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The Nigeria Basic Health Care Provision Fund (BHCPF): A Systematic Review of Policy Design, Implementation, Achievements and Challenges

Emmanuel Bola Jonah[1*]; Mary Ojonema Onoja-Alexander[2]; Ogwuche Igoche John[3]; Alabi Oladele Joshua[4]; Adah Patrick[5]

[1,2,3,4,5]Primary Health Care Development Agency. Lokoja- Kogi State

Corresponding Author: Emmanuel Bola Jonah[1*]

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Abstract: The Nigeria Basic Health Care Provision Fund (BHCPF) is one of the most significant reforms in health financing in Nigeria. It was created to strengthen Nigeria's health sector, improve access to healthcare, strengthen Primary Health Centres (PHCs), support emergency response and public health security, and support vulnerable groups. The BHCPF is also intended to accelerate the country's shift towards Universal Health Coverage (UHC), so that Nigerians can access equitable and affordable medical care. The National Health Act of 2014 (Section 11) established the BHCPF specifically to guarantee steady funding for essential healthcare services. It helps lower the out-of-pocket costs that push families into poverty and concentrates on improving health outcomes for those who need it most — women, children, and low-income communities. This review provides an overview of what is known about the BHCPF since 2014, including how it was developed, how it has been used in practice, what has worked, how it is managed, and where it continues to face challenges. As of 2026, official documents, policy papers, and research articles present a mixed but broadly positive picture. The BHCPF has enhanced access to critical care, improved facility budget control, expanded the number of people covered by health insurance, and improved the consistency of PHC funding. However, implementation has been limited by governance concerns, delays in fund release, inadequate state-level capacity, weak accountability, and persistent regional inequities. The review concluded that although the BHCPF is a transformative health financing model, its future viability depends on reinforcing accountability frameworks, strengthening state-level preparedness, improving transparency, and ensuring sustainable funding.

Keywords: *Basic Health Care Provision Fund, BHCPF, Health Financing, National Health Act, Primary Health Care, Universal Health Coverage.*

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I. INTRODUCTION

➢ *Background of the Study*

Nigeria's health system is beset by persistent problems, including inadequate primary health care (PHC) infrastructure and public health spending that remains well below recommended levels. Out-of-pocket spending accounts for over 70% of the country's total health expenditure, while the government's health budget accounts for less than 5% of total expenditure — far below the 15% Abuja target. Most Nigerians are at risk of catastrophic health payments, as only about 5% of the population has health insurance. Primary care clinics frequently lack basic amenities, medicines, and qualified staff, and poor, rural, and informal-sector households often sell assets or avoid care altogether when ill. Women, children, people with disabilities, and internally displaced persons have been disproportionately affected by these conditions, prompting policymakers to develop clearer financial protection mechanisms — for example, covering maternal care, children, and other vulnerable groups (Alawode et al., 2022).

To address these gaps, the 2014 National Health Act (Section 11) established the Basic Health Care Provision Fund (BHCPF), with the overarching goal of moving Nigeria significantly towards Universal Health Coverage (UHC). The BHCPF directs committed public and partner funds into PHC by financing a Basic Minimum Package of Health Services

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(BMPHS), strengthening facility operations, and subsidising care for impoverished and vulnerable Nigerians (Federal Republic of Nigeria, National Health Act, 2014).

The BHCPF is essentially designed to:

- Ensure that all Nigerians, particularly the underprivileged and disenfranchised, have access to essential PHC — preventive, promotive, curative, and rehabilitative.
- Provide PHCs with consistent funding for medicines, supplies, personnel, and upkeep; and
- Provide emergency and public health services through dedicated components.

➢ *Statement of the Review Problem*

Despite the introduction of the BHCPF as a major health financing reform to strengthen PHC and accelerate progress towards UHC, several systemic challenges continue to undermine its effectiveness. Existing evidence indicates that many PHC facilities still suffer from inadequate infrastructure, limited access to functional medical equipment, unreliable electricity and water supply, and poor transportation — particularly in rural and underserved communities (Federal Ministry of Health [FMoH], 2020; World Health Organization [WHO], 2023).

Shortages and inequitable distribution of skilled health workers — including medical officers, nurses, midwives, and Community Health Extension Workers (CHEWs) — continue to limit the quality and availability of essential health services despite BHCPF investment in human resource development (National Primary Health Care Development Agency [NPHCDA], 2024; World Bank, 2022). In addition, periodic stock-outs of essential medicines, vaccines, laboratory commodities, and other consumables remain common in many PHC facilities due to procurement delays, weak logistics management, and supply-chain inefficiencies (Onwujekwe et al., 2019; Odinenu et al., 2025).

Implementation of the BHCPF has also been uneven across Nigeria. States with stronger governance structures, higher institutional capacity, and greater political commitment have generally demonstrated better fund utilisation and service delivery outcomes than states with weaker implementation capacity, resulting in geographical inequities in access to quality PHC services (Chukwuma, 2023; World Bank, 2022). Governance challenges — including delays in fund disbursement, weak financial accountability, inadequate monitoring and evaluation, and occasional reports of diversion of health commodities — continue to affect the efficiency and sustainability of the programme (FMoH, 2020; WHO, 2023).

Although numerous government reports, policy documents, and empirical studies have examined specific components of the BHCPF, the available evidence remains fragmented. Most existing studies focus on individual aspects such as health financing, direct facility financing, insurance coverage, or service delivery, with relatively few studies providing a holistic synthesis of the Fund's policy design, implementation, achievements, and challenges. This fragmentation limits the evidence base available to guide policy reform and improve implementation.

