NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

BHCPF Implementation status update

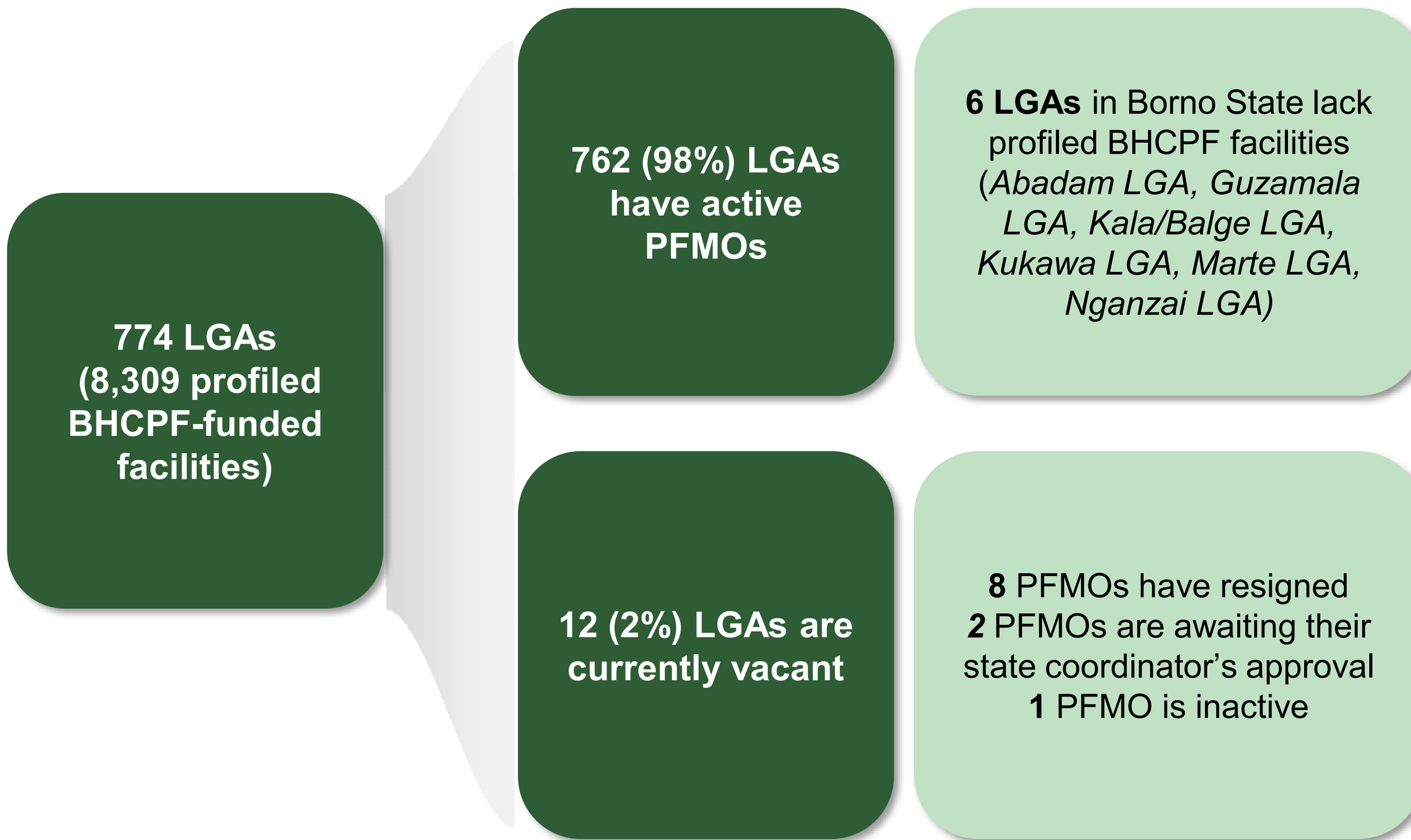
SEPT 2025

BHCPF progress update

Completed | Ongoing | Not started | Details to follow

Milestones	Status	Updates
Hire, onboard and deploy Performance and Financial Management Officers (PFMOs) to LGAs.	Completed	• Recruited, onboarded and deployed PFMOs across all 36+1 states on 26th May 2025. • **762 PFMOs** have been deployed, representing **98%** of LGAs nationwide. • PFMOs visited **7,898 PHCs, representing 95% of all BHCP-funded health facilities** nationwide. This is a 35% increase compared to the number of facilities visited in the month of July.
BHCPF 2.0 Guidelines and Funds Disbursement	Ongoing	• BHCPF Guidelines approved by the HCM. Dissemination expected with Q3 fund disbursement in September 2025. • Q1 and Q2 funds have been disbursed to qualifying states. • Q3 disbursement will be based on BHCPF 2.0; **2 DFF tiers (High/Low)**, based on outputs and facility performance.
BHCPF PHC Financial Management Platform Development	Ongoing	• Following successful pilot testing of the PHC-FMS and post-pilot upgrades; NPHCDA has engaged with the states through the ESs to commence roll-out. • We plan to commence roll-out in September, beginning with a few states, scaling up to the rest of the states from Q4 2025
Expand DFF to cover 17,600 PHCs	Ongoing	• Completed the Phase 2 assessment and functionality categorization of additional **18,045 non-BHCPF facilities** that will provide database evidence for DFF expansion • Analyzed the projected spread of the additional facilities to be onboarded across states and zones, using equality and equity criteria. Actual number for expansion will be based on amount of funding available.

PFMOs have been deployed to 98% of LGAs nationwide



Full list of the 12 Vacant LGAs

Awaiting SC approval | X *Resigned/ Inactive*

State	LGA	Status
Adamawa	Fufore	X
Bauchi	Katagum	...
Imo	Isu	X
Kwara	Irepodun	X
Nasarawa	Toto	X
Niger	Mariga	X
Ogun	Imeko Afon	X
Ondo	Odigbo	X
Oyo	Ogbomosho South	X
Taraba	Karim Lamido	X
Yobe	Bursari	...

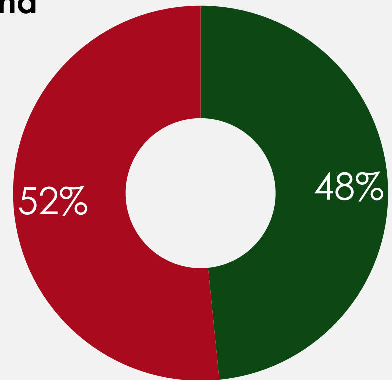
- **Work is currently ongoing to fill the gaps in the vacant LGAs**
- **39 LGAs where PFMOs would need support due to the high number of PHCs have been identified, and potential candidates have been identified**

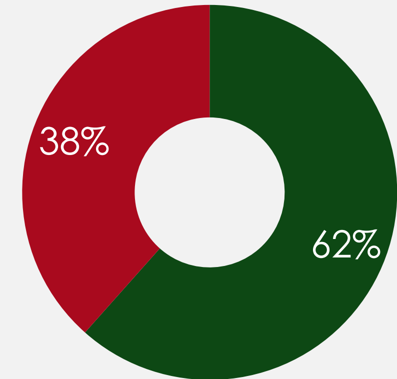
Analysis of PHC Budgets Plans and Disbursements

So far in the month of August, PFMOs have collected data from 7,898 facilities, with 5,062 reported to have a business plan and 3,174 of them approved.

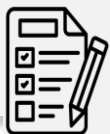
7,898
(95%)
Facilities Visited by PFMO

₦633.9K
Average Business Plan Budget per Facility

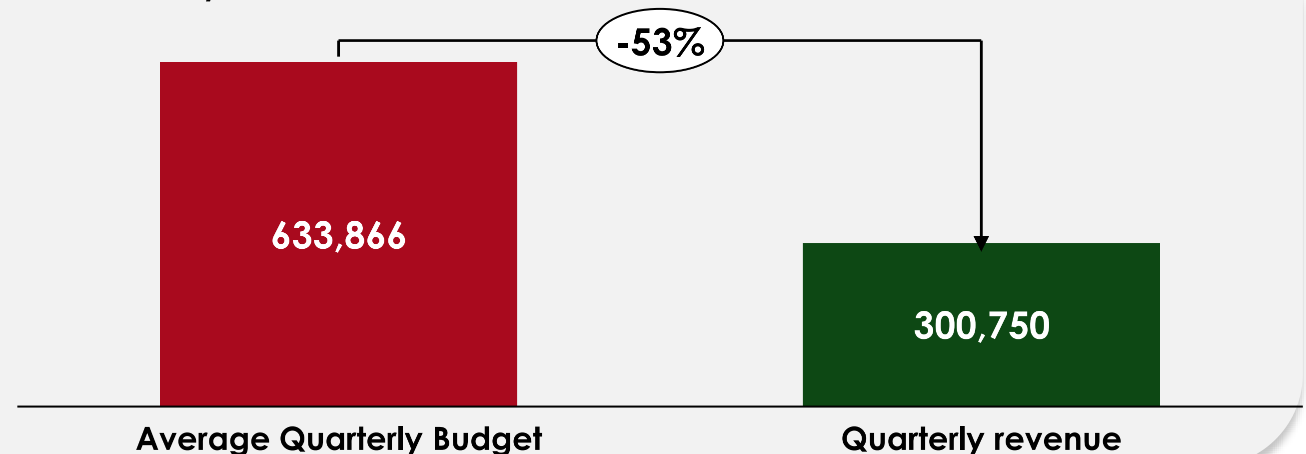




5,062
(64%)
Visited Facilities have a Business Plan



3,174
(63%)
Submitted Business Plans have been Approved



We tracked 18 services across the facilities. 1,124 (14%) PHCs offer all services, with the most common being immunization and vaccination (IV) and maternal and child health (MCH), offered by 98% of the facilities.

