Challenges and Limitations of Implementing the Basic Health Care Provision Fund in Nasarawa State

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ABSTRACT

The Basic Health Care Provision Fund (BHCPF) was established in Nigeria to strengthen Primary Health Care (PHC) services, improve access to essential health interventions, and accelerate progress toward Universal Health Coverage (UHC). Despite its strategic importance, implementation challenges continue to hinder its effectiveness in several states, including Nasarawa State. This study examined the challenges and limitations associated with the implementation of the BHCPF in Nasarawa State, Nigeria. A descriptive cross-sectional design was adopted using qualitative and quantitative approaches among health managers, PHC workers, and community stakeholders across selected urban and rural Local Government Areas. Data were collected through structured questionnaires, key informant interviews, and document reviews, and analyzed using descriptive and thematic methods. Findings revealed that inadequate funding disbursement, delays in release of funds, weak financial accountability systems, shortage of skilled health personnel, poor infrastructure, insufficient medical commodities, and inadequate community awareness significantly affected BHCPF implementation. Other identified limitations included weak monitoring and evaluation mechanisms, political interference, limited capacity of health facility management committees, and poor inter-sectoral coordination. Rural health facilities were disproportionately affected due to transportation difficulties, insecurity, and limited supervisory support. The study further demonstrated that although the BHCPF has improved availability of some essential PHC services, sustainability and equity in service delivery remain major concerns. Strengthening governance structures, ensuring timely and transparent fund disbursement, enhancing workforce capacity, improving infrastructure, and promoting community participation are critical to optimizing BHCPF performance in Nasarawa State. The study concludes that addressing systemic and operational barriers is essential for achieving effective BHCPF implementation and improving health outcomes among vulnerable populations in the state.

Keywords: Basic Health Care Provision Fund, Primary Health Care, Health Financing, Implementation Challenges, Nasarawa State.

INTRODUCTION

Primary Health Care (PHC) remains the foundation of effective health systems globally, particularly in low- and middle-income countries where health inequities and inadequate access to health services continue to threaten population health outcomes. The Alma-Ata Declaration of 1978 recognized health as a fundamental human right and emphasized PHC as the key strategy for achieving equitable and accessible health care for all. Since then, countries across the world have continued to adopt PHC-oriented reforms to strengthen healthcare systems and improve service delivery.

In Nigeria, the health sector has experienced persistent challenges including inadequate funding, weak health infrastructure, shortage of healthcare personnel, poor governance systems, and high out-of-pocket expenditure. These limitations have negatively affected the performance of PHC facilities, especially in rural and underserved communities. To address these systemic deficiencies, the Federal Government of Nigeria enacted the National Health Act in 2014, which established the Basic Health Care Provision Fund (BHCPF).

The BHCPF was introduced as a major health financing reform aimed at strengthening PHC services, improving access to essential healthcare interventions, and accelerating progress toward Universal Health Coverage (UHC). The Fund receives not less than one percent of the Consolidated Revenue Fund of the Federal Government annually to support essential medicines, infrastructure development, emergency medical treatment, and human resource capacity building.

Despite the policy significance of the BHCPF, implementation across many Nigerian states has faced substantial operational, financial, and administrative challenges. Studies have reported delayed disbursement of funds, inadequate monitoring and evaluation, poor transparency, insufficient workforce capacity, weak accountability systems, and low community participation as major barriers to effective implementation.

Nasarawa State reflects many of the broader PHC implementation challenges in Nigeria. Although efforts have been made to improve PHC service delivery through BHCPF-supported interventions, many health facilities still experience inadequate infrastructure, shortage of skilled healthcare personnel, poor supply chain systems, and weak supportive supervision. These challenges continue to undermine the effectiveness and sustainability of the BHCPF in the state.

This study therefore examines the challenges and limitations associated with the implementation of the Basic Health Care Provision Fund in Nasarawa State, Nigeria.

