Enabling Collaborative Leverage for Reaching Universal Health Coverage Targets for Enrollee, Vulnerable and Hard-to-Reach Population in Kogi State by 2030 (A Scoping Review)

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ABSTRACT

This descriptive exploratory study was funded by the Kogi State Basic Health Care Provision Fund (BHCPF) - National Primary Health Care Development Agency (NPHCDA) Gateway and the integrated supportive supervisory (ISS) survey for Q2, 2025 was a scoping review conducted to observe the status of the revitalization projects at ward focal Basic Health Care Provision Fund (BHCPF) PHCs (n=51) between the 16th to 19th of July, 2025. The non-exposure assigning descriptive study was focused on the tracking and analysis of strategic system performance covering quarter two of 2025 as a criterion for management decision making for action to be taken towards the improvement of equitable and qualitative uptake of BMPHS by enrollee and vulnerable and hard-to-reach population in line with the improvement of universal health coverage (UCH) and compliance with all stipulated project timelines provided by funders to contractors of projects (NPHCDA, Global Fund and PSHAN) in 18 LGAs from the 3 senatorial districts of Kogi State. The data was obtained through a semi-structured checklist that was deployed online for real-time capture by 15 supervisors and monitors on the link: https://ee.kobotoolbox.org/x/CzKEK3Of. The process that provided the quantitative and qualitative data for the analytical epidemiology on the revitalization project status of PHCs (n=51) adhered to the PRISMA-ScR guideline for the scoping review of qualitative observations obtained during the exercise where the PHCs (n=51) were visited. The results are representative of 10% of projects nearing completion with finishing touches required compared to 25% of sites with activity on-site, but with insufficient pace. Lack of accommodation affects staff retention and performance observed in 60% of PHCs visited, while 40% of the PHCs visited have boreholes are that are dysfunctional or community-funded. The identification and quantification of proximate socio-ecological moderators and mediators is towards enabling one-health environment for the scale-up of risk-pooling in line with the goals of the SDG 3.8.

Keywords: Basic Health Care Provision Fund (BHCPF), PRISMA-ScR, Universal Health Coverage (UHC), Kogi State Primary Health Care Development Agency (KSPHCDA), Integrated Supportive Supervisory (ISS) survey.

INTRODUCTION

Background Information

The descriptive exploratory study was conducted through epidemiologic analytical methodology to observe the performance of categorical, qualitative and quantitative operational indicators covering the second quarter of 2025. The Integrated Supportive Supervisory (ISS) exercise captured the data during a four-day process on an open data kit online real-time in 18 Local Government Health Authority (LGHA) and 51 PHCs, through the analytical epidemiology to observe selected indicators from the semi-structured checklist for a PRISMA-ScR guideline applied scoping review based on the test of hypothesis at 95% CI based on prioritization from the qualitative indicator yield analyzed on QDA Miner lite and Microsoft Copilot.

The determinants of the revitalization status, infrastructural deficiencies, operational and environmental concerns were derived through analysis. The essential public health function variables covering the

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Administrative systems and infrastructure, Health Financing and Financial Management System, Human Resources for Health, Reproductive, Maternal, Newborn Maternal and Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N), Essential drugs, Laboratory, Health Management Information System (HMIS) and ICT, Patient Care Management, Clinical Utilization, Community Involvement and Client Perception was designed as a strategic approach towards the improvement of the Universal Health Coverage towards reaching the SDG 3 2030 targets in Kogi State.

The identification, quantification, characterization and analysis of relevant proximate outcome indicators was conducted from observations made by n=15 monitors and supervisors during the planned exercise by top management of the Kogi State Primary Health Care Development Agency (KSPHCDA) after a one-day pre-planning meeting for supervisors and monitors on the 15th of July 2025 to reduce confounding error. The study prioritized and selected 11 indicators outcome indicators for the scoping review and applied PRISMA- ScR process for analysis towards improved fiscal alignment or compliance to stipulated BHCPF ward focal (n=51) revitalization projects funded by NPHCDA gateway, Global Fund and PSHAN. The evaluation of supply-side risk factors was to determine the accessibility, quality and equitability of scalable basic minimum package of health services (BMPHS) for uptake by enrollee, vulnerable, and hard-to-reach population.

Justification

The analysis through the analytical epidemiology to observe selected 11 qualitative outcome indicators from the checklist that applied PRISMA-ScR scoping review guideline covered the three senatorial districts of Kogi State (n=51). The descriptive exploratory survey was conducted to provide evidence for inference towards action required by management towards ensuring the alignment and compliance for the revitalization projects.