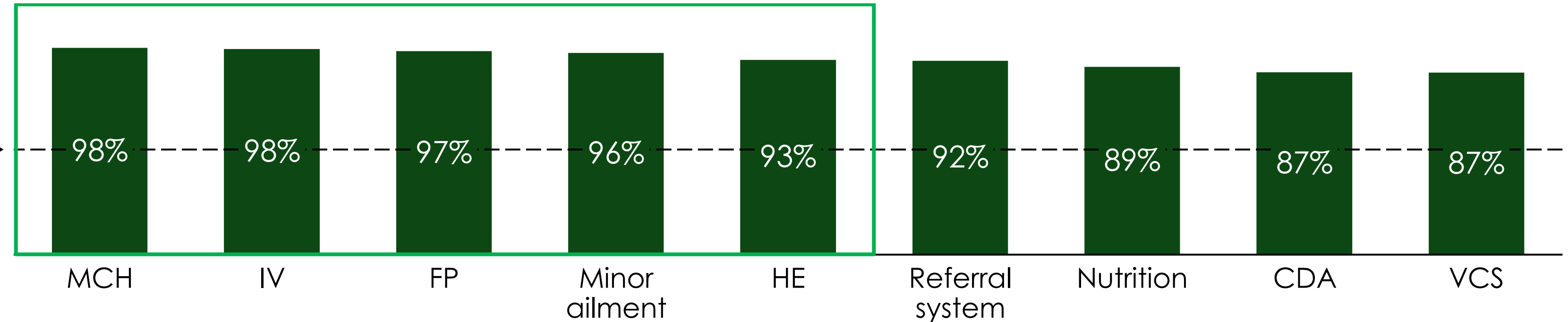
Number of facilities rendering all tracked services:

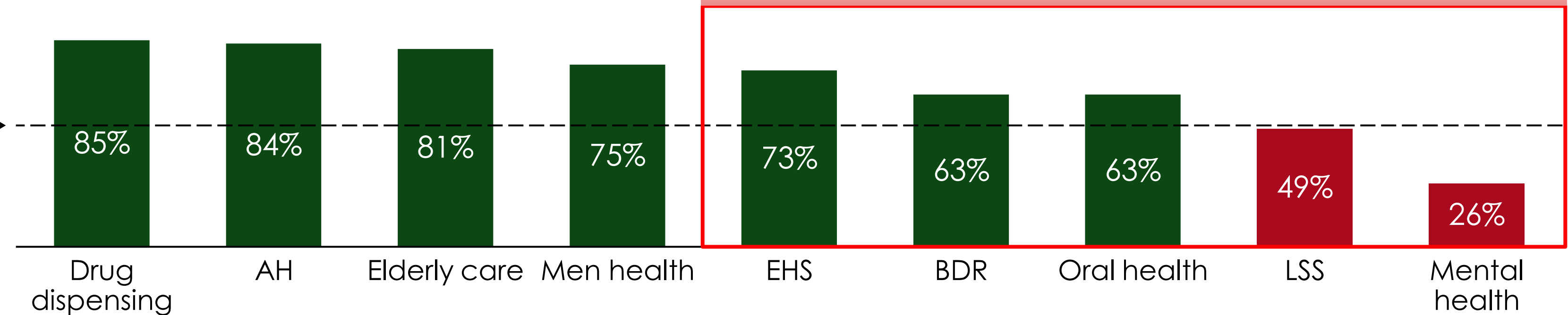
1,124
(14%)

Total number of tracked services:

18

Breakdown of health services offered across the facilities





KEYS: MCH: Maternal and child health; IV: Immunization and Vaccination; FP: Family Planning; HE: Health Education, CDA: Community development activities; VCS: Voluntary counselling and screening; AH: Adolescent health; EHS: Environmental health services; BDR: Birth and death registration; BDR: Birth and Death Registration; LSS: Life saving services

Using data evidence, additional DFF PHC facilities will be onboarded based on the outlined criteria, addressing equity and equality

Approach for Distribution of Additional BHCPF PHCs

Approach	Description	Distribution Result
1 No BHCPF Facility Wards where there are no BHCPF facilities	• Cover all wards without existing validated BHCPF facilities but with *PHCs delivering services (at least Functional Level 1)*	• •**620 wards** spread across 21 States
2 LGAs with High Need LGAs with gaps in BHCPF coverage	• Additional PHCs have been allocated to LGAs based on prioritisation score	• Poor health outcomes • BHCPF facility density ((LGA Land Mass ÷ Number of BHCPF PHCs). LGAs below the average of **131 km² per PHC** • Population density ((LGA population count ÷ Number of BHCPF PHCs), LGAs above average density of **25,765 people per PHC**

- Each LGAs score was weighted between 1 – 4 **(4 = high need)** and **(1= low need)** per score, and multiplied by a defined multiplier - 2.4

- **We have further identified the need to expand the equity considerations to factor in hard to reach (HTR) LGAs and are currently revising the criteria to accommodate this.**
- **We will reach out to the Executive Secretaries for inputs to finalize the criteria and subsequently identify facilities for expansion.**

All states except one have submitted Q3 and Q4 2024 retirements

S/N	STATE	Q3 2024 Retirement	Q4 2024 Retirement	Remark
1	Abia	Cleared	Cleared	Funds disbursed on 14th August 2025
2	Adamawa	Cleared	Cleared	Funds disbursed on 14th August 2025
3	Akwa Ibom	Cleared	Cleared	Funds disbursed on 14th August 2025
4	Anambra	Cleared	Cleared	Funds disbursed on 14th August 2025
5	Bauchi	Cleared	Cleared	Funds disbursed on 14th August 2025
6	Bayelsa	Cleared	Cleared	Funds disbursed on 14th August 2025
7	Benue	Cleared	Cleared	Funds disbursed on 14th August 2025
8	Borno	Cleared	Cleared	Funds disbursed on 14th August 2025
9	Cross Rivers	Cleared	Cleared	Funds disbursed on 14th August 2025
10	Delta	Cleared	Under review	**Q1 funds disbursed on 14th August 2025, Q2 pending**
11	Ebonyi	Not submitted	Cleared	**Not Cleared for Q1 disbursement,** but Q2 funds disbursement done
12	Edo	Cleared	Under review	**Q1 funds disbursed on 14th August 2025, Q2 pending**
13	Ekiti	Cleared	Cleared	Funds disbursed on 14th August 2025
14	Enugu	Cleared	Cleared	Funds disbursed on 14th August 2025
15	FCT	Cleared	Cleared	Funds disbursed on 14th August 2025
16	Gombe	Cleared	Cleared	Funds disbursed on 14th August 2025
17	Imo	Under review	Under review	**Processing and awaiitng clearance for disbursement**
18	Jigawa	Cleared	Cleared	Funds disbursed on 14th August 2025
19	Kaduna	Cleared	Cleared	Funds disbursed on 14th August 2025
20	Kano	Cleared	Cleared	Funds disbursed on 14th August 2025

S/N	STATE	Q3 2024 Retirement	Q4 2024 Retirement	Remark
21	Katsina	Cleared	Cleared	Funds disbursed on 14th August 2025
22	Kebbi	Cleared	Cleared	Funds disbursed on 14th August 2025
23	Kogi	Cleared	Cleared	Funds disbursed on 14th August 2025
24	Kwara	Cleared	Cleared	Funds disbursed on 14th August 2025
25	Lagos	Cleared	Cleared	Funds disbursed on 14th August 2025
26	Nasarawa	Cleared	Cleared	Funds disbursed on 14th August 2025
27	Niger	Cleared	Cleared	Funds disbursed on 14th August 2025
28	Ogun	Cleared	Under review	**Q1 funds disbursed on 14th August 2025, Q2 pending**
29	Ondo	Cleared	Cleared	Funds disbursed on 14th August 2025
30	Osun	Cleared	Cleared	Funds disbursed on 14th August 2025
31	Oyo	Cleared	Cleared	Funds disbursed on 14th August 2025
32	Plateau	Cleared	Cleared	Funds disbursed on 14th August 2025
33	Rivers	Cleared	Under review	**Q1 funds disbursed on 14th August 2025, Q2 pending**
34	Sokoto	Cleared	Cleared	Funds disbursed on 14th August 2025
35	Taraba	Cleared	Cleared	Funds disbursed on 14th August 2025
36	Yobe	Cleared	Cleared	Funds disbursed on 14th August 2025
37	Zamfara	Under review	Under review	**Processing and awaitng clearance for disbursement**

NPHCDA

Funds disbursement

25 states (68%) are yet to submit Q1 2025 Retirement to process disbursement for Q3 2025

