PRIMARY HEALTH CARE RENAISSANCE THOUGHT LEADERSHIP PROGRAMME

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Leadership, Governance and Accountability in Primary Health Care: Closing the Gaps that Weaken Performance and Trust.

By Dr. Abdullahi Jibril Mohammed,

Author, Primary Health Care Renaissance in Nigeria: Strengthening the Foundation of the National Health System; and Trust Renewal, The Integrity Call for Better Health for All.

Convener/CEO: Initiative for Health Accountability and Transparency

Founder: Health Development Academy

Reimagining PHC. Inspiring Transformation. Improving Health Outcomes.

Introduction: The Leadership, Governance and Accountability Question

Nigeria does not lack policies, institutions, programmes or investments in Primary Health Care. Over the years, considerable effort has gone into building facilities, recruiting health workers, supplying commodities, introducing financing mechanisms and launching successive reform initiatives.

Yet a fundamental question remains:

Why do significant investments and repeated reforms still fail to translate consistently into functional facilities, quality services and better experiences for citizens?

Part of the answer lies beyond infrastructure, workforce and financing.

It lies in leadership, governance and accountability.

Leadership provides direction. Governance determines how decisions are made, responsibilities assigned, resources managed and institutions coordinated. Accountability ensures that those entrusted with responsibilities explain their actions, demonstrate results and face corrective action or consequences where performance falls short.

A health system may have buildings, personnel, medicines, equipment and funding, but without effective leadership, sound governance and enforceable accountability, these inputs will not consistently translate into results.

Leadership, governance and accountability must therefore be treated not simply as administrative functions, but as fundamental determinants of PHC performance, integrity and public trust.

Fundamental Principles of Leadership and Governance in Primary Health Care

Good leadership and governance in PHC should be anchored on fundamental principles that shape how the system is directed, managed and improved.

1. Clear Vision and Strategic Direction

Leadership begins with clarity of purpose.

Every level of the PHC system should understand what it is trying to achieve, the standards expected, the population it serves and the results against which performance will be measured.

National policies must translate into state priorities, Local Government implementation and measurable improvements at facility and community levels.

The ultimate direction must remain clear:

accessible, equitable, people-centred and quality Primary Health Care that produces better health outcomes.

2. Clarity of Roles, Responsibilities and Authority

For every major PHC function, it should be possible to answer:

Who is responsible? Who has authority to act? Who provides the resources? Who monitors performance? Who is accountable for results?

Shared responsibility must never become diluted accountability.

3. Stewardship and Responsible Resource Management

Leadership is an act of stewardship.

Financial resources, personnel, medicines, infrastructure, equipment, information and institutional authority must be managed responsibly and directed towards improving people's health.

Every resource committed to PHC should have a traceable pathway to improved services and health outcomes.

4. Transparency

Good governance requires openness in decision-making, resource allocation, expenditure, service standards and performance.

Transparency should not merely make information available. Information must be understandable and useful for decision-making and accountability.

5. Participation and Community Voice

Communities should participate in identifying priorities, assessing services, providing feedback and monitoring performance.

People should not merely receive PHC services; they should have a meaningful voice in how those services are governed.

6. Equity and Inclusion

Good governance continuously asks:

Who is being reached and who is being left behind?

Leadership must ensure that poverty, geography, gender, disability, insecurity or social disadvantage do not systematically determine access to quality PHC.

7. Evidence-Informed Decision-Making

Routine information, financial data, workforce information, facility assessments, patient experience and community feedback must inform planning and corrective action.

The important question is not merely whether data exist, but whether they are used to improve performance.

8. Responsiveness

Governance must identify problems and act on them.

Identify → Respond → Correct → Verify.

A system that repeatedly documents deficiencies without correcting them is collecting information without exercising effective governance.

9. Integrity and Ethical Leadership

Leadership must model fairness, professionalism, responsible use of authority and ethical conduct.

Integrity is inseparable from public confidence and trust.

10. Coordination and Functional Integration

Institutions, programmes and stakeholders should work as parts of one PHC system rather than as isolated structures.

The objective must be functional integration rather than institutional fragmentation.

11. Continuous Learning and Improvement

Strong institutions recognise weaknesses, learn from experience, adapt and improve.

Supervision and performance reviews should therefore identify not only who failed, but what failed, why it failed and what must change.

Fundamental Principles of Accountability in Primary Health Care

Accountability deserves particular attention because it is the mechanism that converts leadership and governance commitments into measurable responsibility for results.

Accountability is not simply about finding fault or imposing sanctions.

At its core, accountability means that those entrusted with authority, resources and responsibilities must be answerable for how they use them and for the results they produce.

Effective PHC accountability should rest on the following principles.

1. **Clear Responsibility**

There can be no meaningful accountability where responsibility is unclear.

