PRIMARY HEALTH CARE RENAISSANCE BLOG SERIES

The Systems and Structures that Power Primary Health Care in Nigeria: The Rules, Actors and Machinery of Care

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INTRODUCTION:

What Really Makes Primary Health Care Work?

When most people think about Primary Health Care, they think about a health facility.

They picture a clinic in a community, a nurse or community health worker attending to patients, medicines on the shelves, immunisation sessions, antenatal care, treatment of common illnesses and referral of complicated cases.

Picture of a clinic in a community, a nurse or community health worker attending to patients,

These are the visible expressions of Primary Health Care.

But behind every functioning PHC facility lies something much larger.

1. There are laws that define responsibilities.
2. Policies that establish priorities.
3. Institutions that provide leadership.
4. Governments that finance services.
5. Agencies that regulate standards.
6. Health workers who deliver care.

7. Supply systems that move medicines.
8. Information systems that generate intelligence.
9. Purchasing mechanisms that pay for services.
10. Supervisory structures that monitor performance.
11. Communities that use, influence and increasingly demand accountability from the system.

Together, these constitute the systems and structures that power Primary Health Care.

The quality of care received by a pregnant woman in a rural community, therefore, is rarely determined by the health worker alone.

Her experience may depend on decisions taken months earlier and hundreds of kilometres away, about financing, workforce deployment, procurement, regulation, data, infrastructure and governance.

This is why understanding PHC requires us to look beyond the walls of the facility.

We need to understand three fundamental dimensions:

The Rules — what governs the system.

The Actors — who makes the system work.

The Machinery — how the system converts policies and resources into care.

Together, they determine whether Primary Health Care functions as a collection of programmes and facilities or as an integrated system capable of delivering better health for all.

PART ONE: THE RULES

The Architecture of Authority, Responsibility and Accountability

Every health system operates according to rules.

Some are formal: laws, regulations, policies, guidelines, standards, financing arrangements and institutional mandates.

Others emerge through administrative practice and relationships between institutions.

In Nigeria, this architecture is particularly important because health responsibilities are distributed across the federal, state and local levels of government.

The Constitution provides the wider governmental framework, while legislation, policies, regulations and administrative arrangements further define how health-sector responsibilities are exercised.

For PHC, one landmark reform was the **National Health Act 2014**, which provided a statutory framework for Nigeria's health system and established the Basic Health Care Provision Fund.

Another important institutional reform has been the effort to consolidate fragmented PHC responsibilities at state level through the **Primary Health Care Under One Roof** approach.

More recently, national health-sector reforms have sought to strengthen coordination across governments and partners and to position PHC more firmly within the broader movement towards Universal Health Coverage.

But rules matter only when they influence what actually happens.

A policy does not immunise a child.

A guideline does not deliver a medicine.

A regulation does not automatically produce quality.

A budget allocation does not guarantee that money reaches the health facility.

Rules become meaningful only when institutions have the authority, capacity, resources and accountability mechanisms required to implement them.

The central governance question is therefore not simply:

Do we have policies?

It is:

Do our rules create clear responsibilities and enable institutions to deliver results?

PART TWO: THE ACTORS

Who Actually Powers Primary Health Care?

Nigeria's PHC system involves a wide network of actors.

Understanding their roles is essential because fragmentation often begins when responsibilities overlap, coordination is weak or accountability becomes unclear.

The Federal Government

At federal level, the **Federal Ministry of Health and Social Welfare** provides national policy direction and overall stewardship of the health sector.

It establishes national priorities, develops policies and standards, coordinates major reforms and provides leadership in engagements with states, development partners and other stakeholders.

The National Primary Health Care Development Agency

The **National Primary Health Care Development Agency (NPHCDA)** occupies a central position in Nigeria's PHC architecture.

Its mandate places it at the heart of national efforts to strengthen Primary Health Care, including technical support, immunisation, PHC development, system strengthening and collaboration with states and other partners.

But national institutions cannot directly manage every frontline service.

Nigeria's federal structure makes subnational leadership indispensable.

State Governments and State PHC Agencies or Boards

States translate national direction into operational reality.

State Ministries of Health provide policy leadership and stewardship within their jurisdictions, while State Primary Health Care Development Agencies or Boards play important roles in organising and managing PHC systems.

The effectiveness of these institutions significantly influences workforce deployment, supervision, infrastructure, commodity availability, financial management and facility performance.

