REPORT OF THE FOLLOW-UP CORRUPTION RISK ASSESSMENT ON THE NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

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And

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DISCLAIMER

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ACRONYMS

ACTU	Anti-Corruption and Transparency Unit
BHCPF	Basic Health Care Provision Fund
BPP	Bureau of Public Procurement
CAC	Corporate Affairs Commission
CEO	Chief Executive Officer
CFRN	Constitution of the Federal Republic of Nigeria
CPD	Continuous Professional Development
CRA	Corruption Risk Assessment
DFF	Decentralized Facility Financing
DQIP	Data Quality Improvement Plan
FAR	Fixed Asset Register
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FM	Financial Management
ICPC	Independent Corrupt Practices and Other Related Offences Commission
ICT	Information and Communications Technology
ISS	Integrated Supportive Supervision
IIAS	Integrated Institutional Assessment System
KPI	Key Performance Indicator
LGAs	Local Government Areas
LGHA	Local Government Health Authority
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NASS	National Assembly
NCH	National Council on Health
NGO	Non-Governmental Organisation
NHA	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
PFMO	Performance and Financial Management Officers

PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PPC	Public Procurement Committee
SMOH	State Ministry of Health
SMOLG	State Ministry of Local Government
SOP	Standard Operating Procedure
SPHCB/A	State Primary Health Care Board/Agency
SPHCDB	State Primary Health Care Development Board
TBEC	Technical Board Evaluation Committee
TSA	Treasury Single Account
UHC	Universal Health Coverage
VVM	Vaccine Vial Monitor
WDC	Ward Development Committee

EXECUTIVE SUMMARY

1.1 INTRODUCTION

The Independent Corrupt Practices and Other Related Offences Commission (ICPC), in collaboration with the Centre for Social Justice (CSJ) conducted a review of the implementation of the recommendations arising from the 2015 Corruption Risk Assessment (CRA) and Integrity Plan of the National Primary Health Care Development Agency, (NPHCDA). The review covered the period 2015 to 2025. This is in line with the ICPC's preventive mandate under Sections 6 (b – d) of the Corrupt Practices and Other Related Offences Act, 2000. This assessment builds upon the 2015 Corruption Risk Assessment, which examined the core operational, financial, and governance practices and structures of the NPHCDA.

This executive summary provides an overview of the findings from the review. It highlights material corruption risks, assesses the effectiveness of reforms undertaken, and outlines strategic actions required to safeguard public resources, strengthen Primary Health Care (PHC) delivery, and enhance Nigeria's progress toward Universal Health Coverage (UHC).

1.2 KEY FINDINGS

The review revealed mixed but average progress, with notable improvements in some areas, persistent gaps in others, and emerging service delivery concerns affecting healthcare provision nationwide. The review score of the extent of implementation of the 2015 recommendations stands at 58%, reflecting a partial compliance rating based on the assessment template. The key findings are stated hereunder.

1.2.1 Governance, Policies, and Compliance

a. NPHCDA plays a central role in Nigeria's PHC governance and UHC delivery. However, its enabling Act of 1992 found in Cap. N69, Laws of the Federation of Nigeria 2004 is outdated and misaligned with current PHC realities.

b. While robust national policies and guidelines exist, weak enforcement and fragmented sub-national governance continue to dilute accountability.

c. Incomplete implementation of PHC Under One Roof (PHCUOR) across states sustains overlapping mandates and corruption risks.

d. In consideration of Nigeria's federal system of governance, NPHCDA's regulatory authority over states remains constrained, limiting its ability to enforce minimum standards and compliance.

1.2.2 Oversight of the State Primary Health Care Development Boards

a. NPHCDA's oversight role over SPHCBs is critical but uneven across states, with some regulatory functions effectively ceded to state authorities.

b. Variations in autonomy, capacity, and political commitment at state level create inconsistent compliance with national standards.

c. Weak enforcement of guidelines sustains governance fragmentation and corruption vulnerabilities.

d. Stronger oversight requires clearer regulatory authority and consistent supervisory engagement.

1.2.3 Regulation of Primary Healthcare Centres

a. PHC facilities remain the most vulnerable point for corruption and service delivery failure.

b. Common risks include absenteeism, poor work ethics, inadequate supervision, and weak community co-management.

c. Effective regulation will depend on routine supervision, leadership continuity, and community accountability structures.

1.2.4 Financial Management and Fund Utilisation

a. Financial standard operating procedures (SOPs), performance-based financing manuals, and Basic Health Care Provision Fund (BHCPF) Guidelines are in place, strengthening procedural controls.

b. Persistent risks include late disbursement of funds, pressure to approve ineligible expenditures, idle balances at facility level, and uneven retirements.

c. Infrastructure gaps in outsourced storage facilities expose public assets to loss and deterioration.

d. Financial controls exist but effectiveness depends on timely release of funds, supervision, and enforcement of protocols and procedures.

1.2.5 Performance and Financial Management Officers (PFMO)

a. The PFMO initiative represents a strategic reform to strengthen financial accountability and operational transparency at facility level.

b. PFMO roles align with BHCPF compliance, monitoring, and performance tracking.

c. Early implementation shows promise, but impact depends on scale, institutionalisation, and sustained funding.

d. PFMO effectiveness is contingent on integration with existing systems and strong oversight support.

1.2.6 Oversight of the Basic Health Care Provision Fund (BHCPF)

a. BHCPF remains a core financing instrument for strengthening PHC and advancing UHC.

b. NPHCDA provides technical guidance, fund disbursement, and oversight through its implementation pathway.

c. Delays in quarterly releases and limited capacity at facility level reduce the effectiveness of BHCPF investments.

d. Safeguarding BHCPF funds requires continuous sensitisation, supervision, and strengthened accountability mechanisms.

1.2.7 Human Resources, Staffing, and Representation

a. Chronic understaffing at zonal, state, and facility levels undermines supervision, service delivery, continuity, and internal controls.

b. Leadership absenteeism at facility level and weak succession/onboarding mechanisms create accountability gaps.

c. Promotion processes are regular, but transfer and deployment criteria lack transparency and participation.

d. Ethical instruments exist, but internalisation of anti-corruption values remains uneven.

1.2.8 ICT Systems and Operational Tools

a. Gradual digitalisation has improved transparency, including Open LMIS, BHCPF dashboards, and emerging financial management applications.

b. Data visibility and interoperability have improved, but facility-level integration and data quality gaps persist.

c. Weak data integrity continues to affect forecasting, resource allocation, and performance monitoring.

d. Technology reforms require stronger governance, supervision, and accountability to deliver full impact.

1.3 KEY RISKS AND RECOMMENDED STRATEGIC ACTIONS

a. The identified key risks include the following.

- **Fragmented PHC governance** across federal, state, and local levels continues to diffuse accountability and enable corruption.
- **Outdated NPHCDA enabling law** limits regulatory authority, enforcement power, and system coherence, to adequately address current realities.

- **Delayed and inconsistent BHCPF disbursements** weaken financial discipline, service continuity, and value for money.
- **Weak sub-national oversight capacity**, particularly among State Primary Health Care Boards (SPHCBs) and PHC facilities, undermines compliance with national standards.
- **Human resource constraints and leadership gaps** at facility and state levels increase fiduciary and service delivery risks.
- **Persistent data quality and ICT integration gaps** impair forecasting, monitoring, and performance management.
- **Ethical frameworks not fully internalised**, reducing their deterrent and preventive impact.

b. Recommended Strategic Actions

- **Initiate legislative review and amendment** of the NPHCDA Act to strengthen regulatory powers, enforcement authority, and alignment with PHCUOR and BHCPF realities.
- **Enforce minimum governance and compliance standards** for SPHCBs and PHC facilities as a condition for continued BHCPF access.
- **Institutionalise timely and predictable BHCPF disbursement cycles**, linked to performance, compliance, and verified retirements.
- **Scale and fully embed the PFMO programme** as a permanent accountability mechanism at facility and state levels.
- **Strengthen supervisory systems**, including clear rules on leadership presence, onboarding, and succession at PHC facilities.
- **Deepen ICT and data governance reforms**, ensuring full facility-level integration, data validation, and routine performance use.
- **Reinforce ethical culture and deterrence**, through sustained sensitisation, protection of whistle-blowers, and visible sanctions for non-compliance.

c. Expected Strategic Outcome

- A more coherent, accountable, and corruption-resilient PHC system that safeguards public funds, improves service delivery, and accelerates progress toward Universal Health Coverage.