➢ *Knowledge Gap*

A review of the existing literature reveals a significant gap in comprehensive evidence synthesis on the BHCPF. Specifically, there is limited systematic evidence that simultaneously examines:

- The policy design and theoretical foundation of the BHCPF;
- The implementation strategies and financing mechanisms adopted across different gateways;
- The achievements and outcomes of the programme in strengthening PHC and improving health service delivery;
- The remaining implementation challenges, governance issues, and policy implications for achieving Universal Health Coverage in Nigeria.

Addressing this knowledge gap through a systematic review provides policymakers, programme implementers, researchers, and development partners with consolidated evidence on what has worked, existing implementation bottlenecks, and priority areas for strengthening the BHCPF as a sustainable mechanism for financing primary healthcare in Nigeria.

➢ *Justification of the Review*

The Basic Health Care Provision Fund (BHCPF) represents one of Nigeria's most significant health financing reforms aimed at strengthening PHC and accelerating progress towards UHC. Since its operationalisation in 2019, numerous studies, government reports, and development-partner evaluations have examined various aspects of the BHCPF. However, the available evidence is dispersed across different sources, focuses on specific components of the programme, and often provides fragmented insights into its performance (FMoH, 2020; Onwujekwe et al., 2019).

There is therefore a need for a comprehensive systematic review that synthesises the existing evidence into an integrated understanding of the Fund's policy design, implementation, achievements, and challenges. This review is justified because it consolidates existing evidence from peer-reviewed literature, policy documents, government reports, and development-partner publications into a single body of knowledge, enabling a more comprehensive assessment of the BHCPF's contribution to strengthening PHC service delivery, improving financial protection, and advancing UHC in Nigeria (WHO, 2023; World Bank, 2022). The findings will also inform policymakers and programme managers by providing evidence on successful implementation strategies, existing bottlenecks, and lessons learned from the rollout of the BHCPF across different states. Evidence-informed policymaking is critical to improving resource allocation, strengthening governance and accountability, and enhancing the efficiency of health financing reforms (World Bank, 2022; Chukwuma, 2023).

This review will further support ongoing BHCPF reforms by identifying areas requiring policy modification

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and implementation strengthening, including Direct Facility Financing (DFF), the Vulnerable Group Fund (VGF), procurement systems, human resource management, and monitoring and evaluation frameworks (FMoH, 2020; NPHCDA, 2024). Furthermore, the review identifies existing research gaps. Although numerous studies have examined individual aspects of the BHCPF, limited research has systematically synthesised evidence across the programme's financing gateways, implementation mechanisms, health system outcomes, and governance challenges. Identifying these gaps provides direction for future research and impact evaluation (Onwujekwe et al., 2019; WHO, 2023).

Lastly, the review provides evidence to guide Nigeria's journey towards UHC. By examining how the BHCPF has influenced healthcare access, service quality, financial risk protection, and health system strengthening, the review generates practical recommendations for improving implementation and ensuring the programme's sustainability. These findings will be valuable to policymakers, development partners, researchers, and other stakeholders committed to achieving Sustainable Development Goal 3 (SDG 3), particularly the target of ensuring healthy lives and promoting well-being for all at all ages (United Nations, 2015; WHO, 2023).

➢ *Goal of the Review*

The primary goal of this systematic review is to critically examine and synthesise the existing evidence on the policy design, implementation, achievements, and challenges of the BHCPF in Nigeria. Specifically, the review assesses how the BHCPF has contributed to strengthening primary healthcare service delivery, improving health financing, enhancing financial risk protection, and advancing Nigeria's progress towards UHC (FMoH, 2020; WHO, 2023).

In addition, the review evaluates the effectiveness of BHCPF implementation strategies, identifies key successes and implementation bottlenecks, and generates evidence-based recommendations to inform policy reform, improve programme performance, and support sustainable health system strengthening in Nigeria (Onwujekwe et al., 2019; World Bank, 2022). By consolidating evidence from empirical studies, policy documents, and institutional reports, the review provides a comprehensive understanding of the BHCPF's role in improving access to quality primary healthcare and achieving equitable health outcomes across the country (Chukwuma, 2023).

The following questions were carefully considered in this systematic review:

- What informed the policy design of the BHCPF?
- How has the BHCPF been implemented?
- What implementation challenges exist?
- What achievements have been recorded?
- What policy lessons can strengthen the BHCPF?

➢ *Scope of the Review*

In this review a thorough examination of the literature on Nigeria's BHCPF since its establishment in 2014. Evidence from Nigerian and international sources — peer-reviewed research, government and non-governmental organisation reports, and other grey literature — published between 2014 and 2026 is covered. The review evaluates the BHCPF's contribution to PHC strengthening, financial protection, and UHC in Nigeria, focusing on its design, implementation, and consequences at the national and subnational levels.

II. METHODOLOGY

➢ *Inclusion Criteria*

Studies and reports pertaining to the BHCPF or its components (the emergency fund, insurance for vulnerable populations, and PHC funding) in Nigeria were included. Qualitative approaches (interviews, case studies), quantitative approaches (surveys, quasi-experimental evaluations), and mixed-methods studies were all of interest. Peer-reviewed journal articles, official government documents (laws, guidelines, press releases), reports from organisations such as WHO, the World Bank, and NGOs, and relevant conference proceedings were all considered. Because English is Nigeria's official language, only English-language materials were used. Reviews or commentaries that did not present new information were generally excluded unless they offered essential background.