Local Governments

PHC happens locally.

Local government structures therefore remain essential to supervision, community mobilisation, environmental and public health functions, local planning and support for frontline service delivery.

But the effectiveness of local structures depends greatly on the clarity of their responsibilities, their managerial capacity, access to resources and their relationship with state-level institutions.

The National Health Insurance Authority and State Health Insurance Agencies

The movement towards Universal Health Coverage has made health purchasing increasingly important.

The **National Health Insurance Authority**, alongside State Social Health Insurance Agencies and other purchasing arrangements, forms part of the machinery for expanding financial protection and purchasing healthcare services.

Their role highlights an important distinction:

Financing healthcare is not simply about raising money.

It is about determining **who pays, who receives resources, what services are purchased, for whom, under what standards and with what accountability for performance.**

Regulatory Institutions

Professional councils and other regulatory bodies protect standards of professional practice and patient safety.

They help define who may practise, the standards expected of practitioners and mechanisms for professional accountability.

Regulation is therefore not peripheral to PHC.

It is one of the foundations of public trust.

Health Workers

Then come the people who transform the system into care.

Doctors.

Nurses.

Midwives.

Community Health Officers.

Community Health Extension Workers.

Junior Community Health Extension Workers.

Pharmacists and pharmacy personnel.

Laboratory professionals.

Environmental health personnel.

Health information officers.

Managers.

Community-based workers.

And many others.

For the patient, these professionals are often **the health system**.

The quality of their interaction can determine whether the citizen leaves the facility reassured or disappointed, treated or untreated, respected or humiliated—and whether that person chooses to return.

Communities

There is one actor that must never be treated as an afterthought:

the community.

Communities are not merely beneficiaries.

They are stakeholders, partners and co-producers of health.

Traditional institutions, religious leaders, civil society organisations, community structures, Ward Development Committees, women's groups, youth organisations, patients and caregivers can all influence health-seeking behaviour, service utilisation, accountability and trust.

A PHC system disconnected from its community may be administratively complete yet socially ineffective.

PART THREE: THE MACHINERY OF CARE

How Does the System Actually Produce Healthcare?

Rules tell the system what should happen.

Actors determine who should make it happen.

But machinery determines **how it happens**.

This machinery consists of the operational systems that convert resources into services.

1. Financing: Moving Money to Where Care Happens

Healthcare cannot function without predictable financing.

Funds must move from revenue sources and financing mechanisms through institutions and purchasing arrangements until they eventually support frontline services.

The critical question is:

Does financing actually reach the point of care in a timely, adequate and predictable manner?

A PHC facility without operational financing cannot maintain equipment, address routine needs, support outreach or respond effectively to local problems.

The financing machinery must therefore connect national priorities with frontline functionality.

2. The Workforce System: Putting the Right People in the Right Places

Recruiting health workers is only one part of workforce management.

The machinery must also recruit, deploy, train, supervise, motivate, assess and retain them.

The real objective is not merely more workers.

It is:

the right workers, with the right competencies, in the right places, at the right times, supported by the right working environment.

3. Medicines and Supply Chains: From Warehouse to Patient

Procurement is not the same as availability.

Medicines may exist in a central warehouse while patients encounter empty shelves at the facility.

An effective supply system must connect forecasting, quantification, procurement, warehousing, inventory management, distribution and last-mile delivery.

The true measure of success is not how much was purchased.

It is whether the patient receives the medicine when it is needed.

4. Health Information: From Registers to Decisions

Every day, PHC facilities generate information.

Who attended?

What conditions were treated?

How many children were immunised?

Which medicines are running low?

Which patients were referred?

Where are disease patterns changing?

The machinery of information must transform these observations into intelligence.

This requires reliable data collection, digital systems where appropriate, analysis, feedback and most importantly, action.

The objective is not simply to produce reports.

It is to create a continuous cycle:

Data → Intelligence → Decision → Action → Improved Performance.

5. Referral Systems: Connecting Levels of Care

No PHC facility can provide every service.

A functioning PHC system must therefore be connected to secondary and tertiary services through reliable referral pathways.

Referral is more than writing a note and telling a patient to go elsewhere.

A functional referral system requires clear protocols, communication, transportation where necessary, receiving facilities capable of providing the required care, feedback to the referring provider and continuity after the patient returns to the community.