1.4 IMPLEMENTATION TIMELINE FOR STRATEGIC ACTION

A. Short-Term (0 – 12) Months

Objective: Contain high-risk exposures and improve predictability.

- Enforce **BHCPF disbursement timeliness** through fixed release calendars and escalation protocols.
- Issue **mandatory compliance directives** to SPHCBs and PHC facilities tied to BHCPF access.
- Scale **rapid onboarding and handover protocols** for facility leadership to prevent knowledge and control gaps.
- Strengthen **supervisory visits and spot checks**, especially for facilities with repeated compliance issues.
- Intensify **ethics sensitisation and Code of Conduct reinforcement** across HQ, zonal, and state offices.
- Address **critical infrastructure risks** (e.g., storage facilities, cold chain vulnerabilities) through immediate corrective actions.

B. Mid-Term (1–3 Years): Institutionalise Accountability and Performance

Objective: Embed reforms into systems, structures, and incentives.

- **Fully institutionalise the PFMO programme** nationwide, with clear mandates, reporting lines, and performance metrics.
- Standardise **financial, procurement, and performance reporting systems** across all states and facilities.
- Achieve **full facility-level integration of ICT systems** (Open LMIS, BHCPF dashboards, financial tracking tools).
- Strengthen **SPHCB governance capacity**, including board oversight, financial autonomy, and compliance enforcement.
- Introduce **performance-linked incentives and sanctions** for PHC facilities and state boards.
- Formalise **succession planning and staffing norms** to address chronic understaffing and leadership gaps.

C. Long-Term (3–5 Years): Structural Reform and System Resilience

Objective: Secure sustainability, improve service delivery and cultural change.

- **Review and amend the NPHCDA Establishment Act** to reflect current PHC, PHCUOR, and BHCPF realities.

- Consolidate **clear regulatory authority** for NPHCDA to enforce national PHC standards across states.
- Embed **data-driven governance** as a core decision-making culture at all levels of PHC administration.
- Strengthen **inter-governmental coordination frameworks** to reduce fragmentation and overlapping mandates.
- Entrench **ethical leadership and integrity culture**, with visible consequences for misconduct and protection for whistle-blowers.
- Position NPHCDA as a **high-trust, high-performing regulator** for sustainable UHC delivery.

1.5 CONCLUSION

The NPHCDA has recorded measurable, average but uneven progress in implementing the 2015 Integrity Plan. While foundational systems have been created in some areas, their operationalisation is inconsistent, and several high-risk areas remain unaddressed. Strengthening governance, deepening digital systems, improving procurement transparency, and consolidating accountability frameworks at federal and sub-national levels should be implemented expeditiously.

2. REPORT OF THE REVIEW ON THE IMPLEMENTATION OF THE RECOMMENDATIONS ARISING FROM THE 2015 CORRUPTION RISK ASSESSMENT AND INTEGRITY PLAN OF THE NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

2.1 BACKGROUND AND STRATEGIC CONTEXT

The National Primary Health Care Development Agency is a cornerstone of Nigeria's primary health care system and a key institutional driver of the country's pursuit of Universal Health Coverage. Given its central role in policy formulation, technical support, and oversight, particularly through the implementation of the BHCPF, the integrity of NPHCDA's operations is directly linked to health outcomes, equity, and public trust.

Established in 1992 by Decree No. 29 and merged with the National Programme on Immunisation (NPI) in 2007, the NPHCDA operates as a parastatal under the Federal Ministry of Health and Social Welfare. Its mandate includes developing national PHC policies, standards, guidelines, and supporting States and Local Government Areas (LGAs) in planning, implementation, monitoring, supervision, and standardisation of PHC services.

Corruption remains a significant challenge to effective healthcare delivery globally and within Nigeria. Diversion of funds, financial abuse, mismanagement of resources, and weak accountability systems translate into drug shortages, outdated equipment, neglected facilities, and compromised patient care. Past CRAs, special audits, and systems studies—most notably the 2021 GAVI Programme Audit—have demonstrated that corruption risks in the PHC space are systemic rather than episodic.

The 2021 GAVI Programme Audit identified inter alia granular failures in vaccine supply chain management and data integrity, revealing a causal loop in which inaccurate data undermined forecasting, leading to sub-optimal resource allocation and wastage. These findings underscore the need for periodic CRAs as preventive tools to safeguard public resources and strengthen institutional integrity.

The 2015 Corruption Risk Assessment (CRA) identified institutional, procedural, and environmental factors capable of facilitating corruption within the NPHCDA. This review assesses the extent to which the remedial actions contained in the Integrity Plan were implemented between 2015 and 2025. The assessment reviews progress made, evaluates the effectiveness of reforms, and identifies persisting and emerging corruption risks across headquarters, zonal and state offices, and PHC facilities.

2.2 OBJECTIVES AND SCOPE OF THE ASSESSMENT

The primary objective of this assessment is to ascertain the level of implementation of remedial actions identified in the 2015 CRA and documented in the Integrity Plan over the

period 2015–2025. Specifically, the assessment seeks to:

- Evaluate the extent to which identified corruption risks have been mitigated;
- Assess the effectiveness of anti-corruption reforms and system-strengthening initiatives;
- Identify persisting and emerging risks across institutional, operational, and cultural dimensions; and
- Provide evidence-based insights to inform policy, regulatory, and management decisions.

The scope of the assessment covers NPHCDA headquarters, zonal and state offices, and the Agency's technical and regulatory oversight role over sub-national PHC systems, with particular emphasis on the BHCPF implementation pathway.

2.3 METHODOLOGY AND ANALYTICAL FRAMEWORK

The methodology for this review is based on the ICPC CRA tools, and involves a combination of qualitative and quantitative approaches to assess the effectiveness of NPHCDA processes. Major activities include:

a. **Desk Review of Documents:** Analysis of past CRA report and the 2021 GAVI Programme Audit. Assessment of SOPs and policy Instruments, monitoring reports, compliance checklists, procurement records and financial records.

b. **Interviews and Interactions:** Engagements with management staff, Anti-Corruption and Transparency Unit (ACTU), State Offices and PHC workers.

c. **Field Visit Observations*:*** Visitation to selected PHCs (mostly beneficiaries of the BHCPF), SPHCDBs.

The draft report was validated with the leadership of NPHCDA. A score of 1/3 signifies very poor performance while 2/3 signifies moderate performance. 3/3 is about full compliance with the recommendations.

2.4 LEGAL, POLICY, AND INSTITUTIONAL FRAMEWORK

The NPHCDA was established by an enabling law promulgated in 1992 during the Ibrahim Babangida military administration. While the law was incorporated into the Laws of the Federation of Nigeria 2004, no substantive legislative review has occurred since its promulgation. Sections 1 and 2 of the Act establish the Agency and its Governing Board, while Part II outlines its functions.

Over three decades later, the absence of legislative review has become a major governance constraint. The PHC landscape has evolved significantly, particularly following the enactment of the National Health Act in 2014, the introduction of the Primary Health Care Under One Roof (PHCUOR) policy, and the establishment of the BHCPF. The outdated legal framework limits NPHCDA's regulatory authority and enforcement capacity.