S/N	STATE	Q1 2025 Retirement	Cleared for Disbursement	Remark
1	Abia	Not submitted	No	
2	Adamawa	Under review	No	Retirement undergoing audit review
3	Akwa Ibom	Not submitted	No	
4	Anambra	Not submitted	No	
5	Bauchi	Under review	No	Retirement undergoing audit review
6	Bayelsa	Under review	No	Retirement undergoing audit review
7	Benue	Not submitted	No	
8	Borno	Under review	No	Retirement undergoing audit review
9	Cross Rivers	Not submitted	No	
10	Delta	Not submitted	No	
11	Ebonyi	Not submitted	No	
12	Edo	Not submitted	No	
13	Ekiti	Under review	No	Retirement undergoing audit review
14	Enugu	Not submitted	No	
15	FCT	Under review	No	Retirement undergoing audit review
16	Gombe	Not submitted	No	
17	Imo	Not submitted	No	
18	Jigawa	Under review	No	Retirement undergoing audit review

S/N	STATE	Q1 2025 Retirement	Cleared for Disbursement	Remark
19	Kaduna	Not submitted	No	
20	Kano	Not submitted	No	
21	Katsina	Not submitted	No	
22	Kebbi	Not submitted	No	
23	Kogi	Under review	No	Retirement undergoing audit review
24	Kwara	Under review	No	Retirement undergoing audit review
25	Lagos	Not submitted	No	
26	Nasarawa	Not submitted	No	
27	Niger	Not submitted	No	
28	Ogun	Not submitted	No	
29	Ondo	Under review	No	Retirement undergoing audit review
30	Osun	Not submitted	No	
31	Oyo	Under review	No	Retirement undergoing audit review
32	Plateau	Not submitted	No	
33	Rivers	Not submitted	No	
34	Sokoto	Under review	No	Retirement undergoing audit review
35	Taraba	Not submitted	No	
36	Yobe	Not submitted	No	
37	Zamfara	Not submitted	No	

PHC Revitalization: Progress as at 20th August 2025 *(based on reported data from the PHC Dashboard)*

National funding sources | Partner/ Private sector | State Government / Partner joint funding sources

	Number of facilities proposed for revitalization*	1. BOQ cleared by NPHCDA / Partner	3. PHC Revitalization work ongoing	4. PHC revitalization work completed
Total		**3,724**	**3,127**	**1,295**
National Funding[1]	331	331	207	124
Solar Power Intervention	72	72	34	38
Solar Borehole Intervention	71	71	11	-
IMPACT / BHCPF for States[2]	3,373	3,210	1,899	469
State Funds[4]	1,266		907	631
Private Sector[3]	387[5]		17	38
Global Fund	200	40	19	-
Other Partners[6]			30	33
UNICEF – Solar Power	418[7]		-	-

1. Includes: Constituency Projects, Other NPHCDA appropriations budget, intervention Funds, Funding from Large Anonymous donors, The Susan Thompson Buffet Fund // 2. Projected numbers for revitalization based on available funding and ballpark estimates // 3. Private sector direct investment into PHC facility upgrade mainly through PSHAN // 4. State government funds based on self reports // 5. Minimum of 387 projected for 2027 based on PSHAN's target of 774 (1 per LGA) by 2032. 6. Sokoto State WB FADAMA (19), PLAN International (8), GAVI/UNICEF – Bayelsa (10), UNICEF PHC Challenge – Jigawa (7) 7. UNICEF Solarization (371 from GAVI CDS and 47 CRIBS)

* - Proposed number based on available funding at the start of the process

Immediate next Steps on the roll out of BHCPF 2.0

S/N	Action
1	Revise DFF criteria in collaboration with states
2	Update the BHCPF training manual in collaboration with other Gateways ,states and Partners.
3	Train participants in early adopter states on the BHCPF Financial Management System

We have 3 asks

01 Support in identifying suitable PFMO candidates for the vacant LGAs

02 Facilitate access to business plans by the PFMOs

03 Fast-track submission of Q1 2025 retirements

Thank you

NPHCDA
National Primary Health Care Development Agency

Penalties for Late OR Non-submission of Quarterly Retirement Documentation:

In the event a state submits **late** or **incomplete** retirement documentation beyond the stipulated quarterly deadline, the following shall apply:

- Late submission by state of retirement reports (inclusive as required programme reports and conduct of remediation activities if applicable), but within the '**grace period**' the state **shall forfeit 10% of its total funds for the quarter to the central Gateway pool**.
- Should the state further miss the final **deadline** stipulated, there would be no authorization for disbursement to the state for that quarter and the funds shall be forfeited to the central pool of the NPHCDA Gateway TSA Account.

NPHCDA
National Primary Health Care Development Agency

TOR: Performance and Financial Management Officer (PFMO)

Scope of work	Conduct multiple physical verification visits to all BHCPF primary healthcare (PHC) facilities (≈ **twice monthly**) within their assigned LGAs each month, covering 10 PHCs, to ensure efficient operations

Terms of reference (ToR)

Fiduciary management

- Track and verify the receipt and utilization of funds disbursed to PHC facilities, including DFF, capitation, and other funding sources.
- Monitor PHC expenditure for ineligible spending and ensure compliance with financial regulations, including withdrawal limits.
- Validate reported income and expenses against actual on-ground activities and physical evidence, such as stock records and service delivery.

Accountability and Verification

- Support effective documentation of facility client utilization records and maintain routine updates of the PHC database
- Implement and follow up on corrective actions from financial and performance audits, as directed by NPHCDA.
- Provide independent, evidence-based reports on facility compliance, risk areas, implementation of targeted interventions, and overall transparency in fund usage.

Operational support

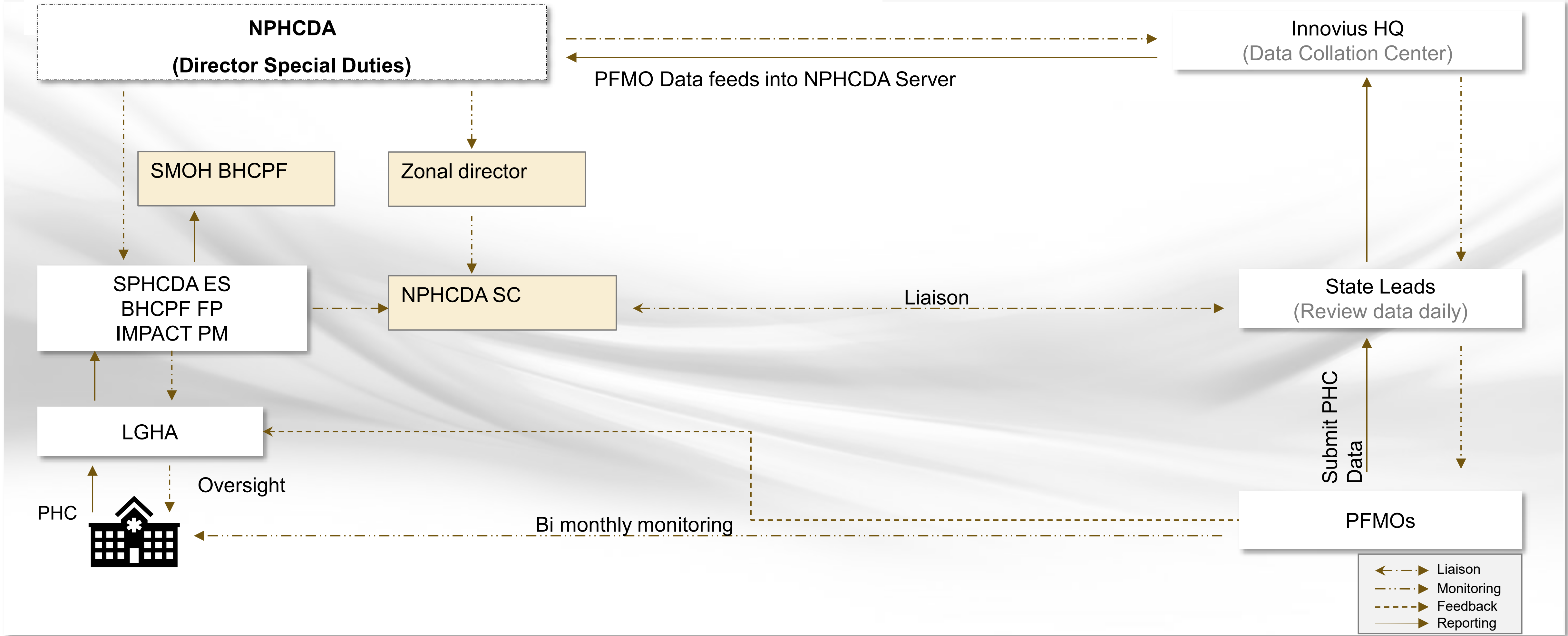
- Ensure PHCs submit accurate, complete, and timely quarterly **business plans and expenditure reports** through capacity building
- Collect and update data on PHC infrastructure, HRH, equipment, and service delivery to support planning and resource allocation.
- Support the PHC in improving work processes and performance through field observations, feedback, and technical advice.