The inferences from the PRISMA-ScR guided scoping review provided leverage for prioritization of opportunities, risk-factor amelioration and analysis to outline the categorization of moderators and mediators in the three senatorial districts of Kogi State from data obtained online real-time (see 3.1) from an ISS survey.

Objectives Of the Study

The objectives of the study are specifically as follows: -

1. To identify, quantify and characterize 11 outcome performance indicators of PHC revitalization projects from the observations made during a four-day ISS process for improving analytical epidemiology and presentation to management for action to be taken to tackle challenges.
2. To utilize PRISMA-ScR scoping review to qualify 11 prioritized outcome indicators performance, compliance and the identification of the probability of risk factor variable hindering the revitalization process and results.

Research Questions

1. What is the level of fiscal alignment and compliance with timelines and processes for revitalization projects in the 18 LGHA that determine demand and supply-side risk factors to UHC at ward level BHCPF sites?
2. What are the optimization of integration measures to reduce fragmentation due to slow or non-commencement of revitalization projects at ward level BHCPF sites?
3. What are the moderators and mediators of the determinants of leadership and essential public health functions explored?

Research Hypothesis

BHCPF ward focal sites for revitalization (n=51) in Kogi State have performed or not-performed linked associated indicators compared set timelines for project completion.

H_0: The performance and non-performance in the revitalization projects of BHCPF ward focal PHCs (n=51) are equal to 0% (p=0)

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H_1: The performance and non-performance are not equal to 0% in the revitalization projects of BHCPF ward focal PHCs (n=51) ($p \neq 0$)

We reject null hypothesis if Sig<0.05.

Definition Of Key Terms

General

Basic Health Care Provision Fund (BHCPF) is a three-pronged approach to the financing of the strengthening of health systems and services at basic obstetric care or primary health care level backed-up by the 2014 National Health Act (NHA). The BHCPF is derived from 1% of the consolidated revenue fund to promote Universal Health Coverage through the NPHCDA, NHIS and CDC Gateways.

Health Security and Emergency Preparedness refers to a systematic approach to identifying, assessing and mitigating health risks associated with potential emergencies and disasters so that no one is left behind.

Essential public health functions. The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness [9].

Collaborative care. Care that brings together professionals or organizations to work in partnership with people to achieve a common purpose.

Primary Health Care (PHC) is a system and a whole society approach that is the first point of contact for health care focused on equitable improvement of the health status and wellbeing of the population as early as possible along the continuum of care through health promotion, disease prevention and treatment, rehabilitative and palliative prongs (WHO 2024). The PHC transformational role is a logical and crucial focus in primary care development.

Fragmentation (of health services). (a) Coexistence of units, facilities or programmes that are not integrated into the health network; (b) the lack of service coverage of the entire range of promotion, prevention, diagnosis, treatment, rehabilitation and palliative care services; (c) the lack of coordination among services in different platforms of care; or (d) the lack of continuity of services over time.

Health. State of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.

Health benefits package. The type and scope of health services that an NHIS buys from a ward focal Basic Health care Provision Fund (BHCPF) Primary Health Care centre on behalf of its enrollees.

Health governance. The wide range of steering and rule-making related functions carried out by governments and decision-makers as they seek to achieve national health policy objectives. Governance is a political process that balances competing influences and demands. It includes: maintaining the strategic direction of policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behaviour of a wide range of actors, from health care financiers to health care providers; and establishing transparent and effective accountability mechanisms [9].

Health in All Policies approach. An approach to public policies across sectors that systematically takes into account the implications for health and health systems of decisions, seeks collaborations, and avoids harmful health impacts in order to improve population health and health equity. A Health in All Policies approach is founded on health-related rights and obligations. It emphasizes the effect of public policies on health determinants and aims to improve the accountability of policy-makers for the effects on health of all levels of policy-making [9].

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV August 2025 | Special Issue on Public Health

Universal Health Coverage (UHC) refers to availability and scalability of qualitative health services that they need, when and where they need them, without financial hardship.

Horizontal integration. Coordination of the functions, activities or operating units that are at the same stage of the service production process; examples of this type of integration are consolidations, mergers and shared services within a single delivery platform [9].

Indicator. Explicitly defined and measurable metric, that helps in the assessment of the structure, process or outcomes of an action or a set of actions.

Integrated health services. The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the health system [9].