PHC is universally recognised as a cost-effective foundation for achieving UHC. However, PHC remains the weakest link in Nigeria's health system due to fragmentation, overlapping mandates, weak referral system, and poor intergovernmental coordination. The constitutional framing of health as a concurrent responsibility has resulted in fragmented financing, diffuse accountability, wastage and increased corruption risks—particularly in PHC infrastructure development and service delivery.

2.5 INSTITUTIONAL ASSETS AND SAFEGUARDS

Despite these challenges, NPHCDA possesses significant institutional assets that enhance its capacity to deliver on its mandate. However, it remains vulnerable in a high-corruption environment. These assets include:

- Strong goodwill and credibility among development partners, resulting in sustained extra-budgetary support;
- Zonal and state office structures that enable integrated supportive supervision and grassroots outreach;
- Functional ICT infrastructure, including the website of the Agency and BHCPF dashboard;
- Institutional autonomy and constructive working relationships with supervisory authorities;
- An established administrative structure with staff training opportunities;
- Robust policy instruments, including national PHC guidelines and standards; and
- Budgetary allocations and donor funding supporting Agency operations.

Protecting these assets requires sustained investment in institutional integrity and corruption prevention.

2.6 KEY CORRUPTION RISKS AND FINDINGS

Identified risks are categorised under three broad areas: environmental, organisational, and personnel-related risks.

2.6.1 Environmental and Governance Risks

Despite the availability of constitutional, legislative, and policy frameworks, including the National Health Act and PHC Guidelines 2022, these instruments have not translated into commensurate improvements in PHC service delivery. Interaction gaps persist at meso and micro levels.

PHCUOR has been implemented in at least 23 states, while 13 states are yet to fully adopt the framework. Even in implementing states, transitional challenges and limited financial autonomy persist, sustaining governance fragmentation and corruption vulnerabilities.

At facility level, spot assessments revealed absenteeism, leadership gaps, pressure to approve ineligible BHCPF expenditures from local government health workers, WDC members, etc; delayed fund releases, idle facility accounts, and weak supervision. This highlights the need for stricter supervisory controls and rapid on boarding mechanisms.

2.6.2 Organisational and Systems Risks

Although NPHCDA has established procurement and financial SOPs aligned with the Public Procurement Act 2007 and other public finance policies, implementation gaps remain. Selective tendering practices, particularly during emergencies, continue to pose corruption risks. Oversight mechanisms involving ACTU and BPP require strengthening.

The 2021 GAVI Programme Audit highlighted systemic failures in vaccine forecasting, cold chain management, data integrity, and accountability. In response, NPHCDA introduced reforms including structured forecasting tools, electronic inventory systems, and cold chain governance improvements. While progress has been recorded, facility-level gaps persist.
Asset management systems are moderately strong, with periodic verification exercises. However, fixed asset registers are not available and there are concerns regarding outsourced warehouse conditions, particularly at Idu, Abuja. This underscore the need for sustained monitoring and enforcement of storage standards.

2.6.3 Personnel and Ethical Risks

Despite the existence of a Code of Ethics and Whistle-Blowing Policy, variations persist in staff understanding and internalisation of ethical standards. Staffing shortages, overtime without compensation, and perceived lack of transparency in transfer decisions were highlighted during field interactions. Uneven staffing across zonal and state offices undermines effective supportive supervision.

3.0 THE KEY OBSERVATIONS

This Table captures corruption risks identified in the 2015 CRA of the NPHCDA, recommended measures, and evidenced required to show compliance. It also includes the remarks of the CRA Review Team, implementation status and the rating.

RISK	MEASURES RECOMMENDED	REQUIRED EVIDENCE	NPHCDA Self-Assessment	CRA's Follow up Assessment Team Remarks	Implementation Status	Rating
Duplication and waste in establishment and renovation of Primary Healthcare Centres	Review enabling Law to vest NPHCDA with stronger regulatory authority over the Centres	Reviewed enabling law with clear delineation of responsibility on oversight of PHC system in Nigeria. Documentation/drafts of any steps taken by NPHCDA/MOH/NASS.	Yes. Steps have been taken by the Legal Department	The NPHCDA Act, which was enacted since 1992, still remains the enabling law of the NPHCDA. While the NPHCDA Act has not been reviewed, there have been other important legislative and policy frameworks, such as the National Health Act (2014), the National Health Policy (2016), and National Health Insurance Authority Act (2022) that are intended to support/ drive effective PHC system in the country. For example, through the implementation of BHCPF provided under the NHA, NPHCDA has developed guidelines for its Pathway (Component). According to information provided by the NPHCDA's representatives during the field work phase, a draft has been prepared by its legal department to kick start the process. However, NPHCDA did not make the draft available to the Assessment Team.	Not implemented as no concrete steps have been taken to review the enabling Law to vest NPHCDA with stronger regulatory mandates.	1/3
	Generate accreditation standards/ guidelines for establishment of primary healthcare centers for	Accreditation standards/guidelines that respond to the recommended measure	Yes, guidelines have been developed; Integrated Institutional Assessment System (IIAS) Progress report	The foundation for corrupt risk is usually present in the fragmented fiduciary responsibilities and ownership structure of PHC system in Nigeria in which diverse levels of government, including legislators, private CSR, and individual philanthropies construct/build/renovate/rehabilitate PHC	Moderately implemented via development of guidelines, such as the Primary Health Care Guidelines (March	2/3

	government, private sector, legislators and other stakeholders.			facilities with little regard for standardisation. The concern here is the wide discretionary powers in the allocation of constituency projects by NASS; indiscriminate construction of PHCs without given serious thoughts on their functionality. In light of the previous CRA recommendation, addressing this challenge requires empowering the NPHCDA with clear regulatory power to enforce compliance with the minimum standards and guidelines for the PHC system. Furthermore, there is the need for a legal and regulatory framework guiding the formulation, implementation and location of constituency projects including health related projects.	2022), the Standards and Regulatory Framework for Primary Healthcare Practice in Nigeria (March, 2022) etc.	
Diversion of NPHCDA resources through misapplication of procurement procedures	Develop and disseminate Agency specific procurement guidelines. This should delineate roles and responsibilities within the procurement value chain to reduce monopoly	New procurement guideline with clear delineation of responsibility for oversight of PHC system in Nigeria.	Yes. The Guideline has been developed.	The NPHCDA Standard Operating Procedures Manual for Procurement Processes (January 2018) was approved by the Executive Director on the 19th of March 2021 three years after the preparation of the draft document; and more than five years after the pilot CRA report. The SOP Manual provides procedural guide for NPHCDA procurement unit staff, delineating their roles and responsibilities as well as inter-relationship between departments/units within the Agency with regards to procurement process to ensure consistent application of policies and procedures.	Implemented	**3/3**
	Organise procurement training for staff at all levels.	Report of procurement capacity building sessions.	Yes. NPHCDA has sent some procurement staff for continuous procurement	Evidence of past two annual procurement retreats conducted in 2017 and 2019 were cited.[1] Granted that during COVID-19 pandemic social distancing measures curtailed physical meetings between 2020	Moderate implementation	**2/3**