Core deliverables

- PFMOs are required to submit:
  - Monthly Performance and Financial Reports for each assigned LGA with overall performance metrics
  - Documentation of Findings and Best Practices, including fiduciary risks, success stories, and recommendations

- **We request that the PFMOs be given all necessary support to carry out their assigned duties.**
- **As part of their duties, they will need to view and potentially upload photos of business plans of facilities**

A multi-level management framework enables oversight and coordination of PFMO activities across all implementation levels



- **At the national level,** the ED NPHCDA, IMPACT PM, Director of special duties, state and zonal coordinators participate in **quarterly high-level steering** meeting.
  - **A monthly operational** meeting is also held with the director of special duties, IMPACT PM, Innovius and state leads
- **At the state level,** monthly hybrid debriefs are held with Executive Secretaries, BHCPF focal persons, Innovius state leads, PFMOs, and key officials from SMOH & NPHCDA
- **At LGHA levels, bi-monthly verbal feedback** sessions take place between PFMOs, and LGA coordinators
- **At health facility level,** PFMO officers carry out **bi-weekly visits** to strengthen routine supervision.

NPHCDA: National Primary Health Care Development Agency; **BHCPF**: Basic Health Care Provision Fund; **SMOH BHCPF**: State Ministry of Health's Basic Health Care Provision Fund; **SPHCDA ES**: State Primary Health Care Development Agency Executive Secretary; Basic Health Care Provision Fund Focal Person; **LGHA**: Local Government Health Authority; **LGAC**: Local Government Area Coordinator; **PFMO**: Program Financial Management Officer.
SOURCE: Team analysis,

NPHCDA

OPERATIONAL RESEARCH ON COST OF RUNNING PRIMARY HEALTHCARE CENTERS IN NIGERIA (OpEX)

NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY
Partnership for Service

R4D

hprg
Health Policy Research Group
University of Nigeria

OUTLINE

Introduction

Research Questions, Aim & Objectives

Study setting, design and approach

Data Collection

Data Analysis and Findings

Conclusion and Recommendation

Introduction

- Primary Health Care (PHC) is a critical component of the healthcare system in Nigeria and the operational expense in PHC is a significant part of healthcare management.

- Insufficient public funding forces PHC facilities to charge high user fees, limiting access and contributing to Nigeria’s 70% out-of-pocket healthcare expenditure.

- Residents then seek primary care at secondary and tertiary health facilities (provided at a higher cost) - a situation that promotes inefficiencies in the health system

hprg Health Policy Research Group University of Nigeria

- Insufficiency of public financing of the PHC facilities has led to most facilities receiving no or grossly inadequate and inconsistent financial support from the government for their expenses.
- Inadequate availability of funds at public PHCs results in inadequate and poorly maintained equipment, stock-out of drugs and commodities, non-conduct of community outreach activities, skilled staff shortages, and low staff motivation.
- Need to identify the cost of running a PHC and recommend optimum DFF

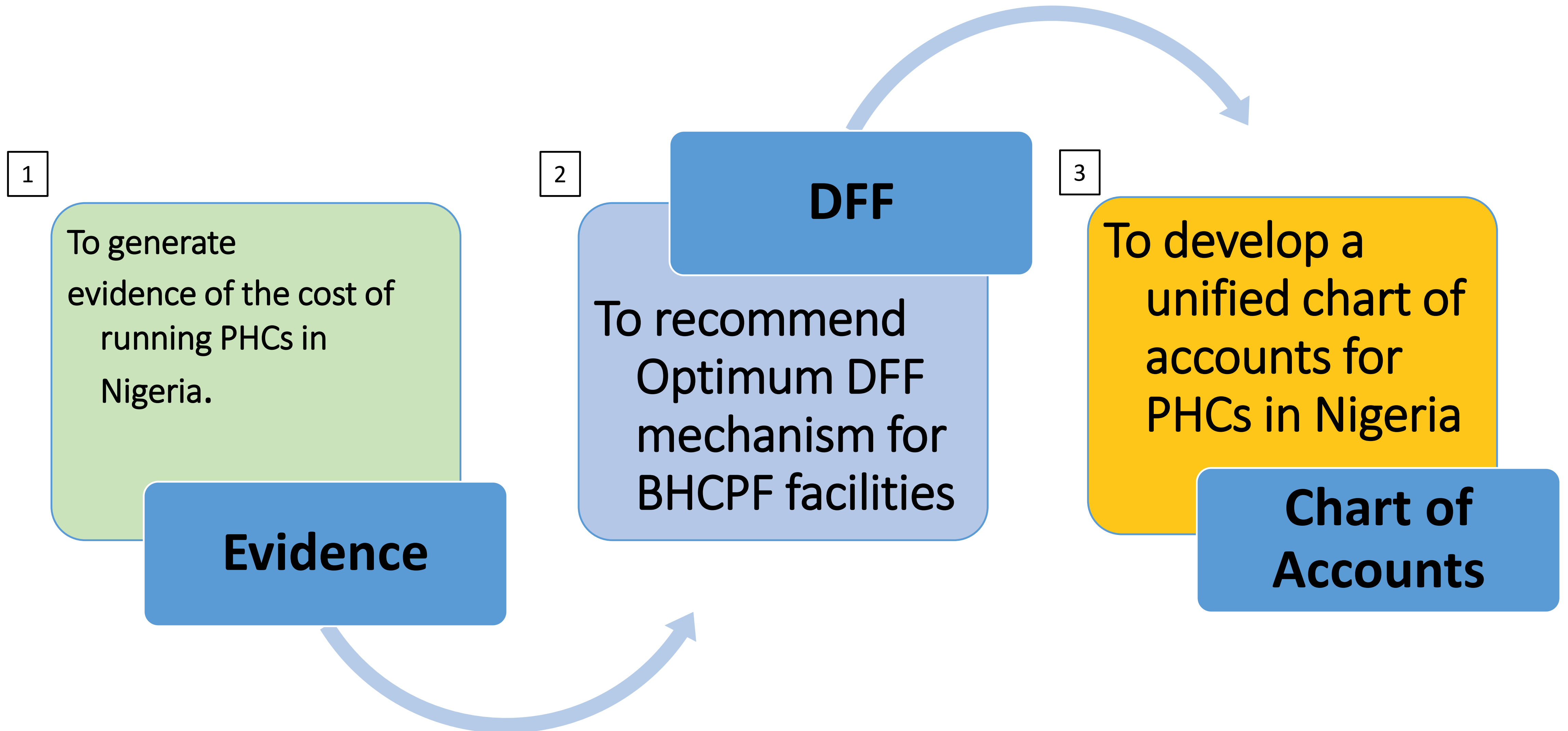
Research questions

- What are the unit operating costs of running PHC facilities that will inform the allocation of optimum DFF that BHCPF facilities would require given other funding streams?
- What Optimum DFF mechanism will be recommended for BHCPF facilities?
- How do we develop a unified chart of accounts for PHCs in Nigeria to capture all expenditure and revenue at the PHC level?

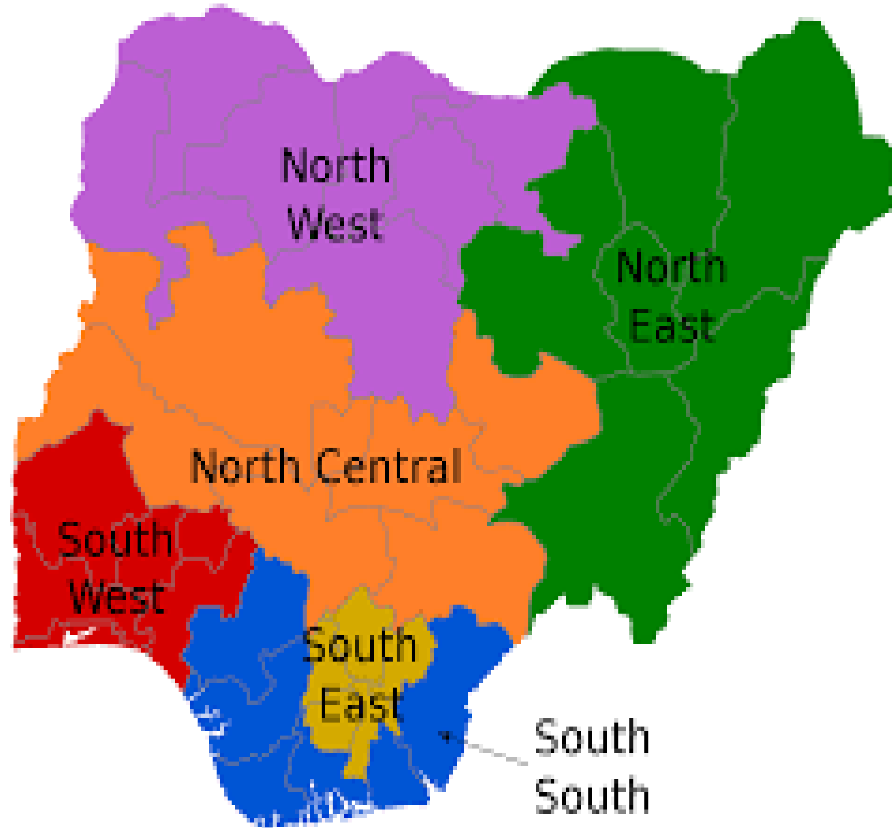
Aim

To examine the operational costs incurred in PHCs from both empirical and estimated perspectives. Thus, some evidence will be provided that can be used to guide the decision on the levels of operational expenditures that PHCs require to function and could be the basis of DFF of such health facilities.

