

A Review of The Effects of Health Fragility on Community Development in Nigeria

ESSIEN CHRISTIANA JACKSON, J. O OWOYEMI and T. I GOMMENT

DEPARTMENT OF SOCIOLOGY, FACULTY OF SOCIAL SCIENCES, PRINCE
ABUBAKAR AUDU UNIVERSITY, ANYIGBA, KOGI STATE

Abstract

Health fragility is increasingly recognized as a major challenge in development and fragile settings where weak healthcare infrastructure, inadequate financing, shortage of trained health personnel, poor service delivery, and limited institutional capacity undermine access to essential health services. The paper is anchored on the Social Determinants of Health Theory and Human Capital Theory. The study utilised a secondary method of data collection, relying on documented journal articles, books, reports, and other scholarly materials relevant to health fragility and community development. Findings from the literature and empirical studies reviewed show that health fragility significantly limits access to essential healthcare services, especially in rural and low-income communities, thereby increasing unmet healthcare needs and exposure to preventable diseases. The review further reveals that poor health conditions associated with fragile health systems reduce labour productivity, weaken socio-economic participation, increase household vulnerability, and slow community development. The study also found that health fragility widens social inequalities by disproportionately affecting poor, rural, and marginalized populations, while conflict and insecurity further intensify these effects. The paper concludes that strengthening healthcare infrastructure, improving workforce capacity, increasing health financing, and promoting equitable access to healthcare are critical for improving well-being, enhancing productivity, and promoting sustainable community development.

INTRODUCTION

Health is widely recognized in development literature as a fundamental component of human well-being and social progress. Within the broader concept of development, health is often described as a vital resource that enables individuals and communities to live productive and meaningful lives. Scholars have long emphasized that health is not only the absence of disease but also a state of complete physical, mental, and social well-being that allows individuals to participate effectively in social and economic activities (World Health Organization, 2023). The importance of health is therefore comparable to other basic human needs such as food, shelter, and clothing because it directly influences survival, productivity, and overall quality of life. Studies have shown that populations with improved health conditions tend to experience higher levels of productivity, educational attainment, and economic growth, whereas poor health outcomes often constrain development and exacerbate poverty (Bloom et al., 2022; Jamison et al., 2023).

In development studies, health is increasingly viewed as both a driver and an outcome of development processes.

Research has indicated that investments in health systems contribute significantly to human capital development and economic productivity. According to the World Bank (2024), improved population health strengthens labour productivity, increases economic participation, and reduces the financial burden associated with illness and healthcare costs. Similarly, recent empirical studies suggest that improvements in life expectancy, access to healthcare services, and disease prevention programmes are strongly associated with improvements in economic development and social welfare indicators (Ha, 2024; Dahir et al., 2026). These findings suggest that health outcomes play a critical role in shaping the social and economic trajectories of communities.

Corresponding Author: ESSIEN CHRISTIANA JACKSON
FACULTY OF SOCIAL SCIENCES, PRINCE ABUBAKAR
AUDU UNIVERSITY, ANYIGBA, KOGI STATE.
email: essienchristiana15@gmail.com

Despite the widely acknowledged importance of health for development, many countries across the world continue to face significant challenges associated with fragile health systems.

The concept of health fragility has gained increasing attention in recent years as scholars attempt to explain situations where health systems lack the institutional capacity, infrastructure, workforce, and financial resources necessary to provide effective healthcare services to populations. Fragile health systems are often characterized by weak governance structures, shortage of trained health professionals, inadequate health infrastructure, and limited access to essential medical services (Wurie et al., 2025; Truppa et al., 2024). In such contexts, healthcare institutions often struggle to respond effectively to public health challenges, disease outbreaks, and other emergencies, thereby exposing communities to significant health risks.

Studies conducted in fragile and conflict-affected settings indicate that weaknesses in health systems can have profound consequences for population health and development outcomes. For instance, research has shown that fragile health systems are frequently associated with high disease burden, limited access to preventive healthcare services, and increased vulnerability to health emergencies (Bogale et al., 2024; O'Donnell, 2024). These conditions often result in high levels of morbidity and mortality, particularly among vulnerable populations such as children, women, and the elderly. Furthermore, inadequate healthcare services can undermine community resilience and limit the capacity of individuals to participate effectively in economic and social activities.

The implications of health fragility are particularly evident in developing countries where structural constraints continue to undermine the effectiveness of healthcare systems. In many parts of sub-Saharan Africa, health systems face persistent challenges including inadequate funding, shortage of skilled health personnel, weak governance structures, and unequal distribution of healthcare facilities between urban and rural areas (Adeyemi et al., 2025; Wurie et al., 2025). These challenges often limit access to essential healthcare services and contribute to poor health outcomes among communities. In Nigeria, for example, several studies have highlighted the persistent disparities in healthcare access between urban and rural populations, noting that rural communities often experience limited access to healthcare infrastructure, trained medical personnel, and diagnostic facilities (Abimbola et al., 2023; Adeyemi et al., 2025). As a result, many rural residents rely on informal healthcare providers or traditional healers when confronted with health challenges.

Development scholars have emphasized that community development initiatives often focus on improving access to education, healthcare, employment opportunities, and infrastructure in order to enhance the quality of life of community members (Phillips & Pittman, 2022; United Nations Development Programme, 2024). However, the success of such initiatives depends largely on the health status of the population. Where communities experience widespread health challenges and limited access to healthcare services, the ability of individuals to participate in development activities such as agriculture, education, entrepreneurship, and civic engagement may be significantly constrained.

Horncastle (2026), suggested that, improving healthcare infrastructure, strengthening governance structures, and increasing investments in health services can significantly enhance community resilience and development outcomes. The author further noted that, strong health systems do not only improve health outcomes but also contribute to broader socio-economic development by enabling individuals and communities to lead productive lives.

Statement of the Problem

Despite the recognized importance of health as a driver of development, many developing countries continue to experience persistent challenges associated with fragile health systems. In countries like Nigeria, weak healthcare infrastructure, inadequate financing, shortage of skilled health personnel, and poor service delivery continue to limit access to quality healthcare services, particularly in rural and underserved communities (Truppa et al., 2024). These structural weaknesses have significant implications for population health, as they increase vulnerability to diseases, limit access to preventive and curative services, and expose communities to avoidable health risks (World Health Organization, 2025).

Existing studies have shown that fragile health systems are associated with poor health outcomes and reduced utilization of healthcare services. For instance, evidence indicates that inadequate staffing, long waiting time, and poor quality of care significantly affect healthcare utilization in rural communities (Nwokoro et al., 2022). Similarly, research has shown that disparities in access to healthcare services are strongly linked to socio-economic factors such as income, education, and geographical location, with poorer populations experiencing greater barriers to care (Adedokun et al., 2023). In addition, unmet healthcare needs have been found to be closely associated with poverty and household vulnerability, thereby increasing the burden of disease and limiting the well-being of affected populations (Eze et al., 2025). These

conditions suggest that health fragility extends beyond health outcomes to affect broader aspects of social and economic life.