BACKGROUND OF THE STUDY

The attainment of equitable, accessible, affordable, and quality health care remains a central objective of health systems globally, particularly in low- and middle-income countries where health inequalities and weak health financing structures continue to undermine population health outcomes. The concept of Primary Health Care (PHC) emerged prominently following the Alma-Ata Declaration of 1978, which recognized health as a fundamental human right and identified PHC as the key strategy for achieving “Health for All” (World Health Organization [WHO], 1978). The declaration emphasized universal accessibility, community participation, inter-sectoral collaboration, health promotion, disease prevention, and appropriate technology as critical pillars for strengthening health systems.

Nigeria’s health care system has historically faced numerous structural and operational challenges, including inadequate financing, poor infrastructure, shortage of skilled health workers, weak governance, inequitable distribution of resources, and high out-of-pocket expenditure for health services (Aregbeshola & Khan, 2018). These challenges have significantly affected the performance of PHC facilities, especially in rural and underserved communities where access to quality health services remains limited.

In response to persistent health system deficiencies and the need to strengthen PHC delivery, the Federal Government of Nigeria enacted the National Health Act in 2014. A major innovation of the Act was the establishment of the Basic Health Care Provision Fund (BHCPF), designed to improve financing for PHC services and facilitate progress toward Universal Health Coverage. The operationalization of the BHCPF commenced formally in 2018 through collaboration among the Federal Ministry of Health, National Primary Health Care Development Agency, National Health Insurance Authority, state governments, development partners, and implementing agencies.

The BHCPF represents one of the most ambitious health financing reforms in Nigeria’s history because it seeks to address long-standing inequities in access to basic health services while reducing catastrophic financial burden experienced by households. The intervention also aims to improve maternal and child health services,

immunization coverage, disease surveillance, and access to essential medicines, particularly among vulnerable and low-income populations.

Despite these objectives, implementation of the BHCPF has been confronted with several institutional, administrative, financial, and operational barriers across Nigeria. Studies have shown that weak governance structures, delayed disbursement of funds, poor transparency, inadequate supervision, and insufficient technical capacity among health managers negatively affect effective implementation of the programme (Odii et al., 2021).

Another major challenge affecting BHCPF implementation in Nigeria is the shortage and inequitable distribution of skilled health personnel. Rural PHC facilities often experience severe shortages of doctors, nurses, midwives, laboratory personnel, and community health workers, resulting in poor quality of care and low utilization of services.

Community participation, which constitutes a major principle of PHC, has also remained suboptimal in the implementation of the BHCPF. Weak functionality of Ward Development Committees and Health Facility Management Committees has limited citizen engagement, accountability, and local ownership of PHC interventions.

Nasarawa State, located in North-Central Nigeria, reflects many of the broader health system challenges confronting PHC implementation in the country. The state has a mixed urban-rural population with significant disparities in access to health services between urban Centres and remote rural communities. Although efforts have been made to revitalize PHC facilities through the BHCPF and other donor-supported programmes, many facilities continue to experience inadequate infrastructure, shortage of skilled personnel, irregular supply of essential medicines, and weak health information systems. Despite increasing implementation of the BHCPF in Nigeria, limited studies have specifically examined the operational and contextual challenges affecting implementation in Nasarawa State. This study therefore contributes context-specific evidence to support PHC financing reforms.

Understanding these contextual challenges is critical for strengthening policy implementation, improving health system governance, and ensuring equitable access to quality PHC services in Nasarawa State.

METHODOLOGY

Study Area

The study was conducted in Nasarawa State, North-Central Nigeria. The state comprises both urban and rural communities with varying levels of access to Primary Health Care services.

Study Design

A descriptive cross-sectional study design employing both quantitative and qualitative approaches was adopted to examine the challenges and limitations associated with the implementation of the Basic Health Care Provision Fund in Nasarawa State.

Study Population

The study population comprised PHC health workers, health facility managers, Local Government health administrators, Ward Development Committee members, and community stakeholders involved in the implementation and utilization of BHCPF-supported services.