Specific Objectives



Study Setting



- The study was conducted in the six geopolitical zones in Nigeria.

hprg
Health Policy
Research Group
University of Nigeria

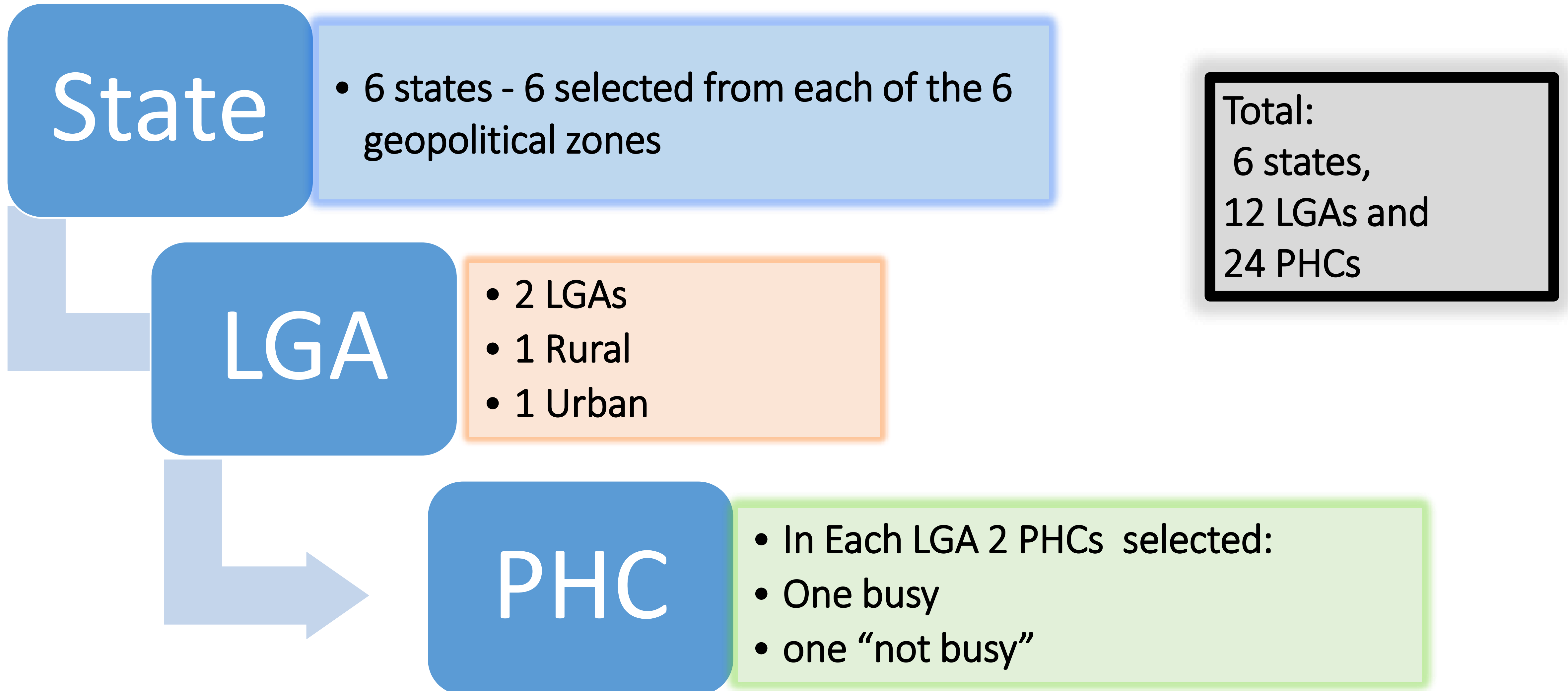
Criteria for selection of study states

- Study was conducted in 6 states
  - 6 were selected from each geo-political zone in the country - 1 state per zone
  - The most populated states in the North and South – Kano and Lagos
  - 2 NSHIP states –Adamawa and Nasarawa (both in the North)
  - 2 medium to low-populated southern states – Enugu and Rivers(to balance the geographical selection)

STUDY STATES

- ADAMAWA
- ENUGU
- KANO
- LAGOS
- NASARAWA
- RIVERS

Study area and sites



BUSY AND NON- BUSY CRITERIA

- **Determining "Busy and Not-Busy" Urban and Rural PHCs based on utilization rate**
- The criterion was the utilization rates of the different PHC centres in the different geographic contexts as shown on the DHIS 2 platform. An average service utilization rate was taken based on this monthly utilization rate and on the location of the LGA (Urban or Rural) except for Rivers State busy facility which is an outlier if included. The average came to 1971 persons per month for a Busy Urban PHC and 873 persons per month for a Busy Rural PHC. However, we realized that some of our selected PHCs in some states will not even be qualified as a Busy PHC. It then shows that this is a context-specific decision and differs from one geographical zone to another.

Study design and research approach

This Study used :

- A Cross-sectional retrospective health facility-based survey from the health provider perspective.

- Mixed-methods approach that combined both literature review (on the costs of running PHCs, on direct facility financing and on Chart of accounts) and quantitative data collection methods and analysis techniques.

Data Collection

Description

- A pair of enumerators per PHC (1 filling electronic and the other paper-based tool). 8 enumerators per State and supervised by a HPRG, NPHCDA and R4D staff.

- An interviewer administered structured costing Excel template was developed and revised after the pre-test done during the ToT workshop and adopted for the Study

The data collection tool was pre-tested in 4 selected health centers in the Federal Capital territory, a location that was not selected for the study

Cost components and drivers of the Excel-based template for data collection

Cost Component		Cost drivers
1	Personnel cost (Adhoc Staff and Stipend)	Payment for hire of BHCPF nurses, security personnel, cleaners, and ad-hoc staff, cost of in-house facility-based training and stipend for staff
2	Maintenance	Payment for maintaining any facility equipment, solar, borehole, air conditions, etc.
3	Drugs And Consumables	Total cost of drugs procured, test kits, catheters, intravenous infusions, sutures, creams, swabs, cotton wool, etc

Cost components and drivers of the Excel-based template for data collection (cont.)

4.	Utility	Electricity, airtime, DSTV/cable subscription, buying water, internet services, Fuel or diesel and lubricants for generator, kerosene for lamps, cooking gas.
5	Transportation	Transport for outreaches, meetings, data validation, LGA for HMIS purposes, to bank, for collection of drugs, nutrition supplements, nets, vaccines, for purchase of fuel and lubricants for generator/ambulance /keke/ motorcycles.
6	Waste Management	Payment of professional waste disposal, buying waste bins, all colours of waste disposal bags, movement of wastes, actual waste disposal.

Cost components and drivers of the Excel-based template for data collection (cont.)

7	Meetings	Hosting of management /facility meetings, Transport and refreshment (Per diem) for WDC meetings, Transport for community dialogue discussion, Transport for quality improvement meetings, refreshment for QoC meetings.
8	Stationary	Registers, writing materials eg pens, pencils, exercise books, envelops, letter headed papers, plain papers, toner, POS receipt, ink, photocopies, stamp pad, patient cards.
9	Bank and other financial Charges	Printing bank statements, cheque books, transfer charges, account maintenance charges, cyber security charges, POS charges, bank charges, SMS charges

Cost components and drivers of the Excel-based template for data collection (cont.)

10	Supplies	Procurement of detergents, disinfectant, bleach, sanitizers, soap (liquid and tablets), other cleaning agents, insecticides/fumigation, mob, broom, packers, mob bucket, bucket.
11	Security	Payment for vigilante, buying batteries, torch, matchet, uniform
12	Others	Public enlightenment programs, welfare packages eg food for demonstration during ANC.

ANALYSIS OF THE MONTHLY, BIANNUAL ANNUAL & INFLATION ADJUSTED ANNUAL OPERATIONAL EXPENDITURE(OpEX) OF RUNNING PHCs IN NIGERIA

TABLE 1 - UNIT COST PER PHC

STATE	NAME OF PRIMARY HEALTHCARE CENTRE (PHC)	MONTHLY UNIT COST (₦)	BIANNUAL UNIT COST (₦)	ANNUAL UNIT COST (₦)	Inflation Adjusted Annual Unit Cost (₦)
Adamawa	Jambutu UB	1,642,905.29	9,857,431.72	19,714,863.44	26,417,917.01
	Atiku Abubakar UNB	418,758.49	2,512,550.94	5,025,101.88	6,733,636.52
	Demsa RB	298,694.63	1,792,167.79	3,584,335.58	4,803,009.68
	Dwan RNB	297,257.02	1,783,542.09	3,567,084.18	4,779,892.80
Enugu	New Haven UB	773,808.46	4,642,850.74	9,285,701.48	12,442,839.98
	Coal Camp UNB	196,064.50	1,176,387.00	2,352,774.00	3,152,717.16
	Ozalla RB	595,636.33	3,573,818.00	7,147,636.00	9,577,832.24
	Ndi-Uno Uwani RNB	155,006.25	930,037.50	1,860,075.00	2,492,500.50

Kano	Gwagwarwa UB	4,845,304.27	29,071,825.61	58,143,651.22	77,912,492.63
	Tudun Murtala UNB	381,673.80	2,290,042.77	4,580,085.54	6,137,314.62
	Jogana RB	568,261.99	3,409,571.93	6,819,143.86	9,137,652.77
	Mesar Tudun RNB	171,594.13	1,029,564.77	2,059,129.54	2,759,233.58
Lagos	Ikeja UB	N526,369.82	3,158,218.94	6,316,437.88	8,464,026.76
	Opebi UNB	N220,722.18	1,324,333.10	2,648,666.20	3,549,212.71
	Ita-Elewa RB	N4,133,689.20	24,802,135.20	49,604,270.40	66,469,722.34
	Ipakodo RNB	1,301,908.71	7,811,452.25	15,622,904.50	20,934,692.03

