Primary Health Care Renaissance Blog Series

Episode:

From Building Blocks to Transformation: A Strategic Agenda for a Primary Health Care Renaissance in Nigeria

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Introduction

For decades, health system strengthening has been framed around a familiar set of building blocks: leadership and governance, health financing, the health workforce, service delivery, health information systems, and access to essential medicines and technologies. These building blocks remain indispensable. They provide the basic architecture within which a health system operates and without which sustained improvements in population health would be difficult to achieve.

Yet the persistent weaknesses of Primary Health Care (PHC) demonstrate that having the building blocks in place is not enough.

Across many health systems, particularly in low- and middle-income countries, considerable investments have been made in infrastructure, workforce development, health programmes, medicines, information systems and financing mechanisms. Nevertheless, the experience of many citizens remains one of fragmented services, unreliable facilities, stock-outs, long waiting times, inadequate staffing, weak referral systems, high out-of-pocket expenditure and limited confidence in public health services.

The challenge is therefore no longer simply what components a health system should have, but how those components function together to produce results for people.

This is where the idea of a Primary Health Care Renaissance becomes important.

Renaissance implies more than rehabilitation, restoration or incremental reform. It suggests renewal: a deliberate rethinking of the way PHC is governed, financed, organised, delivered, measured and experienced by communities.

A PHC Renaissance is not an argument for abandoning the health-system building blocks. Rather, it is an argument for moving beyond the building blocks.

The next phase of PHC reform must focus on the relationships between them: how governance enables financing; how financing supports workforce performance; how workforce capacity translates into quality service delivery; how commodities and technologies enable providers to deliver care; how information guides decisions; and how communities hold the entire system accountable.

The overall objective is not a stronger collection of institutions, facilities, programmes and inputs.

It is a health system that consistently delivers accessible, affordable, equitable, quality and people-centred care.

Moving Beyond the Building Blocks

The building-block approach has provided an important framework for diagnosing weaknesses within health systems. It has helped governments and development partners identify gaps and organise investments around key system functions.

But there is a danger when the framework becomes an end in itself.

A health system can report more health facilities without those facilities being functional. It can recruit more health workers without ensuring that they are appropriately distributed, supported and productive. It can procure medicines without establishing reliable last-mile distribution. It can deploy digital platforms without ensuring interoperability or using the information generated to improve decisions. It can increase health expenditure without ensuring that funds reach frontline services or are translated into better health outcomes.

Health systems do not fail merely because individual building blocks are weak. They also fail when the blocks are fragmented, poorly coordinated, inadequately financed, weakly accountable, or disconnected from the people they are intended to serve.

Consider the PHC facility.

A facility may have a building, but a building alone does not constitute PHC. It needs skilled and motivated health workers. Those workers need medicines, diagnostics, equipment, electricity, water, infection-prevention systems and functional referral arrangements. The facility needs financing that is timely and adequate. It needs management capable of solving problems. It needs information that allows managers to understand utilisation, quality and performance. And it needs a relationship with the community it serves.

The absence of any one of these elements can compromise the entire service.

This illustrates an important principle:

Health-system performance is determined not only by the strength of individual components, but by the quality of the connections between them.

The strategic imperative, therefore, is to move from strengthening isolated building blocks to building an integrated, people-centred and accountable PHC system.

The Case for a Primary Health Care Renaissance

The concept of a PHC Renaissance recognises that the context in which PHC operates has changed.

Population needs are changing. Urbanisation and population growth are altering patterns of service demand. Communities increasingly expect responsive and respectful services. The burden of disease is becoming more complex, with infectious diseases continuing to coexist with non-communicable diseases, maternal and child health challenges, mental health needs and emerging health threats.

At the same time, technology is transforming how health information is generated and used. Citizens are increasingly able to compare experiences and demand greater transparency. Governments face fiscal constraints and must demonstrate greater value from every unit of public expenditure.

These changes require a different conception of PHC.

PHC should not be understood simply as the lowest level of the health system.

It is the foundation of the health system.

A strong PHC system prevents avoidable illness, provides early diagnosis and treatment, manages common conditions, supports maternal and child health, delivers essential public health interventions, manages chronic diseases, connects communities to higher levels of care and helps protect households from unnecessary financial hardship.

A Renaissance therefore means repositioning PHC from a residual component of the health system to its strategic centre of gravity.

Six Strategic Shifts

From Building Blocks to Transformation: Strategic Shifts for Primary Health Care Renaissance

A PHC Renaissance requires deliberate shifts across the major dimensions of the health system.

1. From Administration to Accountable Governance

Leadership and governance are often discussed in terms of policies, committees, plans and administrative structures. These are important, but governance must ultimately be judged by whether it enables institutions and individuals to deliver results.