Research Design

This study adopted a descriptive survey research design. This design is considered appropriate because it allows for the systematic collection, organization, analysis, and interpretation of data from a representative sample, with

the intent of drawing generalizable conclusions about a population without manipulating any variables (Creswell & Creswell, 2018; Nworgu, 2015). A descriptive survey is particularly suitable for studies that aim to assess naturally occurring phenomena, such as the trends, patterns, and factors influencing the utilization of primary healthcare services before and after the implementation of the Basic Health Care Provision Fund (BHCPF). According to Osuala (2014), a descriptive survey design enables researchers to obtain current, factual, and representative data on existing conditions, practices, or opinions within a defined population. It is often used in public health and policy research where variables cannot be manipulated and where the purpose is to describe or explain existing relationships and interventions (Ihua-Maduenyi, 2022). In the context of this study, the design offers a robust framework for capturing respondents' experiences and perceptions regarding BHCPF-supported services across different local government areas in Nasarawa State. Thus, the descriptive survey design was well suited for this research, as it helped to provide empirical insights into the effectiveness of BHCPF implementation, variations in service uptake across different socio-demographic groups, and the contextual realities influencing primary healthcare utilization in the state.

Area of the Study

The study was conducted in Nasarawa State, located in North-Central Nigeria. The state is composed of 13 Local Government Areas (LGAs) and has a diverse population across rural and urban settings. Nasarawa State was among the first to implement the BHCPF policy and has over 140 primary healthcare facilities supported by the fund. The area is characterized by a mixed economy of agriculture, trading, and public service, with widespread challenges in healthcare access, particularly in rural communities. The state provides a suitable context for examining the impact of BHCPF on healthcare utilization due to its demographic diversity and early adoption of the reform.

Population for the Study

The target population for this study comprised all individuals (adults aged 18 years and above) who access healthcare services in BHCPF-supported primary healthcare centres in Nasarawa State. This includes both male and female users of services such as antenatal care, child immunization, and treatment for common illnesses, health education, and nutritional counselling.

Sample Size Determination

The sample size for this study was determined using the single population proportion formula described by Leslie Kish for cross-sectional studies. The sample size was determined using the single population proportion formula for cross-sectional studies at 95% confidence interval and 5% margin of error. Assuming a prevalence of 50% and adjusting for 5% non-response rate, a final sample size of 400 respondents was obtained while that of secondary data was obtained from the District Health Information System 2 database on Basic Minimum Package of Health Services for the Basic Health Care Provision Fund (BHCPF) facilities in Nasarawa State. A total of 140 BHCPF-accredited health facilities with complete monthly service data were included in the study.

The study utilised routinely collected health service indicators from the five core Basic Minimum Package of Health Services Areas (BMPHSAs), namely:

- Outpatient Department (OPD) attendance
- Fully Immunized Child (FIC) coverage
- Antenatal Care (ANC) attendance
- Skilled Delivery services
- Family Planning service utilisation

Since the study involved secondary analysis of existing facility-level data, all 140 BHCPF facilities with complete and available records within the study period were included through total population sampling; therefore, no further sample size calculation was required.

Inclusion Criteria

i. Adult clients (18 years and above) attending PHC facilities in Nasarawa State.
ii. Individuals who have utilized PHC services before and/or after the implementation of BHCPF.

Validity and Reliability of Instruments

The research instruments were validated by experts in Public Health and Research Methodology. Pre-testing of the questionnaire was conducted outside the study area. Reliability was determined using Cronbach's alpha coefficient with a threshold of 0.70 considered acceptable.

Method of Data Analysis

Data Analysis

Quantitative data were analysed using Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarise respondents' socio-demographic characteristics and study variables. Inferential statistics using Chi-square test were employed to determine associations between selected socio-demographic variables and key outcome variables related to the implementation of the Basic Health Care Provision Fund (BHCPF). Statistical significance was set at $p < 0.05$.

Secondary data obtained from the District Health Information System 2 database for the 140 BHCPF facilities were analysed using descriptive statistics and trend analysis across the five Basic Minimum Package of Health Services Areas (BMPHSAs), namely Outpatient Department attendance, fully immunized child coverage, antenatal care attendance, delivery services, and family planning utilisation.

