

Financial feasibility of using the Basic Health Care Provision Fund to provide a basic minimum Maternal and Child Health benefit package in Nigeria

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This policy brief is based on a research report: "Using the Basic Health Care Provision Fund to provide Maternal and Child Health Services in Nigeria: program costing and financial feasibility analysis". The study was undertaken in the three states in Nigeria and is available from the BMGF, Abuja office. For more information about this publication, please contact Obinna Onwujekwe, e-mail: Obinna.onwujekwe@unn.edu.ng

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Key conclusions:

- 1) The BHCPF is potentially a good step towards providing affordable healthcare for all, particularly the vulnerable members of the society, but the current level of funding will not assure universal health coverage for all pregnant women and children under five in the three states.
- 2) Allocating just 1% of consolidated revenue fund of the federation as the BHCPF will not be enough to assure universal financial protection of a basic minimum benefit package for all pregnant women and children under five in the state.
- 3) Various funding scenarios show the inadequacy of available funds to meet the needs of the target beneficiaries.
- 4) The funds are not enough to cover all potential pregnant women in each state, assuming that the basic minimum benefit package covers only pregnant women, even using 100% of the BHCPF
- 5) The only feasible option is funding of only child services utilizing at least 70% of the CRF.
- 6) States would require more funds in order to provide MCH services to target beneficiaries. More than half of those who need these services cannot access them in the States.
- 7) Even when other cost components such as overheads and capital are removed from the benefit package, available funds from the BHCPF and State counterpart are inadequate to meet the required level of coverage.
- 8) In order to meet the stated target of providing units of a thin benefit package adequate enough to provide maximum coverage, additional funds are required.

Key policy recommendations:

- 1) The available funds should be used immediately to cover the maximum numbers of mothers and children that it can, whilst sourcing for additional funds to ensure universal coverage of MCH services
- 2) There is a need to re-evaluate the level of funds to be allocated as BHCPF and the analysis shows that at least 4% of CRF is the minimum that will cover the all target beneficiaries within the state based on just 50% of the BHCPF to the NHIS.
- 3) Counterpart funding must be entrenched in the design and implementation of the program, so as to ensure that more beneficiaries are covered.

OBJECTIVES OF THE STUDY:

1. To determine the unit costs of the maternal and child health (MCH) services in three states in Nigeria
2. To determine the financial feasibility of using the Basic Healthcare Provision Fund to provide a basic minimum benefit package to cover all pregnant women and under-five children in Nigeria

INTRODUCTION

The defunct Millennium Development Goals (MDG) office in the Nigerian presidency, using funds from the Debt Relief Gains (DRG) to fund the National Health Insurance Scheme (NHIS) to implement a free Maternal and under-five children's healthcare program in some states in the country. The program was implemented between 2008 and 2015 in 12 states. Although there is no hard evidence from an impact evaluation, anecdotal evidence shows that the Free MCH provided needed services to many women and children. It also led to improvements in infrastructure and quality of healthcare services in the participating states. Hence, there is a demand from both beneficiaries, providers and other health system stakeholders for the reactivation and scaling-up of the program either in the original or in a new form.

The possibility to reactivate and scale-up the Free MCH program has been provided with the passage of the National Health Act in 2014 and the creation of a Basic Health Care Provision Fund (BHCPF) in the Act. The fund is equivalent to at least 1% of the Consolidated Revenue of the Federation. This fund is to be matched with counterpart funds from states, and will be allocated through the National Health Insurance Scheme (NHIS [50%]), the National Primary Health Care Development Agency (NPHCDA [45%]) and the Federal Ministry of Health (5%).

The fund is expected to provide an essential package of health services to citizens (a basic minimum benefit health package) and to improve the infrastructure, drugs and consumables in primary healthcare facilities in Nigeria. The BHCPF will provide additional revenue to support primary healthcare services and help the country to achieve universal health coverage.