The shift should therefore be from administration to accountable stewardship.

Leadership at national, state, local government and facility levels must be connected to clearly defined responsibilities and measurable expectations. Roles must be sufficiently clear to reduce duplication, gaps and conflicting mandates.

Accountability must also become more than compliance with procedures.

Managers should be able to answer fundamental questions:

1. Are services available when communities need them?
2. Are health workers present and productive?
3. Are essential medicines available?
4. Are resources reaching frontline facilities?
5. Are patients receiving respectful and quality care?
6. Are referrals functioning?
7. Are performance problems identified and addressed quickly?

This requires a culture in which data, supervision, performance reviews and community feedback are used not simply to identify failures but to solve problems.

Accountability should be supportive, transparent and results-oriented.

The objective is not to create a punitive system in which managers hide problems. It is to create a learning system in which problems are visible, responsibilities are clear, corrective action is taken and improvements are recognised.

Good governance should ultimately make it easier—not harder—for frontline providers to deliver good care.

2. From Fragmented Financing to Strategic Purchasing

Financing is one of the strongest determinants of whether PHC systems can function effectively.

Yet the issue is not simply how much money is spent on health. It is also how money flows through the system, what it purchases, when it arrives, and whether it is aligned with population health needs.

Fragmented financing can produce fragmented services.

Different programmes may have separate funding streams, reporting requirements, procurement systems, workforce arrangements and performance indicators. While programme-specific investments can produce important results, excessive fragmentation can increase transaction costs and weaken the coherence of PHC.

A PHC Renaissance requires a shift towards strategic purchasing.

Resources should increasingly be linked to clearly defined services, population needs, quality standards and measurable results. Financing mechanisms should create incentives for continuity of care, prevention, quality improvement and appropriate referral rather than rewarding fragmentation or simply counting activities.

Predictability is equally important.

A facility cannot plan effectively if essential operating funds are delayed or uncertain. Health workers cannot provide quality services if medicines and basic supplies are intermittently unavailable. Communities cannot rely on services that are operational one month and dysfunctional the next.

Strategic financing must therefore address four fundamental questions:

Who receives the money?

For what services?

Based on which needs and performance criteria?

With what accountability for results?

The ultimate objective is to ensure that financing follows health needs and supports the services that communities actually require.

3. From Workforce Numbers to Workforce Performance

The health workforce is the human face of PHC.

Yet workforce policy has often focused heavily on numbers: how many doctors, nurses, midwives, community health workers or other cadres are available.

Numbers matter, but they are only the beginning.

The more important question is whether the workforce is available, appropriately skilled, supported, motivated, distributed and enabled to perform.

A health worker without essential medicines cannot provide complete care. A provider without adequate equipment or diagnostics is constrained. A worker who is consistently absent or overwhelmed by excessive workload cannot sustain quality services. Similarly, a well-trained provider working in a poorly managed facility may have limited opportunity to perform effectively.

A Renaissance must therefore move from a narrow focus on workforce expansion to workforce performance and retention.

This means strengthening:

1. Equitable deployment;
2. Supportive supervision;
3. Continuous professional development;
4. Clear roles and scopes of practice;
5. Appropriate task-sharing;
6. Staff motivation and recognition;
7. Safe and enabling working environments;
8. Performance management;
9. Career development; and
1. Mechanisms for retaining skilled personnel in underserved communities.

PHC workers must be treated not simply as inputs into the system but as strategic assets whose performance determines whether the system delivers value.

The objective should be a workforce that is present, competent, motivated and connected to the communities it serves.

4. From Facility-Based Provision to Integrated, People-Centred Care

One of the limitations of a facility-centred conception of PHC is that it can make the facility the endpoint of the health system rather than part of a broader continuum of care.

But people's health needs do not begin at the facility door.

They begin in households, schools, workplaces and communities.

A strong PHC system should therefore connect households, communities, community-based providers, PHC facilities, referral hospitals and public health institutions.

This requires greater emphasis on prevention, health promotion, early detection, continuity of care and effective referral.

For example, a woman who presents at a PHC facility for antenatal care should not be viewed simply as a single service encounter. She should be connected to a continuum that includes skilled maternity care, postnatal care, newborn services, immunisation, family planning, nutrition and appropriate referral when complications arise.

Similarly, a person living with hypertension or diabetes should not receive care only when symptoms become severe. PHC should support screening, diagnosis, treatment, counselling, medicine availability, follow-up and referral when necessary.

This is what people-centred care means in practice.

It means organising the health system around people's journeys through care, rather than around administrative programmes.