[1] See, a Report on Procurement Staff Retreat held at Access International Hotel, Independence Way, Kaduna State 16th - 19th May, 2017 as well as

			capacity development training programme organised by BPP and Procurement retreat. On-the-job guidance, regular supervisory reviews, and usage of SOP Manual as a day-to-day reference tool.	and 2021, procurement capacity building sessions should have been held from 2022 to expose procurement unit staff to the contents of the SOP Manual for Procurement Processes following its formal approval in 2021. This is important as the Manual recognises the need for continuous professional development to ensure that staff of the Procurement Unit maintain and enhance the knowledge and skills required for their jobs. According the NPHCDA, "procurement staff continue to receive on the job guidance, participate in regular supervisory reviews, and utilise the SOP Manual as a day-to-day reference tool, which collectively ensures a reasonable level of procedural consistency". "The procurement unit already possess personnel with substantial experience in procurement processes, enabling them to effectively execute their SOP-defined responsibilities".		
	Develop Agency price lists, for goods and services which are usually supplied to Agency Review and update Agency's list of contractors.	Agency Price List reviewed from time to time in view of fundamental macroeconomic changes. Reviewed and updated Agency's list of contractors[2]	Yes	Responsibility for price intelligence and cost benchmarking—through periodic market surveys and the maintenance of an in-house reference price list—has been assigned to the User Departments. These measures are intended to mitigate integrity risks and enhance transparency in procurement decisions. The NPHCDA stated that it does not maintain a list of "current contractors," noting instead that it operates a suppliers' database for communication purposes. The Agency	Moderate Implementation	**2/3**

[2] The new procurement rules under the Public Procurement Act prohibits MDA registration of contractors.

				further affirmed that its procurement processes are fully competitive and transparent, with contract awards benchmarked against historical contracts, market quotations, and prevailing industry standards, in compliance with the Public Procurement Act (2007) and the NPHCDA Procurement SOP Manual. Existing oversight arrangements include internal audit reviews, multi-level management approvals, and contract performance monitoring.		
	Develop an Agency Code of Ethics, an Internal Practice Note for monitoring transfer of funds from NPHCDA to states and or monitoring implementation along budget lines.	Agency Code of Ethics, an internal Practice Note for monitoring transfer of funds from NPHCDA to states and or monitoring implementation along budget lines.	The Decentralised Facility Finance (DFF) Guidelines of BHCPF. Existing FM tools and reporting structures have long ensured that the BHCPF disbursements are made based on verified and accurate retirements, in line with the guidelines. Presently, these tools have evolved into a FM application which reportedly provides visibility	The NPHCDA' SOP Manual for Finance and Account Processes, the Guideline for BHCPF programme implementation,[3] the new Performance and Financial Management Officers (PFMO) project, including M&E Framework as well as ISS are institutional mechanisms developed to monitor transfers of funds from NPHCDA to states. Aside from the SOP Manual for Finance and Accounts processes (approved March 2021), the NPHCDA Performance-based Financing User Manual (Vol. 2, December 2020); the PFMO Project has been designed as a nationwide intervention to enhance accountability for PHC management. Established as part of BHCPF reforms in July 2025, the PFMO project seeks to addresses the systemic inefficiencies at the PHC facilities by ensuring improved financial accountability, operational transparency, and equitable healthcare access. The PFMO initiative establishes a cadre of skilled	Implemented	**3/3**

[3] Funding through the NPHCDA Gateway consists of 35% Decentralised Facility Financing (DFF), which is disbursed directly to PHCs. This includes 20% for essential drugs, vaccines, and consumables, and 15% for facility maintenance, equipment, and transport. An additional 10% is allocated to Human Resources for PHC interventions, with 5% minium for midwives and up to 5% for Community Based Health Workers (CBHWs).

			into the flow and fund usage.	professionals (with 772 active PFMOs deployed across all the LGAs) to track PHC's financial and operational management; and intended to ensure compliance with the BHCPF guidelines.		
	Agency Procurement Guidelines to include rules on the maintenance of Fixed Asset Registers (FARs) in the NPHCDA and in the states	Agency Procurement Guidelines mandating the maintenance of Fixed Asset Registers in place	Yes. The Agency conducts asset verification exercise twice annually in all zonal offices to ensure accuracy, accountability, and proper documentation.	The Procurement Guidelines contain the requirement of Fixed Assets Registers. The Assessment Team sighted the NPHCDA-compiled Store Verification List, not a Fixed Asset Register (2024), which includes recommendations for the Internal Audit Department to conduct regular cost-verification exercises and spot-tagging of all Agency assets. However, improvements are required to strengthen documentation, knowledge management, and record-keeping practices.	Moderately implemented	**2/3**
	Create a document tracking and sign off systems that ensures traceability of individual action, sign off and responsibility for procurement steps.	Document Tracking Guidelines/Policy	Yes	NPHCDA Internal KPIs and Procurement SOP take care of tracking and sign off systems that ensures traceability of individual action, sign off and responsibility for procurement steps. NPHCDA engages in pre and post payment checks for all procurement ensuring compliance with the PPA 2007 and the NPHCDA Procurement SOP.	Implemented	**3/3**
	Develop and implement performance contracts for Agency leaders which include improvements in procurement practice and outcomes as indicators	Performance contracts for CEO and Management in place enabling periodic measurements of improvements or otherwise in procurement practice and outcomes	NPHCDA Internal KPIs and sign off system ensures traceability of individual action, and responsibility for procurement steps.	The Agency avers that it maintains a comprehensive records for key procurement transactions, and ensure performance KPIs are monitored through established reporting mechanisms, mitigating the risk of process breaches. However, Management did not make available any performance contract document for the Management and Agency's CEO to the Assessment Team.	Not implemented	**1/3**

	Improved regularity and BPP procurement audits and other supervisory efforts with reports identifying individual wrong doing and recommending disciplinary actions	Report of BPP procurement audits showing decisions on complaints and identifying individuals responsible for infractions and recommending disciplinary actions against them.	No procurement audit conducted by the BPP since 2015	No evidence to indicate the BPP conducted any periodic procurement audit on the Agency's procurement practices or processes to ascertain the extent of compliance with the PPA and Guidelines. However, Auditor General and Senate Probe Reports on NPHCDA including those from GAVI and other partners confirmed infractions[4] and have raised concerns on 'habitual' disregard for procurement law.[5] Accordingly, the Executive Director/CEO should be compelled to enforce Auditor-General's recommendations and sanctions in line with the provisions of the Financial Regulations.	Not Implemented	**1/3**
	ACA directives pursuant to Section 6 of ICPC Establishment Act on constituency projects	ACA Directives from ICPC on establishment of ACTU	No response	ACTU is improperly constituted in NPHCDA and it has not been sending staff to the anti-corruption academy run by ICPC.	Low	**1/3**
Lack of adequate infrastructure support in many primary healthcare centers.	Negotiate infrastructure support for centres with international partners and private sector and improve budget funding	Infrastructure support documentation from international partners, donors, private sector and improved budget funding.	Yes. PHC remains the core responsibility of state governments and LGAs. NPHCDA provides technical and programmatic support. The Agency however continues to mobilise resources through the World	While there is significant potential to mobilise infrastructure support for PHCs through international partners, development donors, and private-sector initiatives—such as access-to-finance schemes and adopt-a-health-facility programmes—these efforts remain insufficiently coordinated and require an integrated national framework. During field visits across four states, the assessment team observed ongoing PHC infrastructure projects being implemented under the World Bank–supported IMPACT Project, underscoring both the scale of investment	Moderate	**2/3**

[4] https://www.gavi.org/sites/default/files/audit/pa/programme-audit-report-Nigeria-October-2022.pdf
[5] See, Premium Times report (August 20, 2018). Auditor General reveals Nigerian agency 'notorious' for disregarding accountability issues.