This policy brief assumes that the basic minimum health package will cover all pregnant women and under-five children as the most vulnerable group, responsible for the greatest health burden and whose indicators are sources of understanding the performance of the health system. Nigeria has a maternal mortality ratio of 576 per 10,000 live birth and Infant and under-5 mortality rates of 69 and 128 deaths per 1,000 live births, respectively (DHS, 2013). At these mortality levels, one in every 15 Nigerian children dies before reaching age one, and one in every eight does not survive to his/her fifth birthday.

Hence, any basic minimum health package in Nigeria must include basic services for pregnant women and under-five children. Especially, the lifetime risk of maternal death indicates that 1 in 30 women in Nigeria will have a death related to pregnancy or childbearing (DHS, 2013). Although many of these deaths are preventable, problems with access to health facility, attendance by skilled birth personnel and coverage and quality of health care services contribute to the elevated morbidities and mortalities. Much of these challenges arise due to inadequate and ineffective funding of maternal and child health interventions.

This policy brief reports on the financial feasibility of using the BHCPF and other available public revenue (either singly or in combination) to provide free maternal and child health (MCH) services, which are considered the basic minimum benefit package that the fund should provide. This will help in reactivating and scaling up a program similar to the NHIS-MDG Free MCH program in the country. The policy brief also examines the potentials of additional funding options for extending coverage with a basic minimum (thin) maternal and child health benefit package.

METHODS USED

Concept of Financial feasibility:

A financial feasibility assessment involves a comparison of all revenue sources to anticipated costs or expenditure, such that an excess of income over expenditure confirms viability. Hence, two components are required: a costing of the service and an analysis of the revenue that will be used to provide the service at the stated costs.

Study area and data collection

The study focused primarily on three states: Imo, Kaduna and Niger. In each state, two local government areas (LGAs) - one urban and one rural, were purposively chosen for facility and LGA level data collection. Within each state, two primary healthcare facilities were visited in each of the two LGAs, to allow for the performance of financial feasibility based on different contexts. The study team comprised health economists, public health specialists and financial analysts. Information was collected between April and June 2016 from staff of health facilities, local government councils, and from the state ministries of health.

A basic minimum benefit package, divided into maternal and child services was used for the purpose of the analysis. The services in the benefit package included antenatal care (ANC), delivery, post-natal care (PNC), family planning (FP), treatment of malaria, pneumonia, diarrhea, and routine immunization. Other routine services such as health education and growth promotion services, provided alongside earlier mentioned services, are assumed to be included in the personnel, capital and overhead expenditures for the services within the specific benefit package. The total service cost for drugs and consumables were based on the provision of MCH services constituting a standard benefit package for a pregnant woman and a child under 5years.

In order to determine the extent of coverage for the target beneficiaries from the available revenue, a funding-gap analysis was performed using 3 major scenarios for the states. Scenario 1 is based on the funding of drugs and consumables only, Scenario 2 is based on the funding of drugs, consumables and overheads only, while Scenario 3 focuses on the funding of all cost items (i.e. drugs, consumables, overheads, personnel and capital). For each of the three scenarios, three possibilities are considered: a) All available funds would be utilised to provide maternal services only; b) Only child services would be provided from the available revenue; and c) All MCH services would be provided. Tables 1, 2 and 3 further summarize the specific methods applied for the determination of costs, revenue, benefits and financial feasibility.

Table 1 presents the basis for deriving that data on demographics. This is in relationship to the target population, utilization weights for facilities and numbers of standard PHC facilities per state.

Table 1: Demographic figures

SUBJECT	DESCRIPTION
DEMOGRAPHICS	
Target population	Under 5-year-old Children (20%) and Pregnant Women (5%) out of a projected population of the state for 2015, based on 2006 Census figures and a growth rate of 3.2 (Imo), 3.0 (Kaduna), and 3.4 (Niger) (<i>Federal Republic of Nigeria: 2006 Population Census, http://www.nigerianstat.gov.ng</i>)
Utilization weights for facilities	Capital, personnel and variable costs were allocated to MCH services based on the Utilization weights, determined as the proportion of all outpatient service users that attended for MCH services
Number of standard PHC facilities in the state	1 PHC per ward (<i>NPHCDA, Minimum Standards for Primary Health Care in Nigeria</i>)

Table 2 elaborates on the methods that were used to compute different costs and revenue. Costs were categorized into capital, overhead, personnel costs and drugs & consumables. Revenues were estimated at the PHC state and National levels. All the costs and revenues were in 2015 levels. The cost of delivering MCH services in 2015 were categorized into capital (i.e. building, transport, medical equipment and others) costs, and recurrent (i.e. drugs & consumables, personnel and overheads) costs.