5. From Data Collection to Intelligence for Action

Health systems increasingly generate enormous amounts of data.

But more data does not automatically mean better decisions.

The real value of information lies in its ability to answer practical questions and trigger action.

A PHC Renaissance must therefore move from data collection to intelligence for action.

Frontline managers should be able to identify which services are underperforming, where stock-outs are occurring, which facilities have workforce gaps, where utilisation is changing and which communities are being left behind.

Information systems should support decision-making rather than create additional reporting burdens.

Digitalisation offers enormous potential, but technology should be treated as an enabler rather than an objective in itself.

A digital platform that produces reports nobody uses has limited value.

The goal should be an information ecosystem that is:

1. Interoperable;
2. Timely;
3. Reliable;
4. User-friendly;
5. Secure;
6. Relevant to decision-makers; and
7. Connected to action.

At the facility level, this could mean using routine data during regular performance meetings to identify problems and agree corrective actions.

At the local government or state level, it could mean identifying facilities requiring targeted support.

At the national level, it could mean tracking equity, efficiency, quality and population health outcomes.

The transformation occurs when information becomes intelligence, intelligence becomes decisions, and decisions become improved performance.

6. From Commodity Availability to Resilient Supply Systems

No PHC system can function effectively when essential medicines, vaccines, diagnostics and other health commodities are routinely unavailable.

Stock-outs undermine clinical quality, frustrate health workers and erode public confidence.

The conventional response is often to procure more commodities.

But resilient supply systems require more than procurement.

They require accurate forecasting, appropriate quantification, efficient purchasing, effective warehousing, reliable distribution, inventory visibility, last-mile delivery and accountability at every stage.

The strategic shift should therefore be from commodity availability as an isolated procurement objective to resilient supply as a core health-system capability.

Supply chains should be designed around the needs of frontline service delivery.

Data from facilities should inform forecasting. Procurement should reflect actual consumption and population needs. Distribution systems should be capable of responding to changing demand. Facilities should have the skills and tools necessary to manage inventory effectively.

Most importantly, stock availability should be treated as a performance indicator of the health system, not merely a logistics issue.

When a patient arrives at a facility and receives the medicine they need, multiple building blocks have worked together: financing, procurement, supply chain management, workforce capacity, governance and service delivery.

That is integration in action.

Integration Is the Transformative Principle

These six shifts cannot succeed independently.

Governance influences financing.

Financing shapes workforce deployment and service delivery.

Workforce capability determines whether investments in infrastructure and commodities translate into effective care.

Medicines and technologies determine whether providers can deliver appropriate treatment.

Information systems reveal whether investments are producing results.

Community engagement determines whether services are trusted, used and improved.

The defining feature of a PHC Renaissance must therefore be functional integration.

Instead of viewing the building blocks as separate pillars, they should be understood as an interconnected system organised around one central purpose:

meeting people's health needs effectively, equitably and with dignity.

This requires a change in the way reforms are designed.

Rather than asking:

How can we strengthen the workforce?

We should also ask:

How will workforce improvements interact with financing, supervision, medicines, information and service delivery?

Rather than asking:

How can we digitise PHC?

We should ask:

What decisions will better information enable, who will make them, and what resources or authority will they have to act?

Rather than asking:

How many facilities have been rehabilitated?

We should ask:

How many facilities are fully functional, consistently staffed, adequately supplied and delivering quality services?

This is the difference between inputs and functionality.

Putting People and Trust at the Centre

There is another dimension that conventional health-system frameworks can understate: trust.

A technically functional PHC system that communities do not trust will struggle to achieve its potential.

People must believe that health facilities will be open when needed, that competent providers will attend to them, that medicines will be available, that they will be treated respectfully, and that the system will respond when something goes wrong.

Trust is built through repeated experiences.

It is built when a pregnant woman arrives at a facility and receives timely, respectful care.

It is built when a child receives the required vaccine without unnecessary barriers.

It is built when essential medicines are available.

It is built when health workers are present.

It is built when communities can raise concerns and receive a response.

And it is lost when facilities are routinely closed, providers are absent, medicines are unavailable, informal payments become unavoidable or complaints disappear without resolution.

Community participation should therefore move beyond consultation to meaningful partnership.

Communities should have mechanisms to influence priorities, monitor service quality, provide feedback and participate in accountability processes.

Patient experience, community feedback, grievance redress and public accountability should become integral measures of PHC performance.

In this sense, trust is not an additional building block.

It is an outcome of how well all the building blocks work together for people.

From Access to Effective Coverage

Another important shift is from measuring access to measuring effective coverage.

A facility within geographical reach does not necessarily mean that a population has access to quality healthcare.