Without these connections, the health system becomes a collection of isolated facilities.

6. Supervision and Performance Management

Health systems cannot improve what they do not see.

Supportive supervision should identify operational problems, strengthen provider capacity and enable managers to take corrective action.

Performance reviews should ask:

Are facilities functional?

Are workers present?

Are medicines available?

Are patients receiving appropriate care?

Are referrals completed?

Are resources being used effectively?

What do patients say about their experience?

And what corrective action is being taken?

This shifts supervision from inspection towards **continuous performance improvement**.

7. Quality and Patient Safety

Access alone is not enough.

People must have access to care that is safe, effective and respectful.

Quality therefore needs to be embedded throughout the machinery of PHC—from clinical standards and infection prevention to medicine safety, respectful care, grievance redress and continuous quality improvement.

The objective cannot simply be:

Did the patient reach the facility?

We must also ask:

Did the patient receive the care they needed, safely, respectfully and effectively?

THE CONNECTIONS MATTER MORE THAN THE COMPONENTS

Here lies one of the most important lessons for Nigeria's PHC transformation.

A country may have all the necessary institutions and still have a poorly functioning system.

Why?

Because institutions do not automatically create integration.

Imagine a PHC facility with a newly renovated building.

The infrastructure system has delivered.

But there is no midwife.

The workforce system has failed.

Suppose a midwife is deployed.

But essential medicines are unavailable.

The supply system has failed.

Suppose medicines arrive.

But the facility has no reliable operational financing.

The financing system is failing.

Suppose financing improves.

But referral arrangements are dysfunctional.

Continuity of care fails.

And suppose all of these are available, but patients are treated disrespectfully and complaints are ignored.

Trust fails.

This illustrates a fundamental systems principle:

The performance of PHC is constrained by the weakest critical connection in the patient's journey.

Transformation therefore requires more than strengthening individual institutions.

It requires strengthening **relationships between institutions and functions**.

WHO IS ACCOUNTABLE WHEN PHC FAILS?

This is one of the most difficult questions in a complex health system.

When a facility has no medicine, who is accountable?

When workers are absent, who acts?

When financing is delayed, who explains why?

When equipment breaks down, who is responsible for restoring functionality?

When a referral fails, who follows the patient?

When poor-quality care occurs, who responds?

And when communities repeatedly complain without receiving answers, where does accountability ultimately reside?

Complex governance arrangements can sometimes allow responsibility to become diffused.

Everyone has a role.

Yet nobody appears fully accountable for the final outcome.

A PHC Renaissance must address this.

Responsibilities should be clear.

Performance should be visible.

Problems should have identifiable owners.

And accountability should follow the entire chain from policy to patient.

FROM INSTITUTIONAL MANDATES TO SHARED OUTCOMES

The institutions within the health system naturally have different mandates.

But citizens do not experience mandates.

They experience **care**.

A mother does not care which institution was responsible for procuring an essential medicine.

She cares whether the medicine is available.

A patient requiring emergency referral is unlikely to be concerned with jurisdictional debates.

The patient needs the referral system to work.

This means that while institutional mandates remain important, the health system must increasingly organise itself around **shared outcomes**.

Those outcomes include:

Functional facilities.

Reliable services.

Competent and available health workers.

Essential medicines.

Financial protection.

Continuity of care.

Quality.

Equity.

Patient experience.

Trust.

And ultimately, better health.

THE PATIENT JOURNEY AS THE TRUE TEST OF THE SYSTEM

Perhaps one of the most powerful ways of assessing the PHC system is to stop looking at it from the perspective of institutions and begin looking at it from the perspective of the patient.

Consider a pregnant woman living in an underserved community.

Can she identify an appropriate PHC facility?

Can she physically reach it?

Is it open?

Is a skilled provider present?

Is she treated respectfully?

Are essential medicines and diagnostics available?

Can she afford the services?

If complications develop, can she be referred quickly?

Will the referral facility receive her?

Will information follow her through the system?

Will she receive follow-up after returning home?

If the answer to any critical question is no, then somewhere within the machinery of care, a connection has failed.

This is why the patient journey may provide a more meaningful assessment of health-system functionality than any institutional organogram.

TOWARDS A FUNCTIONAL PHC ECOSYSTEM

Nigeria's next generation of PHC reform should therefore seek to create what might be called a **functional PHC ecosystem**.