Table 2: Methods for deriving costs and revenue

SUBJECT	DESCRIPTION
COSTS	
Capital cost	The capital asset/items were annualized to allow for differential timing of capital assets. The share of the capital costs for MCH services was determined by adjusting the total costs by the facility utilization weight for MCH services. Unit costs were determined based on the patient visits for MCH.
Overhead costs	Total Annual expenditure on administration and overheads including travels & transport, utility, printing & stationery, maintenance, fuel & lubricant, staff training, and financial charges. The share of the overhead costs for MCH services was determined by adjusting the total costs by the facility utilization weight for MCH services. Unit costs were determined based on the patient visits for MCH.
Personnel costs	Total Annual expenditure on salaries of staff, including short term informal employees paid by the facility to fill gaps where these existed. The share of the personnel costs for MCH services was determined by adjusting the total costs by the facility utilization weight for MCH services. Unit costs were determined based on the patient visits for MCH.
Drugs and consumables	Cost of drugs and consumables for management of specific maternal and child conditions based on treatment standards prescribed by the SURE-P MCH services. (<i>USAID DELIVER PROJECT, Task Order 4. 2014. Nigeria: 2014-2015 SURE-P Maternal and Child Health Commodity Requirements and Financing Needs. Arlington, VA.: USAID DELIVER PROJECT, Task Order 4.</i>) Where different drugs (e.g. Amoxicillin and Co-trimoxazole) or commodities (e.g. IUCDs and Depo Provera) could be used, the costs were adjusted to reflect the probability of their use as reflected by the facility utilization records. A Uniform price list for drugs was used which was sourced from the Enugu State's drug revolving fund systems which was comprehensive and representative. Facility prices were not used because of inconsistencies and over-inflation in some cases especially where the drugs were sourced from private pharmacies.
State level cost of services	Average cost of services per facility times the recommended number of standard PHC facilities in a state (1 PHC per ward)
REVENUE	
PHC facility revenue i.e. internally generated revenue (IGR)	Average IGR from MCH services provided in the facility and the monetary value of the stock of drugs available in the facility's drug revolving fund, scaled up to the state level based on the recommended number of standard PHC facilities in the state
LGA revenue	Average PHC budget at LGA level, scaled up to state level based on the number of LGAs in the state.
Estimation of state level revenue from PHC level and LGA level	Average revenue per PHC times number of standard PHC facilities in a state, scaled up to the state level based on the recommended number of standard PHC facilities in the state
National level revenue	1% of the Consolidated Revenue of the Federation distributed as specified in the National Health Act
State's share of the BHCPF	BHCPF shared equally across 36 states and the Federal Capital Territory

FINANCIAL FEASIBILITY ANALYSIS

A coverage and funding gap analysis is performed in this scenario to show the impact of different levels of revenue when only drugs and consumables are provided under maternal and child care services. The standard costs of a thin benefit package for the different states are multiplied by the number of target beneficiaries to determine the amount required for the year. On Revenue components are varied in the different options to enable a sensitivity analysis of the adequacy of coverage for the target beneficiaries. Financial feasibility is determined by the excess or otherwise of revenue over costs. Finally, the additional funding requirement needed is computed to assist future planning.