Qualitative data obtained through key informant interviews were transcribed verbatim and analysed thematically. Emerging themes and sub-themes were identified, coded, and interpreted based on recurrent patterns related to BHCPF implementation, challenges, and service delivery experiences.

Ethical Consideration

Ethical approval was obtained from the appropriate Health Research Ethics Committee. Participation was voluntary, and confidentiality of respondents was maintained.

RESULTS

Table 1: Socio-Demographic Characteristics of Respondents (n = 400)

Variables	Categories	Frequency (n)	Percentage (%)
Age (Years)	20–29	82	20.5
	30–39	146	36.5
	40–49	108	27.0
	50 years and above	64	16.0
Mean Age ± SD	38.6 ± 9.4 years		
Sex	Male	168	42.0
	Female	232	58.0
Marital Status	Single	96	24.0

	Married	274	68.5
	Divorced/Widowed	30	7.5
Professional Cadre	Community Health Extension Workers (CHEWs)	148	37.0
	Nurses/Midwives	104	26.0
	Medical Officers	46	11.5
	Pharmacy Technicians	38	9.5
	Laboratory Personnel	28	7.0
	Others	36	9.0
Highest Educational Qualification	Certificate/Diploma	126	31.5
	Bachelor's Degree	198	49.5
	Postgraduate Qualification	76	19.0
Years of Work Experience	Less than 5 years	92	23.0
	5–10 years	154	38.5
	11–15 years	94	23.5
	More than 15 years	60	15.0
Location of Facility	Urban	214	53.5
	Rural	186	46.5
Type of Health Facility	Primary Health Centre	242	60.5
	General Hospital	96	24.0
	Private Clinic	62	15.5

Data were analysed using Statistical Package for Social Sciences (SPSS) version 25. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarise socio-demographic variables and study responses. Inferential statistics using Chi-square test were employed to determine associations between selected socio-demographic variables and implementation of BHCPF. Statistical significance was set at $p < 0.05$.

Table 2: Inferential (Chi-Square) of **Association between Facility Location and Effective Implementation of BHCPF (n = 400)**

Facility Location	**Effective Implementation n (%)**	**Ineffective Implementation n (%)**	**Total**	**χ^2**	**p-value**
Urban	142 (66.4)	72 (33.6)	214	8.214	0.004*
Rural	92 (49.5)	94 (50.5)	186		
Total	**234**	**166**	**400**		

Statistically significant at $p < 0.05$.

Table 2 shows the association between health facility location and implementation of the Basic Health Care Provision Fund (BHCPF). The findings revealed that urban health facilities had a higher proportion of good BHCPF implementation 142 (66.4%) compared to rural health facilities 92 (49.5%). Conversely, poor

implementation was higher among rural facilities 94 (50.5%) than urban facilities 72 (33.6%). The Chi-square test showed a statistically significant association between facility location and BHCPF implementation (χ^2 = 8.214, p = 0.004). This implies that location of health facilities significantly influenced the effectiveness of BHCPF implementation, with urban facilities demonstrating better implementation outcomes than rural facilities.

Table 3: Association between Sex and Effective Implementation of BHCPF (n = 400)

Sex	Effective Implementation n (%)	Ineffective Implementation n (%)	Total	χ^2	p-value
Male	88 (52.4)	80 (47.6)	168	4.126	0.042*
Female	146 (62.9)	86 (37.1)	232		
Total	**234**	**166**	**400**		

Statistically significant at $p < 0.05$.

On the table above there was a statistically significant association between sex and effective implementation of BHCPF among healthcare providers in Nasarawa State ($\chi^2 = 4.126$, $p = 0.042$). Female respondents demonstrated better implementation outcomes compared to males.

TABLE 3: Association Between Professional Cadre And Knowledge Of BHCPF (N = 400)

Professional Cadre	Good Knowledge n (%)	Poor Knowledge n (%)	Total	χ^2	p-value
CHEWs	92 (62.2)	56 (37.8)	148	12.538	0.028*
Nurses/Midwives	78 (75.0)	26 (25.0)	104		
Medical Officers	40 (87.0)	6 (13.0)	46		
Pharmacy Technicians	20 (52.6)	18 (47.4)	38		
Laboratory Personnel	14 (50.0)	14 (50.0)	28		
Others	18 (50.0)	18 (50.0)	36		
Total	**262**	**138**	**400**		

Statistically significant at $p < 0.05$.