Nasarawa	Doma Road UB	1,388,223.81	8,329,342.84	16,658,685.68	22,322,638.82
	Angwan Yakubu UNB	601,818.90	3,610,913.42	7,221,826.84	9,677,247.96
	Wamba Road RB	3,783,894.88	22,703,369.26	45,406,738.52	60,845,029.62
	Gwanje Akwanga RNB	709,602.41	4,257,614.44	8,515,228.88	11,410,406.70
Rivers	Rumuokwurusi UB	11,095,028.53	66,570,171.18	133,140,342.36	178,408,058.76
	Rumuolumeni UNB	2,558,883.88	15,353,303.26	30,706,606.52	41,146,852.74
	Akpajo RB	752,013.90	4,512,083.41	9,024,166.82	12,092,383.54
	Eteo-Eleme RNB	128,325.86	769,955.16	1,539,910.32	2,063,479.83

ANALYSIS OF THE COMPREHENSIVE EXPENDITURE (WITH PERSONNEL SALARIES) OF RUNNING PHCs IN NIGERIA (MONTHLY, BIANNUAL, ANNUAL & INFLATION ADJUSTED ANNUAL)

hprg

TABLE 12 - UNIT COST PER STATE (ANNUAL, BIANNUAL AND MONTHLY)

STATE	NAME OF PRIMARY HEALTHCARE CENTRE (PHC)	MONTHLY UNIT COST (₦)	BIANNUAL UNIT COST (₦)	ANNUAL UNIT COST (₦)	Inflation Adjusted Annual Unit Cost (₦)
Adamawa	Jambutu UB	2,349,257.83	14,095,546.96	28,191,093.92	37,776,065.85
	Atiku Abubakar UNB	930,028.65	5,580,171.90	11,160,343.80	14,954,860.69
	Demsa RB	1,200,023.00	7,200,138.01	14,400,276.02	19,296,369.87
	Dwan RNB	919,247.24	5,515,483.44	11,030,966.88	14,781,495.62
Enugu	New Haven UB	1,517,527.05	9,105,162.30	18,210,324.60	24,401,834.96
	Coal Camp UNB	1,134,668.07	6,808,008.43	13,616,016.86	18,245,462.59
	Ozalla RB	2,582,199.28	15,493,195.66	30,986,391.32	41,521,764.37
	Ndi-Uno Uwani RNB	724,110.34	4,344,662.04	8,689,324.08	11,643,694.27

Kano	Gwagwarwa UB	10,168,992.88	61,013,957.30	122,027,914.61	163,517,405.57
	Tudun Murtala UNB	1,491,166.01	8,946,996.03	17,893,992.06	23,977,949.36
	Jogana RB	1,957,597.45	11,745,584.67	23,491,169.35	31,478,166.92
	Mesar Tudun RNB	659,927.52	3,959,565.09	7,919,130.18	10,611,634.44
Lagos	Ikeja UB	2,635,163.71	15,810,982.26	31,621,964.52	42,373,432.46
	Opebi UNB	1,037,656.33	6,225,938.00	12,451,876.00	16,685,513.84
	Ita-Elewa RB	13,219,019.19	79,314,115.12	158,628,230.25	212,561,828.53
	Ipakodo RNB	7,193,606.49	43,161,638.93	86,323,277.86	115,673,192.33

Nasarawa	Doma Road UB	3,032,289.25	18,193,735.48	36,387,470.96	48,759,211.09
	Angwan Yakubu UNB	1,211,009.35	7,266,056.10	14,532,112.19	19,473,030.34
	Wamba Road RB	5,775,772.12	34,654,632.72	69,309,265.44	92,874,415.69
	Gwanje Akwanga RNB	1,167,756.32	7,006,537.92	14,013,075.84	18,777,521.63
Rivers	Rumuokwurusi UB	13,573,458.50	81,440,750.98	162,881,501.96	218,261,212.63
	Rumuolumeni UNB	4,833,469.26	29,000,815.53	58,001,631.06	77,722,185.62
	Akpajo RB	2,989,961.76	17,939,770.53	35,879,541.06	48,078,585.02
	Eteo-Eleme RNB	881,265.14	5,287,590.86	10,575,181.72	14,170,743.50

KEY OPEX COST DRIVERS IN PHCs ACROSS THE SIX GEOPOLITICAL ZONES OF NIGERIA

OPEX COST DRIVERS ACROSS THE SIX STATES

Sum of Transportation
Sum of Meetings
Sum of Waste Management
Sum of Bank and Other Finance Charges
Sum of Drugs and Consumables
Sum of Utility
Sum of Stipend for PHC Personnel
Sum of Maintenance
Sum of Adhoc Personnel Cost
Sum of Stationeries
Sum of Supplies
Sum of Security
Sum of Other Expenses

COST IN NAIRA

250000000
200000000
150000000
100000000
50000000
0

Adamawa
Enugu
Kano
Lagos
Nasarawa
Rivers
Total

STATES

KEY FINDINGS

The annual cost of operating a PHC centre in Nigeria averages ₦18.7 million annually and ₦1.6 million monthly with urban (₦2.1 million) and busy PHCs (₦2.5 million)

This varied across the geopolitical zones with some rural busy facilities (Lagos and Nasarawa states) incurring more cost than their urban counterparts.

KEY FINDINGS

- The cost drivers differed across the states, with drugs and consumables, meetings and stationary ranking high amongst the operational costs, while personnel cost contributed the most to the comprehensive cost of running a PHC in Nigeria

The major OPEX cost drivers are drugs and consumables (35%), ad-hoc personnel (30%), maintenance (15%) and utility (8%).

RECCOMENDATIONS

The amount to be sent as direct facility financing (DFF) should be based on various contexts, locations, and utilization, to cover the identified funding gaps.

RECOMENDATIONS

- Prioritize Rural and Busy PHCs: Rural busy PHCs have high patient inflow and significant funding gaps. A DFF allocation of at least ₦780,000 monthly would help cover their operational shortfalls.
- Allocate Lower DFF for Urban and Less Busy PHCs to adequately support these facilities to meet operational costs of effectively running the PHCs..

RECCOMENDATIONS

- Adjust DFF Based on Inflation: Annual inflation adjustments should be factored into DFF allocations to maintain adequate funding as operational costs rise
- Consider Supplementary Funding Options: States should explore partnerships and alternative funding sources, particularly for rural and low-revenue PHCs, to complement the DFF and reduce reliance on out-of-pocket expenses for patients.

THANK YOU

hprg

National Primary Healthcare Development Agency

Update on Last Mile Interventions: Visibility (OpenLMIS) & Delivery (DRIVE)

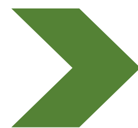
Department of Logistics & Health Commodities
Presentation for State Executive Secretaries

September 2025

Last Mile Visibility – OpenLMIS Update

Mid-year 2025 Priorities

- Integrating the OpenLMIS and DHIS2, followed by user acceptance testing to ensure seamless interoperability.
- Field testing of completed stock management module in selected Health facilities in the country
- Development of last mile visibility indicators dashboard on OpenLMIS with ingested health facility data from the DHIS2

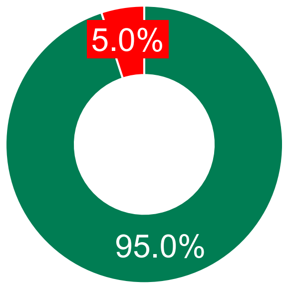


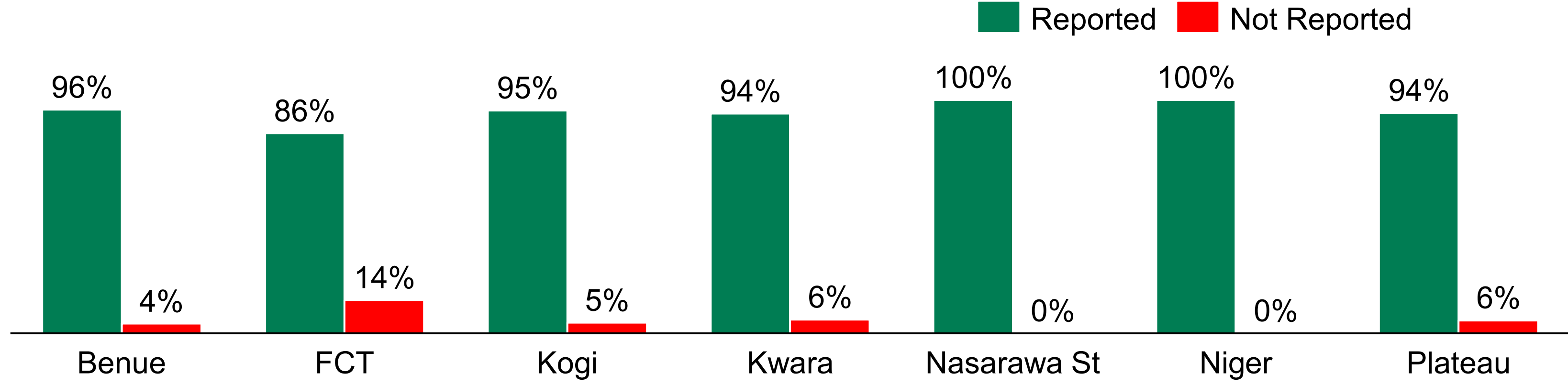
Status

- Completed a **field testing across 72 facilities** in 3 states (Kaduna, Ogun, and Nasarawa) gathering data from immunization sessions to inform stock and service delivery data at the end of each session for the reporting dashboards.
- Completed exchange of service level data from the DHIS2 to the OpenLMIS (Doses opened, HF stock status, wastage rate)
- Developed **new features** for vaccines stock management on the system:
    - Homepage summary dashboard.
    - Data validation improvements.
    - Stock on Hand page modification.

