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Impact of Basic Healthcare Provision Fund on Primary Healthcare Service Utilization in Nasarawa State, Nigeria: A Comparative Study

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ABSTRACT

This comparative study evaluates the impact of the Basic Healthcare Provision Fund (BHCPF) on primary healthcare service utilization in Nasarawa State, Nigeria. The study assesses the differences in healthcare service utilization before and after the implementation of BHCPF, with a focus on vulnerable populations. Data were collected from the 147 BHCPF primary healthcare funded facilities, stakeholders that included healthcare personnel, and community members through surveys, interviews, and observations. The findings indicate an insignificant increase in healthcare service utilization, particularly among vulnerable populations, after the implementation of BHCPF. The study also identifies challenges, including inadequate infrastructure, insufficient healthcare personnel, and inefficient financial management systems. The results suggest that BHCPF has the potential to improve primary healthcare service utilization in Nasarawa State, but addressing the identified challenges is crucial to sustaining the gains. The study's findings have implications for policy and practice, highlighting the need for targeted interventions to strengthen primary healthcare systems and ensure that the benefits of BHCPF reach the most vulnerable populations.

Keywords: Basic Healthcare Provision Fund (BHCPF), Comparative study, Primary Healthcare Service Utilization Nasarawa State, Nigeria, Healthcare Service Delivery, Universal Health Coverage (UHC)

INTRODUCTION

The Basic Healthcare Provision Fund (BHCPF) represents one of Nigeria's most ambitious and transformative health financing reforms in recent history, designed to reposition primary healthcare (PHC) as the central pillar of equitable, efficient, and people-centered health service delivery. Enshrined in Section 11 of the National Health Act of 2014 and formally implemented in 2018, the BHCPF was conceived to address decades of systemic neglect, chronic underfunding, and fragmented service delivery that have long characterized the Nigerian health system, especially at the PHC level (Federal Ministry of Health [FMoH], 2020; Uzochukwu et al., 2023). Historically, health expenditure in Nigeria has been heavily dominated by out-of-pocket payments, with limited public investment and reliance on donor-driven vertical programs. This has disproportionately affected poor and rural populations, creating substantial financial barriers to care and worsening health inequities (World Health Organization [WHO], 2021; Okafor et al., 2022). The BHCPF thus emerged as a strategic intervention to expand the fiscal capacity of health institutions and ensure that every Nigerian, regardless of socioeconomic background or geographical location, can access a Basic Minimum Package of Healthcare Services (BMPHS).

As emphasized by the Federal Ministry of Health (2020), the overarching goals of the BHCPF are to: (1) expand fiscal space for health, (2) provide financial risk protection for the poor, and (3) strengthen PHC delivery across all 774 local government areas in the country.

At the core of its design, the BHCPF functions as a catalytic health financing mechanism, receiving at least 1% of the Consolidated Revenue Fund (CRF) of the Federation annually, as mandated by law. This statutory allocation is supplemented by funds from development partners such as the World Bank, the Global Financing Facility, and other external sources. The BHCPF adopts a dual-gateway disbursement structure, involving both the National Health Insurance Authority (NHIA) and the National Primary Health Care Development Agency (NPHCDA). The NHIA oversees demand-side financing, including the subsidization of health insurance premiums for vulnerable populations, while the NPHCDA manages supply-side investments, which cover facility upgrades, procurement of essential drugs and commodities, training of healthcare workers, emergency response capacity, and operational support for PHC facilities (World Bank, 2021; Uzochukwu et al., 2023). This multi-channel disbursement approach aims to decentralize healthcare delivery, improve financial autonomy at the facility level, and enhance efficiency, transparency, and accountability in public health spending (Ekezie et al., 2022). When effectively implemented, it also fosters community responsiveness, builds trust in formal health systems, and enhances the resilience of Nigeria’s PHC network.

A central operational thrust of the BHCPF is its provision for a Basic Minimum Package of Healthcare Activities (BMPHA), a standardized, cost-effective set of essential health services that should be universally accessible through all functional PHC facilities in Nigeria. These services include, but are not limited to, maternal and child health care, antenatal services, skilled birth attendance, routine immunization, family planning, malaria prevention and treatment, nutrition interventions, and health education (FMoH, 2020; WHO, 2021). The BMPHA serves as a critical operational benchmark for implementing UHC, as it encompasses both preventive and curative care priorities aligned with Nigeria’s broader commitments to reduce maternal and under-five mortality, control infectious diseases, and enhance quality of life. By financing the delivery of these services through direct facility funding, the BHCPF seeks to reduce financial barriers, increase service uptake, and improve health equity (Okafor et al., 2022). According to Onwujekwe et al. (2021), when properly executed, the BMPHA not only improves access to care but also enhances PHC facility functionality, community confidence, and continuity of care. It further reduces the reliance on informal or unregulated care providers and curtails catastrophic health expenditures, a major contributor to household poverty in Nigeria.