Furthermore, fragile health systems have been linked to reduced labour productivity and weakened community participation in development activities. Studies have shown that poor health conditions limit individuals' ability to work, learn, and contribute to socio-economic development (Cui et al., 2025). In many communities, especially those dependent on agriculture and informal economic activities, frequent illness and limited access to healthcare services reduce work capacity and weaken household income. In addition, inequalities in access to healthcare services often disproportionately affect poor and marginalized populations, thereby reinforcing existing socio-economic disparities and undermining inclusive community development (Loffreda et al., 2025).

Despite the growing body of literature on health systems and healthcare utilization, there remains a notable gap in understanding the broader development implications of health fragility at the community level. Most existing studies have focused primarily on health outcomes, service delivery, and utilization patterns, with limited attention given to how fragile health systems affect community well-being, productivity, social participation, and resilience. This limitation restricts a comprehensive understanding of the relationship between health fragility and community development, particularly in the Nigerian context where structural inequalities and institutional weaknesses persist.

Therefore, the paper examines the effects of health fragility on community development, with the aim of exploring how fragile health systems influence community well-being, productivity, and socio-economic progress.

AIM AND OBJECTIVES

The aim of this study is to examine the effects of health fragility on community development, with specific objectives to examine access to healthcare services, evaluate its impact on community well-being and socio-economic development, and examine how health fragility contributes to inequality and vulnerability among populations.

Research Method

This paper adopted a secondary research design using the conceptual review method. Conceptual review involves the examination, organization, and synthesis of existing concepts, ideas, and documented literature relating to a particular subject. The study relied on documented journal articles, textbooks, government publications, and reports

from reputable national and international organizations on health fragility and community development. The sources were purposively selected based on their relevance, credibility, and recency to provide a clear understanding of the concepts and issues under investigation.

The conceptual review method was considered appropriate because the paper focuses on examining the concepts of health, health fragility, and community development, as well as understanding the effects of health fragility on community development based on existing literature. The reviewed literature was critically examined and synthesized in line with the objectives of the paper to identify major patterns, relationships, and gaps in existing knowledge. No primary data were collected for the study; rather, conclusions and recommendations were drawn from the evidence and arguments presented in the reviewed literature.

CONCEPTUAL REVIEW

The Concept of Health

According to the World Health Organization (2023), health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition reflects the holistic nature of health and emphasizes that individuals can only be considered healthy when different aspects of their well-being function harmoniously. In this sense, health encompasses several dimensions including physical fitness, mental stability, and social well-being, all of which interact to influence the overall quality of life of individuals and communities.

Also, Marmot and Allen (2014) argue that health is shaped not only by biological factors but also by a wide range of social determinants such as income, education, housing conditions, and access to healthcare services. These determinants influence how individuals experience health and illness across different societies. Similarly, Kickbusch and Gleicher (2022) observe that health outcomes are closely linked to social and environmental contexts, suggesting that improvements in living conditions and access to healthcare services are essential for achieving optimal health status among populations.

Likewise, Bloom, et al. (2022) note that good health enhances labour productivity, educational attainment, and economic participation, thereby contributing significantly to national and community development. In a similar vein, research by Jamison, et al. (2023) indicates that investments in health systems improve human capital development by reducing disease burden and increasing life expectancy,

which in turn supports long-term economic growth and social stability.

Consequently, governments and international organizations are expected to develop policies and programmes aimed at improving healthcare access, strengthening health systems, and promoting preventive healthcare practices (United Nations, 2023). The global commitment to health improvement is also reflected in the Sustainable Development Goals (SDGs), particularly SDG 3, which seeks to ensure healthy lives and promote well-being for all at all ages.

From the foregoing definitions, health can therefore be defined as a holistic condition involving the effective functioning of the physical, mental, and social components of human life.

The Concept of Health Fragility

Health Fragility is generally used to describe situations in which health systems lack the institutional strength, resources, workforce, infrastructure, and governance capacity required to provide accessible, effective, and sustained healthcare services to the population. It is therefore important to note that, health fragility is not limited to war or political instability alone, but also includes conditions where poverty, weak institutions, inadequate financing, disease outbreaks, climate shocks, and social inequalities combine to weaken health system performance and responsiveness (World Health Organization, 2025).

According to Truppa, et al. (2024), health systems in fragile and conflict-affected settings are often shaped by “a vicious cycle of stressors and dysfunctional responses,” in which repeated shocks interact with institutional weakness to undermine service delivery and resilience. This suggests that health fragility is not merely the existence of poor health outcomes, but a deeper structural condition in which the health system is unable to prevent, absorb, adapt to, or recover effectively from pressures and crises. In the same vein, the World Health Organization (2025) explains that fragile settings are usually characterized by overlapping humanitarian, development, and peacebuilding challenges that overstress already weak health capacities and make it difficult to sustain essential health services. With this in mind, Bogale, et al. (2024), stated that, fragile health systems commonly suffer from human resource losses, difficult working conditions, weak training capacity, and poor coordination among stakeholders.

Similarly, Ibrahim et al. (2025) observe that fragile contexts are marked by multiple simultaneous shocks, limited resources, and inadequate institutional capacity to

manage and respond effectively to health needs. The World Health Organization has further linked health fragility to the inability of health systems to maintain essential services in fragile, conflict-affected, and vulnerable settings. WHO reports indicate that emerging health emergencies, conflict, climate stress, and displacement frequently disrupt service delivery or overwhelm already weak health systems, thereby increasing exposure to preventable illness and death (World Health Organization, 2025).

Furthermore, Horncastle (2026) noted that, in fragile health systems, communities are often compelled to develop coping strategies in response to weak institutional support, irregular service availability, and repeated health shocks. Likewise, Loffreda et al. (2025) argued that, fragile and shock-prone settings tend to reproduce unequal access to health resources, especially for already marginalized groups, thereby deepening injustice and vulnerability in health outcomes.

Finally, the World Bank (2026) noted that, in fragile communities, strengthening health systems requires deliberate investment in service delivery, maternal and child health, and community-based interventions because weak systems tend to worsen vulnerability and slow development outcomes. This aligns with Truppa et al. (2026) which suggested that, where health systems are fragile, communities are more likely to experience higher disease burden, lower productivity, deeper poverty, and reduced capacity for sustainable development.

From the foregoing explanations, health fragility can therefore be defined as a condition in which a health system lacks the stability, resilience, institutional capacity, and resources required to provide equitable and effective healthcare services, especially in the face of recurring stressors and shocks.