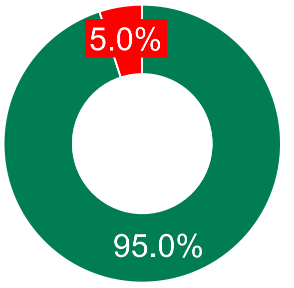
OpenLMIS Utilization Rate Across Northern States

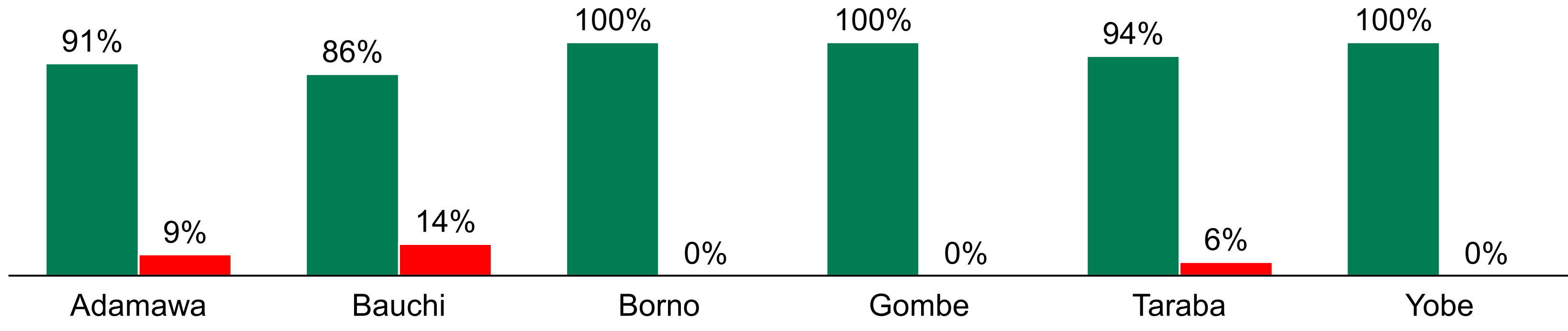
North Central Performance



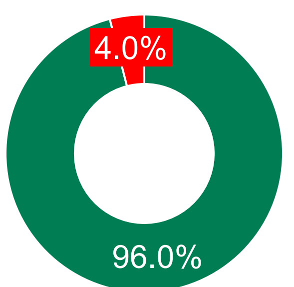


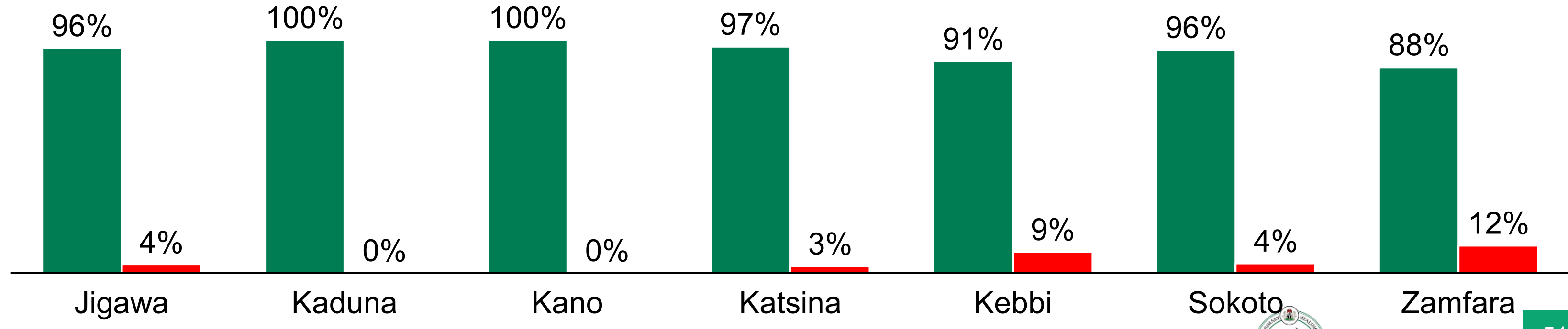
North East Performance





North West Performance

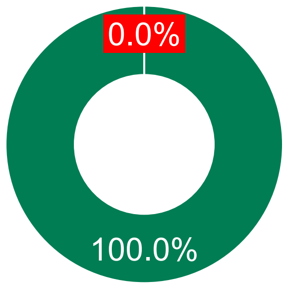


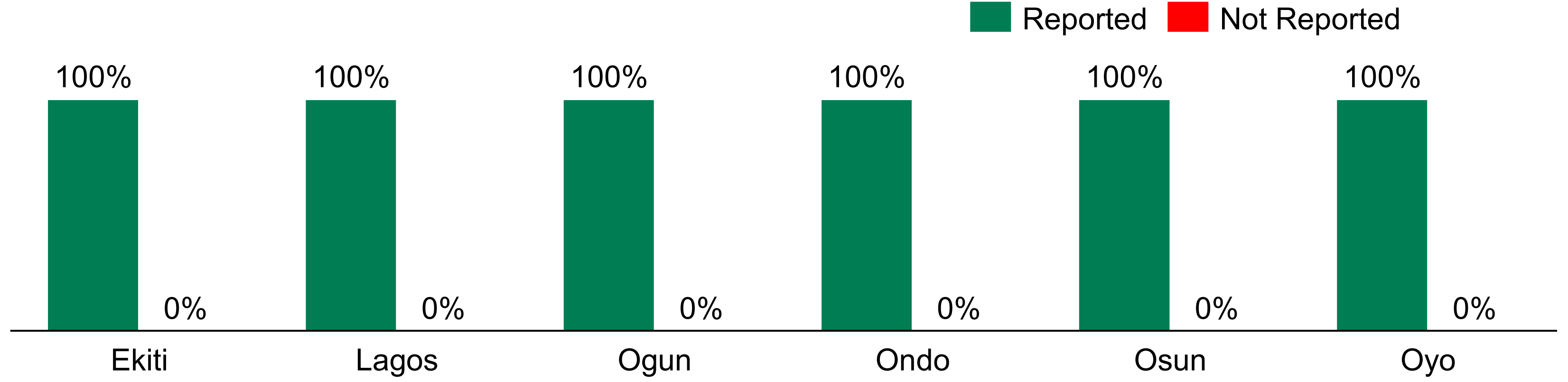


NPHCDA

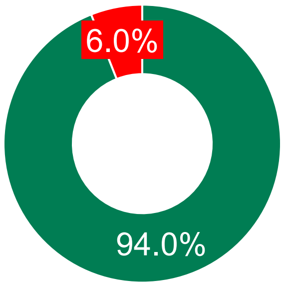
OpenLMIS Utilization Rate Across Southern States