In states like Nasarawa, where geographical terrain, poverty, and weak infrastructure have long constrained access to health services, the BHCPF presents a unique opportunity to re-engineer health service delivery. Nasarawa, like many sub-national entities in Nigeria, has faced significant disparities in healthcare access, especially between rural and urban areas. Recent evaluations by Ekezie et al. (2022) show that where BHCPF has been effectively implemented, there have been observable improvements in drug availability, increased staff presence, revitalization of dormant PHC centres, and better community involvement in healthcare governance. However, the extent of these improvements varies considerably across wards and local governments due to persisting bottlenecks. Many health facilities still struggle with irregular fund disbursement, low awareness among community members, and human resource constraints. These implementation gaps continue to affect the actual utilization of services, limiting the extent to which the fund’s potential is translated into improved population health outcomes.

Moreover, the success of the BHCPF hinges on the strength of institutional governance and accountability mechanisms at both the federal and state levels. States are required to meet certain prerequisites such as establishing State PHC Boards, enacting enabling legislation, and setting up State Health Insurance Schemes (SHIS), before becoming eligible to receive funds. Even when these structures exist on paper, their operationalization varies widely. As emphasized by Uzochukwu et al. (2023), common challenges include political interference, poor monitoring systems, weak data collection platforms, and inadequate absorptive capacity at the facility level. These constraints often lead to inefficiencies, misuse of funds, and poor service delivery, thereby undermining the transformative potential of the BHCPF. This points to the need for improved performance-based monitoring, community oversight mechanisms such as Ward Development Committees (WDCs), and stronger incentives for state compliance and accountability.

Importantly, the Basic Healthcare Provision Fund (BHCPF) plays a strategic role in Nigeria's pursuit of Universal Health Coverage (UHC) and the 2030 Sustainable Development Goals (SDGs), particularly SDG 3, which emphasizes ensuring healthy lives and promoting well-being for all at all ages. By directly channeling financial resources into Primary Healthcare (PHC), the BHCPF seeks to correct long-standing equity and service delivery gaps that have impeded Nigeria's progress toward UHC (Federal Ministry of Health, 2020; World Health Organization, 2021). Its focus on financing a Basic Minimum Package of Health Activities (BMPHA) is aligned with global best practices for expanding access to essential, high-impact interventions at the community level (Okafor, Adebayo, & Yusuf, 2022). Furthermore, the BHCPF complements global financing initiatives such as the World Bank's IMPACT project and the Global Financing Facility, both of which aim to enhance health system resilience and reform health financing mechanisms in low- and middle-income countries (World Bank, 2021). In doing so, the BHCPF not only bolsters Nigeria's capacity to deliver cost-effective and equitable health services but also enhances its credibility among international development partners, thereby attracting additional technical assistance and funding support (Uzochukwu et al., 2023).

In the context of this study, the BHCPF is more than a statutory budgetary allocation, it symbolizes a paradigm shift in Nigeria's public health delivery model, emphasizing decentralization, accountability, and community ownership. Through localized resource flow and direct facility financing, the fund aims to reach the most underserved populations and strengthen trust in public healthcare systems (Ekezie, Ekpenyong, &Adepoju, 2022). Evaluating its implementation in Nasarawa State is crucial to understanding whether the BHCPF is achieving its intended objectives: namely, increasing service utilization, enhancing equitable access, and improving population health outcomes through the delivery of the BMPHA. The degree to which the BHCPF has influenced health-seeking behaviour, facility functionality, and community participation will offer critical insights into how innovative funding mechanisms can be optimized for inclusive, sustainable, and people-centered healthcare reform, particularly in fragile and inequitable health systems (Ameh, Usman, & Olukade, 2023; Uzochukwu et al., 2023).

The Basic Minimum Package of Health Activities (BMPHA) is a foundational component of Nigeria's health policy architecture, particularly within the framework of primary healthcare (PHC) reforms. It represents a strategically defined and evidence-informed set of essential health interventions that are expected to be universally available and equitably delivered at the PHC level across all geopolitical zones of the country. The BMPHA is deeply rooted in the principle that health is a fundamental human right, and as such, every Nigerian, regardless of geographical location, gender, income, or social status should have access to standardized, life-saving, preventive, Promotive, and basic curative services (Federal Ministry of Health (FMoH), 2020). It operationalizes the vision of the Basic Healthcare Provision Fund (BHCPF) by specifying the scope of services that health facilities are mandated to provide, thereby linking resource allocation with service delivery benchmarks.

The development of the BMPHA emerged as a direct response to entrenched health inequities and preventable health burdens across Nigeria, especially in rural and underserved areas where access to quality healthcare is weakest. The package includes critical interventions such as antenatal care, skilled birth attendance, childhood immunization, integrated management of childhood illnesses (IMCI), treatment of malaria and other common infectious diseases, family planning, nutrition services, health education, and management of non-communicable diseases (NCDs) and neglected tropical diseases (NTDs) (World Health Organization, 2021). These components were selected based on epidemiological priorities and cost-effectiveness criteria, with the aim of maximizing health gains at minimal cost, and reducing both morbidity and mortality, particularly among vulnerable populations such as women and children.

From a policy and governance perspective, the BMPHA is more than just a clinical service package; it reflects Nigeria's commitment to equitable healthcare financing, access, and accountability. The package aligns with Sustainable Development Goal (SDG) 3.8, which calls for universal health coverage, including access to essential services and protection against catastrophic health expenditure (United Nations, 2022). As a policy instrument, the BMPHA serves as a guiding framework for planning, budgeting, and performance monitoring across all tiers of government. It is also used as a yardstick for assessing PHC functionality, including infrastructure adequacy, workforce availability, commodity supply chains, and service utilization (Okafor, Adebayo, & Yusuf, 2022). In

this way, the BMPHA enables a results-based approach to health system strengthening, ensuring that financing flows under the BHCPF are tied to measurable improvements in service readiness and delivery.