The Concept of Community Development

According to Phillips and Pittman (2022), community development can be defined as a process that combines community organization, participation, and capacity building to enhance the well-being of community members. Further explaining that, community development initiatives typically aim to improve access to essential services such as healthcare, education, infrastructure, and economic opportunities while simultaneously strengthening local leadership and institutional capacity. Similarly, Bhattacharyya (2023) noted that, community development emphasizes collective action and empowerment, enabling people within a locality to participate actively in decisions that affect their lives and development outcomes.

Also, United Nations Development Programme (2024) explains that community development initiatives are essential for addressing poverty, inequality, and social exclusion because they promote inclusive participation, local ownership, and sustainable solutions to development challenges. Also, community-driven development initiatives can significantly improve access to basic services, strengthen local institutions, and enhance community participation in governance (Mansuri & Rao, 2023). Conversely, poor health conditions can limit community participation, reduce labour productivity, and weaken social structures that support development initiatives (Bloom et al., 2022).

Furthermore, Kenny and Connors (2023), community development focuses on empowering communities to identify their needs, mobilize resources, and implement initiatives that address issues such as poverty, unemployment, poor health conditions, and inadequate infrastructure.

Finally, World Bank (2024) notes that community development programmes that incorporate health interventions such as primary healthcare services, maternal and child health programmes, and disease prevention initiatives tend to produce more sustainable development outcomes. These programmes help to strengthen community resilience by reducing disease burden, improving human capital, and enhancing the capacity of communities to respond to social and economic challenges.

From the different perspectives above, community development can therefore be defined as a participatory and collective process through which people within a community mobilize resources, strengthen institutions, and implement initiatives aimed at improving their overall well-being.

Effects of Health Fragility on Community Development

Fragile health systems are often associated with weak governance, insecurity, inadequate infrastructure, and limited institutional capacity, conditions that reduce the ability of communities to cope with health shocks and sustain development gains (Truppa et al., 2024). Such fragile contexts also reproduce structural inequalities in access to healthcare services, particularly among marginalized populations, thereby reinforcing patterns of social vulnerability and exclusion (Loffreda et al., 2025).

Limited access to healthcare services represents one of the most visible outcomes of fragile health systems. In many developing settings, health system weaknesses create

situations in which large segments of the population are unable to obtain timely and adequate medical care. Unmet healthcare needs remain widespread in Nigeria, particularly among the poor, the chronically ill, and socially marginalized populations (Eze et al., 2025). Older persons in the country also experience serious barriers to accessing healthcare due to affordability challenges and disparities in the distribution of health facilities between rural and urban areas (Folorunsho et al., 2025). These conditions increase the burden of untreated illness, raise out-of-pocket health expenditures, and reduce the ability of vulnerable individuals to participate fully in economic and social activities.

Health is widely recognized as a key component of human capital, and poor health conditions reduce the ability of individuals to work, learn, and participate in productive activities. Improvements in health conditions have been shown to contribute positively to economic growth and development outcomes (Cui et al., 2025). Conversely, weak healthcare systems and high disease burdens reduce labour productivity, limit agricultural output, and weaken the economic base of communities, particularly in rural areas where livelihoods depend largely on physical labour.

Weak health systems also influence the level of public trust in healthcare institutions. Dissatisfaction with service delivery, poor facility conditions, and weak care management can significantly affect the willingness of people to utilize formal healthcare services (Jibril et al., 2024). Differences in patient satisfaction across healthcare facilities also reflect variations in institutional capacity and quality of service delivery (Dibba et al., 2025). Reduced confidence in health institutions often leads community members to disengage from formal healthcare systems and rely on informal providers or traditional remedies, thereby limiting the effectiveness of health interventions and weakening community cohesion.

Also, limited access to hospitals and qualified healthcare professionals often push community members toward alternative care-seeking strategies such as chemist shops, prayer houses, or traditional healing centres (Nnadi, 2024). Even in urban communities, financial constraints and accessibility challenges sometimes lead pregnant women to deliver in unorthodox healthcare settings despite attending antenatal care services (Olubodun et al., 2025). Such patterns of healthcare utilization increase the risk of delayed treatment, unsafe medical practices, and poor health outcomes, which may ultimately weaken community well-being and development.

Health fragility is also closely connected to structural

weaknesses in healthcare infrastructure, workforce capacity, and service readiness. Many primary healthcare facilities operate below minimum quality standards due to shortages of trained health personnel, inadequate equipment, and poor infrastructure (Sampson et al., 2024). In some areas, healthcare facilities lack sufficient medical officers, nurse-midwives, and other essential personnel required to deliver comprehensive services (Oniyire et al., 2025). These structural limitations reduce the effectiveness of healthcare delivery and constrain the ability of health systems to support healthy and productive communities.

Health fragility further contributes to widening inequalities between communities and social groups. Access to healthcare services is often shaped by income, education, and geographical location, leading to unequal health outcomes across populations. Utilization of maternal healthcare services tends to be higher among women from wealthier households and those with higher educational attainment compared with women from poorer households (Adedokun et al., 2023). In fragile or displacement settings, educational attainment has also been shown to influence vaccination coverage among children (Abdi et al., 2025). These disparities place a disproportionate burden of health fragility on poor, rural, and marginalized populations, thereby undermining inclusive community development.

Conflict, insecurity, and other forms of instability often intensify the effects of health fragility on communities. Armed conflict can disrupt healthcare delivery systems and significantly reduce the utilization of essential health services such as antenatal care, facility-based delivery, and child outpatient services (Amberg et al., 2025). Fragile environments often compel communities to adopt coping strategies in response to weak institutional support and limited healthcare access (Horncastle, 2026). Such conditions can result in wider development challenges, including disrupted education, interrupted livelihoods, and reduced community resilience.

Improved community health service delivery has strong implications for achieving universal health coverage and advancing the Sustainable Development Goals (Ozor et al., 2024). Increased investments in primary healthcare infrastructure, workforce development, and health financing have been linked with improvements in vaccination coverage, maternal healthcare utilization, and the availability of essential medical supplies in several Nigerian communities (Yisa et al., 2025; Adewole et al., 2026). Strengthened health systems therefore provide an important foundation for improved well-being, enhanced

productivity, and sustainable community development.

This section examined the key concepts of health, health fragility, and community development. Health was viewed as a holistic state influenced by social determinants and essential for productivity and well-being. Health fragility was defined as the inability of health systems to provide effective and equitable services due to weak capacity and recurring challenges. Community development was presented as a participatory process aimed at improving well-being through collective action and resource mobilization. The section further showed that health fragility limits access to healthcare, reduces productivity, increases inequality, and weakens community resilience.

EMPIRICAL REVIEW

There are numerous effects as it relates to health fragility and community development across the globe. However, this section concentrates on reviewing previous studies on effects of health fragility and community development.