Table 3: Feasibility and Gap Analysis

SUBJECT	DESCRIPTION
BENEFIT PACKAGE	
Unit cost of thin benefit package	<p>Maternal: The amount that will be required per year to provide free maternal health services to a pregnant woman that uses formal ANC at an average of 4 times, have normal deliveries in health facilities, and receives post-natal care and family planning service. This is weighted based on the utilization pattern of various maternal health services in facilities used</p> <p>Child: The amount that will be required per year to provide a set of health services for an under-five year old child that visits the health facility three times a year. This is weighted based on the utilization pattern of various child health services in facilities used.</p> <p>Either mother or child: The amount required for either a mother or child which is the sum of: Unit maternal cost <i>times</i> probability of being a mother (0.2), and Unit child cost <i>times</i> probability of being a child (0.8), based on the demographic figures. State level costs are multiples of the unit costs.</p>

Although many scenarios were examined in the study, the main feasibility analysis was the Scenario 1, where it is assumed that only drugs and consumables are provided under maternal and child care services. Scenario also reflects the situation in the defunct NHIS-MDG Free MCH program. Table 4 shows the sub-scenarios under Scenario 1 that were analyzed. Scenarios 1a to 1c assume that there will not be any counterpart funding and all the funds will be from the 1%CRF. Scenarios 1d to 1f assume that there will be full counterpart funding from the states and LGAs.

Table 4: FEASIBILITY AND GAP ANALYSIS

Overall approach	Revenue minus the total cost of defined package, analyzed for different scenarios of revenue and cost. Analysis was done for maternal, child and all target beneficiaries at the state level per year.	
	COST	REVENUE
Scenario 1a	Drugs & Consumables only	0.5(1%CRF) = NHIS only
Scenario 1b	Drugs & Consumables only	0.7(1%CRF) = 0.5: NHIS for basic package & 0.2: NPHCDA for drugs and consumables only
Scenario 1c	Drugs & Consumables only	0.95(1%CRF) = 0.5: NHIS for basic package & 0.45: NPHCDA
Scenario 1d	Drugs & Consumables only	0.5(1%CRF) + 0.25[0.5(1%CRF)]* *State's counterpart fund
Scenario 1e	Drugs & Consumables only	0.7(1%CRF) + 0.25[0.7(1%CRF)]* *State's counterpart fund
Scenario 1f	Drugs & Consumables only	0.95(1%CRF) + 0.25[0.95(1%CRF)]* *State's counterpart fund

KEY FINDINGS

Demographics

The target MCH population figures for 2015 were 1,306,143 (Imo), 1,994,184 (Kaduna), 1,334,287 (Niger). The target number of health facilities were 418, 255 and 274 for Imo, Kaduna and Niger states respectively. Based on the facility outpatient attendance records, the utilization weights for MCH services in facilities in each state were 0.83 (Imo), 0.85 (Kaduna) and 0.9 (Niger). The findings show that the average utilization of maternal services in 2015 was 817 (Imo), 4,690 (Kaduna) and 2,623 (Niger). For child services, average utilization for this same period was 3,658 (Imo), 8,671 (Kaduna) and 5,555 (Niger).

Cost Analysis

The total capital cost attributable to MCH services for the states for 2015 were - 248,852,530 Naira (Imo), 149,420,695 Naira (Kaduna), and 182,132,833 Naira. For 2015, the average unit capital costs for the states were 133.1 Naira (Imo), 43.9 Naira (Kaduna) and 81.3 Naira (Niger). Average unit personnel costs were 2,506.6 Naira (Imo), 676.5 Naira (Kaduna) and 1,748.0 Naira (Niger). Average unit overhead costs were 80.1 Naira (Imo), 9.7 Naira (Kaduna) and 19.9 Naira (Niger). See Table 5 below.

Table 5: Unit capital, personnel and overhead costs for maternal or child health service

	Utilisation ratio	Unit capital cost	Unit cost of benefit package (drugs & consumables)	Unit personnel cost	Unit Overhead cost
IMO (Average)		133.1		2,506.6	80.1
Maternal Package	0.18	33.1	4,826.6	2,506.6	80.1
Child Package	0.82	33.1	128.4	2,506.6	80.1
KADUNA (Average)		43.9		676.5	9.7
Maternal Package	0.35	43.9	4,773.6	676.5	9.7
Child Package	0.65	43.9	114.7	676.5	9.7
NIGER (Average)		81.3		1,748.0	19.9
Maternal Package	0.32	81.3	4,759.0	560.6	19.9
Child Package	0.68	81.3	281.2	1,187.4	19.9

Table 6 shows that the unit costs of providing drugs and consumables for various MCH services at a standard PHC facility in 2015. For example, unit cost for antenatal care was 2,837.6 Naira, normal delivery was 1,503.2 Naira while malaria treatment costs 472.4 Naira per child.