The operationalization of the BMPHA under the BHCPF has introduced a new financing model where funds are directly disbursed to PHC facilities that meet specific accreditation criteria such as having a functional Ward Development Committee (WDC), basic equipment, trained personnel, and an approved work plan. These funds are earmarked for ensuring uninterrupted service provision, procurement of essential commodities, infrastructure maintenance, and performance monitoring (Federal Ministry of Health, 2020). Evidence from several states suggests that this financing approach has contributed to improved availability of drugs, better staff retention, and increased user satisfaction (Ekezie, Ekpenyong, &Adepoju, 2022). However, despite these gains, implementation challenges persist. Studies have documented irregular fund flows, weak supervision systems, insufficient technical capacity at the facility level, and low public awareness of the BMPHA, all of which compromise its impact (Uzochukwu, Etiaba, & Mbachu, 2023).

One of the unique strengths of the BMPHA lies in its emphasis on integrated and people-centered care, which moves away from fragmented or disease-specific programs that often fail to address the holistic health needs of communities. Instead, it promotes comprehensive, continuous, and coordinated care throughout the life course. This is particularly relevant in Nigeria's health system, where service fragmentation and donor dependency have undermined sustainability. By enabling integrated service delivery, the BMPHA enhances early diagnosis, reduces service duplication, and fosters stronger provider-patient relationships—factors that are crucial for improving trust and long-term health-seeking behavior (Ameh, Usman, &Olukade, 2023).

In the context of Nasarawa State, where this study is situated, the availability, quality, and utilization of BMPHA services are crucial indicators of the effectiveness of BHCPF implementation. While some local government areas have reported improvements in PHC functionality and service access, other areas continue to struggle with inadequate staffing, logistical delays, weak monitoring structures, and socio-cultural barriers that hinder uptake. Notably, in rural and remote communities, mistrust in formal healthcare systems, preference for traditional medicine, and physical inaccessibility continue to pose significant obstacles to service utilization, even when the BMPHA is technically available (Uzochukwu et al., 2023).

Ultimately, the BMPHA represents the measurable expression of Nigeria's equity-driven health financing reforms. It embodies the principles of rights-based healthcare, affirming that essential services should be publicly funded, locally delivered, and universally accessible. In the context of this study, assessing the extent to which PHC facilities in Nasarawa State deliver the BMPHA, and the degree to which populations utilize these services, provides critical insight into the functional and systemic dimensions of the BHCPF. These assessments are not only essential for gauging policy effectiveness but also for informing future adjustments in resource allocation, health workforce planning, and community engagement strategies.

Aim and Objectives of the Study

The study aims at assessing the impact of the Basic Healthcare Provision fund (BHCPF) with a focus on the Basic minimum package of activities and utilization of primary healthcare services in Nasarawa State.

Research Questions

What is the extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities (BMPHA)?

Significance of the Study

The study will contribute to a more nuanced understanding of the determinants of primary healthcare utilization in the Nigerian context. It will provide a robust foundation for evidence-based decision-making, help evaluate the success of ongoing health reforms, and support efforts toward achieving universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs) in Nigeria.

METHODS AND MATERIALS

A multistage sampling technique will be used. In the first stage, eight LGAs will be selected using simple random sampling. In the second stage, two BHCPF-supported PHC facilities will be selected from each selected LGA using purposive sampling (based on functionality and client volume), making a total of 18. In the third stage, six clients/ patents will be selected from each of the 18 selected PHC facilities using systematic random sampling, bringing the total sample size to 108 as the sample of respondents that will provide responses to the questionnaires.

Data collection will be carried out by the researcher with the assistance of trained field enumerators. Prior to data collection, informed consent will be obtained from all participants. The enumerators will be trained on ethical research practices, extraction of the secondary data, questionnaire administration, and how to ensure respondent confidentiality. The secondary data collection process will involve extracting data from the DHIS2 platform using a standardized data extraction tool. The data to be extracted shall include: Outpatient attendance for the number of patients attending outpatient services at 147 primary healthcare facilities implementing the BHCPF program; Antenatal care attendance for the number of pregnant women attending antenatal care services at 147 primary healthcare facilities implementing the BHCPF program; Delivery services for the number of deliveries conducted at the 147 primary healthcare facilities implementing BHCPF program; Immunization services for the number of children who completed their immunization against vaccine-preventable diseases at the 147 primary healthcare facilities implementing BHCPF program; and Family planning services for the number of clients accessing family planning services at 147 Primary Healthcare facilities implementing BHCPF. The questionnaires will be administered face-to-face using printed copies or tablets, depending on the accessibility of the location.This will be collected through administration of the Questionnaire on Utilization of Primary Healthcare Services After Introduction of Basic Healthcare Provision Fund and its Implementation to a representative sample of primary healthcare users in the study area through Google form on WhatsApp and retrieved after completion by the respondents.