➢ *Search Strategy*

Evidence for this review was gathered through broad searches across major academic databases, including PubMed, Scopus, Google Scholar, and African Journals Online. Official sources such as the Federal Ministry of Health, the NPHCDA, and the National Health Insurance Authority (NHIA) were also checked. Searches were refined using Boolean operators (AND/OR), with terms such as “BHCPF” AND Nigeria AND “primary health care”, to keep results focused and relevant. Reference lists of key publications were also searched for additional studies, and reports from the World Bank, WHO, and various NGOs were reviewed to identify policy briefs and evaluations of the BHCPF.

➢ *Screening and Selection*

Titles and abstracts were screened for relevance after de-duplication, after which full texts of potentially relevant sources were obtained. A PRISMA flow diagram was used to record the screening process (records identified, screened, excluded, and included), ensuring transparency in inclusion decisions. Disagreements were resolved through discussion, following independent screening by two reviewers.

➢ *Data Extraction*

A standard extraction form was developed to document publication details, study design and methodology, setting (national or state-specific), BHCPF components addressed, outcomes measured, and contextual notes (e.g., funding amounts, dates) for each included source. Outcomes of interest included PHC access and utilisation; health outcomes

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such as immunisation coverage and maternal/child mortality; equity and insurance coverage measures; and financial protection indicators (out-of-pocket spending, insurance enrolment). Narrative data on stakeholder roles, governance frameworks, implementation processes, and reported successes or difficulties were also extracted.

➢ *Quality Assessment*

Established frameworks were used to evaluate study validity: Critical Appraisal Skills Programme (CASP) checklists for qualitative studies, Joanna Briggs Institute (JBI) tools for quantitative studies, and transparency and rigour standards (e.g., WHO guidelines) for institutional reports. Risk of bias — including selection and measurement bias — was assessed for every empirical study. Press releases and policy statements were treated as authoritative but descriptive, rather than as evidence in the traditional sense.

➢ *Data Analysis*

Given the variety of data types, a narrative synthesis approach was used for quantitative findings (descriptively summarising published results) and a thematic synthesis approach for qualitative findings (coding text for themes). Variability in study designs and outcomes made meta-analysis impractical. Results were organised into thematic categories — implementation, impact, challenges, and so on — matching the outline below, with attention throughout to the consistency and strength of evidence across sources.

➢ *Risk of Bias Assessment*

To ensure the credibility, methodological rigour, and reliability of the findings included in this systematic review, the methodological quality and risk of bias of all eligible studies were critically appraised using internationally recognised quality assessment tools. The choice of appraisal instrument aligned with the study design of the included evidence (Joanna Briggs Institute [JBI], 2023; Sterne et al., 2016).

- *Assessment Tools*

✓ *Joanna Briggs Institute (JBI) Critical Appraisal Checklists*

Used to assess the methodological quality of qualitative studies, cross-sectional studies, cohort studies, case-control studies, quasi-experimental studies, and systematic reviews. The JBI tools evaluate study validity, methodological consistency, data collection procedures, and appropriateness of statistical analysis (JBI, 2023).

✓ *Critical Appraisal Skills Programme (CASP)*

Applied to qualitative studies and systematic reviews to evaluate research validity, methodological rigour, credibility of findings, and applicability of the evidence to healthcare practice (CASP, 2024).

✓ *Risk of Bias in Non-randomized Studies of Interventions (ROBINS-I)*

Used for non-randomised intervention and quasi-experimental studies evaluating BHCPF implementation, to assess potential bias arising before, during, and after intervention implementation (Sterne et al., 2016).

- *Assessment Domains*

The following domains were evaluated across the included studies:

✓ *Selection Bias*

Whether participants, facilities, or study populations were appropriately selected, and whether sampling procedures could have introduced systematic differences between comparison groups (Sterne et al., 2016).

✓ *Reporting Bias*

Selective outcome reporting, incomplete reporting of findings, and publication bias that could influence interpretation of results (Higgins et al., 2022).

✓ *Measurement Bias*

The validity and reliability of data collection instruments, outcome measurements, and consistency of measurement procedures across study participants (JBI, 2023).

✓ *Confounding Bias*

Whether important confounding variables were identified, measured, and adequately controlled during study design or statistical analysis, particularly in observational and quasi-experimental studies (Sterne et al., 2016).

✓ *Overall Quality Grading*

Following critical appraisal, each study was assigned an overall methodological quality rating (low, moderate, or high risk of bias) based on the respective tool's scoring criteria. Only studies of acceptable methodological quality were synthesised and interpreted, enhancing the validity and trustworthiness of the review's findings (JBI, 2023; Higgins et al., 2022).

➢ *BHCPF Framework*

The Legal and policy framework: Section 11 of the 2014 National Health Act established a new funding structure for Nigeria's healthcare system, establishing the BHCPF as a catalytic fund for basic healthcare. It stipulates that the Fund must receive at least 1% of the Consolidated Revenue Fund (CRF) annually, and mandates that donor grants and other funds also flow into it, making the BHCPF a multi-source fund. Under the Fund's legal framework, 50% is used to finance the Basic Minimum Package of Health Services (BMPHS) through the national health insurance programme, while the remaining 50% is allocated as follows: 20% for essential drugs, vaccines, and consumables; 15% for the provision and maintenance of PHC facilities, equipment, and transport; 10% for PHC human resource development; and 5% for emergency medical care, managed by a National Emergency Medical Treatment Committee (Federal Republic of Nigeria, National Health Act, 2014).