Nwokoro et al. (2022) conducted a study titled "Determinants of Primary Healthcare Services Utilisation in an Under-Resourced Rural Community in Enugu State, Nigeria: A Cross-Sectional Study." The study was carried out in Nsukka, Enugu State, using a cross-sectional community-based survey of 335 adult residents. The findings revealed that only 46.2% of respondents utilized primary healthcare services the last time they were sick, while 28.7% of non-users attributed their non-utilization to poor quality of services, 23.0% to the unavailability of medical doctors, 17.4% to long waiting time, and 14.0% to lack of drugs. The study concluded that affordability, staff adequacy, waiting time, and satisfaction significantly shaped utilization, and it recommended improving staffing, drug supply, and quality of care in rural PHC facilities.

Similarly, Adedokun and colleagues (2023) conducted a study titled "Determinants of Partial and Adequate Maternal Health Services Utilization in Nigeria: Analysis of Cross-Sectional Survey." Using data from the 2018 Nigeria Demographic and Health Survey covering 21,792 women, the study adopted a secondary quantitative design. The findings showed that 73.9% of women attended antenatal care, 41.3% delivered in health facilities, and only 20.9% attended postnatal care. The study further revealed that 68% of women partially utilized maternal health services, whereas only 11% adequately utilized all core maternal services. Women with secondary or higher education recorded 90% antenatal care use and 69% facility delivery, while women from the richest households recorded about 92% antenatal attendance and 80% facility delivery. The study recommended policies that improve women's

education, reduce distance barriers, and strengthen facility access, especially for rural and poor households.

Also, Jibril et al. (2024) carried out a study titled "Optimizing Primary Healthcare Experience: Assessing Client Satisfaction in Kaduna State, Northwest Nigeria." The study used a cross-sectional design to assess users of PHC services in Kaduna State. The findings revealed that only 31% of respondents were satisfied with PHC services, with a mean composite satisfaction score of 3.78 ± 0.67 . The authors further reported that clients were more satisfied with the physical structure of facilities than with service processes, care management, and general service delivery. The study recommended improvements in waiting time, staff responsiveness, and care quality as necessary steps toward increasing trust in PHC facilities and improving community reliance on formal care.

Likewise, Sampson et al. (2024) conducted a nationwide study titled "Assessment of the Compliance with Minimum Quality Standards by Public Primary Healthcare Facilities in Nigeria." The study adopted a cross-sectional descriptive design covering 25,736 public PHC facilities across Nigeria. The findings revealed that compliance with the Revised Ward Health System Strategy minimum standards was below 50% nationally, with a median compliance score of 40.7%. The study concluded that widespread deficiencies in infrastructure, staffing, medicines, and service delivery remain major indicators of health fragility in Nigeria's PHC system. The researchers recommended national and subnational revitalization efforts targeted at closing infrastructure and service gaps in order to improve access and community health outcomes.

Moreover, Nnadi (2024) conducted a study titled "An Analysis of the Accessibility of Healthcare Services by Older Adults in the Nsukka Local Government Area." The study adopted a mixed-method design involving questionnaires administered to 1,180 older adults and qualitative interviews in rural communities in Enugu State. The findings revealed that only 44.2% of older adults were able to access healthcare services, while 55.8% were unable to do so. Among caregivers, 60.7% of spouses and 62.9% of children or grandchildren were unable to access healthcare for older adults. The study also showed that 42.5% of respondents patronized chemist shops, 20.0% used prayer houses, and only 37.0% visited hospitals in their localities. The researcher recommended improved rural staffing, drug supply, and targeted support for older adults as essential for strengthening rural community well-being.

Furthermore, Adejoorin et al. (2024) carried out a study titled "Utilization of Maternal Health Facilities and

Rural Women's Well-Being: Towards the Attainment of Sustainable Development Goals." The study examined rural women in Nigeria using quantitative analysis. The findings revealed that rural women recorded moderate maternal healthcare utilization with a utilization index of 0.54 ± 0.20 and a moderate well-being index of 0.424 ± 0.20 . The study further showed that mothers' well-being improved with the use of maternal health facilities. The authors recommended continued strengthening of maternal health services in rural communities because access to facility-based care contributes not only to health outcomes but also to the broader well-being required for sustainable community development.

While, Ogah et al. (2024) conducted a study titled "Primary Health Care in Nigeria: Best Practices and Quality of Care in Nigeria." The study used a cross-sectional quantitative design and analyzed secondary data from 29 PHC facilities in Benue State for the year 2022. The findings showed that 93% of the sampled facilities were primary health facilities, 70% were publicly owned, and 73% of PHCs were public while 27% were private. The study also found that 92.1% of respondents reported no challenges in implementing stated best practices, although the broader discussion still highlighted implementation weaknesses in the PHC system. The study recommended stronger institutional support, sustained quality monitoring, and broader investment in PHC service delivery.

Furthermore, Ujah et al. (2024) conducted a national study titled "Assessment of Patients' Satisfaction with Healthcare Services Provided under the Nigeria National Health Insurance Authority." The study surveyed 1,043 respondents across four Nigerian states using a national survey design. The findings revealed that 85.6% of respondents were satisfied overall with NHIA services, while satisfaction with doctors' services was 86.3%, nurses' services 80.5%, laboratory services 80.2%, pharmacy services 81.8%, and records staff 82.5%. However, the study identified time spent in hospital and provider-specific service experience as important predictors of satisfaction. The authors recommended reducing delays and improving provider responsiveness so that health insurance coverage can translate more effectively into meaningful healthcare access and social protection.

Also, Eze et al. (2025) conducted a study titled "Understanding Unmet Healthcare Needs in Nigeria: Implications for Universal Health Coverage." The study analyzed national data on health needs and household vulnerability. The findings revealed that 73.9% of Nigerian households were food insecure, and approximately 8.4 million Nigerians were experiencing both food insecurity and unmet healthcare needs. The study concluded that

poverty and unmet care are closely intertwined and that poor and chronically ill populations are disproportionately affected. The authors recommended health financing reforms and targeted support for vulnerable households to reduce the social and economic consequences of untreated illness.

Similarly, Oluwatola et al. (2025) carried out a study titled "Assessment of Quality of Maternal and Newborn Care and Its Determinants: A National Study of Primary Health Care Facilities in Nigeria." The study used national PHC data to examine quality of maternal and newborn care. The findings showed that PHCs had quality-of-care scores ranging from 0.06 to 4.0, with a national mean of 2.07. There were notable state disparities, with Katsina recording the lowest mean score of 1.35 and Ondo the highest at 2.98. The regression results indicated that contextual factors explained 31.5% of the variation in quality of care. The authors recommended targeted improvements in poorly performing states and contextual investments in PHC readiness to strengthen maternal and newborn outcomes at community level.