THEORETICAL FRAMEWORK

In the context of this study, which assesses the impact of the Basic Healthcare Provision Fund (BHCPF) on the utilization of primary healthcare services in Nasarawa State, the IMB model provides a useful framework for understanding the dynamics that influence individuals' engagement with the Basic Minimum Package of Healthcare Activities (BMPHA). These include services such as maternal and child health, immunization, family planning, nutrition, and treatment for common illnesses.

From an information standpoint, it is essential that beneficiaries, particularly in rural and underserved communities, are aware of the services made available through BHCPF support. This includes not only awareness of what the BMPHA entails, but also where services are provided, whether they are free or subsidized, and how they can be accessed. Without this foundational knowledge, even well-funded healthcare services may remain underutilized. Misinformation or lack of targeted community health education campaigns can perpetuate misconceptions and limit engagement with available health services.

The motivation component of the model addresses both personal attitudes and social influences that determine whether individuals choose to use available services. Personal motivation includes beliefs about the relevance and quality of PHC services, perceived health needs, and trust in healthcare providers. Social motivation refers to community norms, religious or cultural values, and the extent of encouragement or discouragement from peers, family members, or local leaders. In areas where healthcare-seeking behaviours are influenced by traditional practices or where trust in government-funded programmes is low, motivation may be significantly constrained despite adequate service availability.

The third pillar, behavioural skills, encompasses the practical competencies and self-efficacy required to access and use health services effectively. These skills range from navigating local health systems, understanding treatment regimens, to communicating with healthcare providers. In many rural areas of Nasarawa State, physical barriers such as distance to health facilities, language differences, or administrative hurdles (e.g., lack of identity documentation) may hinder service uptake. The IMB model emphasizes that even when individuals are well-

informed and motivated, they may still fail to engage with services if they lack the skills, confidence, or logistical capacity to do so.

Importantly, the IMB model asserts that these three components are interconnected: behavioural skills serve as the conduit through which information and motivation are translated into concrete actions. In simple cases, such as visiting a clinic for immunization, information and motivation may be sufficient. However, for more complex behaviours, such as enrolling in long-term family planning programmes or seeking antenatal care early in pregnancy, interventions must actively build the necessary behavioural competencies.

Applied to this study, the IMB model suggests that the success of the BHCPF in improving the utilization of primary healthcare services depends not solely on the availability of funding or service expansion, but on the degree to which communities are adequately informed, sufficiently motivated, and practically equipped to access and benefit from those services. For example, a woman may know that antenatal care is free at a BHCPF-supported facility, but may still be deterred by cultural taboos, household decision dynamics, or the absence of female providers. Thus, policy success requires a multi-faceted approach that addresses behavioural, informational, and systemic gaps simultaneously. Thus, the Information-Motivation-Behavioural Skills model offers a strong theoretical basis for evaluating the mechanisms through which the BHCPF influences health-seeking behaviour in Nasarawa State. It helps explain why some individuals engage actively with PHC services while others do not, even when services are physically accessible and financially supported. As such, it serves as a guiding framework for interpreting programme effectiveness and designing future interventions that aim to increase the equitable utilization of primary healthcare services in the state. BHCPF's Impact on Healthcare in Nasarawa State

The World Bank (2022) conducted a national-level implementation review of the BHCPF, drawing lessons from pilot states including Nasarawa, Lagos, and Kano. The report used administrative data, technical audits, and stakeholder interviews to identify persistent implementation bottlenecks. Key challenges highlighted included infrastructure decay, inadequate planning at the facility level, unclear expenditure frameworks, and political interference. The report observed that although BHCPF had increased visibility and some funding predictability for PHCs, many facilities lacked the absorptive capacity to manage and utilize the funds effectively. In states like Nasarawa, the report acknowledged improvements in visibility but still documented gaps in infrastructure readiness and institutional governance. The study emphasized the need for greater investment in managerial capacity, local accountability, and transparent planning to ensure that the benefits of BHCPF are fully realized. These findings reinforce the systemic and multi-level challenges identified in the current study.

Okechukwu and Ibrahim (2020) conducted a qualitative study to explore socio-cultural and systemic barriers affecting the implementation of BHCPF in rural PHC centres in North-Central Nigeria. The study involved interviews with healthcare workers,local leaders, and patients in Niger and Kogi States. Findings revealed that despite the infusion of BHCPF funds, deep-seated cultural beliefs, preference for traditional medicine, and community mistrust of government services significantly limited service uptake. Additionally, healthcare providers cited frequent supply chain disruptions and weak health information systems as barriers to effective service delivery. The study concluded that while BHCPF implementation may appear structurally sound, poor cultural integration and community disconnection can erode its effectiveness. This aligns with the current study in Nasarawa State, where health workers also identified cultural and infrastructural bottlenecks as serious constraints.

Nwosu and Adewale (2020) examined political and institutional challenges in BHCPF implementation across Kogi and Zamfara States. The study adopted a policy analysis framework using document review and elite interviews with state health officials. It found that weak political will, funding delays, and bureaucratic centralization severely hampered the programme's success. Facilities often waited months for disbursement, lacked autonomy to spend funds, and faced excessive reporting requirements. Moreover, limited participation of local stakeholders in decision-making led to poor programme ownership at the grassroots level. The authors recommended decentralizing financial authority and strengthening local health governance. These insights complement the findings from Nasarawa State, suggesting that even where BHCPF is implemented, its potential is restricted by system-level inefficiencies and poor state–LGA coordination.