A person may live close to a PHC facility but find that:

The facility is closed;

1. The appropriate provider is unavailable;
2. Medicines are out of stock;
3. Diagnostic services are unavailable;
4. The cost of care is unaffordable;
5. The quality of care is poor; or
6. referral services are inaccessible.

The Renaissance agenda must therefore distinguish between nominal access and effective access.

The relevant question is not simply whether a facility exists.

It is whether people can obtain the right care, at the right time, from the right provider, at an affordable cost and with an acceptable level of quality.

This requires a stronger focus on quality improvement.

Quality should not be regarded as a specialised programme operating alongside PHC. It should be embedded into everyday management.

Every facility should have a culture of continuous improvement in which teams routinely examine performance, identify gaps, test solutions and monitor whether those solutions work.

Equity Must Be a Core Measure of Success

A health system can improve its average performance while leaving vulnerable populations behind.

A PHC Renaissance must therefore place equity at the centre of measurement and decision-making.

Geographical disparities, gender inequalities, socioeconomic differences and the needs of underserved populations must be visible in planning and resource allocation.

The communities with the greatest barriers to care may require greater investment rather than equal investment.

This means moving from a simple question of:

“How much are we investing?”

to:

“Who benefits from the investment, who remains excluded, and what are we doing about it?”

Equity should therefore be considered across financing, workforce distribution, infrastructure, medicines, service availability, quality and health outcomes.

The test of PHC transformation is not only whether the system performs better overall.

It is whether it performs better for those who have historically been least well served.

From Programmes to Platforms

Another opportunity for a PHC Renaissance is to rethink the relationship between vertical health programmes and the broader health system.

Disease-specific programmes have often been successful in mobilising resources, building technical expertise and achieving targeted results. However, when programmes operate through parallel structures, they can sometimes increase fragmentation.

The future should increasingly emphasise PHC as a platform through which multiple health needs can be addressed.

The PHC facility should be capable of providing an integrated package of services rather than functioning as a collection of disconnected programmes.

This does not mean eliminating specialised programmes.

It means ensuring that programme investments strengthen the underlying PHC platform wherever possible.

A successful programme should leave behind stronger systems, stronger workers, stronger information systems, stronger supply chains and stronger community relationships.

That is how programme success becomes health-system success.

The Role of Local Leadership

A genuine PHC Renaissance cannot be delivered exclusively from the national level.

PHC is ultimately experienced locally.

The functionality of a facility depends heavily on local management, local supervision, community relationships, workforce availability, commodity flows and the responsiveness of the institutions responsible for supporting frontline services.

This makes subnational leadership critical.

States and local governments need the authority, capacity, information and resources required to manage PHC effectively.

At the same time, decentralisation without accountability can simply move inefficiency closer to communities.

The solution is not decentralisation alone.

It is empowered and accountable local governance.

Local managers should have sufficient operational flexibility to solve problems while being held accountable for agreed standards and results.

This balance between autonomy and accountability is essential to creating responsive PHC systems.

A New PHC Performance Compact

The transition from building blocks to transformation also requires a new understanding of performance.

Traditional health-sector monitoring often focuses heavily on activities and inputs:

1. Number of facilities constructed;
2. Number of health workers trained;
3. Amount of medicines procured;
4. Number of reports submitted;
5. Number of outreach sessions conducted.

These indicators remain useful, but they do not tell the whole story.

A transformation-oriented performance framework should move progressively towards:

Functionality.

Is the facility open, staffed, equipped and supplied?

Quality.

Are patients receiving appropriate and respectful care?

Continuity.

Are patients receiving follow-up and appropriate referral?

Efficiency.

Are resources being converted into services and outcomes effectively?

Equity.

Are underserved populations benefiting?

Experience.

Do people trust and value the services they receive?

Outcomes.

Are preventable illness, complications, deaths and financial hardship being reduced?

This creates a much stronger performance chain:

Inputs → Functionality → Quality → Utilisation → Continuity → Outcomes → Trust

The closer PHC monitoring moves towards this chain, the more meaningful performance management becomes.

From Reform to Transformation

Nigeria's PHC challenge cannot be addressed through infrastructure rehabilitation, additional funding, workforce recruitment or digitalisation in isolation.

Each is important.

But transformation occurs only when these investments reinforce one another within a coherent system.

A newly renovated PHC facility that has no health worker is not transformation.

A trained health worker without medicines is not transformation.

A digital information system that does not influence decisions is not transformation.

A financing mechanism that does not reach frontline services is not transformation.

A community engagement strategy that does not give communities meaningful influence is not transformation.

Transformation occurs when the system begins to function differently as a whole.