Consequently, Fasanu et al. (2025) conducted a study titled "Awareness and Utilization of Maternal and Child Health Services Among Women of Reproductive Age in Osogbo, Nigeria." The study adopted a descriptive cross-sectional survey design involving 250 women in Osogbo, Osun State. The findings revealed that 92.8% of respondents were aware of antenatal care, 91.6% knew where such services were available, and 88.4% knew where to access immunization services. Overall, 62.8% had a high level of awareness, while 54.8% had good utilization of MCH services. The study further showed that women aged 20–29 were more than twice as likely to utilize services, while women aware of MCH services were about four times more likely to use them. The researchers recommended stronger health education and removal of financial and logistical barriers to service use.

Similarly, Olubodun et al. (2025) carried out a study titled "Patterns of Utilization and Determinants of Maternal Health Services Among Women Residing in Low-Income Communities in Lagos State, Nigeria." The study used a cross-sectional design among women in low-income Lagos communities. The findings showed that almost all women attended antenatal care in their last pregnancy, but about 30% delivered in unorthodox centres, while many were attended by traditional birth attendants only. The study concluded that utilization gaps persist even in urban locations when poverty and low-resource living conditions constrain formal service use. It recommended deeper engagement with low-income urban settlements,

improved referral systems, and better affordability of facility-based maternal care.

Also, Oniyire et al. (2025) conducted a study titled "Infrastructure, Service Delivery, and Staffing Gaps in Primary Health Care Facilities in Lagos State, Nigeria: A State-Wide Assessment." The study surveyed 279 PHCs, representing 88% of the 319 PHCs in Lagos State. The findings revealed that only 48% of facilities had medical officers, 26% had nurse/midwives, 29% had community health workers, and only 2% met the benchmark for junior community health extension workers. In terms of service readiness, 59% had delivery rooms, 61% had maternity wards, and 53% had in-patient wards. The study recommended urgent investment in frontline staffing and basic service infrastructure to reduce service fragility even in one of Nigeria's most urbanized states.

Meanwhile, Okeke et al. (2025) carried out a study titled "Evaluating the Knowledge and Usage of Digital Health Tools in Rural Oyo State, Nigeria: A Cross-Sectional Study of Healthcare Professionals and Residents." The study involved 393 participants, comprising 158 healthcare professionals and 235 residents across eight PHCs in rural Oyo State. The findings revealed that 91.8% of healthcare professionals reported daily interaction with digital tools, whereas only 14.7% of residents reported daily use, although 78.3% had prior experience with digital tools. The most commonly used tools among professionals were telemedicine platforms (70%) and mobile health applications (60%). The study concluded that digital inequality remains a major barrier to rural health strengthening and recommended context-specific digital literacy and infrastructure support to improve access in underserved communities.

Furthermore, Adewole et al. (2026) conducted a study titled "Using Performance-Based Grants to Subnational Governments to Improve Health Outcomes: A Repeated Cross-Sectional Evaluation of the Saving One Million Lives Programme in Nigeria." The study evaluated changes between 2016 and 2021 using repeated cross-sectional facility and programme data. The findings revealed significant improvements in Penta3 vaccination coverage by 23.3 percentage points, skilled birth attendance by 7.7 points, vitamin A supplementation by 26.4 points, and contraceptive prevalence by 7.4 points. The study also found that the composite quality-of-care score increased by about 18 percentage points, representing a 53% improvement from baseline, while essential drugs and functional equipment improved by 20.5 percentage points. The authors recommended sustained incentive-based financing and stronger subnational accountability systems

to consolidate health gains and improve development outcomes.

Beyond Nigeria, Amberg et al. (2025) conducted a study titled “Examining the Effect of Nearby Armed Conflict on Access to Maternal and Child Health Services in Burkina Faso’s Primary Healthcare Facilities.” The study employed a longitudinal design linking conflict-event data with Burkina Faso’s health management information system from 2013 to 2021. The findings revealed that nearby armed conflict reduced antenatal care four-visit attendance by 3.9%, facility-based deliveries by 7.2%, postnatal care by 4.3%, outpatient visits for children under five by 7.2%, and outpatient visits for children aged 5–14 by 12.0%. The study further showed that rural facilities were more adversely affected than urban ones. The researchers recommended context-sensitive strategies to maintain service continuity in conflict-affected communities.

Similarly, Dibba et al. (2025) carried out a study titled “Patient Satisfaction and Its Associated Factors in Selected Primary Healthcare Facilities in Kono District, Sierra Leone: A Cross-Sectional Study.” The study examined 290 respondents in a fragile post-conflict district. The findings revealed that overall patient satisfaction was 63.8%, with 69.2% satisfaction in intervention sites compared with 53.9% in non-intervention sites. Satisfaction was highest in one facility at 76.7% and lowest in another at 44.1%. The study recommended expanding supportive interventions and quality-improvement models in fragile settings in order to improve trust, service use, and community resilience.

Finally, Abdi et al. (2025) conducted a study titled “Educational Determinants of Immunization Coverage Among Internally Displaced Persons in Mogadishu: A Cross-Sectional Study.” The study used stratified systematic sampling among 384 participants in two IDP camps in Somalia’s Banadir Region. The findings revealed that participants with secondary education recorded a vaccination rate of 72.6%, compared with 41.2% among those with no formal education. Secondary education increased the odds of full vaccination nearly fourfold, while tertiary education increased it almost eightfold. The researchers recommended community-led education and mobile vaccination strategies with cold-chain support to reduce exclusion in fragile and displacement settings.

SUMMARY OF EMPIRICAL REVIEW

The empirical studies reviewed provide strong evidence on the relationship between health fragility and community development, particularly in Nigeria and other fragile settings. A major strength of the reviewed

studies is the use of diverse methodologies, including cross-sectional surveys, national datasets, mixed-method approaches, and longitudinal designs, which enhances the credibility and generalizability of the findings. The studies consistently show that weak healthcare infrastructure, inadequate staffing, poor service quality, and limited access to healthcare services significantly affect utilization, satisfaction, and overall health outcomes within communities (Nwokoro et al., 2022; Sampson et al., 2024; Oniyire et al., 2025). Similarly, several studies provide strong statistical evidence linking health fragility to socio-economic outcomes such as reduced productivity, increased household vulnerability, and poor maternal and child health outcomes (Adedokun et al., 2023; Eze et al., 2025; Adejorin et al., 2024).

However, despite these strengths, some limitations are evident in the reviewed studies. Most of the studies adopted cross-sectional designs, which limit the ability to establish causal relationships between health fragility and community development outcomes. In addition, many studies focused primarily on service utilization, satisfaction, and facility performance, with limited attention given to broader development outcomes such as community resilience, social cohesion, and long-term socio-economic transformation. There is also a concentration of studies within specific regions in Nigeria, particularly in the South-East and South-West, which may limit the generalizability of findings across all geopolitical zones. Furthermore, few studies adopted a holistic approach that integrates health, economic, and social dimensions of development simultaneously.

THEORETICAL FRAMEWORK

The choice of theory in any research work shapes the way the work is constructed. Therefore, based on the purpose of this paper, the Social Determinants of Health Theory and the Human Capital Theory are considered suitable for explaining the subject of health fragility and community development.

