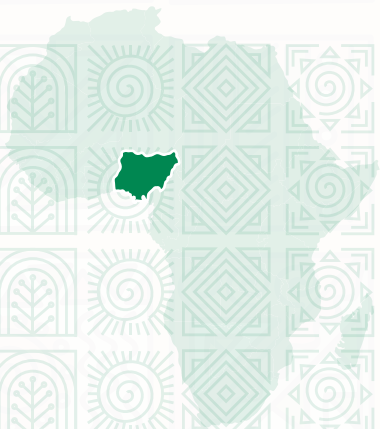
EXEMPLARS SERIES

AFRICAN RENAISSANCE

Strengthening primary healthcare through ring-fenced financing and direct facility funding

Nigeria



Strengthening primary healthcare through ring-fenced financing and direct facility funding

Nigeria

This exemplar looks at Nigeria's use of ring-fenced primary health care financing through the Basic Health Care Provision Fund and Direct Facility Financing. The focus is on how legal reform and fund-flow design improved predictability, transparency, and frontline delivery in a large federal system.

Core exemplar

Legislating ring-fenced primary health care financing through the Basic Health Care Provision Fund (BHCPF), supported by Direct Facility Financing.

Why it matters for ALM: It shows how law, earmarked public finance, and direct transfers to facilities can improve predictability, transparency, and service delivery in a large federal system.

Primary ALM contribution: More money for health, more health for the money, and governance and accountability, with growing effects on equity and financial protection.

Replicability potential: High for decentralized or federal systems seeking to protect PHC financing and reduce leakage between national budgets and frontline facilities.

1. Context: Financing Primary Health Care in a Federal System

Nigeria's health financing challenge is defined by both scale and fragmentation. With more than 220 million people spread across 36 states and 774 local government areas, the country has long operated one of Africa's most decentralized—and most uneven—health systems. Before reform, out-of-pocket spending exceeded 70% of total health expenditure, primary health care facilities were chronically underfunded and understaffed, and federal allocations often failed to reach the front line.

The 2014 National Health Act marked the turning point. It created the Basic Health Care Provision Fund (BHCPF), requiring at least 1% of the Consolidated Revenue Fund, plus donor contributions, to be set aside as a protected financing stream for primary health care. The 2022 NHIA Act then replaced the 2004 NHIS Act and shifted the country toward statutory insurance coverage. Together, these laws form the core legal architecture behind Nigeria's response to the ALM commitments.

2. Mechanism: Ring-Fenced Financing and Direct Facility Funding

The BHCPF operates through four institutional gateways, each targeting a distinct function:

- NPHCDA Gateway (45 %): Channels Direct Facility Financing (DFF) to validated primary health centres for vaccines, essential drugs, consumables, equipment maintenance, and human resources. Implementation commenced May 2019.
- NHIA Gateway (50 %): Provides health insurance coverage for poor and vulnerable Nigerians through the Basic Minimum Package of Health Services (BMPHS), purchasing services from eligible providers through State Health Insurance Agencies. In 2025 a dedicated Catastrophic Health Insurance Fund (₦25 billion) was added to cover cancer care and dialysis.
- NEMT Gateway (1 %): Provides emergency ambulance services through the National Emergency Medical Services and Ambulance System (NEMSAS).
- NCDC Gateway (4 %): Supports public health security, disease surveillance, and epidemic preparedness.