➢ *Funding Mechanisms*

In practice, BHCPF funding comes from three primary sources: (a) the federal grant (1% of the CRF), (b) donations

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from overseas donors, and (c) additional partners, including the private sector. Funds are received through a dedicated Treasury Single Account (TSA). According to official guidelines, 35% of the BHCPF (the NPHCDA gateway portion) is paid directly to PHC bank accounts as Decentralised Facility Financing (DFF), used for consumables, minor repairs, transportation, community outreach, and medicines. A further 10% is set aside for PHC workforce support, such as incentives or pay for community health workers and midwives. Around half of the funds go to the NHIA gateway to cover capitation and fee-for-service BMPHS payments to approved facilities, while 5% funds emergency ambulance and urgent care systems (NEMSAS) (NPHCDA, BHCPF Guideline, 2025).

- *Governance*

Management of the BHCPF is multi-layered. Oversight at the federal level is carried out by a Ministerial Oversight Committee (MOC), chaired by the Health Minister. The three implementing agencies (NPHCDA, NHIA, and the National Emergency Medical Treatment [NEMT] Committee) collaborate on policy and planning through an operational "Gateways Forum." State Oversight Committees (SOCs), modelled on the federal structure, ensure that state insurance agencies and health authorities implement BHCPF programmes at the state level. Each PHC is required to have a functional Ward Development Committee (WDC) or health facility committee to support community engagement at facility level. Overall, the structure is designed to ensure checks and balances: funds are managed through designated gateways, planning and budgeting occur at every level, and community actors participate in monitoring through WDCs and civil society organisations (CSOs) (NPHCDA, BHCPF Guideline, 2025).

- *Beneficiaries*

The BHCPF's target population is wide-ranging but explicitly pro-poor. The BMPHS is available to all Nigerians, with priority given to vulnerable populations. Pregnant women, children under five, people with disabilities, prisoners, refugees, internally displaced persons, and other marginalised groups can access free or subsidised care under the Vulnerable Group Fund (VGF), a component of the BHCPF managed by the NHIA. The BHCPF therefore aims to increase access both socioeconomically (by insuring the poorest) and geographically (through at least one PHC per ward). In practice, millions of low-income beneficiaries have been enrolled by state insurance agencies (Esomonu et al., 2022).

Alignment with policy goals: The BHCPF fits squarely within global and national health priorities. Internationally, it supports SDG 3 (Good Health and Well-being) and the broader push for UHC; nationally, it aligns with Nigeria's National Strategic Health Development Plan. At its core, the BHCPF directs funding to where it is most needed — primary health care. As the NPHCDA describes it, dedicated BHCPF financing "ensures operational funding is available at PHCs to deliver quality primary healthcare services nationwide, especially in rural areas, targeting low-income households" (NPHCDA, 2023). This direct support is a major step towards realising UHC and the SDGs in Nigeria. Health officials and civil society groups have also highlighted the BHCPF as a key tool for expanding health insurance and protecting families from catastrophic health costs. In recognition of growing demand, there are ongoing discussions in the National Assembly to increase the allocation from 1% to 2% of the CRF (Federal Republic of Nigeria, National Health Act, 2014).

- *Implementation and Operationalisation*

Fund disbursement and financial management: In the early years, BHCPF funding was released quarterly into the TSA of each gateway agency. Thirty-five percent of the funds were transferred directly to PHC bank accounts as DFF under the NPHCDA gateway, used by facilities for outreach, supervision, minor repairs, and essential medicines. Human resource funds (10%) are distributed through State Health Agencies, with at least half allocated to midwives and the remainder to community health workers. The NHIA gateway purchases BMPHS services from approved providers at predetermined capitation or fee-for-service rates, while the 5% emergency response allocation (ambulances, training) is managed through the NEMT gateway (NPHCDA, BHCPF Guideline, 2025).

Accountability measures have also been strengthened: the NPHCDA sets financial standards for spending, and facilities must submit quarterly reports and business plans to access funding. More recent reforms, described as "BHCPF 2.0," have introduced stricter oversight — for example, requiring digital recording of recipient identities to prevent fraud, and establishing a joint task force with the Independent Corrupt Practices Commission (ICPC) to monitor the use of grassroots funds. New guidelines aim to resolve misalignments and delays observed during early implementation, such as slow submission of facility plans and delayed transfer of state counterpart funding. Disbursements are now subject to stricter signature requirements and financial reporting deadlines, reflecting a broader push for transparency (NPHCDA, BHCPF Guideline, 2025).

Integration with existing programmes: The BHCPF was designed to supplement, rather than replace, existing health programmes. Under the NHIA gateway, the BMPHS largely overlaps with services already prioritised by insurance and public health programmes, so states link BHCPF funding with their health insurance schemes — enrolling BHCPF-eligible beneficiaries and providing PHC services (such as vaccinations and malaria treatment) within the insurance benefit package. BHCPF's PHC funding has also coincided with national campaigns for immunisation and maternal health; one study found that integrated measles, rubella, and polio campaigns achieved 92% coverage in northern states following BHCPF deployment, partly due to PHCs' improved cold-chain and outreach capacity. Similarly, the 5% emergency fund has been used alongside maternal health initiatives to finance emergency obstetric care, benefiting hundreds of women. In short, ring-fencing resources for PHC delivery is the BHCPF's main innovation, but the funds are frequently used within the broader framework of NHIS

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schemes and vertical health programmes (Uzochukwu et al., 2018).