			Bank IMPACT project, BHCPF, and partners such as UNICEF and Global Fund to support states in revitalising PHC facilities.	opportunities and the importance of improved coordination, standardisation, and sustainability mechanisms. Public funding - appropriation and actual releases has not substanatially improved over the period.		
Corrupt acts can occur at different levels within the Agency due to absence of strong internal anti-corruption enforcement regime within the NPHCDA	Implement Agency Specific Code of Ethics.	NPHCDA Code of Ethics/Anti-corruption policy	There is a Code of Ethics	The NPHCDA has produced a Code of Ethics as well as a Whistle-Blowing Policy and Response for its staffers in the conduct of all official duties. However, NPHCDA's ACTU has no budget line.	Moderately	**2/3**
	Ensure that core values are communicated and socialised to become part of the culture through norms, guidelines, procedures and regular staff training.	Training Reports. Evidence showing that the Code has been dispatched to all staff members	Code of Ethics dispatched to all staff members but the Agency has not sent staff for anti-corruption training	Aside from the NPHCDA's Code of Ethics and Whistle-blowing Policy and Response document, the ACTU roll-on banner with conspicuous anti-corruption messaging placed in one of the floors at the Agency's headquarter by the ACTU Desk Office serves as a reminder to staff members that the fight against corruption is a fight by all, among others. However, the Team could not ascertain the extent to which NPHCDA's staff have internalised the contents of the Code of Ethics.		
	Develop and implement performance contracts for Agency leaders that include ethics enforcement as clear indicators	Signed Performance Contracts. Reporting and performance measurement based on the performance contracts.	Staff sign undertaking averring that they understand the ethics and values of NPHCDA	Even though the NPHCDA reported that staff sign undertaking, there was no evidence of signed performance contract or undertaking by Agency Leaders.	Low	**1/3**

Absence of country level primary healthcare co-ordination and planning that harmonises plans between Federal, State and Local Governments	Convene annual planning forum which brings together federal, state and local government authorities only to set national healthcare priorities	Minutes of Annual Planning Forums /minutes of National Council on Health showing resolutions for improved synergy on primary healthcare between different levels of government or new policy framework harmonises federal, state and local governments level primary health care service delivery.	Yes, there are coordination and planning mechanisms for PHC.	Aside from the National Council on Health (NCH) which serves as apex policy making body on health matters, the Forum of SPHCDB/As has also provided the platform for PHC stakeholders. The Team saw minutes of a Virtual Meeting the NPHCDA's leadership held with the Executive Secretaries of SPHCB/A on June 29, 2020. It is instructive to note that the virtual meeting was held during the height of COVID-19 lockdown period as the major agenda was devoted to the pandemic response. Nonetheless, presentations were made in subsequent meetings on Revised BHCPF Guidelines and PHC Model Level 2 facility. Mechanisms such as PHC Integrated Supportive Supervision (ISS); Quarterly interactive sessions with the Forum of Executive Secretaries of SPHCDA are considered as good practice. However, our Team engagement with some of the Executive Directors of SPHCDs during state visits identified a need for shared decision making through co-creation, enhanced visibility for the Executive Secretaries, exposing them to regular cross country opportunities for shared learning and visits.	Moderately	**2/3**
Loss of external goodwill because internal M&E process does 'not red-flag' procurement anomalies.	Strengthen internal M&E process to become a more effective watchdog,	Reviewed M&E Policy Manual	No response	The NPHCDA's M&E system faces several systemic challenges, including inadequate human resources, poor data quality and management, insufficient funding and weak coordination. Aside the foregoing, the M&E activities are often underfunded and rely heavily on partners' support. Addressing these issues requires a comprehensive	Low	**1/3**

				approach involving increased investment, capacity building, technological upgrades, and the promotion of a data-driven culture across the organisation and its partners.		
	Provide platform through quarterly management meetings for areas of concern to be discussed and addressed before external stakeholders assume the watchdog role	Minutes of quarterly management meetings addressing red flags in procurement and other anomalies	No response	NPHCDA did not provide minutes of quarterly management meetings.	Low	**1/3**
The absence of an effective quality control mechanism to ensure value for money in terms of the quality of goods supplied	Develop standard specifications for commonly acquired items.	Quality Control Policy/ Guidelines in NPHCDA/Primary Health Care Procurement.	Yes, the Agency already applies multiple layers of technical review, inspection, and verification through user departments, national and state consultants, project supervision by staff, including pre and post internal audit of all procurement which collectively ensure that goods, works, and	NPHCDA acknowledged that the full operationalisation of the Quality Control Policy as outlined in its Procurement SOP Manual is still in progress, noting that the claim of significant systemic risks is overstated. Accordingly, the Agency insists that "Quality checks are documented and enforced for all procurement; emphasising that "historical contract performance has not indicated widespread deficiencies, substandard deliveries, or contract failures attributable to weak quality control. Hence, the current practices and oversight mechanisms sufficiently support compliance with the PPA and do not point to systemic exposure to financial loss or reputational harm.	Moderate	**2/3**

			services meet required standards.			
	Develop approval system for technical specifications in case of complex or uncommon goods and materials including testing methods if necessary.	Developed approval system for technical specifications in case of complex or uncommon goods and materials Documentation showing implementation vis minutes of meetings, testing reports, store receipt documentation, etc.	NPHCDA maintains established due diligence procedures, multi-level financial authorisation requirements, and documented emergency procurement protocols that provide adequate safeguards against fraud, inflated pricing, and engagement of unqualified contractors. Furthermore, routine internal audits, management reviews, and external oversight mechanisms have consistently demonstrated adherence to the PPA and internal SOP, with no confirmed findings of diversions of	Apart from the PPA and BPP's regulations, the NPHCDA's SOP Procurement Manual as well as donor funded procurement guidelines provide clear approval system for all the procurement processes, including in cases of complex or uncommon goods and materials (technical specifications). However, NPHCDA response did not specifically address the issue.	Moderate	**2/3**

			funds or fraudulent contractor engagement. While improvements in documentation and emergency procurement tracking are underway, the current control environment does not substantiate claims of procurement abuse or systemic integrity breakdown.			
	Clear delineation of roles at point of receipt of stores in a way that ensure personal liability for mistakes and infractions on quality of materials received.	Delineation of roles in an SOP or policy framework.	Roles have been delineated in SOPs and Guidelines and communicated to staff.	Relevant SOPs for the effective operation and maintenance of stores and facilities are available. Pasted on the notice board of NPHCDA'S Vaccines Cold Store at Oshodi, Lagos State are clear role delineations, including SOP on Responding to Remote Temperature Monitoring Alarms and the Step by Step Description on How to Resolve Heat Temperature Alerts from “Beyond Wireless”. Temperature are monitored regularly and recorded twice daily (morning and night) on the chart pasted on the exterior of the cold room storage. Fire safety equipment was sighted. Security personnel including escorts accompanying distribution across the SW Zone were available.	Moderately Implemented	**2/3**

Weak internal complaint and Whistle Blowers System	Develop and popularize an Agency Whistle Blowers Policy	The Whistle Blowers Policy and reports/minutes of meetings showing its implementation.	Whistle-Blowing and Response Policy developed and operationalised.	The NPHCDA has developed an internal Whistle-Blowing and Response Policy and a Code of Ethics. However, the Team could not ascertain the extent to which NPHCDA's staff have internalised the contents of the Code of Ethics, and or any reports from the ACTU Desk Office.	Implemented	**3/3**
Absence of effective Fixed and Movable Asset Management System	Make it mandatory for fixed and movable assets registers to be opened in each PHC detailing, date of purchase, value of assets, year of manufacture, purchaser, name installation, etc.	Fixed and Moveable Assets Policy and Register(s) showing implementation of the policy.	NPHCDA maintains a robust, Agency wide asset management and verification system. A comprehensive assets record framework is in place, capturing the movement and status of assets at the Headquarters, as well as across all Zonal Offices. The Agency's asset register is diligently maintained by a dedicated Assessment Management Unit with clear operational procedures. Furthermore, the	The NPHCDA did not provide a Fixed or Moveable Asset Register. They only provided a Store verification List. However, they have a policy document which includes recommendations for the Internal Audit Department to conduct regular cost-verification exercises and spot-tagging of all Agency assets. The Assessment Team also reviewed the “List of Items Verified by Internal Audit (2024 – Supplies to Stores)” and the “List of Items Verified by Internal Audit (Supplies to Stores, Second Quarter 2025). Furthermore, although some PHC facilities visited tagged their assets, no PHC presented a fixed or movable asset register.	Low	**1/3**