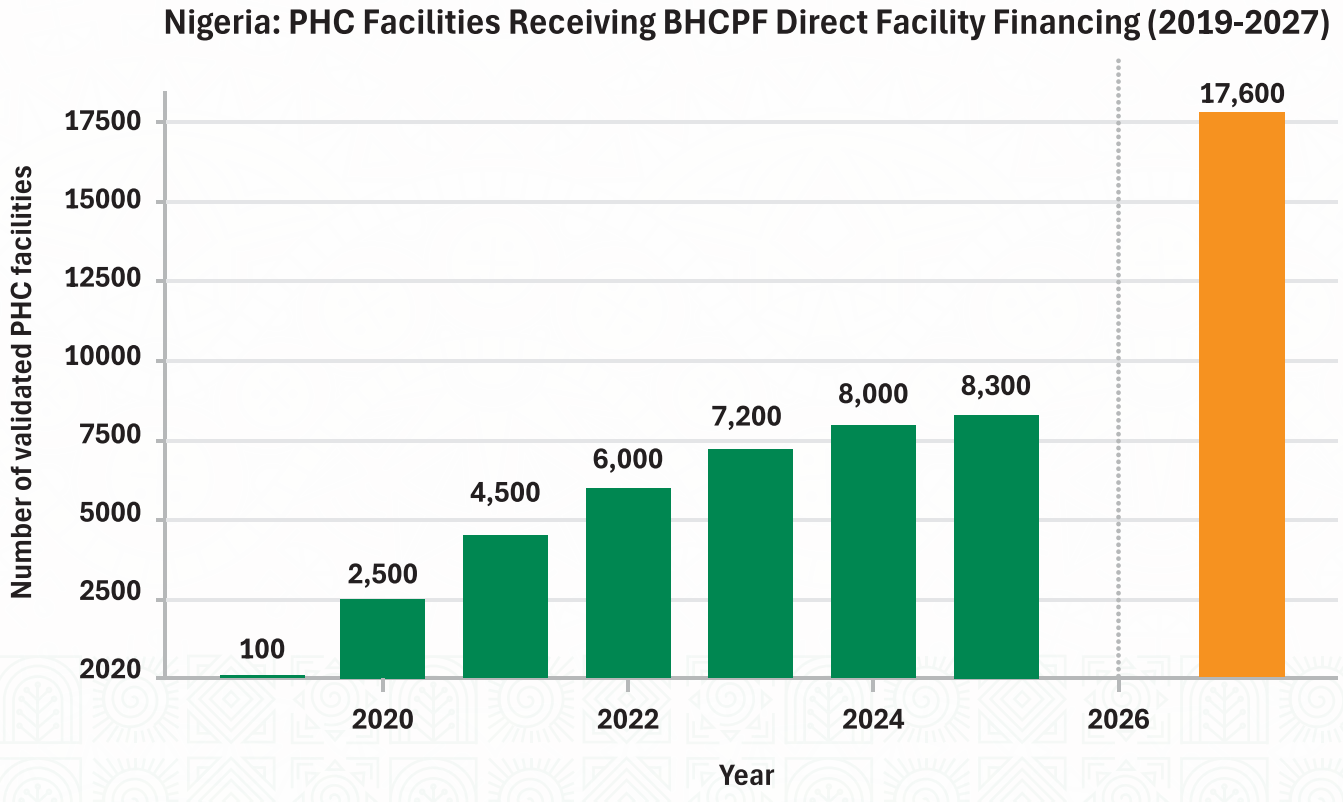


Figure N-1. Nigeria: PHC Facilities Receiving BHCPF Direct Facility Financing (2019–2027). Coverage grew from 100 facilities at launch to 8,300 by 2025, with a federal target of 17,600 revitalized PHCs by 2027.