A facility is functional because it has the people, resources, commodities, management and information required to provide care.

A health worker is effective because the system around them enables performance.

A patient receives appropriate care because financing, workforce, commodities, information, referral systems and governance work together.

A community trusts the system because its experience consistently demonstrates reliability, dignity and responsiveness.

That is the transition from building blocks to transformation.

The Questions That Should Define the Next Generation of PHC Reform

The next generation of PHC reform must ask harder questions.

Are resources reaching frontline services?

Are facilities actually functional?

Are health workers present, competent and productive?

Are essential medicines consistently available?

Are diagnostic services functioning?

Are referrals completed?

Is data driving decisions?

Are managers empowered to solve problems?

Are communities participating meaningfully?

Are patients treated with dignity?

Are vulnerable populations receiving their fair share of investment?

Are health services becoming more affordable?

And, ultimately:

Are people receiving better care and achieving better health outcomes?

These questions shift the focus from what the system has to what the system does.

That is the essence of transformation.

A Practical Agenda for a Primary Health Care Renaissance

A Renaissance requires more than a compelling narrative. It requires an implementation agenda.

Five priorities can provide a practical starting point.

1. Define what a functional PHC facility means

A clear national or subnational standard should specify the minimum requirements for functionality, including staffing, essential medicines, diagnostics, infrastructure, equipment, utilities, financing, information and governance.

The objective should be to move from counting facilities to measuring functional facilities.

2. Establish integrated PHC performance management

Performance management should bring together governance, financing, workforce, commodities, information, quality and community experience rather than treating them as separate domains.

3. Align financing with PHC priorities

Funding streams should progressively become more coherent, predictable and responsive to population needs, while creating incentives for quality, continuity, equity and results.

4. Empower frontline and local managers

Managers closest to service delivery need the authority, information and resources required to solve operational problems, alongside clear accountability for performance.

5. Make communities co-producers of PHC

Communities should not simply be recipients of health services. They should be partners in identifying needs, monitoring performance, improving trust and shaping service delivery.

The Bigger Idea: Rebuilding the Social Contract Around PHC

A **Primary Health Care Renaissance** is not just about building hospitals or clinics. It's about transforming the entire system of care.

It is about making health care more **people-centered**, focusing on **prevention**, **community involvement**, and **equity**, not only on physical facilities.

It is about renewing the relationship between the health system and the population.

Citizens contribute through taxes, insurance premiums, community participation and their trust in public institutions. In return, they reasonably expect health services that are available, affordable, respectful and effective.

PHC is one of the most visible expressions of this social contract.

When the PHC facility works, people see the state working.

When it does not, the failure is experienced directly by households.

This makes PHC not merely a technical health-sector issue but an important dimension of public-sector performance and social development.

A successful PHC Renaissance can therefore contribute to stronger institutions, greater social trust and improved human development.

Conclusion: From Building Blocks to a Living System

The building blocks of a health system remain essential.

But a building is not defined by its bricks.

It is defined by what the completed structure enables people to do.

The same is true of health systems.

The workforce, financing, governance, information, service delivery, medicines and technologies are necessary components. But their real value emerges only when they are connected into a functioning system that responds to people's needs.

The future of PHC therefore requires a shift:

From inputs to functionality.

From fragmentation to integration.

From administration to accountability.

From expenditure to value.

From workforce numbers to performance.

From data collection to intelligence.

From facility availability to effective coverage.

From consultation to community partnership.

From access to quality, equity and outcomes.

And ultimately:

From reform to transformation.

A Primary Health Care Renaissance is about converting structures into functionality, investments into services, services into better experiences, and better experiences into measurable improvements in population health.

It is about building a PHC system that people can rely on—not occasionally, not only during campaigns, and not only when external support is available, but every day.

The building blocks provide the foundation.

Integration makes the system work.

Accountability sustains performance.

Trust gives it legitimacy.

Equity gives it purpose.

Better health outcomes are the ultimate measure of transformation.

Exciting News! I am thrilled to announce my forthcoming book:

Primary Health Care Renaissance in Nigeria: Strengthening the Foundation of the National Health System

The book envisions a Primary Health Care Renaissance in Nigeria, one that positions primary care as both the foundation and the entry point of the national health system. It moves beyond the traditional focus on physical facilities to embrace community-driven care, preventive strategies, and equity. At its core, this vision calls for rebuilding the very pillars of the health system, fostering resilience, and ensuring well-being for all Nigerians.

The book highlights:

- Why primary health care is the cornerstone of national health.
- Practical strategies for strengthening Nigeria's health system.
- A vision for equitable, accessible, and sustainable care.

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