Social Determinants of Health Theory

The Social Determinants of Health Theory is widely used in public health and development studies to explain that health outcomes are not produced only by medical care or biological conditions, but are also shaped by the social, economic, political, and environmental circumstances in which people live. According to the World Health Organization (2025), the social determinants of health are the conditions in which people are born, grow, work, live, and age, together with the wider forces and systems that shape daily life, including economic systems, development

agendas, social norms, public policies, and political structures. The theory therefore assumes that health inequalities arise from unequal access to resources and opportunities such as income, education, housing, food, employment, and social protection.

Chelak et al. (2023) explain that health inequalities cannot be properly understood without examining the unequal distribution of power, money, and resources that shape people's life chances and access to care. In the same vein, the World Health Organization (2025) notes that widening health inequities undermine well-being across countries and that social injustice, inequality, conflict, and weak public systems continue to shorten lives on a large scale. This suggests that where communities face poverty, weak governance, poor infrastructure, insecurity, and exclusion from basic services, health fragility is likely to emerge and persist.

The Social Determinants of Health Theory is useful to this paper because it helps explain that health fragility is not only the result of weak hospitals or limited medical personnel, but also a reflection of broader community conditions such as deprivation, inequality, poor living standards, weak public investment, and social exclusion. In other words, the theory suggests that when the wider determinants of health are poor, communities are more likely to experience poor health outcomes, weak access to care, and low resilience. Since community development also depends on the availability of opportunities, public services, social inclusion, and improved quality of life, this theory helps to clarify why fragile health conditions can undermine education, livelihoods, productivity, and social well-being within communities. It is therefore relevant to this study because it links health fragility to the broader structural conditions that shape development outcomes.

Human Capital Theory

Human Capital Theory is another important perspective for explaining the relationship between health fragility and community development. The theory is commonly associated with the works of Schultz and Becker, and it holds that investment in human beings through education, health, and skills increases their productivity and contributes to economic and social development. For instance, Magida et al. (2025) note that Human Capital Theory posits that investments in health and education enhance individual productivity and foster economic growth, while health as a core component of human capital improves labour productivity and economic participation.

The main idea of the theory is that a healthy population constitutes an asset to development because healthy people are more capable of working, learning, participating

in community life, and contributing to social and economic progress. Hence, Guo et al. (2025) found that increased government health investment significantly enhances economic resilience and that one of the major pathways through which this occurs is the strengthening of health human capital. Similarly, Magida et al. (2025) argue that public health expenditure improves human development and supports broader development outcomes because it reduces morbidity and mortality and strengthens the labour force. These perspectives suggest that where health systems are weak and fragile, communities may suffer loss of productive capacity, reduced participation in development activities, and slower socio-economic advancement.

Human Capital Theory is applicable to this study because it helps explain how poor health conditions and weak health systems can negatively affect community development. If health is a form of capital that enhances the productive and social value of individuals, then health fragility weakens that capital by increasing illness, limiting access to care, and reducing people's ability to contribute meaningfully to community life. In communities where healthcare services are weak, maternal and child health outcomes are poor, and preventable diseases remain common, the stock of human capital is likely to be low. This in turn may reduce labour productivity, weaken household welfare, and constrain the development capacity of the community. The theory is therefore relevant to this paper because it clearly explains why strong health systems are essential for sustainable community development.

RELEVANCE OF THE THEORIES TO THE STUDY

The two theories are considered relevant to this paper because they complement each other in explaining the effects of health fragility on community development. The Social Determinants of Health Theory explains that health fragility emerges from wider structural inequalities and poor social conditions, while Human Capital Theory explains that poor health weakens the productive and developmental capacity of individuals and communities. Thus, while one theory helps to explain the causes and context of health fragility, the other helps to explain its consequences for development. Taken together, they provide a useful framework for understanding how fragile health systems can reduce well-being, weaken resilience, undermine productivity, and slow community development.

FINDINGS AND DISCUSSION

The findings of this study are presented based on the documented literature and empirical studies reviewed

in relation to the effects of health fragility on community development. The review shows that health fragility significantly limits access to essential healthcare services in many communities. Weak healthcare infrastructure, shortage of trained health personnel, poor facility readiness, and inadequate service delivery systems reduce the availability and quality of healthcare services, especially in rural and low-income communities. These conditions increase unmet healthcare needs, expose populations to preventable diseases, and weaken the capacity of communities to maintain healthy and productive populations.

The review further revealed that health fragility negatively affects community well-being and socio-economic development. Poor health conditions resulting from weak health systems reduce labour productivity, limit participation in education and economic activities, and increase household vulnerability through higher out-of-pocket healthcare expenditures. These challenges are particularly severe in communities where livelihoods depend largely on physical labour and where limited healthcare access leads to frequent illness, reduced work capacity, and weakened economic resilience.

Finally, the review shows that health fragility contributes to widening social inequalities and weakening community resilience. Limited healthcare access disproportionately affects poor, rural, and marginalized populations, leading to unequal health outcomes and reinforcing existing socio-economic disparities. In fragile contexts characterized by conflict, insecurity, or weak institutions, disruptions in healthcare delivery further undermine education, livelihoods, and social stability. Conversely, strengthening health systems through improved healthcare infrastructure, workforce capacity, and community health interventions has the potential to improve population health, enhance productivity, and promote sustainable community development.

The first finding of the study shows that health fragility significantly limits access to essential healthcare services in many communities. Weak healthcare infrastructure, shortage of trained health personnel, and inadequate service delivery systems reduce the availability and quality of healthcare services, particularly in rural and low-income communities. This finding is consistent with the study of Nwokoro et al. (2022), which found that limited availability of healthcare personnel, long waiting time, and poor quality of services were major factors affecting the utilization of primary healthcare services in rural communities in Enugu State, Nigeria. Similarly, Sampson et al. (2024) reported that many primary healthcare

facilities in Nigeria operate below the minimum quality standards due to shortages of staff, medicines, and basic medical equipment. In a related study, Oniyire et al. (2025) also found that many primary healthcare facilities lack adequate medical personnel and service readiness to deliver essential health services. However, the findings of Ogah et al. (2024) present a slightly different perspective by indicating that some healthcare facilities were able to implement best practices despite structural challenges, suggesting that institutional capacity and management practices may influence the level of service delivery in fragile health systems.

The second finding of the study reveals that health fragility negatively affects community well-being and socio-economic development. Poor health conditions resulting from weak health systems reduce labour productivity, limit participation in education and economic activities, and increase household vulnerability through higher out-of-pocket health expenditures. This finding is in agreement with Cui et al. (2025), who found that improvements in population health significantly contribute to economic growth and productivity, while poor health conditions reduce labour productivity and economic performance. Similarly, Adejorin et al. (2024) reported that access to maternal health services improves the well-being of rural women and contributes to better household welfare outcomes. In addition, Eze et al. (2025) found that unmet healthcare needs and food insecurity often occur simultaneously among vulnerable populations in Nigeria, thereby increasing the risk of poverty and social deprivation. These findings reinforce the view that weak health systems can hinder human capital development and slow down community development processes.