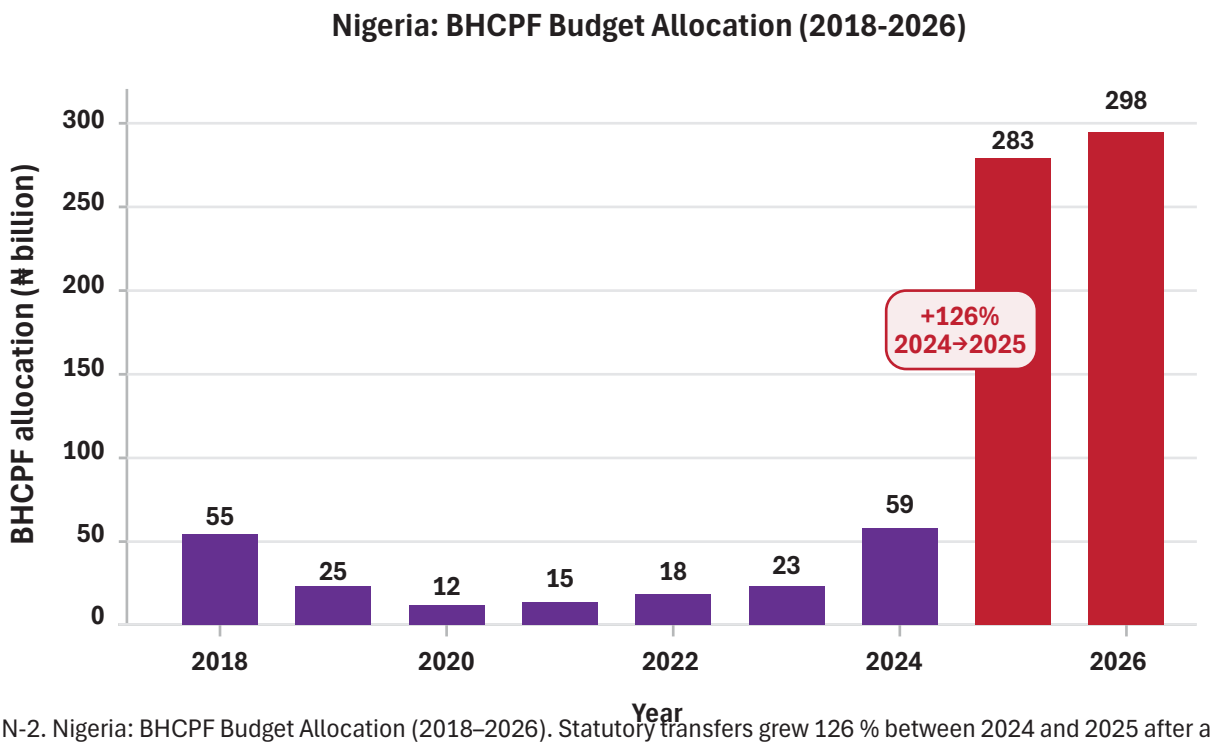


Figure N-2. Nigeria: BHCPF Budget Allocation (2018–2026). Statutory transfers grew 126 % between 2024 and 2025 after a 2020 COVID dip; 2026 approved allocation is ₦298.4 billion.

The critical innovation is Direct Facility Financing (DFF) — bypassing state governments to send funds directly to PHC facility bank accounts. This addresses the historic leakage problem where allocations were absorbed at state and LGA level before reaching service delivery points. Digital financial tracking enhances transparency. Revised BHCPF 2.0 guidelines rolled out mid-2025 under the Sector-Wide Approach (Swap) add performance management overlays and state-level readiness scorecards.