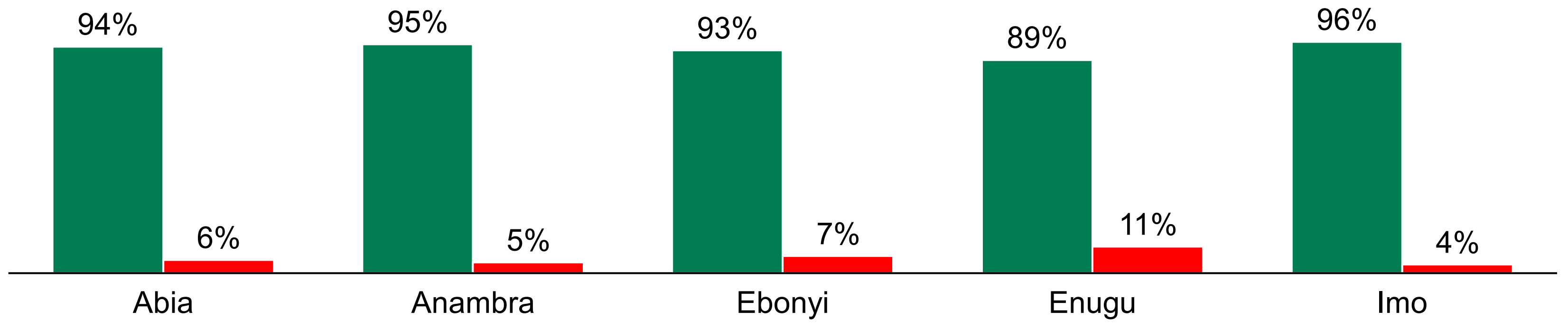
South West Performance



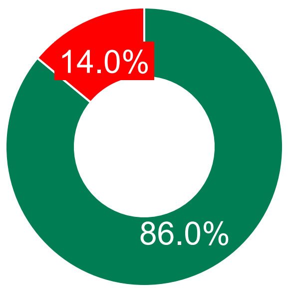


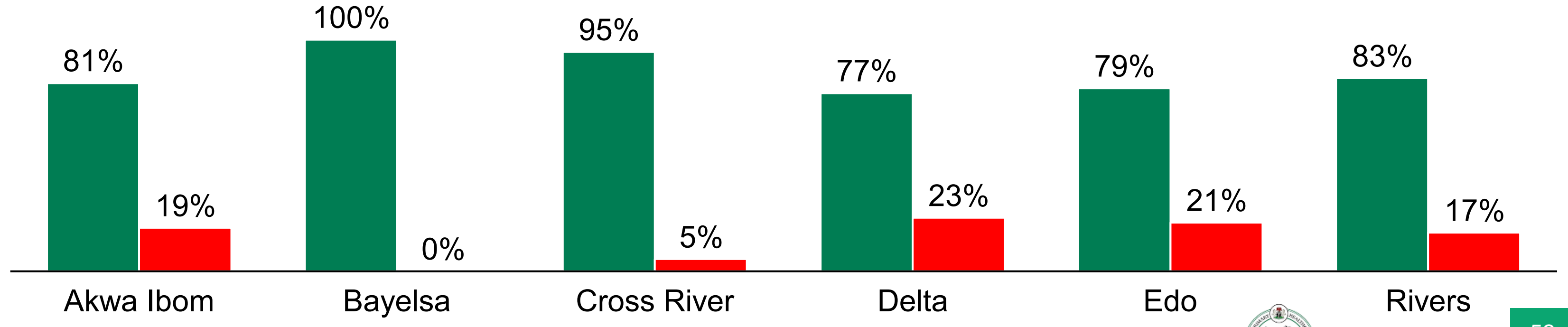
South East Performance





South South Performance





NPHCDA

Non-Reporting Cold stores Across the Northern States

North Central
Benue
Ado LGA Cold Store
FCT
Abaji LGA Cold Store
Kogi
Ofu LGA Cold Store
Kwara
Asa LGA Cold Store
Plateau
Bassa-P LGA Cold Store

North East
Adamawa
Madgali LGA Cold Store
Toungo LGA Cold Store
Bauchi
Bauchi LGA Cold Store
Bogoro LGA Cold Store
Dambam LGA Cold Store
Taraba
Gassol LGA Cold Store

North West
Jigawa
Garki LGA Cold Store
Katsina
Mai'Adua LGA Cold Store
Kebbi
Fakai LGA Cold Store
Zuru LGA Cold Store
Sokoto
Illela LGA Cold Store
Zamfara
Kaura Namoda Satellite Cold Store
Talata Mafara Satellite Cold Store

Non-Reporting Cold stores Across the Southern States

South South
Akwa Ibom
Eastern Obolo LGA Cold Store
Etim Ekpo LGA Cold Store
Mkpat Enin LGA Cold Store
Nsit Atai LGA Cold Store
Obot Akara LGA Cold Store
Oruk Anam LGA Cold Store
Cross River
Biase LGA Cold Store
Delta
Aniocha South LGA Cold Store
Bomadi LGA Cold Store
Ika North East LGA Cold Store
Okpe LGA Cold Store
Oshimili North LGA Cold Store
Udu LGA Cold Store
Edo
Etsako Central LGA Cold Store
Etsako East LGA Cold Store
Ovia North-East LGA Cold Store
Owan West LGA Cold Store
Rivers
ABUA-ODUAL LGA COLD STORE
Emohua LGA Cold Store
Omumma LGA Cold Store
Oyigbo LGA Cold Store
Omumma LGA Cold Store
Oyigbo LGA Cold Store

South East
Abia
Ukwa East LGA Cold Store
Anambra
Ihiala LGA Cold Store
Ebonyi
Ivo LGA Cold Store
Enugu
Nkanu West LGA Cold Store
Udi LGA Cold Store
Imo
Obowo LGA Cold Store

NPHCDA

Roadmap to Operationalize and Scale Up Last-Mile Vaccine Delivery

Ongoing

Next Steps

	1	2	3
Activities	Release of RFP for Vendor engagement	Contracting and Onboarding of Vendors	Commence DRIVE implementation in states
Responsibility	National PMT/UNICEF	SPHCB, NPHCDA and UNICEF	SPHCB/State PMT
Timeline Duration	2 Weeks	2 Weeks	Immediate. following Step 2

Implementation will commence in 12 states and scaled up nationwide

Demand Generation for PHC Revitalization

SEPTEMBER, 2025

Background

- Primary Health Care (PHC) is the foundation of Nigeria's health system. While significant progress has been made over the years on the supply site through the PHC Revitalization policy, service utilization still remains low in most PHCs due to poor awareness, weak community engagement, and socio-cultural barriers.

- Revitalizing PHC requires not only improving infrastructure and service quality, but also stimulating community demand and trust in the PHC services.

- Demand generation is critical to ensure communities utilize available PHC services.

- It ensures that households actively seek and use available health services, thereby reducing preventable deaths and improving population health outcomes

Demand Generation for PHC Revitalization Priorities 4 key objectives

1. Increase awareness of available PHC services (RMNCAH+N/MAMII Immunization, NVI, etc.)
2. Build trust in PHC facilities by highlighting improvements in quality, availability, and responsiveness
3. Promote behaviour change for health-seeking practices (ANC visits, immunization, family planning, skilled delivery, etc.).
4. Strengthen community ownership of PHC through participation and accountability

NPHCDA Priority Areas for Demand Generation and Key Barriers to uptake

Priority Areas

- Routine Immunization - Zero-dose & NVI
- RMNCAH+N/MAMII
- NPSIAs
- PEI
- BHCPF

Key Barriers

- Knowledge gaps (low awareness, myths & misconceptions)
- Accessibility (distance, cost, availability of services).
- Trust issues (quality of care, provider attitude).
- Sociocultural factors (gender norms, decision-making power)

Our Support to PHC Revitalization is Anchored on 5 NPHCDAs Priority Areas and Initiatives

The department support five of the NPHCDA's strategic priorities and initiatives

1. **Priority 1.4:** Improve brand and reputation of NPHCDA/SPHCDAs with stakeholders and citizens
2. **Priority 2.4:** Improve coverage of routine immunization and reduce zero-dose children
3. **Priority 2.6:** Re-establish trust in the PHC system
4. **Priority 3.1:** Streamline integrated NPSIAs to maximize quality and reduce outbreaks of VPDs.
5. **Priority 3.2:** Re-organizes polio campaigns to improve effectiveness and interrupt the transmission of cVPV2

Strengthening demand generation for Primary Health Care (PHC) revitalization means creating and sustaining awareness, trust, and active use of PHC services by individuals, families, and communities

What Demand Generation Means for PHC Revitalization

1. Stimulating community awareness, trust, and acceptance of PHC services
2. Addressing barriers to access and utilization of PHC services
3. Encouraging healthy behaviours and timely care-seeking
4. Building accountability between communities and the Health facilities

Key Strategies for Strengthening Demand Generation for PHC Revitalization

Strategy	Description
1 Community Engagement and Ownership	▪ Involve traditional, religious, and community leaders as health advocates ▪ Sstrengthen Ward Development Committees (WDCs) Village Development Committees (VDCs) and other CRGs ▪ Use participatory approaches (community dialogues, town halls) to build trust
2 Strategic SBCC	▪ Use mass media (radio, TV, jingles), digital platforms, and interpersonal communication to promote PHC services ▪ Understanding barriers and develop targeted messages to address myths, misconceptions, and cultural beliefs. ▪ Highlight success stories and testimonies from community
3 Improving User Experience	▪ Ensure respectful, client-centered care that restore trust ▪ Feedback & grievance systems ▪ Reduce waiting times, stockouts and hidden charges

Key Strategies for Strengthening Demand Generation for PHC Revitalization

Role	Description
4 Partnerships & Multi-Sectoral collaboration	▪ Work with schools, markets, youth & women's groups ▪ Strengthen engagement with CSOs & private sector to amplify demand ▪ Link demand generation to social protection programs (NHIS, BHCPF)
5 **Community Based Intervention**	▪ Leverage community health workerforce (CHWF) to deliver household-level education and referrals ▪ Organize outreach services in underserved areas ▪ Leverage community based groups to support demand generation activities

Key demand generation activities under NPHCDA priority areas in relation to PHC revitalization

Priority 2.4: Improve coverage of routine immunization and reduce zero-dose children

Massive awareness creation on immunization (RI, Polio, NPSIAs) and other primary health care services through mass media and social media campaigns

Community engagement/actions to promote participation and ownership

Priority 2.6: Re-establish trust in the PHC system

Formative research to understand barriers, knowledge and attitude gaps and guide messages development

Citizens engagement for feedback and information sharing

Three (3) Pathways to improving Demand for PHC Services

Pathway	Description
Political will & leadership	Sustained government support for effective implementation of demand generation activities at all levels
Data-driven planning	Using community surveys, HMIS, and feedback tools to track service uptake for informed decision making
Training	Continuous capacity building for frontline workers on interpersonal communication for improved provider- client relations

Thank you