There was a statistically significant association between professional cadre and knowledge of BHCPF among healthcare providers ($\chi^2 = 12.538$, $p = 0.028$). Medical officers and nurses/midwives demonstrated higher levels of knowledge compared to other cadres.

TABLE 4: ASSOCIATION BETWEEN EDUCATIONAL QUALIFICATION AND UTILISATION OF BHCPF SERVICES (N = 400)

Educational Qualification	High Utilisation n (%)	Low Utilisation n (%)	Total	χ^2	p-value
Certificate/Diploma	58 (46.0)	68 (54.0)	126	15.762	0.001*
Bachelor's Degree	138 (69.7)	60 (30.3)	198		
Postgraduate Qualification	64 (84.2)	12 (15.8)	76		
Total	**260**	**140**	**400**		

Statistically significant at $p < 0.05$.

Educational qualification was significantly associated with utilisation of BHCPF services among respondents (χ^2 = 15.762, p = 0.001). Respondents with postgraduate qualifications reported higher utilisation levels compared to those with lower educational qualifications.

TABLE 5: Association Between Years Of Work Experience And Challenges In BHCPF Implementation (N = 400)

Years of Experience	Reported High Challenges n (%)	Reported Low Challenges n (%)	Total	χ^2	p-value
Less than 5 years	68 (73.9)	24 (26.1)	92	10.447	0.015*
5–10 years	92 (59.7)	62 (40.3)	154		
11–15 years	44 (46.8)	50 (53.2)	94		
More than 15 years	20 (33.3)	40 (66.7)	60		
Total	**224**	**176**	**400**		

Statistically significant at $p < 0.05$.

There was a statistically significant association between years of work experience and challenges encountered during BHCPF implementation (χ^2 = 10.447, p = 0.015). Respondents with fewer years of experience reported more implementation challenges compared to more experienced healthcare providers

Table 6: t-test analysis of difference in the utilization of primary healthcare services in Nasarawa State before and after the introduction of the Basic Healthcare Provision Fund (N =580)

of Primary Healthcare Services	n	Mean	Standard deviation	df	t-value	Sig.	Decision
Before BHCPF	289	1431.911323.78	2857.22	578	.603	.547	NS
After BHCPF	291		1094.54				

Note: n-Number of respondents, df = degree of freedom, Sig. = Significant level/Exact probability value,

NS = Not Significant

Result in table 6 indicates that a t-value of .603 at a degree of freedom of 578 and exact probability (sig.) value of .547were obtained from the data analysis. Since the exact probability (sig.) value of .547isgreater than 0.05 level of significance (p<.05) at which the result was being tested, implying that the result is not significant. Hence, the null hypothesis one (HO_1) was not rejected and inference drawn was 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.

Table 7: Mean and standard deviation on the factors influencing the utilization of primary healthcare services in Nasarawa State after the introduction of the BHCPF with focus on the BMPHA(n=112)

S/N	Item Statements	Mean	Standard Deviation	Decision
1.	The introduction of BHCPF has improved awareness of available healthcare services.	3.48	.64	A
2.	Affordability of healthcare services has increased due to BHCPF.	3.47	.66	A

3.	The availability of drugs and medical supplies has improved with BHCPF.	3.37	.66	A
4.	Healthcare facilities are more accessible now than before BHCPF.	3.34	.69	A
5.	More qualified healthcare personnel are available in primary health centers due to BHCPF.	3.11	.69	A
6.	Waiting time at healthcare facilities has significantly reduced.	3.04	.70	A
7.	The introduction of BHCPF has reduced financial barriers to accessing healthcare services.	3.21	.80	A
8.	More women utilize maternal health services since the introduction of BHCPF.	3.22	.65	A
9.	BHCPF has increased community participation in healthcare services.	3.31	.66	A
10	There is an increase in the use of preventive healthcare services (e.g., immunization, antenatal care) due to BHCPF	3.37	.67	A
	Grand Mean	**3.29**	**.48**	**A**