Stakeholder engagement: The implementation guidelines place strong emphasis on broad participation. WDCs and facility committees are required to take part in planning and supervision at local level, and civil society organisations have been included in oversight forums to monitor health spending and promote transparency. Consultative forums have been held at national and state level, including with NGOs and donor partners, to guide the BHCPF's rollout — for example, WHO and UNICEF praised the Fund's evidence-based management in the 2025 annual BHCPF assessment. Despite these efforts, community awareness of BHCPF benefits has been inconsistent, and several assessments have found that many intended beneficiaries remain unaware of the programme (WHO, 2023).

Capacity-building and infrastructure: Implementation plans included substantial training and facility upgrades in recognition of skills gaps and readiness issues. A BHCPF training manual was developed for "training-of-trainers" workshops focused on management procedures and quality improvement for PHC staff, ward committee members, and local supervisors. Although skill shortages remain a challenge, many PHC staff report having received updated guidelines and refresher training. Infrastructure grants have supported clinic renovations and the installation of basic equipment; one study found that hundreds of PHCs have been revitalised through BHCPF and allied initiatives, with over 900 facilities upgraded under early BHCPF programmes and thousands more in progress. The BHCPF has also strengthened supply chains, with 20% of funds designated for essential medicines and immunisations at PHCs, providing a buffer stock of previously scarce supplies (Nigeria Health Watch, 2025; Uzochukwu et al., 2018).

Variations across states: Implementation has varied considerably by region. A 2024 mixed-methods study of six northern states (Bauchi, Borno, Kaduna, Kano, Sokoto, and Yobe) found that success depended heavily on planning and coordination. BHCPF funds were disbursed more smoothly in states with early start-up activity, established financial management systems, and partner support, while delays elsewhere stemmed from insufficient state-level oversight and slow approval of facility business plans. A separate survey in Kano State found that 62% of PHC staff were aware of the BHCPF and 57% were actively using the funds, though inadequate infrastructure, weak data systems, and staff shortages hindered fuller uptake. Overall, some states have pioneered effective strategies — such as equitable targeting of the poorest wards — while others lag due to administrative bottlenecks or insufficient capacity, underscoring the importance of local context to BHCPF's effectiveness (Igbokwe et al., 2024).

III. IMPACT AND OUTCOMES

- *Healthcare Access and Utilisation*

New data point to significant improvements in PHC utilisation in areas where the BHCPF is in effect. Government reports indicate that primary health care service use has grown substantially since the BHCPF's implementation — Nigeria recorded over 80 million PHC visits in the first half of 2025, a fourfold increase over baseline, attributed largely to BHCPF-financed improvements. Findings revealed that the number of BHCPF-supported functional facilities had expanded from 8,800 at baseline to 13,000, with plans to reach 17,000 in the next phase of implementation (Federal Ministry of Health, 2025).

Comparisons between facilities show that BHCPF-funded clinics provide more services than those without funding (Federal Ministry of Health, 2025). Recent evaluations found that BHCPF-supported PHCs recorded better service delivery — including more immunisations and maternal visits — and higher patient utilisation than non-supported PHCs. Socioeconomic and geographic equity have also improved: the Vulnerable Groups Fund has enrolled more than 21 million low-income Nigerians in insurance plans, with targeting mechanisms directing payments towards rural and underprivileged wards. By late 2025, 2.4 million vulnerable individuals were registered in BHCPF-supported insurance, providing a clear pathway to coverage for the poorest. By allocating resources at the grassroots level — at least one PHC per political ward — the BHCPF has begun to close historical service coverage gaps between urban and rural areas (Federal Ministry of Health, 2025).

- *Quality of PHC Services*

BHCPF's focus on facility readiness has led to modest quality improvements. DFF disbursements have enabled PHCs to stock basic medicines and maintain equipment, improving service continuity and reducing stock-outs (Quality of Care National Secretariat, 2019). Systematic surveys remain limited, but early patient and staff feedback points to increased satisfaction in BHCPF-supported facilities, with building upgrades and staff incentives appearing to improve morale. The 2025 government review found that BHCPF clinics "demonstrated stronger performance" on delivery measures compared with other clinics, though facility-level readiness still varies: many PHCs remain understaffed and lack specialists, and follow-up supervision is inconsistent (Federal Ministry of Health, 2025).

- *Health Services Package*

Evidence on the health impact of the BHCPF is still growing, but early results point to real improvements, particularly for mothers and children (Yahaya et al., 2025). Uptake of the minimum services package — including antenatal care (ANC 1 and 4), family planning, delivery services, newborn and postnatal services, immunisation, nutrition, laboratory services, and HIV, malaria, and tuberculosis care and treatment — appears to be improving where BHCPF-supported services are in place, largely due to increased access to quality primary healthcare and essential

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maternal and child health supplies (FMoH, 2022; NPHCDA, 2023).

In BHCPF-supported facilities, maternal deaths have declined. The Federal Ministry of Health reported approximately a 12% reduction in facility-based maternal mortality following BHCPF reforms (FMoH, 2022). Immunisation has also improved — investments in cold-chain systems and service delivery helped integrated measles, rubella, and polio campaigns reach about 92% coverage in targeted northern states (NPHCDA, 2023; WHO, 2023). The BHCPF's effect on malaria, tuberculosis, and HIV/AIDS has not yet been fully assessed, but its support for free childhood immunisation, malaria diagnosis and treatment, and other essential services is expected to strengthen disease control (WHO, 2023; UNICEF, 2023). Long-term data on under-five mortality remain limited, but simulation models and health systems analyses suggest that improved access to quality PHC through the BHCPF will likely reduce preventable illness and death among children over time (World Bank, 2022; WHO, 2023). Overall, available evidence suggests the BHCPF is already contributing to better health outcomes, though comprehensive long-term evaluations are needed to measure the full extent and sustainability of these gains (FMoH, 2022; World Bank, 2022).