Population-based approach. An approach to health services that uses information about the population to make decisions about health planning, management, and geographical location. Such an approach seeks to improve the effectiveness and equity of interventions, and to achieve improved health and distribution of health in the population. This is achieved in the context of the culture, health status, and health needs of the geographical, demographic, or cultural groups represented by a population [9].

LITERATURE REVIEW

Epidemiology Of Moderators and Mediators of Leadership and Enssential Public Health Functions at Bhcpf Sites

The reduction of risk factors that exacerbate neo-natal, child and maternal mortality in Kogi State are linked to the 54.9% and 61.1% of women who took iron supplementation during pregnancy and delivered by a skilled provider respectively. In the 5-year period preceding the 2021, and 10-year period preceding 2024 comparatively, the infant, child and under-five mortality rates per 1,000 for Kogi State were 52, 16, 67 and 59, 21, 78 representing 11.8%, 23.8% and 14.1% increase respectively [2, 3, 21].

The Skilled Birth Attendant (SBA), coverage for women within the age bracket of 15-49 years with a live birth in the last two years who during pregnancy were attended to, at least once was 61.1% in 2024 for Kogi State comparable to 78.9% in 2021 representing 22.5% decline. [2, 3, 22, 23]. The determinants of the equitability of the basic minimum package of health services [14, 6, 25, 26], have linkages to several indicators coefficients and provide insight into the burden of morbidity and the extent of the progress made by the health security and emergency preparedness strategy. The proportion of births attended by skilled health personnel has improved by 8 percentage points from 35% in 2003 to 43% in 2018 in Nigeria [14, 5] compared to the availability of essential drugs, availability of vaccines, minimum equipment and minimum infrastructure which was 46%, 80%, 17% and 10% in 2016 respectively[25].

In 2016 the Nigerian macro inputs paradigm; the PHC facility density (per 100,000 population) was 18.3 and the Health worker density (per1,000 population) was 2.52 which is comparable to a 0.70 Health worker density (per 1,000 population) in Kogi State in 2023 [13, 25].

In Kogi State by 2023, 84.87%, 92.45%, 97.21%, 83.70% 55.52%, 79.88%, 19.42% and 57.9% of public PHC facilities provide; ANC services, iron supplement as part of ANC services, folic acid tablet as part of ANC services, family planning counselling as part of ANC services, STI diagnostic and treatment services, monitors hypertension as part of ANC services, participated in the Most recent MNCH Week in the Past 6 Months by State, and appropriate management of PPH respectively[33]. It was observed that the 1st, 4th and 8th Antenatal Care (ANC) visits, Penta 3 crude coverage rate, number of pregnant women who received haematinics improved during the conducted oMNCHW first round between the 29th of July to the 2nd of August, 2024 and the second round of the oMNCHW from the 28th of January to the 1st of February, 2025. The progress made in reaching a Penta 3 coverage of 89.9% in July, 2024 experienced a 20.93% drop to 71.1% in November, 2024 [18].

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Determinants Of Leadership and Essential Public Health Function at Ward Focal Relevance (Strategic and Operational).

The three core areas of the Universal Health Coverage comprises of multisectoral policy and action; empowered people and communities; primary care and essential public health functions as the core of integrated health services [16, 6]. OOP expenditure represents about 56.3% of total health spending in the country [35] and with a high OOP healthcare expenditure as a proportion of current health expenditure, there is an association to the implication of the low level of health insurance coverage for the population with the very high risk of impoverishment due to health expenses. The OOP healthcare expenditure as a proportion of current health expenditure rose by 12.07% to 56.3% in 2021 from 2012 comparable to 58.3%, 49.8% and 46.0% in Burundi, Yemen and Bangladesh respectively. The OOP healthcare expenditure as a proportion of current health expenditure in Africa, Asia, Europe and Americas were 35.8%, 32.3%, 16.4% and 27.1% respectively [28, 34, 35].

Nigeria's burden of reproductive, maternal, neonatal and child health conditions is among the highest in the world with the lifetime risk of a woman dying from pregnancy, childbirth, or postpartum complications of 1 in 19, compared to 1 in 4900 in developed countries and it also has a high malaria and tuberculosis (TB) burden. Nigeria bears the highest malaria burden globally, accounting for nearly 27% of the world's malaria cases. Moreover, the country has an increasingly growing incidence of non-communicable diseases (NCDs) which have been estimated to account for 29% of deaths in Nigeria in 2016. The incidence of NCDs, such as cardiovascular diseases, cancer, and diabetes, is on the rise. [26, 32, 36, 37, 38].