			Agency conducts assets verification exercises twice annually in all zonal offices nationwide to ensure accuracy, accountability, and proper documentation. All Agency assets are properly recorded, collated, and updated in line with established asset management protocols.			
Lack of transparency and accountability at primary healthcare centres and in management of state transfers	Develop and disseminate Standard Operating Procedures in every healthcare centre	The new Standard Operating Procedure (SOP) Reports of dissemination meetings, training or dispatch of circulars on the new SOP .	Yes. The BHCPF Guidelines have developed accountability mechanisms which is being adapted and implemented across board. The NPHCDA's existing financial management tools and reporting structures have ensured that the BHCPF	The Review Team observed that the NPHCDA Pathway—outlined in the *NPHCDA Component of the Basic Health Care Provision Fund: A Handbook for Primary Health Care Workers* — have addressed the issues of transparency and accountability at the sub-national level. There are reports of training meetings. However, the 2023 National Health Facility Survey assessed financial management practices across health facilities, including the administration of collections, expenditures, and income from multiple sources. Survey findings indicate that only 35.0% of health facilities were able to produce records of funds expended, while 25.8% maintained up-to-date expenditure	Moderate	**2/3**

			disbursements are made based on verified and accurate retirements, in line with the Guidelines. Presently, these tools have evolved into a financial management application which provides visibility into the flow and fund usage.	records. In addition, 21.1% of facilities reported that their financial records were reconciled with cash-at-hand. Disaggregated analysis reveals significant disparities by level of care: only 33.4% of primary health facilities had available expenditure records, compared with 60.9% of secondary health facilities. Similarly, expenditure records were up to date in just 24.9% of PHC facilities, compared with 46.9% at the secondary level. Reconciliation of expenditure records with cash-at-hand was reported by 20.5% of PHC facilities, compared with 36.0% of secondary health facilities.		
	Provide dedicated funding for central M&E on improved performance measurement at state and local government levels.	Budget lines showing dedicated funding for central M&E for improved performance measurement at state and local government levels. Evidence of budgetary releases and implementation of enhanced M&E. New Performance Measurement Tools	There is dedicated budget line for M&E but releases are poor and the Agency undertakes performance measurement. New Integrated Supportive Supervision Tools is available as a performance measurement tool	The Team found no evidence of dedicated funding for central monitoring and evaluation (M&E), nor evidence of budgetary releases or implementation of enhanced M&E activities. However, new Performance Measurement Tools have been developed.	Low	**1/3**
	Develop performance measurement tools	Documents showing deployment of New Performance	PHC Integrated Supportive Supervision Tools	Integrated Supportive Supervision (ISS) at the Primary Health Care (PHC) level provides the oversight, verification, and	Implemented	**2/3**

	to be administered across all heath care centres annually	Measurement Tools and improvements in transparency and accountability in the primary healthcare centres		performance-improvement platform through which Performance and Financial Management Officers (PFMOs) operate. While ISS is the mechanism, PFMOs are the specialised functionaries embedded within that mechanism. Therefore, the recruitment of PFMOs has established a strong foundation for the deployment of the performance measurement mechanism.		
	Strengthen M&E mechanisms within state and local government authorities	M&E Tools and protocols and their implementation	PHC Integrated Supportive Supervision Tools	PHC remains the core responsibility of state governments and LGAs. NPHCDA provides technical and programmatic support. The Review Team could not ascertain effort made in the strengthening of the M&E mechanisms at state and local government level beyond the performance management tools introduced by NPHCDA and routine collection and collation of HMIS at subnational level. To strengthen M&E, OICs leading public PHCs should undergo mandatory training on M&E, the implementation of business plans, wider adoption of electronic health records (EHR) to improve health management information systems; improve digital infrastructure to ease the process of M&E.		**2/3**
Poor service delivery due to capacity deficits among primary healthcare workers	Build/strengthen capacity of PHC workers	Reports of training/ capacity building sessions		Poor PHC service delivery is attributed to many factors, including capacity deficits among the healthcare workers at the facilities level. Despite the provisions for the administration of the NPHCDA Gateway of the BHCPF on human resources for PHC, capacity deficits persist.	Low	**1/3**

	Organise training for Ward Development Committees, and also the service providers at community level	Reports of training for Ward Committee members.		The Review Team did not sight report (s) on training of Ward Committee Members. The Revised Ward Health System Strategy of 2023 has classified all PHCs, and determined standards, but it is yet to be operationalised.		**1/3**
					TOTAL SCORE	**58**

4.0 ASSESSMENT OF REFORMS AND INTEGRITY MEASURES

NPHCDA has introduced several reforms aimed at strengthening integrity and reducing corruption risks. These include procurement and financial management SOPs, ICT reforms such as OpenLMIS, strengthened asset management systems, and the PFMO initiative designed to enhance financial accountability and operational transparency at PHC facility level.

While these measures demonstrate institutional commitment to reform, implementation remains uneven. Effectiveness is constrained by delayed fund disbursements, limited capacity at sub-national levels, and weak enforcement of compliance requirements.

4.1 IMPLICATIONS FOR PHC DELIVERY AND UHC

Persisting corruption risks have direct implications for PHC service delivery and Nigeria's progress toward UHC. These include service disruptions, inefficiencies, wastage of scarce resources, inequitable access to care, and erosion of public and donor trust. Strengthening integrity systems is therefore integral to achieving sustainable health outcomes.

4.2 STRATEGIC POLICY OPTIONS (PAIRING IDENTIFIED RISKS WITH RECOMMENDED ACTIONS)

Following the Team's observations and analysis contained in the assessment matrix, the following key risks were identified, with corresponding recommendations proposed to mitigate them.

4.2.1 RECOMMENDATIONS AND IMPLEMENTATION MATRIX

No	Key Risks	Recommendations	Lead Agency	Supporting Agencies	Responsible Person/Unit	Timeline
1.	The NPHCDA Establishment Act (1992) is obsolete and misaligned with current national health laws and policies—particularly the National Health Act (2014), National Health Policy (2016), and NHIA Act (2022). This misalignment has resulted in unclear mandates, regulatory gaps, weak oversight authority, and fragmented governance across federal, state, and LGA PHC structures. Although Primary Health Care is primarily the responsibility of states and LGAs, the outdated Act constrains NPHCDA's ability to effectively provide technical leadership, coordination, monitoring, and supervision of PHC nationwide.	The Federal Ministry of Health and Social Welfare (FMoHSW) and NPHCDA should initiate a comprehensive review and amendment of the NPHCDA Act (1992) to align the Agency's mandate with the current national health policy and legal framework. The revised Act should clarify roles across PHC structures, strengthen NPHCDA's regulatory and enforcement authority, institutionalise BHCPF governance, mainstream digital health, quality assurance, and supply-chain oversight, and enhance internal governance and federal–state coordination. Notwithstanding the federal nature of Nigeria's Constitution and the fact the health is on the Concurrent Legislative List, the revised NPHCDA Act can give stronger regulatory, oversight and enforcement powers to NPHCDA. It can leverage on S.17 (3) (d) of the Constitution viz: *The State shall direct its policy towards ensuring that – (d) there are adequate medical and health facilities for all persons;*	Federal Ministry of Health & Social Welfare (FMoHSW) and NPHCDA.	Federal Ministry of Justice, National Assembly Health Committees, Health Sector Reform Coalition (HSRC)/CSOs	Honourable Minister of Health; Director, Legal Services (FMoHSW); Executive Director/CEO NPHCDA	18 – 24 months