- *Infrastructure, equipment, and transportation*

One of the BHCPF's most visible achievements has been the revitalisation of PHC infrastructure across Nigeria. Through the NPHCDA gateway, 15% of BHCPF resources are allocated to building, renovating, and maintaining PHC facilities, and to providing medical equipment, laboratory systems, and referral transport, with the goal of ensuring that every political ward has at least one functional PHC (FMoH, 2020; NPHCDA, 2024). Implementation reports show real progress: BHCPF support has helped rehabilitate dilapidated PHCs, install solar power and water systems, and provide delivery beds, diagnostic equipment, and ambulances. WHO (2025) notes that about 25% of BHCPF resources go towards infrastructure, equipment, and transportation investments that enable facilities to deliver safer, higher-quality care. To date, more than 1,200 PHCs have been revitalised, and over 8,000 PHCs now receive direct facility financing for routine maintenance and equipment procurement. These improvements have boosted service readiness and patient satisfaction, particularly in rural and underserved areas, although implementation capacity still varies by state, and some PHCs continue to face infrastructure deficits despite available BHCPF funding (Chukwuma, 2023).

- *Financial Protection*

The BHCPF is helping to ease the cost of healthcare for poor and vulnerable households in Nigeria. By funding PHC facilities directly and subsidising health insurance for vulnerable groups, the BHCPF has reduced reliance on out-of-pocket (OOP) payments for essential services (FMoH, 2020; NHIA, 2023). In BHCPF-supported facilities, people enrolled under the BMPHS can access essential services and medicines at no cost, helping to prevent catastrophic health expenditure (FMoH, 2020). Since the launch of the VGF, more than 21 million Nigerians have reportedly accessed healthcare with little or no direct payment, showing clear progress towards protecting households from financial risk (NHIA, 2023). Nigeria Health Watch (2023) similarly found that BHCPF funding directly reduces OOP spending for low-income households by providing free essential medicines and basic healthcare. While comprehensive national data on OOP reductions are still being gathered, growing enrolment of vulnerable people in publicly financed health insurance points to strengthening financial protection (WHO, 2023). The BHCPF's push to expand health insurance coverage also aligns with the broader goal of UHC; as more people become insured, households are expected to spend a smaller share of their income on healthcare over time (WHO, 2023; NHIA, 2023).

- *Essential Drugs, Vaccines, and Consumables*

The BHCPF has also strengthened the supply of essential medicines, vaccines, and medical consumables at PHC level. Twenty percent of the NPHCDA gateway allocation is dedicated to procuring and distributing drugs, vaccines, laboratory reagents, and other supplies needed for the BMPHS (FMoH, 2020). Direct facility financing has helped reduce stock-outs and improved vaccine availability, particularly for maternal and child health services; when medicines are consistently available, public trust in PHCs increases, service use rises, and households spend less out-of-pocket on basic care (Odinenu et al., 2025). BHCPF investment in cold-chain equipment, vaccine logistics, and outreach has also supported immunisation coverage, and WHO (2025) reports that improved access to vaccines and essential supplies through the BHCPF is advancing Nigeria's UHC agenda. Challenges persist, however: procurement delays, occasional stock-outs, and weak supply-chain systems in some states continue to affect performance, underscoring the need for stronger logistics management.

- *Emergency Medical Treatment*

The Emergency Medical Treatment (EMT) Gateway is a major BHCPF innovation. Five percent of BHCPF resources are allocated to the National Emergency Medical Treatment Committee (NEMTC) to strengthen emergency referral systems, ambulance services, trauma care, and emergency preparedness (FMoH, 2020). Through the EMT Gateway, emergency response assets have been mapped, emergency medical centres established, ambulances procured, personnel trained, and standard operating procedures for emergency care developed. These steps have improved referral pathways between PHCs and secondary facilities and reduced delays in accessing urgent care. While implementation is still maturing, stakeholders note that the BHCPF has laid the institutional groundwork for a coordinated national emergency response system; further investment in infrastructure, workforce, and financing will be critical to improving emergency outcomes nationwide.

- *Human Resources Development*

Strengthening the health workforce is another key BHCPF achievement. Ten percent of the NPHCDA allocation is earmarked for recruiting, training, deploying, and retaining PHC staff (FMoH, 2020). The Fund has supported the hiring of nurses, midwives, CHEWs, laboratory

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personnel, and environmental health officers, with priority given to underserved rural areas, while ongoing professional development has built capacity in maternal and child health, disease surveillance, immunisation, and integrated management of childhood illness. Better staffing has translated into more available services, shorter waiting times, and improved quality of care, though workforce shortages, health-worker migration, and uneven distribution across states still limit the BHCPF's full impact (Odinenu et al., 2025).