UHC is reflected in the Nigerian National Health Policy 2016 in the foci of prioritization, optimization and sequencing in a way that guarantees overall results. The required action by stakeholders is to practice epidemiologic approach in the monitoring, mentoring and supportive supervision for compliance with standardization and enforcement guided by four core strategic levers comprising of political commitment and leadership, governance and policy frameworks, funding and allocation of resources, and the engagement of communities and other stakeholders [1, 2, 25, 4].

An essential component to achieving universal health coverage is primary health care (PHC) as a foundation for the Health Systems [25]. To achieve better health outcomes, improved equity, increased health security and better cost efficiency that characterizes primary health care as the core determinant of health systems strengthening (HSS) in Nigeria, the Minimum Standards for Primary Health Care in Nigeria was developed by the National Primary Health Care Development Agency (NPHCDA) in collaboration with Federal Ministry of Health and Social Welfare (FMoHSW) and allied agencies, academia, public health practitioners and development partners in 2023 [1, 6, 9, 23, 24].

The standard of care recognizes three levels of health facilities in Primary Health Care namely: Health Centres, Primary Health Centres and Model/Maternal and Child Primary Health Centres now categorized into Level 1, 2 and 3 respectively. Standardization of PHC systems is related to the amelioration of risk factors that determine health security, emergency preparedness and the achievement of equitable, accessible and qualitative health care services at 239 wards of the 21 Local Government Areas (LGAs) in the State and are the basic operational unit for PHC service delivery in line with the WHO requirement of at least seven HCFs per ward, one of which should be a Primary Health Care centre [13].

The areas of foci for building health systems resilience in Kogi State through health, finance and other sectors include [30]; (i) leverage on the current response to strengthen both health security and epidemic preparedness and health systems; (ii) investment in essential public health functions including those needed for all hazards emergency risk management; (iii) build a strong primary health-care foundation through revitalization policy and practices observed in the development of the Kogi State Primary Health care Development Agency, Minimum Services Package (MSP) 2024-2028 [13] in collaboration with the National Primary Health care Development Agency (NPHCDA), the State Ministries of Health (SMoH), Finance, Budget and Economic Panning (SMoFBEP) and Partners; and the political will of His Excellency Alhaji Ododo Ahmed Usman, the Governor of Kogi State in flagging-off the World Bank funded project: Immunization Plus Malaria Progress by Accelerating Coverage and Transforming services (IMPACT) ₦7,040,000,000 or $8,974,359 USD revitalization

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV August 2025 | Special Issue on Public Health

of eighty-eight Primary Health Care centres across the three senatorial districts of Kogi State on the eleventh of January, 2025 (iv) Improvement in the budgetary appropriation to the Kogi State Primary Health Care Development Agency (KSPHCDA) through Kogi State House of Assembly by 35.88% to ₦9,200,043,635 in 2025 compared to the 2024 baseline [19]. The enrolment of 122,046 by the Kogi State Health Insurance Agency (KGSHIA) as beneficiaries of the risk-pooling support mechanisms for whole-of-society engagement [20]; (v) Improved enabling environments for research, innovation and learning [8]; (vi) Enforcement of the 2014 National Health Act through the Basic Health Care Provision Fund (BHCPF) NPHCDA gateway to authorize and disburse the sum of Six Hundred Thousand Naira only (n=179), Eight Hundred Thousand Naira only (for PHCs with a Quality Assessment Score of >90%) (n=60), and World Bank funded IMPACT project financing release of Eight Hundred and Ninety Thousand Naira only (n=220) as Decentralized Facility Financing (DFF) and capitation from the Kogi State Health Insurance Agency (subject to enrolment) to finance the operationalization of the essential public health functions of (n=239) HCFs representing only 22.12% of 1,080 PHCs in Kogi State. Skilled Birth Attendant engagement (n=79) and empanelment of Community Health Influencers Promoters and Services (CHIPS) (n=196) in four wards per four Local Government Authority as part of the global investment effort in improving the health system foundations and all hazards emergency risk management; and (vii) The Honourable Commissioner for Health, Dr Abdulazeez Adams Adeiza has been committed towards a bolstered political will of the Administration of His Excellency Ododo Ahmed Usman the Governor of Kogi State for the improvement of defragmentation of services towards addressing pre-existing inequities at policy, leadership; and due to risk factors that determine the uptake of scale-up basic minimum package of health services (BMPHS) on marginalized and vulnerable populations by supporting the implementation of the second round on the optimized Maternal Newborn and Child Health Week (oMNCHW) leveraging on support from United Nations Children's Fund (UNICEF) and the World Health Organization [31].