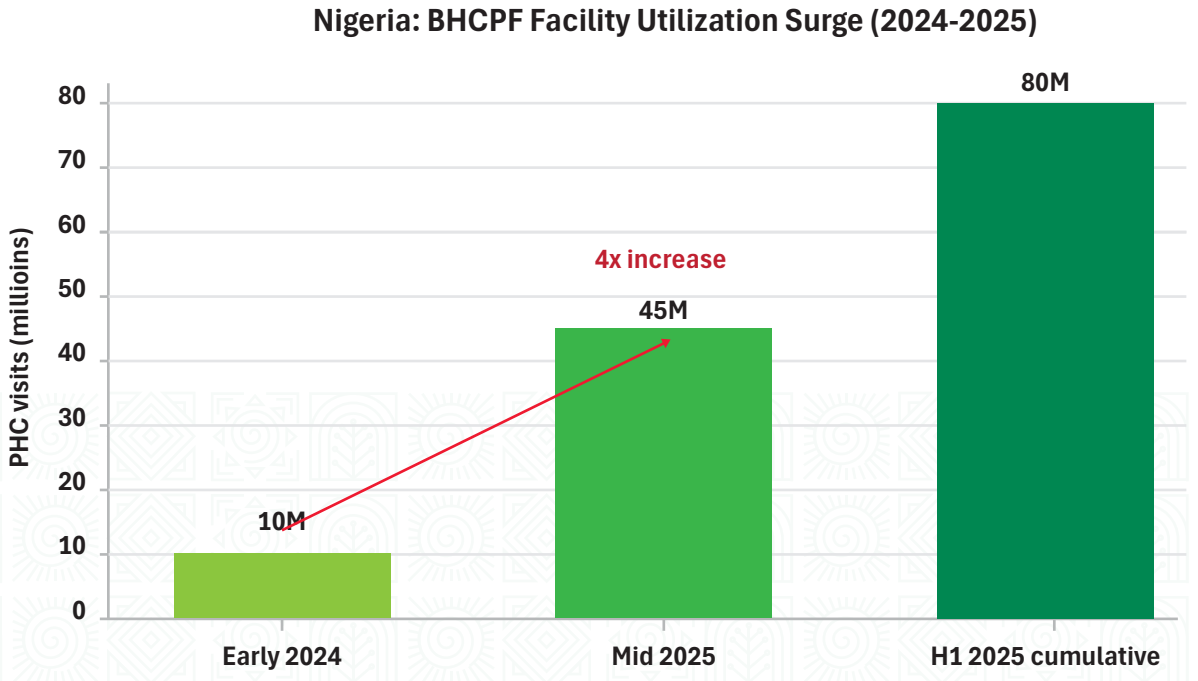


Figure N-3. Nigeria: BHCPF Facility Utilization Surge (2024–2025). Visits to BHCPF-financed PHCs rose approximately 4× in 18 months following BHCPF 2.0 rollout.

3. Outcomes: Expanded PHC Financing and Service Utilization

By 2025, more than 8,300 validated PHC facilities were receiving quarterly DFF, and the federal target had risen to roughly 17,000–17,600 revitalized PHCs by 2027. BHCPF allocations have also expanded sharply, from ₦55.15 billion in 2018 to ₦131.5 billion in 2024 and an approved ₦298.4 billion for 2026. The 2025 federal health budget reached ₦2.48 trillion, or 5.18% of the national budget, with the National Assembly adding ₦300 billion in response to the US foreign-assistance freeze. That is real movement, though still far from the 15% Abuja target.

Service-delivery indicators improved quickly in 2024–2025. Visits to BHCPF-supported facilities rose from about 10 million in early 2024 to 45 million by mid-2025, a four-fold increase. Deliveries attended by skilled birth attendants now exceed 90%. Under the Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII), more than 4,000 free caesarean sections have been performed and 40,000 women reimbursed for emergency obstetric care. NHIA enrolment also rose, from 16.7 million in 2024 to more than 20 million by September 2025, keeping the country on course toward its 2030 target. In December 2025, Nigeria added another important signal by signing a National Health Compact with the World Bank at the Tokyo UHC Forum and committing to train 10,000 pharmaceutical and biotech professionals while expanding local production of vaccines, medicines, and diagnostics.

Key Vulnerability

- **What is at risk:** Execution at scale in a federal system—especially state readiness, purchasing performance, and workforce retention.

- **Why it matters (evidence):** Despite growth in BHCPF funding, only about 19% of Nigerians reported any form of insurance in the 2024 NOI Polls survey, and out-of-pocket spending remains ~71% of total health expenditure. Health's share of the federal budget (5.18% in 2025) is still far below the 15% Abuja target. Implementation varies widely: of 24 states assessed on the first BHCPF scorecard, only 3 met all readiness requirements. External volatility is also material: PEPFAR represented 21% of the 2023 national health budget, so the 2025 US freeze is an acute shock. Meanwhile, health-worker migration ("Japa") is accelerating, and the ₦46 million allocated for the National Policy on Health Workforce Migration is widely viewed as inadequate.

- **What would reduce the risk:** Stronger state level readiness enforcement and technical support, tighter purchaser accountability (including transparent payment and performance management), and a serious workforce retention package aligned to the scale of "Japa" pressures.

4. Nigeria on the ALM Scorecard

Nigeria's ALM scorecard reflects meaningful reform traction at scale, with six commitments rated On Track and four rated Partial. This pattern is consistent with a large federal system that has established strong political and domestic-financing foundations while still working to optimize external partnerships, private-sector integration, and hosting-role visibility. The strongest areas are ring-fenced PHC financing, direct facility financing, and broader governance improvements linked to the BHCPF and NHIA reforms. Overall, the scorecard is aligned with a reform trajectory that is strong in direction and increasingly substantive in delivery, even if some coordination functions remain incomplete.