Bakare and Ajayi (2022) conducted a mixed-method study in three southwestern Nigerian states to assess the training and capacity needs of PHC workers under BHCPF. Using structured questionnaires and in-depth interviews, the study identified insufficient training, lack of standardized operational procedures, and inconsistent supportive supervision as major issues affecting healthcare providers. Health workers often lacked clarity on fund utilization guidelines and felt inadequately prepared to deliver the expanded Basic Minimum Package of Health Services. The study recommended continuous professional development and real-time feedback systems to support PHC staff. These findings are consistent with the Nasarawa-based evidence in your current study, where providers expressed concerns over limited capacity-building and ambiguity in fund management procedures.

Lawal et al. (2023) conducted a facility-based implementation analysis of BHCPF in 12 PHCs across northern Nigeria. The study used facility audits, staff interviews, and patient satisfaction surveys to identify operational bottlenecks. The findings showed that infrastructural deficits, shortage of skilled personnel, and overdependence on temporary staff reduced the quality and consistency of healthcare delivery. Facility managers also reported inadequate support for routine monitoring and weak integration with community health structures. Despite receiving BHCPF funds, many centres operated without functional power, water supply, or equipment for basic diagnostics. The study concluded that implementation success requires more than funding—it demands systemic investment in PHC readiness. This reflects the realities found in Nasarawa State, where implementation progress has been hampered by infrastructural gaps and inconsistent human resource deployment.

Table 1: Mean and standard deviation on level of utilization of primary healthcare services in Nasarawa State before and after the introduction of the BHCPF with focus on BMPHA

Primary Healthcare Services	**Period of Implementation of BHCPF**	**N**	**Mean**	**SD**
General Attendance	Before the introduction of the BHCPF	289	4525.84	7764.48
	After the introduction of the BHCPF	291	4293.27	3703.21
Out-patient Attendance	Before the introduction of the BHCPF	289	2662.25	8477.48
	After the introduction of the BHCPF	291	2101.91	1793.73
Antenatal Total Attendance	Before theintroduction of the BHCPF	289	742.89	1014.46
	After the introduction of the BHCPF	291	941.71	1250.27
X_Deliveries – Total	Before the introduction of the BHCPF	289	184.99	305.23
	After the introduction of the BHCPF	291	136.75	137.99
Penta 3 Given	Before the introduction of the BHCPF	289	254.34	215.36
	After the introduction of the BHCPF	291	259.84	232.67
Fully Immunized < 1 Year	Before the introduction of the BHCPF	289	221.19	175.39
	After the introduction of the BHCPF	291	209.19	188.34
Overall Mean	Before the introduction of the BHCPF	289	1431.91	2857.22
	After the introduction of the BHCPF	291	1323.78	1094.54

Note: n = Number of Respondents, = Mean, SD = Standard deviation

The result in Table 1 shows that the mean level of general attendance in utilization of primary healthcare services before the introduction of the BHCPF (= 4525.84, SD = 7764.48) was higher than the mean after the introduction of the BHCPF(=4293.27, SD = 3703.21). Similarly, the mean forout-patient attendance before the introduction of the BHCPF(= 2662.25, SD = 8477.48) was greater compared to the mean after the introduction of the BHCPF(= 2101.91, SD = 1793.73). The mean X-deliveries – total before the introduction of the BHCPF(= 184.99, SD = 305.23) was also greater when compared with the mean after the introduction of the BHCPF(= 136.75, SD = 137.99). Likewise, the mean for fully immunized < 1 year before the introduction of the BHCPF(= 221.19, SD = 175.39) was greater compared to the mean after the introduction of the BHCPF(= 209.19, SD = 188.34). However, the mean for antenatal total attendance after the introduction of BHCPF (= 941.71, SD = 1250.27) was higher compared to before (= 742.89, SD = 1014.46). In the same way the mean for Penta 3 given after the

introduction of BHCPF (= 259.84, SD = 232.67) was higher compared to before (= 254.34, SD = 215.36). The overall mean primary healthcare services utilization before the introduction of the BHCPF(= 1431.91, SD = 2857.22) was also greater when compared with the mean after the introduction of the BHCPF(= 1323.78, SD = 1094.54). This implies that the introduction of the Basic Healthcare Provision fund (BHCPF)with a focus on the Basic minimum package of activities had no considerable impact on the utilization of primary healthcare services in Nasarawa State.

Table 2: Mean and standard deviation on the extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities (BMPHA)(n=112)

S/N	Item Statements	Mean	Standard Deviation	Decision
1	The treatment of common childhood illnesses is adequately covered under BHCPF.	3.19	0.64	A
2	There has been a reduction in child morbidity due to improved services under BHCPF.	3.16	0.59	A
3	Parents now bring children for treatment more frequently due to BHCPF.	—	—	—
4	Pregnant women now have better access to antenatal services under BHCPF.	—	—	—
5	There is an improvement in the quality of antenatal services under BHCPF.	—	—	—
6	More pregnant women now attend antenatal clinics due to BHCPF.	—	—	—
7	The availability of skilled birth attendants has improved under BHCPF.	—	—	—
8	More women now deliver in healthcare facilities than before BHCPF.	—	—	—
9	There is an improvement in the availability of essential delivery equipment under BHCPF.	—	—	—
10	There is an increase in immunization coverage under BHCPF.	—	—	—
11	Availability of vaccines in health centers has improved.	—	—	—
12	More parents now bring their children for routine immunization due to BHCPF.	—	—	—
13	The availability of family planning services has improved under BHCPF.	—	—	—
14	More women now access family planning services due to BHCPF.	—	—	—
15	There is increased awareness and acceptance of family planning methods in communities.	3.15	0.60	A
	Grand Mean	**3.19**	**0.43**	**A**