The EPHFs represent a more holistic and integrated approach to public health, which is sustainable, cost-effective and efficient, and can effectively advance UHC and other health-related SDGs as prescribed by the Astana vision of primary health care which has interlinkages with the EPHFs identified as a core component [30, 4].

The World Health Assembly Resolution 69.1 is a call-to-action by Member States and WHO to build strong public health systems and to support with action towards the strengthening of EPHFs [29, 30]. The 2019 United Nations Political Declaration on Universal Health Coverage outlined the promotion of more coherent and inclusive approaches to safeguarding UHC, including the provision of EPHFs. [6, 4]. In ensuring that vulnerable and hard-to-reach population and communities receive promotive, protective, preventive, curative, rehabilitative and palliative health services of sufficient quality that they need, without experiencing financial hardship, the concept of Universal Health Coverage of leaving no one behind is exemplified.

METHODOLOGY

Study Design

The non-exposure assigning or descriptive exploratory study observed 11 outcome indicators through the application of the PRISMA-ScR guideline for the categorization of revitalization status, infrastructural deficiencies and operational and environmental concerns. The survey was based on multi-stage random sampling from a population of 18 LGHAs and PHCs (n=51). across the tree senatorial districts The online real-time data capture on the prescribed ISS checklist on the link https://ee.kobotoolbox.org/x/CzKEK3Of was concluded on the 19th of July, 2025 and completed by the n=15 supervised monitors in the company of Director of PHC (DPHC) and Officer-in-Charge (OIC) or their representatives.

Study Area

The study was conducted in 18 LGHA and 51 BHCPF ward focal health care facilities in the 3 senatorial districts of Kogi State and a 0.70/1000 ratio for human resources for health density at basic obstetric care or PHC in line with the 2022 population projection of 5,290,126 by the Nigerian, National Bureau of Statistics (NSB) in 2017 [8, 13]. In Kogi State 63.24% of the population live in rural areas and the demographic subsets of the State are inclusive of 211,605 and 1,058,025 children who are zero to one year and zero to five years respectively and 264,506 pregnant population characterized into 4%, 20% and 22% of the population respectively [13]. Kogi

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV August 2025 | Special Issue on Public Health

State exists in the North Central geopolitical zone of Nigeria, created on the 27th of August, 1991, has a land mass of 29,833 square kilometers located on 7◦30'N and 6◦42'E. The divisions in the state comprise of Igala, Ebira, Kabba, Kogi and Yoruba.

Method of Data Collection

The GIS linked semi-structured checklist was administered on-line through an open data kit on the link https://ee.kobotoolbox.org/x/CzKEK3Of prior to the data capture during the one-day exercise from respondents (n=51) to quantify the performance of selected indicators for characterization of operational and essential public health functions performance indicators.

Data Collection Procedure

The checklist was administered at the ward focal PHCs during the survey encapsulating data capture on line real-time. Information on the conduct of this process, was disseminated to the respondents prior to the recording of demographic, qualitative and categorical responses on the link; https://ee.kobotoolbox.org/x/CzKEK3Of during a 30-60 minutes period during the four-day exercise online real-time for analysis.

Study Instrument

The semi-structured checklist identified 8 demographic and GIS, 33 qualitative and categorical, outcome variables which were used to capture the data inclusive of photographs from the PHCs (n=51) with unique GIS identifier per PHC assigned and returned within the eligibility criteria of being a National Primary Health Care Development Agency (NPHCDA) and National Health Insurance Agency (NHIA) accredited BHCPF ward focal PHCs undergoing revitalization funded by NPHCDA gateway, Global Fund and PSHAN. The GIS enabled semi-structured checklist was designed to obtain data on BHCPF ward focal PHC linked to the exploration of the status of revitalization. The study instrument was revised and pre-tested via the link at Old Market PHC in Lokoja, Kogi State prior to the data capture.

Sampling Technique

The semi-structured checklist was administered through a multi-stage random sampling technique on the link: https://ee.kobotoolbox.org/x/CzKEK3Of by the 15 minitors supported by the Director of PHC (DPHC) on the Officer-in-Charge (OIC). The respondents were informed on the process prior to the administration of the recording of 41 demographic, qualitative and categorical responses on ISS indicators linked to the BHCPF ward focal revitalization projects (n=51) in 18 LGAs.