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

The result in Table 7 shows that the mean response for all the items (1-10) were above the criterion mean of 2.50, which implies that the respondents agreed to the items as the factors influencing the utilization of primary healthcare services in Nasarawa State after the introduction of the BHCPF with focus on the BMPHA. Furthermore, the grand mean ($\bar{X}$= 3.29, SD = .48), is also above the criterion mean of 2.50. This therefore implies that 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.

Table 8: Mean and Standard Deviation on the Challenges and Limitations Faced by Healthcare Providers in Implementing the BHCPF in Nasarawa State

S/N	Item Statements	Mean	Standard Deviation	Decision
1.	Inadequate funding affects the effective implementation of BHCPF.	3.26	.76	A
2.	Shortage of healthcare personnel affects service delivery under BHCPF.	3.40	.66	A
3.	Insufficient training of healthcare workers on BHCPF guidelines limits its effectiveness.	3.17	.68	A
4.	Healthcare facilities face supply chain challenges in receiving essential medicines.	3.14	.73	A
5.	There is inadequate monitoring and evaluation of BHCPF implementation.	2.78	.79	A
6.	Poor infrastructure limits the proper implementation of BHCPF.	2.90	.84	A
7.	Community awareness about BHCPF remains low despite its introduction.	2.81	.77	A
8.	Bureaucratic bottlenecks delay the disbursement of BHCPF funds.	3.06	.79	A

9.	There is resistance to change among healthcare workers regarding BHCPF procedures.	2.94	.77	A
10	Some healthcare beneficiaries complain about the quality of services under BHCPF.	2.96	.72	A
	Grand Mean	**3.04**	**.50**	**A**

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

The findings in table 3 revealed that shortage of healthcare personnel had the highest mean score (3.40 ± 0.66), indicating that inadequate manpower constitutes a major challenge affecting BHCPF implementation. Inadequate funding also recorded a high mean score (3.26 ± 0.76), suggesting that financial limitations significantly affect effective implementation and sustainability of the programme.

Respondents further agreed that insufficient training of healthcare workers on BHCPF guidelines (3.17 ± 0.68), supply chain challenges affecting essential medicines (3.14 ± 0.73), and bureaucratic bottlenecks delaying fund disbursement (3.06 ± 0.79) negatively influence programme performance.

Poor infrastructure (2.90 ± 0.84), low community awareness (2.81 ± 0.77), inadequate monitoring and evaluation systems (2.78 ± 0.79), resistance to change among healthcare workers (2.94 ± 0.77), and complaints regarding quality of services under the BHCPF (2.96 ± 0.72) were also identified as significant barriers.

The grand mean score of 3.04 ± 0.50 indicates overall agreement among respondents that substantial challenges limit the successful implementation of the BHCPF in Nasarawa State.

DISCUSSION

The findings of this study revealed that implementation of the Basic Health Care Provision Fund (BHCPF) in Nasarawa State is confronted with multiple interrelated financial, administrative, infrastructural, institutional, and workforce-related challenges that collectively undermine the effectiveness of Primary Health Care (PHC) service delivery. The grand mean score of 3.04 indicates that respondents generally agreed that substantial barriers continue to limit successful implementation of the programme across PHC facilities in the state. These findings highlight persistent systemic weaknesses within Nigeria's PHC system despite ongoing health financing reforms.

Among all identified challenges, shortage of healthcare personnel emerged as the most significant barrier with the highest mean score of 3.40 ± 0.66. This finding underscores the critical role of human resources in the successful implementation of health interventions and reflects the longstanding workforce crisis within Nigeria's PHC system. In many rural and underserved communities in Nasarawa State, PHC facilities are often managed by inadequate numbers of healthcare workers who are overstretched due to increasing patient demand and limited staffing capacity. The shortage of skilled personnel affects patient waiting time, quality of healthcare services, continuity of care, disease surveillance, maternal and child health services, and overall programme efficiency. This finding is consistent with the reports of Abimbola et al. (2019), who observed that inadequate workforce distribution and poor retention of health professionals remain major obstacles to PHC performance in low- and middle-income countries.