Table 6: Unit costs for Drugs and Consumables for MCH services in the PHC facilities

	MCH SERVICES	Unit cost of drugs & consumables (Naira)
MATERNAL	Antenatal Care	2,837.6
	Normal Delivery	1,503.2
	Postnatal care	339.8
	Malaria in Pregnancy	423.5
	Hypertension in Pregnancy	1,620.8
	Postpartum hemorrhage	507.8
	Family Planning	365.7
CHILD	Treatment of Malaria	472.4
	Treatment of Pneumonia	875.5
	Treatment of diarrhea	443.1
	Routine immunization	71.2
	Measles	100.0
	Neonatal Jaundice	-

To provide a standard package of MCH services, it would cost 21,145.5 Naira (Imo), 9,153.6 Naira (Kaduna) and 8,729.6 Naira (Niger) for a woman, and 8,544.8 Naira (Imo), 2,534.0 Naira (Kaduna) and 4,709.0 Naira (Niger) for child in 2015. See Table 7 below.

Table 7: Cost of maternal (per pregnant woman) and child care (Naira)

State	Weighted service cost	Contact times	Capital	Personnel	Overhead	Service+ Overhead	Service+ Overhead + Personnel	All totals
Maternal								
IMO	4,826.6	6	798.3	15,039.8	480.8	5,307.4	20,347.2	21,145.5
KADUNA	4,773.6	6	263.2	4,058.8	58.0	4,831.6	8,890.4	9,153.6
NIGER	4,759.0	6	487.7	3,363.8	119.2	4,878.1	8,241.9	8,729.6
Child								
IMO	385.3	3	399.2	7,519.9	240.4	625.7	8,145.6	8,544.8
KADUNA	344.0	3	131.6	2,029.4	29.0	373.0	2,402.4	2,534.0
NIGER	843.5	3	243.8	3,562.1	59.6	903.1	4,465.1	4,709.0

Revenue

Table 8 shows that each state would receive 521,013,514 Naira and 468,912,162 Naira as shares of the BHCPF from the NHIS and NPHCDA components respectively. Counterpart funding for each state was also 24,481,419 Naira. Based on the different revenue sources earlier identified, the total revenue for each state is: 7,013,884,907 Naira (Imo), 9,968,254,995 Naira (Kaduna) and 5,202,936,421 Naira (Niger).

Table 8: Revenue Summary for the States

	IMO	KADUNA	NIGER
Revenue	Naira	Naira	Naira
Share of 1%CRF (50% to NHIS)	521,013,514	521,013,514	521,013,514
Share of 1%CRF (45% to NPHCDA)	468,912,162	468,912,162	468,912,162
State's counterpart fund for 95% of 1%CRF	247,481,419	247,481,419	247,481,419
State PHC Budget	99,170,153	111,742,767	616,563,304
LGA PHC Budget	5,003,874,788	8,391,587,249	3,032,116,930
IGR	673,432,872	227,517,885	316,849,093
Donor funding	0	0	0
Expected Revenue (Upper limit)	7,013,884,907	9,968,254,995	5,202,936,421

FINANCIAL FEASIBILITY ANALYSIS

The results of the analyses are shown in the tables below. Note that only the results of Scenario 1 are presented in this policy brief. The other scenarios are presented in the full report.

SCENARIO 1: Only drugs and consumables are provided under MCH services

The entire available amount of the 1% CRF that is allocated to the NHIS (50%) is inadequate to cover the benefit package for all the pregnant women in the three states (Table 9). However, the money will be enough to cover the benefit package for all under-five children in Imo state, but not in Kaduna and Niger states. However, for a comprehensive MCH benefit package, the funds will not be adequate to cover all the beneficiaries in all the states, with significant funding gaps.