Data Analysis

Eleven prioritized categorical indicators for revitalization status (3), infrastructural deficiency (5) and operational and environmental concerns (3) derived from the multi-stage Integrated Supportive Supervisory survey to ascertain the status of revitalization of BHCPF ward focal PHCs, (n=51). The data was collated working with Microsoft Excel followed by analysis of qualitative categorical indicators on QDA Miner lite and Microsoft Copilot with output presented on table 4.2. The PRISMA-ScR guideline was applied on the hypothesis testing of the scoping review based on alignment with compliance for the distribution of selected 11 categorical quantitative and qualitative indicators at a CI of 0.05 and a 0.01 level of significance.

PRESENTATION OF DATA

Results

Table 1: Revitalization Status (n=51)

Indicator	Facility Status	% of Facilities	Remarks
1.01	Not Commenced	30%	Contractor yet to mobilize or communicate commencement date

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV August 2025 | Special Issue on Public Health

1.02	Ongoing but Slow Progress	25%	Activity on-site, but pace is insufficient
1.03	Nearing Completion	10%	Finishing touches required

Table 2: Infrastructure Deficiencies (n=51)

Indicator	Component	% of Facilities	Remarks
2.01	Missing Staff Quarters	60%	Lack of accommodation affects staff retention and performance
2.02	No Borehole/Water Access	40%	Some boreholes are dysfunctional or community-funded
2.03	No Solar Installation	35%	Electricity supply issues hinder service delivery
2.04	Incomplete Toilets/Labs	25%	Hygiene concerns, limited functional space
2.05	No Signage	50%	Lack of construction visibility and identification

Table 3: Operational and Environmental Concerns (n=51)

Indicator	Issue	% of Facilities	Remarks
3.01	Volunteer-Only Staffing	15%	Many facilities managed by volunteers without adequate support
3.02	Erosion and Roof Leaks	10%	Environmental degradation causing building damage
3.03	Poor Contractor Communication	10%	No known contact for contractors and lack of coordination

DISCUSSION

The risk factors identified and quantified during the exercise had several determinants which were 25% (n=51) attributable to delayed or non-commenced work where contractors haven't mobilized to site, and in some cases, not even identified. Incomplete construction or renovation of staff quarters, boreholes, solar installations, and essential infrastructure like toilets and fences are either missing or far from completion. Observation obtained during the exercise where the PHCs (n=51) visited are representative of 10% of projects nearing completion with finishing touches required compared to 25% of sites with activity on-site, but with insufficient pace. Lack of accommodation affects staff retention and performance was observed in 60% of PHCs visited, while 40% of the PHCs visited have boreholes are that are dysfunctional or community-funded.

Poorly communicated project sites where several facilities lacked contractor contact details, and interactions with OICs seem strained. Lack of signage and visibility of project due to absence of construction signposts or boards makes it hard to identify ongoing work. Staffing challenges linked to the availability of volunteer staff running these facilities with little support and infrastructure. Environmental concerns exist where erosion-prone areas and leaking roofs create health and safety risks. Slow progress of work for inaccessible wards like Eforo are sited as slowing down construction timelines.

CONCLUSION

It has been observed that in the health security and emergency preparedness strategy linked to the revitalization projects (n=51) in Kogi State during the period of the ISS exploratory survey that staff accommodation construction is a critical gap in the necessity for better service delivery. The need for action to be taken on the

merger and optimization of units in health care facilities with scattered or redundant units (e.g., labs and family planning rooms) could benefit the communities from restructuring process if the political will is improved to ensure appropriate oversight and funding releases to the contractors. Enhanced water access and solar power are fundamental to operational efficiency and patient care and should be fast-tracked to build trust of the enrollee and community.

The project's accountability should be improved with better oversight with clear timelines and visible site presence to help restore trust and confidence of the stakeholders. The following recommendations are crucial in ensuring health security and emergency preparedness strategic approach that would be effective: -

1. Enforce timely mobilization and documentation of contractor details.
2. Staff accommodation construction should be prioritized to provide quarters to retain health personnel.
3. Water & power access require acceleration by sinking borehole and solar installation for basic operations.
4. Renovation oversight should be linked to set quality standards and the inspection of the infrastructure regularly.
5. Community engagement is relevant in ensuring improved transparency with visible signage and open communication.
6. Environmental resilience linked to climate change require the installation of erosion control measures and repair damaged roofing.

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Appendix "A"

The semi-structured checklist
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