ALM Scorecard Heat-Map	
Country	**Nigeria**
1. Political Agenda	
2. Leverage Partners	
3. Domestic Mobilization	
4. Private Sector	
5. PMPA Harmonization	
6. Operational Undertakings	
7. Monitoring & Reporting	
8. Accountability Framework	
9. Hosting Role	
10. Leveraging AU Support	

Legend: Green = On Track; Amber = Partial; Red = Off Track

5. Key Lessons and Policy Implications

- Legislation can lock in financing. Nigeria's 1% CRF rule created a protected revenue floor that can survive political transitions—an especially important feature in federal systems where health competes with many other priorities.
- Direct Facility Financing is more than an administrative choice. Sending funds straight to facility accounts reduces leakage, improves visibility, and gives frontline providers a more reliable resource base.
- Phased rollout worked better because it was tied to scorecards. State readiness assessments created an incentive structure around performance instead of distributing funds regardless of preparedness.
- Executive action can accelerate insurance uptake. Nigeria's use of executive instruments to require enrolment for government workers shows how presidential systems can push coverage forward even before deeper reforms are complete.
- Special funds for catastrophic and high-visibility services can also build public support. Covering cancer, dialysis, emergency obstetric care, and similar services made the insurance platform more tangible to citizens.

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Key words: More money for health; more health for the money; governance and accountability; ring-fenced financing; health insurance, Domestic resource mobilization; direct facility funding; legal reform; donor transition; Nigeria; Western Africa

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ALM score card sources: Nigeria (6/10 On Track, 4 Partial)
C1: Political agenda — **On Track** Indicators: Tinubu Renewed Hope Agenda; AU HRH Champion 2024; Tokyo Compact Dec 2025 Sources: FMoH Renewed Hope documentation; WB Tokyo Compact Dec 2025
C2: Leverage partners — **On Track** Indicators: WB IMPACT P180780; Global Fund GC7; ₦300B supplementary allocation post-PEPFAR freeze Sources: WB P180780 (projects.worldbank.org); National Assembly 2025 Appropriation
C3: Domestic mobilisation — **Partial** Indicators: BHCPF ₦55.15B→₦298.4B (2018-2026); OOP 71%; budget share 3%→5.2% Sources: Federal Ministry of Finance; DRPCNGR 2025; WHO GHED
C4: Private sector — **Partial** Indicators: 200+ private HMOs; NHIA-accredited facilities; PPP framework for BHCPF Sources: NHIA Annual Reports (nhia.gov.ng); PharmAccess Nigeria
C5: PMPA — **On Track** Indicators: NAFDAC ICH negotiations; Biovaccines Nigeria JV; SmartShield syringe production Sources: NAFDAC (nafdac.gov.ng); Africa CDC PAVM
C6: Operational — **On Track** Indicators: BHCPF growing; NHIA Act 2022 mandatory; NHFS 2024-2028; NHIA enrolment 16.7M→20M+ Sources: NHIA Act 2022 (nhia.gov.ng/resource/nhia-act-2022); NPHCDA BHCPF 2.0
C7: Monitoring — **On Track** Indicators: FMoH JAR 2025; BHCPF visits 10M→45M; state-level readiness scorecards; DHIS2 Sources: FMoH JAR 2025 (health.gov.ng); Premium Times Dec 2025
C8: Accountability — **Partial** Indicators: Parliamentary BHCPF oversight; only 3/24 states met first BHCPF readiness scorecard Sources: National Assembly Health Committee; BudgIT BHCPF tracker
C9: Hosting role — Partial Indicators: Tinubu AU HRH Champion; hosts partnership meetings; not yet ALM-branded convener Sources: AU Assembly/AU/Dec. XXXVIII; FMoH records
C10: Leveraging AU — **On Track** Indicators: HRH Champion role; PIFAH engagement; Tokyo Compact signatory; ECOWAS HF Strategy Sources: AU Assembly Feb 2025; AUDA-NEPAD PIFAH; ECOWAS HF Hub

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