Table 9: Scenario:1a (Revenue: 50% of BHCPF)

State	Unit cost of benefit package (Naira)	Target beneficiaries	Amount required/year (Naira)	Amount available in 2015 (Naira)	Lives covered	Gap/Surplus (Naira)	Additional aggregate fund needed
Maternal							
IMO	4,827	261,229	1,260,836,278	521,013,514	107,947	-739,822,765	-142%
KADUNA	4,774	398,837	1,903,905,766	521,013,514	109,144	-1,382,892,252	-265%
NIGER	4,759	266,857	1,269,963,038	521,013,514	109,481	-748,949,524	-144%
Child							
IMO	385	1,044,915	402,574,841	521,013,514	1,352,332	118,438,672	23%
KADUNA	344	1,595,347	548,852,075	521,013,514	1,514,429	-27,838,562	-5%
NIGER	843	1,067,430	900,339,922	521,013,514	617,706	-379,326,408	-73%
ALL MCH							
IMO	1,274	1,306,143	1,663,411,119	521,013,514	409,110	-1,142,397,606	-219%
KADUNA	1,230	1,994,184	2,452,757,841	521,013,514	423,603	-1,931,744,328	-371%
NIGER	1,627	1,334,287	2,170,302,960	521,013,514	320,315	-1,649,289,446	-317%

The findings show that if the 20% of BHCPF that is allocated to the NPHCDA for drugs and consumables is added to the 50% of the NHIS, the coverage improves and the funding gap decreases. However, the entire available funds will still not be adequate to cover the benefit package for all the pregnant women in the three states. However, the money will be enough to cover the benefit package for all under-five children in Imo and Kaduna states, but not Niger state. However, for a comprehensive MCH benefit package, the funds will still not be adequate to cover all the beneficiaries in all the states, with significant funding gaps.

If the 45% of BHCPF that is allocated to the NPHCDA is added to the 50% of the NHIS (95% BHCPF), the coverage improves and the funding gap significantly decreases. However, the entire available funds will still not be adequate to cover the benefit package for all the pregnant women in the three states. The highest gap was also found in Kaduna State. However, the money will be enough to cover the benefit package for all under-five children in the three states. However, for a comprehensive MCH benefit package, the funds will still not be adequate to cover all the beneficiaries in all the states, with significant funding gaps.

Table 10 shows that if there is counterpart funding of 25% that is added to the 50% of the NHIS, the coverage improves, but the funding gap remains. However, the entire available funds will still not be adequate to cover the benefit package for all the pregnant women in the three states, but the money will be enough to cover the benefit package for all under-five children in Imo and Kaduna states. However, for a comprehensive MCH benefit package, the funds will still not be adequate in all the states, with significant funding gaps.

Table 10: Scenario: 1d (Revenue: 50% of BHCPF plus counterpart fund (0.25 of 50%))

State	Unit cost of benefit package (Naira)	Target beneficiaries	Amount required/year (Naira)	Amount Available in 2015 (Naira)	Lives covered	Gap/Surplus (Naira)	Additional aggregate fund needed
Maternal							
IMO	4,827	261,229	1,260,836,278	651,266,892	134,934	-609,569,386	-94%
KADUNA	4,774	398,837	1,903,905,766	651,266,892	136,430	-1,252,638,874	-192%
NIGER	4,759	266,857	1,269,963,038	651,266,892	136,851	-618,696,146	-95%
Child							
IMO	385	1,044,915	402,574,841	651,266,892	1,690,415	248,692,051	38%
KADUNA	344	1,595,347	548,852,075	651,266,892	1,893,036	102,414,817	16%
NIGER	843	1,067,430	900,339,922	651,266,892	772,132	-249,073,030	-38%
ALL MCH							
IMO	1,274	1,306,143	1,663,411,119	651,266,892	511,388	-1,012,144,227	-155%
KADUNA	1,230	1,994,184	2,452,757,841	651,266,892	529,504	-1,801,490,949	-277%
NIGER	1,627	1,334,287	2,170,302,960	651,266,892	400,394	-1,519,036,068	-233%

The results show that if a counterpart funding of 25% that is added to the 70% of BHCPF (50% NHIS and 20% NPHCDA), the coverage improves, but the funding gap remains. However, the entire available funds will still not be adequate to cover the benefit package for all the pregnant women in the three states. However, the money will be enough to cover the benefit package for all under-five children in the three states. However, for a comprehensive MCH benefit package, the funds will still not be adequate in all the states, with significant funding gaps.