Note: n = Number of Respondents, A = Agreed, D = Disagreed

The result in Table 2 indicates that the mean response for all the items (1-15) were above the criterion mean of 2.50, implying that the respondents agreed to the items. This means the respondents agreed that there is high implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities. In addition, the grand mean (= 3.19, SD = .43), is also above the criterion mean of 2.50, affirming that there is high implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities.

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Table 3: Mean and standard deviation on the challenges and limitations faced by healthcare providers in implementing the BHCPF in Nasarawa State with focus on the BMPHA(n=112)

S/N	Item Statements	Mean	Standard Deviation	Decision
1	Inadequate funding affects the effective implementation of BHCPF.	3.26	0.76	A
2	Shortage of healthcare personnel affects service delivery under BHCPF.	3.40	0.66	A
3	Insufficient training of healthcare workers on BHCPF guidelines limits its effectiveness.	3.17	0.68	A
4	Healthcare facilities face supply chain challenges in receiving essential medicines.	3.14	0.73	A
5	There is inadequate monitoring and evaluation of BHCPF implementation.	2.78	0.79	A
6	Poor infrastructure limits the proper implementation of BHCPF.	2.90	0.84	A
7	Community awareness about BHCPF remains low despite its introduction.	2.81	0.77	A
8	Bureaucratic bottlenecks delay the disbursement of BHCPF funds.	3.06	0.79	A
9	There is resistance to change among healthcare workers regarding BHCPF procedures.	2.94	0.77	A
10	Some healthcare beneficiaries complain about the quality of services under BHCPF.	2.96	0.72	A
	Grand Mean	**3.04**	**0.50**	**A**

Shortage of healthcare personnel affects service delivery under BHCPF.

Note: n = Number of Respondents, A = Agreed, D = Disagreed

The result in Table 3 shows that the mean response for all the items (1-10) were also above the criterion mean of 2.50 for accepting an item, which is indicative that the respondents agreed to the items as the challenges and limitations faced by healthcare providers in implementing the BHCPF in Nasarawa State with focus on the BMPHA.

Additionally, the grand mean (= 3.04, SD = .50), is also above the criterion mean of 2.50. This can be interpreted that healthcare providers are confronted by challenges and limitations such as inadequate funding, shortage of healthcare personnel, insufficient training of healthcare workers, inadequate monitoring and evaluation, poor infrastructure, bureaucratic bottlenecks, among others, in the implementation of the BHCPF in Nasarawa State with focus on the BMPHA.

SUMMARY OF THE FINDINGS

From data analysis and interpretation of results, the following findings emerged.

The introduction of the Basic Healthcare Provision fund (BHCPF) with a focus on the Basic minimum package of activities had no considerable impact on the utilization of primary healthcare services in Nasarawa State. Thus, further analysis revealed that there is no significant difference between the utilization of primary healthcare services in Nasarawa State before and after the introduction of the Basic Healthcare Provision Fund.

The utilization of primary healthcare services in Nasarawa State from 2018 to 2022 differ by the years. However, further analysis showed that there was no significant difference in the utilization of primary healthcare services in Nasarawa State from 2018 to 2022.

The factors influencing the utilization of primary healthcare services in Nasarawa State after the introduction of the BHCPF with focus on the BMPHA include awareness of available healthcare services, affordability of healthcare services, availability of drugs and medical supplies, accessibility of healthcare facilities, availability of qualified healthcare personnel, among others.

There is high extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities.

Healthcare providers are confronted by challenges and limitations such as inadequate funding, shortage of healthcare personnel, insufficient training of healthcare workers, inadequate monitoring and evaluation, poor infrastructure, bureaucratic bottlenecks, among others, in the implementation of the BHCPF in Nasarawa State with focus on the BMPHA.

SUMMARY OF THE FINDINGS

Primary healthcare (PHC) remains the cornerstone of equitable and accessible health systems globally. It serves as the first level of contact for individuals, families, and communities with the national health system and is essential for achieving Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs) (World Health Organization [WHO], 2021). The World Health Organization emphasizes that strong PHC systems are vital for reducing disease burdens, enhancing health equity, and improving the overall resilience of health systems, particularly in low-and middle-income countries like Nigeria (WHO, 2022). However, the actual utilization of PHC services in Nigeria has been suboptimal due to long-standing challenges such as weak infrastructure, inadequate human resources, lack of essential medicines, and poor financing mechanisms (Aregbeshola & Khan, 2021).