➢ *Public Health Security*

This BHCPF gateway reflects Nigeria's commitment to epidemic preparedness and health system resilience. Under this arrangement, 1.25% of BHCPF resources go to the Nigeria Centre for Disease Control (NCDC) to strengthen disease surveillance, laboratory capacity, and outbreak response (NPHCDA, 2024). BHCPF investments have improved surveillance systems, expanded diagnostic capacity, trained frontline workers, and supported rapid detection and response to outbreaks such as cholera, Lassa fever, and COVID-19. WHO (2025) notes that linking public health security financing to PHC strengthening has improved coordination between surveillance and routine care, enhancing health system resilience and supporting progress towards UHC.

In Ogun State, the introduction of a unique patient identifier (the National Identification Number) under BHCPF 2.0 significantly improved data tracking and reduced duplicate claims, illustrating how digital innovation can increase accountability (Federal Ministry of Health, 2025). BHCPF-supported clinics in Kaduna State reportedly increased antenatal care visits after securing more consistent medicine supply (Nigeria Health Watch, 2025). By contrast, security challenges have hindered implementation in some remote areas of Borno and Yobe States, illustrating how local context shapes the BHCPF's impact. Overall, service use and patient satisfaction have risen significantly where BHCPF implementation has been prompt and well managed (such as in Bauchi and Kano), while benefits have been more limited where delays and confusion have persisted, as in parts of Sokoto (Igbokwe et al., 2024).

➢ *Unintended Consequences*

While the BHCPF has largely delivered positive results, some unintended consequences and implementation challenges have emerged. A key concern is governance and accountability: there have been reports of weak oversight, including cases where health commodities supplied through BHCPF facilities were diverted (FMoH, 2020; NPHCDA, 2023), highlighting the need for stronger supply-chain management, greater transparency, and tighter accountability systems. Another issue is uneven distribution — states with stronger governance, better institutional capacity, and higher compliance with BHCPF requirements have tended to attract and use more funds than weaker-performing states, risking a widening of existing gaps in access to quality primary healthcare across the country (World Bank, 2022; Uzochukwu et al., 2018). Some researchers also point to a possible trade-off: the focus on financing the BMPHS may draw attention and health workers away from other important, non-prioritised services, creating opportunity costs in already stretched PHC systems (Onwujekwe et al., 2019; FMoH, 2020). Despite these challenges, most evaluations agree that they are operational rather than structural, and can be addressed through stronger governance, better monitoring and evaluation, improved financial accountability, and continued capacity-building for state and local implementation teams (WHO, 2023; World Bank, 2022).

➢ *Challenges and Barriers*

BHCPF implementation has encountered a number of obstacles at various levels. The key challenges include:

- *Administrative and Bureaucratic Delays:*

Numerous reports describe regular delays in fund distribution. BHCPF reimbursements are occasionally delayed or withheld pending state-level counterpart funds, which are often required for service purchases; in one facility survey, 60–70% of respondents cited “delay in releasing funds” as a problem. Red tape and complex reporting requirements have hampered disbursements at the federal/state interface — for example, a study across six northern states found that late submission of quarterly facility plans delayed timely BHCPF payments.

- *Inefficiencies and Misuse:*

Inadequate financial management systems can lead to misallocation. A qualitative analysis of BHCPF accountability found widespread concerns about transparency and trust, with fears of corruption at different levels, and instances in which funds meant for PHC upkeep were redirected to other municipal expenses. Inadequate financial audits and inflated procurement have also been identified as forms of “leakage” in evaluations, pointing to broader shortcomings in Nigeria's health accounting systems (see Lessons Learned, below).

- *Political and Economic Factors:*

BHCPF implementation has generated political controversy. Funding levels have not risen above 1% of the CRF despite growing demand, and some states have been reluctant to institutionalise the required counterpart payments. Changes in government or health leadership can slow decision-making and disrupt continuity, and political interference has occasionally been observed — for example, BHCPF funds have reportedly been diverted to prominent infrastructure projects by local politicians, potentially distorting priorities. Nigeria's unstable economy and rising healthcare costs also mean the fixed 1% allocation becomes progressively less adequate over time.

- *Monitoring and Data Challenges:*

Monitoring and evaluation of the BHCPF has proven difficult. Weak health information systems make it challenging to track service delivery and outcomes at PHC level, and a WHO assessment identified “poor data management” as a systemic problem. Without reliable data, oversight bodies struggle to verify that funds are yielding the intended results; although early BHCPF guidelines required facilities to produce reports, enforcement has been uneven,

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and impact evidence has often remained anecdotal or dispersed.

- *Health System Capacity:*

Many PHCs lack the staff and resources needed to properly absorb BHCPF funding at facility level. Research indicates a severe shortage of qualified healthcare professionals — in one survey, 85% of PHC managers identified inadequate training as a barrier, and in another, almost 88% of workers reported that their PHC's infrastructure was poor. Even where funds arrive, facilities sometimes struggle to convert them into better service delivery because of these capacity constraints, and national studies suggest these factors together have produced "sub-optimal" adoption in most states.

- *Socio-Cultural Barriers:*

In many areas, there is limited community understanding of and trust in the BHCPF. Multiple reviews found that only about half of the targeted population were aware of the BHCPF or its benefits. Persistent doubts about the quality of public treatment, combined with limited community involvement in PHC oversight, have contributed to mistrust and occasional non-use of upgraded services. Gender norms also play a role — in some areas, women require their spouses' permission to receive care, which can lead to underutilisation of even free services — and ensuring that marginalised groups, such as ethnic minorities and nomadic communities, actually access BHCPF-funded services remains a challenge that many programmes fail to solve.

In conclusion, despite its innovative design, BHCPF implementation has been hampered by bureaucratic inertia, governance shortcomings, and deep-rooted health system inefficiencies. These barriers must be addressed if the Fund is to meet its goals.