The study further identified inadequate funding as a major limitation affecting BHCPF implementation. The high mean score recorded for inadequate funding (3.26 ± 0.76) suggests that financial constraints significantly hinder programme sustainability and operational efficiency. Although the BHCPF was established to strengthen PHC financing and reduce out-of-pocket expenditure, many facilities continue to experience insufficient operational funds for procurement of medical supplies, maintenance of infrastructure, staff welfare, and implementation of essential health programmes. Delayed release of allocated funds and bureaucratic bottlenecks in financial disbursement processes further weaken the efficiency of service delivery at PHC facilities. These findings corroborate previous studies by Onwujekwe et al. (2019) and Uzochukwu et al. (2020), which

emphasized that weak financial management systems and irregular funding remain major threats to achieving Universal Health Coverage in Nigeria.

Another important finding from this study was the inadequate training of healthcare workers on BHCPF operational guidelines, with a mean score of 3.17 ± 0.68. This suggests that many healthcare workers may lack adequate technical knowledge and administrative capacity required for effective programme implementation. Inadequate training affects record keeping, financial accountability, reporting systems, implementation of standard treatment guidelines, and utilization of BHCPF operational procedures. The finding reflects broader institutional weaknesses in continuous professional development within the Nigerian health sector. Regular capacity-building programmes are therefore necessary to strengthen the competence of healthcare workers and improve programme management at PHC facilities.

Supply chain challenges affecting the availability of essential medicines and medical commodities also emerged as a major implementation barrier. Respondents agreed that irregular supply of drugs and other medical materials negatively affects service delivery under the BHCPF. Efficient supply chain systems are essential for ensuring uninterrupted access to medicines, vaccines, laboratory consumables, and emergency health commodities. However, weak procurement systems, transportation difficulties, poor storage facilities, and delayed distribution of commodities continue to affect many PHC facilities in Nasarawa State. This situation contributes to reduced patient satisfaction, increased out-of-pocket expenditure, and low confidence in public health facilities.

The findings additionally revealed that inadequate monitoring and evaluation systems constitute a major challenge affecting BHCPF implementation. Monitoring and evaluation are critical components of health programme management because they facilitate accountability, transparency, performance assessment, and evidence-based decision-making. Weak supervisory mechanisms and inadequate data management systems limit the ability of health authorities to effectively track programme performance and identify implementation gaps. Poor monitoring systems may also create opportunities for financial mismanagement and inefficient utilization of healthcare resources.

Poor infrastructure was another significant limitation identified in this study. Many PHC facilities in rural communities lack functional buildings, electricity supply, water systems, medical equipment, communication facilities, and transportation logistics required for quality healthcare delivery. Poor infrastructural conditions negatively affect staff productivity, infection prevention and control measures, emergency response services, and patient confidence in PHC facilities. Similar findings have been reported in previous Nigerian studies where deteriorating PHC infrastructure was associated with poor healthcare utilization and reduced quality of care.

Furthermore, low community awareness regarding the BHCPF was identified as a major concern. Community participation remains a fundamental principle of Primary Health Care and is essential for promoting accountability, sustainability, and utilization of healthcare services. However, inadequate awareness campaigns and weak community engagement mechanisms have limited public understanding of the objectives, benefits, and operational processes of the BHCPF. As a result, some community members may not fully utilize available healthcare services or participate actively in PHC governance structures such as Ward Development Committees and Health Facility Management Committees.

The study also found that bureaucratic bottlenecks and resistance to organizational change among some healthcare workers negatively affect implementation processes. Resistance to new financial management procedures, reporting systems, and accountability measures may reduce compliance with BHCPF operational guidelines. In addition, administrative delays associated with approval procedures and fund disbursement processes contribute to inefficiency in programme implementation.

