and procurement.	To achieve 100% compliance with extant financial and procurement regulations, guidelines and processes for efficiency, cost effectiveness and value for money.
	To ensure involvement of independent Health Insurance Advocacy groups and "Watchdogs" in 20% of NHIS operations.
Priority Area 6 – Partnership and Stakeholder Coordination	
To promote effective collaboration and coordination of strategic partners and stakeholders.	To promote 100% implementation of Health Insurance Under One Roof (HIUOR) in 2020 - 2021.
	To ensure 100% alignment of development partners' mandate and other stakeholders' activities with NHIS priorities.
Priority Area 7 – Integrated ICT	
To promote ICT integration of NHIS processes to maximise efficiency and enable innovation to advance NHIS goals.	To achieve deployment of ICT infrastructure that meet established standard including data security, integration, and interoperability in 70% of NHIS zones and states, SSHIS, accredited HMOs and Providers..
	To Achieve 70% reduction in lead time for carrying out key internal NHIS processes like accreditation, claims management, access to enrolee register and referral management.
Priority Area 8 – Operations Research and Innovation	
To promote, utilise and sustain excellence in research in health financing and UHC, and innovation for improved health outcomes.	To strengthen the stewardship role of NHIS in health financing research.
	To build institutional capacity to promote, undertake and utilise research for improved decision making
Priority Area 9 – Results-based Monitoring and Evaluation	
To ensure systematic tracking of programmes and activities and the performance of all NHIS operations	To achieve 100% tracking of operations and programme performance using available data.
	To ensure 70% of health financing policy decisions and implementation activities are informed by NHIS data.

Annex 7

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