In response to the persistent underperformance of PHC, the Nigerian government introduced the Basic Health Care Provision Fund (BHCPF) as an integral component of the National Health Act of 2014. The fund officially commenced implementation in 2018 and was designed to revitalize the PHC system by increasing financial access to essential health services, particularly for the poor and vulnerable (National Primary Health Care Development Agency [NPHCDA], 2020). The BHCPF allocates at least 1% of the Consolidated Revenue Fund (CRF) annually to support primary health care delivery through the provision of a Basic Minimum Package of Health Services (BMPHS), especially in rural and underserved communities (Federal Ministry of Health, 2020). The BHCPF represents a strategic shift in Nigeria's health financing structure, aiming to strengthen facility-based service delivery, remove financial barriers to care, and institutionalize service utilization at the grassroots.

Despite this noble policy shift, evidence on the extent to which the BHCPF has enhanced PHC service utilization across states remains limited and context-dependent in Nasarawa State

A deliberate step to ensure BHCPF implementation in Nasarawa State, is to address these healthcare challenges. The fund provides financial support for basic healthcare services, including maternal and child health, communicable disease control, family planning, and essential medicines. The BHCPF implementation also aims to increase access to healthcare services for vulnerable populations, improving the quality of healthcare services and the reduction of out-of-pocket payments for healthcare and therefore enhancing the overall health system and

ensuring universal Health coverage. Significantly the outcome from analyzed data and interpretation of results, the following findings emerged.

1. The introduction of the Basic Healthcare Provision fund (BHCPF) with a focus on the Basic minimum package of activities had no considerable impact on the utilization of primary healthcare services in Nasarawa State. Thus, further analysis revealed that there is no significant difference between the utilization of primary healthcare services in Nasarawa State before and after the introduction of the Basic Healthcare Provision Fund.
2. The utilization of primary healthcare services in Nasarawa State from 2018 to 2022 differ by the years. However, further analysis showed that there was no significant difference in the utilization of primary healthcare services in Nasarawa State from 2018 to 2022.

3. The factors influencing the utilization of primary healthcare services in Nasarawa State after the introduction of the BHCPF with focus on the BMPHA include awareness of available healthcare services, affordability of healthcare services, availability of drugs and medical supplies, accessibility of healthcare facilities, availability of qualified healthcare personnel, among others.
4. There is high extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities.
5. Healthcare providers are confronted by challenges and limitations such as inadequate funding, shortage of healthcare personnel, insufficient training of healthcare workers, inadequate monitoring and evaluation, poor infrastructure, bureaucratic bottlenecks, among others, in the implementation of the BHCPF in Nasarawa State with focus on the BMPHA.

Extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria With Focus on the Basic Minimum Package of Healthcare Activities (BMPHA)

The study also found that there is high extent of implementation of the Basic Healthcare Provision Fund in Nasarawa State, Nigeria with Focus on the Basic Minimum Package of Healthcare Activities. In other words, the BHCPF had been implemented to a high extent in Nasarawa State, particularly with regard to the Basic Minimum Package of Healthcare Activities (BMPHA). This means that there is strong institutional efforts in delivering essential services such as maternal care, immunization, child health, and family planning across primary healthcare centres in the state.This result is expected given that the BHCPF was designed as a direct funding mechanism to strengthen PHC services at the facility level, especially in underserved areas. The Fund mandates the provision of routine services and essential medicines while also allocating resources for staff training and facility infrastructure. In Nasarawa State, the relatively high ratings by respondents suggest that the state government has actively pursued implementation strategies aligned with the fund's objectives.

This finding is supported by Osungbade and Ojerinde (2022), who in their multi-state implementation review found that Nasarawa was among the top five states with visible BHCPF implementation, evidenced by improved availability of vaccines and maternal health commodities. Also, the finding agree with that of Aliyu et al. (2021) who reported that in BHCPF-supported PHCs in Nasarawa, antenatal visits, immunization outreach, and deliveries by skilled attendants had noticeably increased. Furthermore, the finding lends support to that of the study by Agada and Enemuo (2023) who found that family planning awareness and uptake improved in BHCPF-activated PHCs in Nasarawa and Benue States alike, attributing this to structured service delivery protocols funded by the BHCPF.In contrast, the finding is inconsistent with that of Nwosu and Adewale (2020) who observed that in other parts of Nigeria, such as Kogi and Zamfara States, where weak governance and political interference limited BHCPF implementation, highlighting that success is often tied to political will and administrative accountability. Nasarawa's relatively high implementation level thus reflects a coordinated and focused effort by state actors and health authorities.

Challenges and limitations faced by healthcare providers in implementing the BHCPF in Nasarawa State with focus on the BMPHA

The study also revealed that despite the observed implementation successes, healthcare providers in Nasarawa State faced notable challenges in executing the BHCPF framework. These challenges included inadequate funding, shortage of healthcare personnel, insufficient training of healthcare workers, inadequate monitoring and evaluation, poor infrastructure, bureaucratic bottlenecks, among others. These challenges are not surprising given the broader context of Nigeria's health system, which is often characterized by underfunding, inefficiencies, and logistical limitations. The BHCPF, while structurally sound in design, depends heavily on regular fund disbursement, staff capacity, and intergovernmental coordination. Delays in releases from the federal level, unclear operational guidelines, and weak local accountability structures can all erode the intended benefits of the Fund.