➢ *Lessons Learned and Best Practices*

Despite these setbacks, several meaningful strategies and innovations have emerged:

- *Fiduciary Transparency and Accountability:*

Establishing a dedicated TSA and predetermined payout parameters has allowed funds to be allocated directly to facilities, while oversight groups and thorough audits have improved accountability. Promising recent developments include automated fund tracking and a public transaction registry; for example, BHCPF 2.0 established a task force with the ICPC to oversee spending, alongside conflict-of-interest procedures, and WDCs are now required to submit project plans, further improving transparency. Best practice: publish BHCPF spending plans and budgets online, and engage independent auditors to verify the use of funds.

- *Digital Health Tools:*

The introduction of digital IDs for patients is a notable breakthrough — the National Identification Number (NIN) was adopted as a beneficiary ID, improving claims monitoring and reducing fraud. The BHCPF also encourages state insurance agencies to process claims through electronic dashboards, speeding up payments and improving data precision. Best practice: use mobile apps to enrol beneficiaries and schedule appointments, and extend e-claims and real-time reporting to all states.

- *Transformative Service Delivery Models:*

Decentralised Facility Financing (DFF) has reduced procurement delays by giving PHCs direct funds to purchase necessities, and has been identified as a scalable model for other countries. The BHCPF has also encouraged task-shifting by funding midwives and community health workers, and the emergency component (NEMSAS) has funded telemedicine pilots and mobile emergency medical units, expanding reach into rural areas. Best practice: strengthen DFF by tying funding to performance, and use telehealth to support distant PHCs with BHCPF funding.

- *Partnership and Community Ownership:*

Engaging communities through WDCs has proven crucial — in areas where WDCs are active, facility committees help determine spending priorities based on community needs (such as outreach and sanitation facilities), and civil society groups in several states have taken on watchdog roles by conducting social audits of BHCPF utilisation. Involving religious and traditional authorities in promoting the BHCPF (for example, through town-hall meetings) has also increased service uptake. Best practice: make community representation on oversight committees mandatory, and provide WDC members with regular training and opportunities to participate in state BHCPF forums.

- *Scalability and Lessons for Others:*

The BHCPF model — a legally protected, ring-fenced PHC fund — is relatively rare among low- and middle-income countries. Its achievements — direct facility funding, insurance for the vulnerable, and multi-sector governance — offer a model for similar contexts; the combination of supply-side financing with insurance demand incentives, and the emphasis on professionalised monitoring and evaluation (with WHO support), are particularly instructive. Nigeria's approach to PHC coordination through state agencies and community committees could serve as an example for countries with devolved health systems. Scalable practice: establish a statutory PHC fund modelled on Nigeria's approach, with centrally pooled federal funds distributed transparently and monitored by multiple stakeholders.

- *Adaptive Policy Measures and Recommendations:*

Experience shows that adequate and stable funding is essential. At a 2025 UHC session, stakeholders unanimously recommended increasing the BHCPF allocation to 2% of the CRF, arguing that increased financing would enable quicker medicine restocking and extend coverage to the most impoverished wards. Other suggested reforms include tying a portion of BHCPF allocations to equity criteria favouring underprivileged regions (as begun under BHCPF 2.0), requiring state counterpart funding to secure local buy-in, and integrating BHCPF planning into state health budgets to improve efficiency. Best practices include advocating for a legislated increase in the BHCPF percentage, tying funding

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releases to clear performance indicators, and aligning BHCPF programmes with state health plans.

IV. CONCLUSION

The BHCPF is still young, but this review shows it has already made a meaningful difference to primary healthcare in Nigeria. By setting aside at least 1% of federal revenue, plus partner funding, for grassroots health, the Fund has helped reduce financial barriers and strengthen PHC infrastructure. Tens of millions more people are using PHC services each year, and more vulnerable Nigerians are enrolled in health insurance.

In BHCPF-supported communities, facility-based maternal deaths have declined and immunisation rates have risen. Improved medicine supplies and clinic renovations have also raised the overall quality of care (Nigeria Health Watch; WHO African Health Observatory; FMoH; NPHCDA). That said, progress continues to be constrained by persistent challenges: governance gaps and funding shortfalls — including the need to move beyond the current 1% CRF ceiling — limit what the BHCPF can achieve. The experience so far makes one thing clear: funding alone is not enough. Strong accountability systems and the capacity to deliver at federal, state, and local levels are equally essential.

The policy message is straightforward. To move closer to Universal Health Coverage, Nigeria needs to protect and build on BHCPF reforms by increasing funding, simplifying processes, and tightening oversight. The BHCPF offers a useful model of ring-fenced financing for PHC; with BHCPF 2.0 now rolling out, continuous monitoring of performance data and regular programme adjustments can help consolidate early gains and close remaining gaps.

Important questions remain. Few long-term impact studies exist, so there is an urgent need for research on cost-effectiveness, equity, and patients' actual experience in BHCPF facilities. Future work should also incorporate community perspectives, monitor for unintended effects on other health services as BHCPF financing evolves, and examine in greater depth the effectiveness of BHCPF interventions in funded PHCs.

Ultimately, the BHCPF demonstrates Nigeria's commitment to primary care and UHC. Its early results and the lessons learned so far can guide broader health system strengthening. Sustained monitoring and evaluation, and continued openness to policy adjustments — including funding levels — will be key to ensuring the BHCPF delivers on its promise for Nigeria's health sector.

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