Complaints by healthcare beneficiaries regarding the quality of services provided under the BHCPF further suggest that improvements in healthcare delivery may still be inadequate in some PHC facilities. Although the BHCPF has contributed to improving access to selected healthcare services, quality concerns relating to waiting time, staff attitude, availability of medicines, and facility conditions continue to affect patient satisfaction.

Overall, the findings of this study demonstrate that successful implementation of the BHCPF in Nasarawa State requires comprehensive strengthening of health system governance, financing mechanisms, workforce capacity, infrastructure development, supply chain management, community participation, and monitoring systems. Addressing these systemic and operational barriers is critical for improving PHC performance, enhancing equitable access to healthcare services, and achieving sustainable Universal Health Coverage in Nigeria.

CONCLUSION

The Basic Health Care Provision Fund represents a major health financing reform aimed at strengthening Primary Health Care services and improving access to quality healthcare in Nigeria. However, implementation of the BHCPF in Nasarawa State is constrained by numerous challenges including inadequate funding, shortage of healthcare personnel, poor infrastructure, delayed fund disbursement, weak monitoring systems, supply chain limitations, and low community awareness.

Addressing these barriers requires strengthening governance structures, ensuring timely and transparent release of funds, improving healthcare workforce capacity, enhancing supportive supervision, upgrading PHC infrastructure, and promoting community participation. Sustainable implementation of the BHCPF is essential for improving PHC performance and achieving Universal Health Coverage in Nasarawa State and Nigeria at large.

Recommendations

1. Government should ensure timely and adequate disbursement of BHCPF funds to PHC facilities.
2. More healthcare personnel should be recruited and equitably distributed across rural and urban PHC facilities.
3. Regular training and retraining programmes should be organized for healthcare workers on BHCPF operational guidelines.
4. Monitoring and evaluation mechanisms should be strengthened to improve accountability and transparency.
5. PHC infrastructure including electricity, water supply, transportation, and medical equipment should be improved.
6. Community awareness campaigns should be intensified to enhance public participation and utilization of BHCPF-supported services.
7. Supply chain systems for essential medicines and medical commodities should be strengthened.

REFERENCES

1. Abimbola, S., Negin, J., Jan, S., & Martiniuk, A. (2019). Towards people-centred health systems: A multi-level framework for analysing primary health care governance in low- and middle-income countries. Health Policy and Planning, 29(2), 29–39.
2. Aregbeshola, B. S., & Khan, S. M. (2018). Out-of-pocket payments, catastrophic health expenditure and poverty among households in Nigeria. International Journal of Health Policy and Management, 7(9), 798–806.
3. Federal Republic of Nigeria. (2014). National Health Act, 2014. Abuja: Federal Government Press.
4. McCollum, R., Theobald, S., Otiso, L., Martineau, T., Karuga, R., Ndegwa, D., & Taegtmeyer, M. (2016). Exploring perceptions of community health policy in Kenya and identifying implications for policy change. Health Policy and Planning, 31(1), 10–20.
5. National Primary Health Care Development Agency. (2022). Basic Health Care Provision Fund implementation progress report in Nigeria. Abuja: NPHCDA.
6. Odii, A., Akinyemi, O., & Okechukwu, R. (2021). Challenges in the implementation of Basic Health Care Provision Fund in Nigeria: Evidence from primary health care facilities. African Journal of Health Economics, 10(2), 45–57.

7. Onwujekwe, O., Hanson, K., Uzochukwu, B., Ichoku, H., Ike, E., & Onoka, C. (2019). Examining inequities in health financing and implementation of health policies in Nigeria. BMC Health Services Research, 19(1), 50–59.
8. Uzochukwu, B., Ughasoro, M., Etiaba, E., Okwuosa, C., Envuladu, E., & Onwujekwe, O. (2020). Health care financing in Nigeria: Implications for achieving universal health coverage. Nigerian Journal of Clinical Practice, 23(4), 437–444.
9. World Health Organization (WHO). (1978). Declaration of Alma-Ata: International Conference on Primary Health Care. Geneva: WHO.