Similar implementation barriers have been reported by several recent studies. For example, Eze and Adebayo (2021) found that in Kaduna and Kano States, frontline health workers identified bureaucracy and funding delays as key challenges in BHCPF roll-out. Likewise, Akinwale and Obinna (2022), in their evaluation of BHCPF across six states, noted that workforce shortages and poor supervision significantly undermined program

sustainability. Mohammed et al. (2023) added that lack of consistent monitoring and absence of performance-based incentives contributed to demotivation among health workers involved in BHCPF-supported activities. These findings are also consistent with World Bank (2022) reports which highlighted that while BHCPF had increased the visibility of PHC services across Nigeria, issues such as poor planning, inadequate infrastructure, and political interference remained recurring obstacles. In Nasarawa State, the convergence of these challenges, as revealed in your study, underscores the need for systemic reform and multi-sectoral support to ensure that the fund's implementation can be sustained and optimized for impact.

CONCLUSION

Based on the findings of this study, it was concluded that the Basic Healthcare Provision Fund (BHCPF), though widely implemented in Nasarawa State, did not yield a statistically significant improvement in the overall utilization of primary healthcare services. Comparative analyses revealed that service utilization rates before and after the introduction of the BHCPF were largely similar, with no meaningful year-on-year differences recorded between 2018 and 2022. This suggests that while BHCPF has been rolled out in structure and policy, its transformative impact on health-seeking behaviour and service uptake among the population has not been fully realized. However, the study found that the extent of BHCPF implementation with a focus on the Basic Minimum Package of Healthcare Activities (BMPHA) was high, with health workers affirming improved access to antenatal care, immunization, maternal health services, and family planning. Moreover, the study identified key factors influencing PHC utilization post-BHCPF, including awareness of available services, affordability, drug availability, facility accessibility, and the presence of skilled personnel. These factors were widely acknowledged as enablers of service uptake, yet their potential was undermined by systemic challenges. Significant implementation barriers/challenges such as inadequate funding, shortage of trained personnel, poor infrastructure, weak monitoring and evaluation frameworks, and bureaucratic delays, were reported by healthcare providers. These challenges likely account for the observed gap between policy implementation and measurable improvement in healthcare utilization. Overall, the study concludes that while BHCPF is a strategically sound policy initiative with the potential to strengthen Nigeria's PHC system, its full impact is contingent on the removal of structural constraints, community engagement, and stronger health governance mechanisms.

Implications of the Findings

The finding that the Basic Healthcare Provision Fund (BHCPF) had no statistically significant impact on the overall utilization of primary healthcare services in Nasarawa State, despite its widespread implementation, highlights the importance of aligning health financing interventions with community-based health education, systemic health governance, and capacity building strategies. This implies that there is a need for ongoing education of both healthcare providers and community members regarding the objectives, services, and benefits of the BHCPF. It suggests that without adequate health education, even well-structured financial interventions may fail to catalyze expected service utilization outcomes.

The study further found that utilization rates remained statistically unchanged from 2018 to 2022, indicating that resource inputs alone do not necessarily translate into increased healthcare access. This points to an urgent need to revise educational efforts targeting service providers, health administrators, and beneficiaries on how to navigate, deliver, and access primary healthcare within the BHCPF framework. Training modules should therefore emphasize not just fund disbursement mechanics but also community engagement strategies, communication skills, and service quality enhancement techniques.

The identification of awareness, affordability, availability of medical supplies, accessibility of facilities, and human resource adequacy as key factors influencing utilization also carries important educational implications. It implies that policymakers, healthcare managers, and educators need to prioritize capacity development programs that enhance provider-client relationships, promote public health literacy, and empower communities to take active roles in healthcare governance. Furthermore, training curricula for health workers would need to incorporate client-centered communication, transparency in service provision, and inclusive planning, all of which are essential for sustaining public trust and encouraging service utilization.

The reported high extent of BHCPF implementation affirms that state-level rollout can be effective, but this must be accompanied by continuous professional development for health workers. This includes health education on monitoring and evaluation tools, reporting standards, and feedback mechanisms that ensure service quality and accountability. Strengthening the skills of healthcare providers in health communication and behaviour change education is also necessary to bridge the gap between service availability and client uptake.

Finally, the persistence of challenges such as inadequate funding, poor infrastructure, insufficient training, and bureaucratic delays necessitates systemic educational interventions targeting health administrators and policy actors. These would need to focus on leadership development, evidence-based decision-making, resource management, and decentralization strategies to foster responsive and resilient healthcare delivery at the grassroots level.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made:

Federal and State Ministries of Health should complement BHCPF implementation with large-scale community health education campaigns that increase awareness of available services and how to access them, particularly in rural and underserved areas.

Healthcare training institutions and public health education programmes should include BHCPF implementation, monitoring, and service delivery strategies as part of their training curricula for frontline health workers and administrators.

Primary healthcare managers and local government health departments should strengthen community engagement structures, such as ward development committees and health facility boards, to enhance community ownership, accountability, and service demand.

Policy makers and implementers should address systemic barriers such as bureaucratic fund disbursement processes, workforce shortages, and infrastructure deficits, while investing in routine training and capacity-building for healthcare providers involved in BHCPF.

Educational and health planning authorities should facilitate continuous professional development opportunities for health educators and PHC workers, focusing on demand-generation strategies, health promotion communication, and referral linkage systems.

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