		and item 60 of the Excusive Legislative List (Part1) empowering the National Assembly to legislate on: *The establishment and regulation of authorities for the Federation or any part thereof - (a) to promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution;* Similar encompassing federal laws like the ICPC and EFCC Acts were founded on the fundamental objective of the state's mandate to abolish corrupt practices (S.15 (5) – *"The State shall abolish all corrupt practices and abuse of power"*; contained in the same Fundamental Objectives and Directive Principles of State Policy in the Constitution where the health directive is provided and the federal legislative power in item 60 of the Exclusive Legislative List. Finally, where required, constitutional amendments should be pursued to ensure legality and effectiveness.				
2.	Weak Regulatory Control over PHC Infrastructure Development: The absence of legally backed regulatory authority over PHC infrastructure development has resulted in	Amend the NPHCDA Act[2] to grant explicit statutory authority to regulate, approve, certify, and monitor all PHC infrastructure projects, irrespective of funding source. This should mandate	NPHCDA	FMoHSW, State PHC Development Agencies, National Assembly	Executive Director NPHCDA; Director, PHC Systems Development	18 – 24 months

	fragmented implementation, inconsistent standards, uncontrolled funding streams, and the construction of non-functional, duplicative, or abandoned PHC facilities. Constituency projects, CSR initiatives, philanthropic donations, and state-funded projects often bypass national guidelines, undermining PHCUOR objectives and increasing waste and corruption risks.[6]	compliance with national standards, require pre-construction clearance and functionality assessments, establish oversight for constituency and CSR-funded projects, integrate PHCUOR requirements nationwide, and introduce a public registry of PHC infrastructure projects. Similar encompassing federal laws like the ICPC and EFCC Acts were founded on the fundamental objective of the state's mandate to abolish corrupt practices (S.15 (5) – *"The State shall abolish all corrupt practices and abuse of power"*; contained in the same Fundamental Objectives and Directive Principles of State Policy in the Constitution where the health directive is provided and the federal legislative power in item 60 of the Exclusive Legislative List. Finally, where required, constitutional amendments should be pursued to ensure legality and effectiveness.				
3.	**Weak Enforcement of Procurement SOPs:** Inconsistent enforcement of the Procurement SOP Manual exposes the Agency to procurement irregularities, discretionary practices, and non-compliance with the Public Procurement Act (PPA). Limited monitoring, documentation gaps,	Fully institutionalise the Procurement SOP by introducing routine compliance monitoring, a structured update cycle, continuous capacity-building, designated departmental focal persons, progressive digitalisation of procurement processes, and enforcement of sanctions for non-compliance.	NPHCDA	Bureau of Public Procurement (BPP)	Director, Procurement; Head, Due Process Unit	6-12 months

[6] Despite NPHCDA's development of minimum specifications and tracking mechanisms, field visits revealed poor adherence to approved standards in some newly constructed facilities, risking sub-optimal utilisation.

	insufficient staff capacity, and weak inter-departmental coordination reduce the SOP's effectiveness as an operational control tool.	Publishing procurement plans and award information will further strengthen transparency.				
4.	Inadequate Continuous Professional Development for Procurement Staff: The absence of a structured and continuous professional development (CPD) programme for procurement staff has resulted in inconsistent understanding and application of procurement rules, increasing compliance and integrity risks.	Institutionalise a comprehensive CPD programme by resuming annual procurement retreats, delivering targeted SOP and PPA training, mandating induction for new staff, extending training to all units involved in procurement, and partnering with BPP, ICPC, and development partners. Monitoring mechanisms should track learning outcomes and address skill gaps.	NPHCDA	BPP and ICPC	Director, Procurement; Director, Human Resources	Biannually
5.	**Preferential Supplier Practice and Weak Price Intelligence:** Practices resembling informal contractor registration and weak price intelligence functions increase risks of preferential treatment, reduced competition, inflated pricing, and poor value-for-money.	Maintain only an open, non-exclusive supplier database for communication purposes, institutionalise regular market surveys and price benchmarking, strengthen cost-analysis capacity, and mandate periodic compliance checks by Internal Audit and Due Process Units.	NPHCDA	BPP, Internal Audit, ICPC	Director, Procurement; Head, Due Process Unit	Quarterly
6.	**Weak Financial Oversight of BHCPF and PFMO System:** Despite multiple financial control frameworks, inconsistent implementation across states, weak digital tracking, and uneven PFMO functionality pose risks to BHCPF integrity, transparency, and accountability.	Standardise PFMO structures nationwide, expand digital financial tracking, integrate PFMO outputs into BHCPF oversight, strengthen ISS financial verification, provide continuous capacity-building, and formalise escalation mechanisms for non-compliance.	NPHCDA	FMoHSW, State PHC Development Agencies	Director, Finance & Accounts; National BHCPF Coordinator	Monthly/ Quarterly

7.	**Weak Asset Management and Verification System:** Limited physical verification, poor documentation, inadequate tagging, and insufficient audit coverage increase risks of asset diversion, loss, and inaccurate reporting.	Implement a robust, organisation-wide asset (fixed and movable) management system with routine audits, physical and digital asset registers, unique tagging, expanded verification coverage, strengthened internal audit capacity, enforced sanctions, and annual asset accountability reporting.	NPHCDA	Office of the Auditor-General for the Federation	Director, Finance & Accounts; Head, Asset Management Unit; Director, Internal Audit	Quarterly
8.	**Procurement Traceability and Audit Gaps:** Weak documentation, manual workflows, limited audit follow-through, and insufficient integration of performance KPIs create vulnerabilities for process manipulation and non-compliance.	Institutionalise procurement KPIs, digitise approval workflows, conduct quarterly procurement audits, strengthen internal audit independence and capacity, improve inter-departmental coordination, and publish compliance dashboards.	NPHCDA	BPP, Auditor-General	Director, Procurement; Director, Internal Audit	Annually
9.	**Emergency Procurement and Contractor Vetting Risks:** Weak contractor verification and oversight of emergency procurement increase risks of fraud, inflated pricing, and reputational damage.	Strengthen emergency procurement controls, institutionalise contractor verification, enhance audit capacity, enforce transparency for high-value disbursements, and establish a dedicated compliance function.	NPHCDA	BPP, ICPC	Director, Procurement; Head, Compliance / Due Process	Monthly/ quarterly
10.	**Weak External Oversight and Sanctions:** Inconsistent implementation of Auditor-General's and National Assembly recommendations and lack of sanctions increase the risk of recurring procurement violations.	Ensure mandatory BPP audits, enforce implementation of audit findings, apply administrative and statutory sanctions, establish a Procurement Compliance Review Committee, and publish audit outcomes.	FMoHSW	BPP, ICPC, National Assembly Public Accounts Committees, Minister of Health, Development Partners	Permanent Secretary FMoHSW; Executive Director NPHCDA, DG BPP	Annually/ Biennially

11.	**Fragmented PHC Infrastructure Financing:** Uncoordinated PHC investments risk duplication, abandoned projects, and inefficient resource use, threatening national PHC scale-up targets.	Establish an integrated, results-based PHC Infrastructure Investment Framework aligned with DFF, PHCUOR, and digital monitoring systems.	FMoHSW, NPHCDA	NPHCDA, Ministry of Finance, Development Partners	Permanent Secretary FMoHSW; Director, Health Planning, Research & Statistics	12months
12.	**Underfunded Anti-Corruption and Transparency Unit (ACTU):** Lack of a protected budget line undermines ACTU independence and effectiveness.	Create a dedicated ACTU budgetline, ensure operational independence, and provide unrestricted access to records.	NPHCDA	ICPC	Executive Director NPHCDA; ACTU Chairman	6months
13.	**Weak Ethics Awareness and Whistle-Blowing Culture:** Low staff awareness weakens ethical compliance and reporting culture.	Institutionalise mandatory ethics induction, annual refresher training, and expanded ACTU sensitisation programmes	NPHCDA	ICPC, Office of the Head of Civil Service of the Federation	NPHCDA Director, Human Resources; ACTU Chairman	Biannually
14.	**Weak Coordination with State PHC Agencies:** Limited collaboration increases policy–implementation gaps and uneven performance.	Institutionalise structured co-creation, joint decision-making, peer-learning platforms, and strengthened leadership engagement.	NPHCDA	FMoHSW, State Ministries of Health, SPHCDBs	Director, Planning, Research & Statistics	12 Months
15.	**Weak M&E Systems:** Insufficient funding, poor data quality, and fragmented coordination undermine planning and accountability.	Develop and fund a comprehensive M&E reform plan focused on domestic financing, digital systems, capacity-building, and performance management. A dedicated M&E budget line is imperative.	NPHCDA	FMoHSW, State Ministries of Health, SPHCDBs, Development Partners	Permanent Secretary FMoHSW; Executive Director NPHCDA, DG BPP	6 Months
16.	**Weak Quality Control in Procurement:** Inconsistent enforcement of quality control provisions risks substandard procurement outcomes.	Strictly enforce quality control provisions through directives, training, documentation systems, and enhanced oversight.	NPHCDA	BPP, Standards Organisation of Nigeria	Director, Procurement; Director, Internal Audit	Quarterly