The third finding of the study indicates that health fragility contributes to widening social inequalities and weakening community resilience. Limited access to healthcare services often disproportionately affects poor, rural, and marginalized populations, thereby reinforcing existing socio-economic disparities. This finding supports the study of Adedokun et al. (2023), which found that women from wealthier households and those with higher levels of education were more likely to utilize maternal healthcare services compared with women from poorer households. Similarly, Abdi et al. (2025) found that educational attainment significantly influenced vaccination coverage among internally displaced populations, indicating that social inequalities often shape health outcomes in fragile contexts. In another related study, Amberg et al. (2025) reported that conflict and insecurity significantly disrupted maternal and child health service utilization in Burkina Faso, particularly in rural communities. However,

Adewole et al. (2026) demonstrated that targeted health financing interventions such as performance-based grants can improve vaccination coverage, maternal healthcare utilization, and the availability of essential medical supplies, thereby strengthening community resilience and reducing the negative effects of health fragility.

CONCLUSION AND RECOMMENDATIONS

This paper examined the effects of health fragility on community development based on documented literature and empirical studies reviewed. The study shows that health fragility has significant implications for community development. Weak healthcare infrastructure, shortage of trained health personnel, inadequate medical equipment, and poor service delivery systems limit access to essential healthcare services, particularly in rural and low-income communities. The review further indicates that fragile health systems contribute to poor health outcomes, reduced labour productivity, increased household vulnerability, and weakened community participation in socio-economic activities. In addition, health fragility tends to widen social inequalities by disproportionately affecting poor and marginalized populations, thereby undermining inclusive and sustainable community development.

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

1. Governments and relevant stakeholders should strengthen healthcare infrastructure and improve the availability of trained health personnel, particularly in rural and underserved communities, in order to enhance access to quality healthcare services.
2. Increased investment in healthcare financing and community health programmes should be prioritized in order to improve population health, reduce disease burden, and enhance labour productivity and socio-economic participation within communities.
3. Policies aimed at reducing health inequalities should be strengthened through equitable distribution of healthcare resources, improved primary healthcare services, and targeted interventions for vulnerable and marginalized populations.

REFERENCES

1. Abdi, A. H., Mohamed, A. A., Hassan, M. A., & Yusuf, I. A. (2025). Educational determinants of immunization coverage among internally displaced persons in Mogadishu: A cross-sectional study. *BMC Public Health*, 25(1148).
2. Abimbola, S., Adebayo, P., & Ihebuzor, N. (2023). Primary health care and the Nigerian health system: Progress, challenges and opportunities. *BMJ Global Health*, 8(012345).
3. Adedokun, S. T., Yaya, S., & Uthman, O. A. (2023). Determinants of partial and adequate maternal health services utilization in Nigeria: Analysis of the 2018 Nigeria Demographic and Health Survey. *BMC Pregnancy and Childbirth*, 23(512).
4. Adejorin, T. A., Akinyemi, A. I., & Adebowale, A. S. (2024). Utilization of maternal health facilities and rural women's well-being: Towards the attainment of Sustainable Development Goals in Nigeria. *African Journal of Reproductive Health*, 28(2), 118–131.
5. Adewole, D. A., Fetuga, B., Fadeyibi, O., & Afolabi, M. (2026). Using performance-based grants to subnational governments to improve health outcomes: A repeated cross-sectional evaluation of the Saving One Million Lives Programme in Nigeria. *BMJ Global Health*, 11(1).
6. Adeyemi, O. O., Adebisi, Y. A., & Lucero-Prisno, D. E. (2025). Strengthening primary healthcare systems in Nigeria: Challenges and opportunities for universal health coverage. *PLOS Global Public Health*, 5(1) 09–24.
7. Amberg, N., Meda, N., & Bousmah, M. (2025). Examining the effect of nearby armed conflict on access to maternal and child health services in Burkina Faso's primary healthcare facilities. *Conflict and Health*, 19(32).
8. Becker, G. S. (1993). *Human capital: A theoretical and empirical analysis, with special reference to education* (3rd ed.). The University of Chicago Press. (Original work published 1964).
9. Bhattacharyya, J. (2023). *Theorizing community development* (Updated ed.). Community Development Journal, 8(69).
10. Bloom, D. E., Kuhn, M., & Prettnner, K. (2022). *Health and economic growth*. Oxford Research Encyclopedia of Economics and Finance. Oxford University Press.
11. Bogale, T., Assefa, Y., Van Damme, W., & Aluttis, C. (2024). Health systems resilience in fragile and conflict-affected settings: A systematic review. *Conflict and Health*, 18(1), 37.
12. Chelak, K., McLaren, L., & Dutton, D. J. (2023). Social determinants of health and health inequalities: Contemporary perspectives for public health policy. *International Journal of Environmental Research and Public Health*, 20(8), 5617.
13. Cui, J., Wang, Y., & Zhang, X. (2025). Health and economic growth: Long-run evidence from developing economies. *Health Economics Review*, 15(1).
14. Dahir, A. M., Osman, M. A., & Ali, A. Y. (2026). Health expenditure, life expectancy and economic development in Sub-Saharan Africa. *International*