Table 11 shows that if a counterpart funding of 25% that is added to the 50% of the NHIS and 45% of NPHCDA, there will still be funding gaps. The entire available funds will still not be adequate to cover the benefit package for all the pregnant women in the three states. However, the money will be enough to cover the benefit package for all under-five children in the three states, without any funding of maternal health services. However, for a comprehensive MCH benefit package, the funds will still not be adequate in all the states, with significant funding gaps.

Table 11: Scenario: 1f (Revenue: 95% of BHCPF plus counterpart fund (0.25 of 95%))

State	Unit cost of benefit package (Naira)	Target beneficiaries	Amount required/year (Naira)	Amount Available in 2015 (Naira)	Lives covered	Gap/Surplus (Naira)	Additional aggregate fund needed
Maternal							
IMO	4,827	261,229	1,260,836,278	1,237,407,095	256,374	-23,429,184	-2%
KADUNA	4,774	398,837	1,903,905,766	1,237,407,095	259,216	-666,498,671	-54%
NIGER	4,759	266,857	1,269,963,038	1,237,407,095	260,016	-32,555,943	-3%
Child							
IMO	385	1,044,915	402,574,841	1,237,407,095	3,211,788	834,832,254	67%
KADUNA	344	1,595,347	548,852,075	1,237,407,095	3,596,768	688,555,020	56%
NIGER	843	1,067,430	900,339,922	1,237,407,095	1,467,052	337,067,173	27%
ALL MCH							
IMO	1,274	1,306,143	1,663,411,119	1,237,407,095	971,637	-426,004,025	-34%
KADUNA	1,230	1,994,184	2,452,757,841	1,237,407,095	1,006,058	-1,215,350,746	-98%
NIGER	1,627	1,334,287	2,170,302,960	1,237,407,095	760,749	-932,895,865	-75%

OTHER POLICY RECOMMENDATIONS

1. The basic minimum benefit package for both mothers and children provides an initial minimum package to which further services could be added as funding increases.
2. The BHCPF could be channelled to providing only drugs and consumables, with states expected to continue their funding of other cost elements such as personnel and overhead costs. However, adequate steps should be taken to ensure that personnel and overheads are sufficiently provided by states.
3. The available funds could for instance be used to target high priority population groups such as pregnant women and children: (a) residing in rural areas; (b) not covered by any health insurance scheme; (c) deemed to be very poor by their community leaders; etc.
4. The federal and state government should source for additional funds to cover all the targeted beneficiaries.
5. The states should also budget and pay counterpart funding for the BHCPF to cover an appreciable numbers of the target beneficiaries
6. In recognition that BHCPF is insufficient to fund services for the target group, additional funding should be explored from different sources such as normal budget allocations, development partners, health insurance schemes at the national, state and community levels as well as internally generated revenue at state and LGA levels.
7. The accountability mechanisms and reporting systems for any future program must be well laid out and appropriate sanctions for defaults clearly specified.
8. The State Ministries of Health should be encouraged to utilize a similar feasibility/funding gap analysis tool for budget negotiations. This would show in clear and quantitative terms the potential impact of revenue and expenditure decisions on health sector objectives and engender policy level support for improved budgetary allocation to the sector.

Note: A toolkit has been developed that can be used to assess the financial feasibility of the BHCPF to fund MCH services in different states and different contexts.

Additional reading and references:

- Adedoyin Soyibo, Olanrewaju Olaniyan, & Akanni Lawanson. (2009). *National Health Accounts Of Nigeria, 2003 – 2005 Incorporating Sub-National Health Accounts of States*.
- National Population Commission (NPC) [Nigeria] and ICF Macro. (2013). *Nigeria Demographic and Health Survey*. Abuja, Nigeria: ICF International, Rockville, Maryland, USA.

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