17.	**Unsafe Asset Storage Facilities:** Continued use of environmentally compromised storage facilities exposes assets to loss and health risks. Concerns were raised regarding the structural integrity and storage conditions of the outsourced warehouse at Idu in the Federal Capital Territory, used to store supplies valued at ₦1,201,850,640.00 during the second quarter of 2025. Observed conditions present risks of structural deterioration, moisture-related damage (including mould and mildew growth), and potential chemical hazards arising from spilled or compromised medical supplies.	Urgently relocate assets, enforce storage standards, strengthen audit checks, and integrate storage requirements into contracts.	NPHCDA	NPHCDA, Ministry of Finance, Development Partners	Director, Administration; Head, Stores Unit	3 Months
18.	**Weak PHCUOR and BHCPF Alignment:** Fragmented structures and unclear roles undermine accountability and service delivery.	Strengthen PHCUOR consolidation, align BHCPF with performance indicators, enhance digital reporting, and conduct joint reviews.	NPHCDA	FMoHSW, State PHC Agencies	Director, PHC Systems Development; BHCPF Programme Manager	6 Months
19.	**Weak Facility-Level Financial Management:** Inconsistent financial systems increase leakage and reduce service delivery effectiveness.	Standardise facility financial systems, enforce reconciliations and audits, and link BHCPF disbursements to reporting compliance.	State PHC Development Agencies	NPHCDA, FMoHSW	Executive Secretaries of State PHC Development Agencies; PFMO Coordinators	2 Months
20.	**Inadequate Integration of PFMO into ISS:** Fragmented supervision weakens financial oversight.	Integrate PFMO functions into ISS tools, reporting systems, and performance scorecards	NPHCDA	State PHC Agencies	National BHCPF Coordinator; Director, M&E	3 Months

21.	**Weak Capacity of PHC OICs and slow EHR Adoption:** Poor management skills and slow digitalisation undermine data quality and planning.	Institutionalise mandatory OIC certification, accelerate EHR rollout, and embed compliance into supervision frameworks	NPHCDA	State PHC Agencies, Digital Health Partners	Director, Human Resources for Health; Director, Digital Health	12 Months
22.	**Poor Facility Record-Keeping:** Weak documentation undermines BHCPF transparency and accountability.	Institutionalise harmonised record-keeping, train staff, strengthen oversight, and link funding to verified records.	State PHC Development Agencies	NPHCDA	PHC Facility Officers-in-Charge; State PHC Monitoring Units	3 months
23.	**Incomplete Operationalisation of Revised Ward Health System Strategy:** Inconsistent implementation risks uneven PHC functionality.	Fast-track operationalisation through guidelines, costed rollout plans, supervision integration, and accountability mechanisms.	FMoHSW	NPHCDA, State Governments	Director, PHC Systems Development; State PHC Executive Secretaries	3 Months

5. LESSONS LEARNT AND CONCLUSION

5.1 LESSONS LEARNT

It is imperative to draw lessons from this review on the implementation of recommendations from the 2015 CRA of the NPHCDA.

- The first is the absence of continued engagement of the NPHCDA after the conclusion of the CRA eleven years ago. However, continued engagement is necessary to drive compliance with anti-corruption laws and policies and to institutionalise a culture of compliance. An eleven-year gap between the initial assessment and review of compliance with recommendations is too long.
- THE 2021 GAVI report provided a red flag and a lead indicating the need for follow-up action on recommendations.
- Sequel to the first and second lesson is the lesson derived from the challenge of dissemination. Beyond the NPHCDA which was reviewed, there are recommendations that are not within the control and purview of the reviewed Agency and it appears that these agencies have not been deliberately engaged through dissemination.
- Inter-agency collaboration and focus on critical recommendations are relevant for implementation of recommendations, especially where implementation requires reconciliations and actions by regulatory and other agencies.
- Fragmented governance issues and intergovernmental relationships in the Nigerian federal system has been a great challenge in implementing reforms to improve PHC service delivery. NPHCDA's capacity and willingness for reform cannot deliver concrete gains until state and local government partners commit to reforms.
- The implementation of the Basic Health Care Provision Fund seems to be the major source of the few reforms and gains recorded in PHC since 2015.
- Multi-stakeholder forums and engagement seem to be absent in the drive to institutionalise reforms in terms of implementing CRA recommendations. A whole of society approach seems not mainstreamed in the drive for reforms.
- Increased transparency, stakeholder access to information and a monitoring and reporting as it unfolds framework is imperative for deepening the implementation of recommendations.
- Institutionalised periodic peer learning, continuous dialogue and benchmarking has not been mainstreamed for improved implementation of recommendations and systemic reforms.

5.2 CONCLUSIONS

The NPHCDA has recorded measurable, average but uneven progress in implementing the 2015 Integrity Plan. While foundational systems have been created, their operationalisation is inconsistent, and several high-risk areas remain unaddressed. Strengthening governance, deepening digital systems, improving procurement transparency, and consolidating accountability frameworks at federal and sub-national levels remain urgent.

The following implementation framework recommendations drawn from the lessons should be considered by ICPC.

- Yearly or bi-annual review of implementation of recommendations is imperative. A dedicated desk or staff of ICPC can implement the review in collaboration with development partners and civil society organisation working in the sector.
- Improve dissemination of findings and recommendations. This will involve engagement, briefing and interaction with all MDAs that are involved in implementing recommendations and reforms. Beyond the NPHCDA which was reviewed, there are recommendations that are not within the control and purview of the reviewed Agency and these MDAs should be deliberately engaged.
- Inter-agency collaboration is imperative requiring collaboration between the anti-corruption agencies, regulatory agencies, etc. This collaboration will focus on the multi-dimensional tasks required for the full implementation of recommendations.
- Resolving fragmented governance issues and intergovernmental relationships requires political good will and buy-in at the highest level of governance at the federal, state and local government levels. Leadership to secure this buy-in should be provided by the Ministry of Health and Social Welfare and the NPHCDA.
- Gains and reforms derived from the implementation of the Basic Health Care Provision Fund should be sustained and deepened to improve the entire PHC governance beyond activities funded by BHCPF.
- Benchmarking of state level performance and opportunities to learn from the best in class is imperative to drive reforms.
- Multi-stakeholder forums and engagement involving anti-corruption agencies, MDAs, media, civil society and development partners is necessary to drive and institutionalise reforms in terms of implementing systems review and CRA recommendations.
- Deploy a digital dashboard that tracks and shows data and steps on a real time basis on the implementation of systems and CRA recommendations. The dashboard integrates the agency reviewed, ICPC and other agencies with duties for the implementation of reforms.

- Institutionalised peer learning and continuous dialogue between agencies assessed under systems review and CRA is imperative. Furthermore, benchmarking for MDAs to learn from the best in class should be introduced.

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