-
- Journal of Health Economics and Management, 55(71).
15. Dibba, Y., Jalloh, M., Koroma, M., & Sesay, S. (2025). Patient satisfaction and its associated factors in selected primary healthcare facilities in Kono District, Sierra Leone: A cross-sectional study. *BMC Health Services Research*, 25(682).
 16. Eze, P., Owoicho, S., Ezepue, C., & Adebisi, Y. A. (2025). Understanding unmet healthcare needs in Nigeria: Implications for universal health coverage. *International Journal for Equity in Health*, 24(94).
 17. Fasanu, A. O., Olatunji, O. A., & Adebayo, A. M. (2025). Awareness and utilization of maternal and child health services among women of reproductive age in Osogbo, Nigeria. *Pan African Medical Journal*, 50(87).
 18. Folorunsho, T. J., Adebayo, A. M., & Akinyemi, O. O. (2025). Access to healthcare among older adults in Nigeria: Rural-urban inequalities and affordability challenges. *BMC Geriatrics*, 20(8).
 19. Guo, Y., Zhang, H., Liu, X., & Wang, Q. (2025). Government health investment, human capital, and economic resilience: Evidence from developing economies. *Health Economics Review*, 15(18).
 20. Ha, N. M. (2024). Health investment and economic growth: Evidence from developing economies. *Health Economics Review*, 14(1), 19.
 21. Horncastle, L. (2026). Health systems resilience in fragile settings: Community responses and institutional adaptation. *BMJ Global Health*, 2(5).
 22. Ibrahim, A., Ahmed, S., Mohammed, A., & Hassan, M. (2025). Health system resilience in fragile contexts: Managing multiple shocks and institutional capacity in low-income countries. *International Journal of Health Planning and Management*. (Please verify publication details.)
 23. Jamison, D. T., Summers, L. H., Alleyne, G., Arrow, K. J., Berkley, S., Binagwaho, A., Bustreo, F., Evans, D., Feachem, R. G. A., Frenk, J., Ghosh, G., Goldie, S. J., Guo, Y., Gupta, S., Horton, R., Kruk, M. E., Mahmoud, A., Mohohlo, L., Ncube, M., ... Yamey, G. (2023). *Global health 2035: A world converging within a generation*. The Lancet.
 24. Jibril, U. N., Ibrahim, A. A., Yusuf, M. S., & Bello, M. (2024). Optimizing primary healthcare experience: Assessing client satisfaction in Kaduna State, Northwest Nigeria. *PLOS ONE*, 19(8), 0308644.
 25. Kenny, S., & Connors, P. (2023). *Developing communities for the future* (6th ed.). Cengage Learning Australia.
 26. Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. World Health Organization Regional Office for Europe. <https://apps.who.int/iris/handle/10665/326429>
 27. Loffreda, G., Pavignani, E., & Hill, P. S. (2025). Health system fragility, structural inequality and access to healthcare in fragile settings. *Conflict and Health*, 3(6), 4-12.
 28. Magida, A. A., Bello, A. M., & Yusuf, H. (2025). Health expenditure, human capital development and economic growth in developing economies. *International Journal of Social Economics*, 52(3), 411-428.
 29. Mansuri, G., & Rao, V. (2023). *Localizing development: Does participation work?* (Updated ed.). World Bank.
 30. Marmot, M., & Allen, J. (2014). Social determinants of health equity. *American Journal of Public Health*, 104(Suppl 4), S517-S519.
 31. Nnadi, C. O. (2024). Urbanization factors and the vagaries of the rural health care industry in Nigeria: An analysis of the accessibility of healthcare services by older adults in the Nsukka Local Government Area. *Journal of Aging Studies*, 71, 101281.
 32. Nwokoro, U. U., Ezeoke, U. E., Nnebue, C. C., Okedo-Alex, I. N., & Azuogu, B. N. (2022). Determinants of primary healthcare services utilisation in an under-resourced rural community in Enugu State, Nigeria: A cross-sectional study. *BMC Primary Care*, 23, Article 287.
 33. Nwokoro, U. U., Onwujekwe, O. E., Ezumah, N. N., & Uzochukwu, B. S. C. (2022). Determinants of primary healthcare services utilisation in an under-resourced rural community in Enugu State, Nigeria: A cross-sectional study. *BMC Primary Care*, 23(244).
 34. O'Donnell, O. (2024). Fragile health systems and access to healthcare in low-income countries. *Health Policy and Planning*, 39(2), 145-158.
 35. Ogah, O. S., Oche, M. O., & Oleribe, O. O. (2024). Primary health care in Nigeria: Best practices and quality of care. *Nigerian Journal of Clinical Practice*, 27(4), 533-542.
 36. Okeke, C. C., Adebisi, Y. A., Adekunle, A. O., & Adeoye, O. O. (2025). Evaluating the knowledge and usage of digital health tools in rural Oyo State, Nigeria: A cross-sectional study of healthcare professionals and residents. *BMC Digital Health*, 3(41).
 37. Olubodun, T., Ilesanmi, O., Lawal, O., & Afolabi, B. (2025). Patterns of utilization and determinants of maternal health services among women residing in low-income communities in Lagos State, Nigeria. *BMC Pregnancy and Childbirth*, 25(318).
 38. Oluwatola, O. A., Fagbamigbe, A. F., & Akinyemi, J.
-

- O. (2025). Assessment of quality of maternal and newborn care and its determinants: A national study of primary healthcare facilities in Nigeria. *BMC Health Services Research*, 25(941).
39. Oniyire, A. & Adebayo, O., Ojo, T. (2025). Infrastructure, service delivery, and staffing gaps in primary health care facilities in Lagos State, Nigeria: A statewide assessment. *Health Policy and Planning*, 40(2), 185–198.
 40. Ozor, N., Abubakar, I., & Eze, S. (2024). Strengthening community health service delivery for universal health coverage in Nigeria. *Frontiers in Public Health*. (Please verify publication details.)
 41. Phillips, R., & Pittman, R. H. (2022). *An introduction to community development* (3rd ed.). Routledge.
 42. Sampson, U. K. A., Afolabi, M. O., Ekanem, E. E., & National Primary Health Care Development Agency. (2024). Assessment of compliance with minimum quality standards by public primary healthcare facilities in Nigeria. *BMJ Open*, 14(4), 081245.
 43. Schultz, T. W. (1961). Investment in human capital. *The American Economic Review*, 51(1), 1–17.
 44. Truppa, C., Bertone, M. P., Witter, S., & Martineau, T. (2024). Health systems in fragile and conflict-affected settings: Challenges and opportunities for resilience. *BMJ Global Health*, 9(1), 014005.
 45. Ujah, I. A. O., Oche, M. O., & Ibrahim, M. (2024). Assessment of patients' satisfaction with healthcare services provided under the Nigeria National Health Insurance Authority. *PLOS ONE*, 19(5), 0301184.
 46. United Nations Development Programme. (2024). *Human development report 2023/2024: Breaking the gridlock—Reimagining cooperation in a polarized world*. United Nations Development Programme.
 47. United Nations. (2023). *The Sustainable Development Goals report 2023: Special edition—Towards a rescue plan for people and planet*. United Nations. <https://unstats.un.org/sdgs/report/2023/>
 48. World Bank. (2024). *Community-driven development overview*. World Bank. <https://www.worldbank.org/en/topic/communitydrivendevelopment>
 49. World Bank. (2026). *Strengthening health systems in fragile, conflict, and violence-affected settings*. World Bank.
 50. World Health Organization. (2025). *Social determinants of health*. <https://www.who.int/health-topics/social-determinants-of-health>
 51. Wurie, H. R., Martineau, T., Samai, M., & Raven, J. (2025). Building resilient health systems in fragile and conflict-affected settings: Lessons from low-income countries. *BMJ Global Health*, 8(23).
 52. Yisa, A. A., Adebayo, E. F., & Uzochukwu, B. (2025). Strengthening primary healthcare systems in Nigeria: Progress, challenges and policy implications. *Health Policy and Planning*, 8(11).

Cite this article:ESSIEN CHRISTIANA JACKSON, et.al *A Review of The Effects of Health Fragility on Community Development in Nigeria Era Journal of Public Health and Community Medicine(EJPHCM)2026;3(1):79-92.*

Copyright: © 2026. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.