Such an ecosystem would connect:

Rules → Institutions → Resources → Providers → Services → Communities → Outcomes.

Policy would define direction.

Governance would establish responsibility.

Financing would provide resources.

Purchasing would translate resources into defined services.

Workforce systems would provide competent people.

Supply chains would provide medicines and technologies.

Information systems would provide intelligence.

Referral networks would provide continuity.

Regulation would protect standards.

Communities would provide participation and accountability.

And leadership would ensure that the entire system remains focused on results.

The defining characteristic would not simply be the presence of these components.

It would be their **functional integration**.

THE RENAISSANCE QUESTION

This brings us to the deeper question at the heart of the *Primary Health Care Renaissance*:

How do we move from having a PHC architecture to having a PHC system that consistently works?

The answer requires several transitions:

From overlapping responsibilities to clear accountability.

From fragmented programmes to integrated platforms.

From budget allocation to predictable frontline financing.

From workforce numbers to workforce performance.

From procurement to reliable commodity availability.

From data reporting to intelligence for action.

From referral instructions to continuity of care.

From supervision to performance improvement.

From community consultation to community partnership.

From counting facilities to measuring functionality.

And from institutional outputs to outcomes that matter to people.

REBUILDING TRUST THROUGH FUNCTIONALITY

Ultimately, all of these systems and structures converge at one point:

the experience of the citizen.

When the machinery works, the citizen experiences reliability.

When institutions coordinate, the citizen experiences continuity.

When financing works, the citizen experiences greater affordability.

When supply chains work, medicines are available.

When workforce systems work, competent providers are present.

When accountability works, failures are corrected.

And when all these things happen consistently, something even more important begins to emerge:

trust.

Trust cannot be legislated into existence.

It cannot be created by slogans.

It is earned through repeated evidence that the system works.

In this sense, public trust is one of the clearest expressions of system performance.

CONCLUSION: MAKING THE MACHINERY WORK FOR PEOPLE

Primary Health Care is much more than the facility we see.

Behind every consultation lies a network of laws, institutions, financing arrangements, health workers, supply chains, information systems, regulatory mechanisms, referral networks and community relationships.

These are the **rules, actors and machinery of care**.

But their existence alone is not enough.

The true test is whether they work together.

Nigeria does not merely need stronger individual PHC institutions.

It needs stronger connections between them.

It needs rules that clarify responsibility.

Actors empowered and accountable to perform.

Machinery capable of converting resources into reliable services.

Communities with meaningful influence.

And a performance system that measures what ultimately matters to people.

The central question for the next generation of PHC reform should therefore not simply be:

What structures have we created?

It should be:

Are those structures enabling the system to deliver?

Not simply:

How much have we invested?

But:

What has that investment changed for the patient?

Not simply:

How many facilities do we have?

But:

How many are truly functional?

And not simply:

Who has responsibility for Primary Health Care?

But:

Who is accountable for ensuring that Primary Health Care actually works?

That is the transition Nigeria must make.

From structures to functionality.

From mandates to accountability.

From institutions to integration.

From programmes to a system.

From service availability to effective care.

And,

from the machinery of healthcare to better health for every Nigerian.

Because the true measure of a health system is not the sophistication of its structures.

It is whether those structures work together, every day, to deliver the care that people need.

That is the machinery that must power a **Primary Health Care Renaissance in Nigeria**.

FORTHCOMING BOOK

Before I conclude, I am delighted to announce my forthcoming book.

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

It is a work born of deep reflection and commitment, offering fresh insights into the challenges and opportunities of Primary Health Care.

The book explores a vision for repositioning Primary Health Care as both the foundation and a critical entry point of Nigeria's national health system.

It moves beyond the traditional emphasis on physical facilities to explore people-centred care, prevention, community participation, accountability, resilience and equity.

It examines why Primary Health Care remains the cornerstone of national health, presents practical strategies for strengthening the Nigerian health system, and advances a vision for accessible, equitable, quality and sustainable healthcare for all Nigerians.

I look forward to sharing more about the book in forthcoming episodes of the *Primary Health Care Renaissance Podcast Series*.

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Thank you for taking the time to read.

And let us not forget: Primary Health Care cannot be transformed merely by reinforcing its individual components.

Transformation begins when those parts work together for people.

Until our next series, stay committed to better health, stronger systems, and a Primary Health Care Renaissance in Nigeria.