Every institution, programme, manager and service provider must know what is expected, what resources are available and what results they are responsible for delivering.

You cannot hold people accountable for responsibilities that have never been clearly defined.

2. Answerability

Those entrusted with responsibility must be required to explain their decisions, actions, use of resources and performance.

If medicines are unavailable, funds remain unused, health workers are absent or services repeatedly fail, responsible institutions should be able to explain why.

Accountability therefore requires an institutional culture in which asking questions is normal and providing answers is obligatory.

3. Transparency and Access to Information

Accountability requires information.

Budgets, resource flows, service standards, staffing expectations, facility performance and programme results should be sufficiently transparent for managers, oversight institutions, communities and citizens to assess performance.

What cannot be seen is difficult to scrutinise; what cannot be scrutinised is difficult to hold accountable.

4. Measurable Standards and Performance Expectations

Accountability must be anchored to clearly defined standards.

Facilities and programmes should know the minimum services they are expected to provide and the indicators against which their performance will be assessed.

Accountability becomes weak when success is defined vaguely.

It becomes stronger when commitments are specific, measurable and verifiable.

5. Verification

Self-reporting alone is insufficient for strong accountability.

Reported performance should be periodically verified through supervision, facility assessments, financial reviews, data-quality checks, community monitoring and independent verification.

The essential question is:

Can the reported result be independently confirmed?

6. Citizen and Patient Voice

Accountability cannot operate only upward through administrative structures.

It must also operate outward and downward towards citizens and communities.

Patient-experience surveys, community scorecards, citizen report cards, complaints mechanisms, social audits and community monitoring should complement routine administrative reporting.

This allows the system to answer an important question:

Does community and patient experience confirm the improvements reported by institutions?

7. Responsiveness and Corrective Action

Accountability has little value if identified problems produce no action.

When weaknesses are detected, there should be a defined process for correction, responsible persons, timelines and follow-up.

The accountability cycle should therefore be:

Set Expectations → Measure → Report → Verify → Explain → Correct → Follow Up.

8. Consequences and Enforcement

Where persistent failure, negligence, misuse of resources or misconduct occurs, there must be appropriate consequences consistent with established rules and due process.

Conversely, strong performance, innovation and demonstrated improvement should be recognised and encouraged.

An accountability system without credible consequences risks becoming merely a reporting system.

9. Financial Accountability:

Every naira allocated to PHC should be traceable from allocation and release to expenditure, service delivery and, as far as practicable, results.

The question must move beyond:

How much was spent?

to:

What did the expenditure deliver?

Financial accountability must therefore connect money with services, outputs and outcomes.

10. Professional and Ethical Accountability

Health workers and managers have obligations that extend beyond administrative reporting.

They are accountable to professional standards, ethical codes, patient safety requirements and the dignity and rights of those seeking care.

Respectful care, confidentiality, competence, appropriate clinical practice and professional integrity are therefore essential dimensions of PHC accountability.

11. Social Accountability

Citizens and communities should have structured mechanisms through which they can scrutinise commitments, monitor services, provide feedback and demand responses.

Ward Development Committees, community structures, civil society organisations and patient groups can help bridge the gap between institutional reporting and lived experience.

Social accountability turns citizens from passive recipients into active partners in improving the health system.

12. Equity Accountability

Accountability should examine not only overall performance but also who benefits from that performance.

Improving aggregate indicators while leaving remote, poor or vulnerable populations behind should not be regarded as complete success.

Performance must therefore be examined across geography, socioeconomic groups and vulnerable populations.

13. Independent Oversight

Strong accountability benefits from institutions and mechanisms capable of reviewing performance independently of those implementing programmes.

Civil society, communities, professional bodies, oversight institutions, independent verification mechanisms and other legitimate actors can strengthen credibility and identify gaps that internal reporting may overlook.

14. Learning and Continuous Improvement

Accountability should ultimately improve the system.

Its purpose should not be limited to identifying failure.

It should reveal why performance gaps occur, identify solutions and ensure that lessons inform future planning and implementation.

The strongest accountability system is one that makes institutions progressively better at delivering results.

From Principles to Practice: Closing the Accountability Gap

The challenge facing PHC is therefore not merely establishing reporting systems.

Nigeria already generates considerable health-sector information.

The deeper question is whether information leads to answerability, verification, corrective action and improvement.

A facility may submit reports every month and still remain poorly functional.

A programme may meet administrative reporting requirements while communities continue to experience poor services.

Funds may be accounted for financially while the intended service improvements remain invisible.

This distinction is critical.

Reporting is not the same as accountability.

Reporting tells us what institutions say happened.

Accountability asks whether it happened, whether resources were properly used, whether expected results were achieved, whether citizens experienced those results and what happens when they were not achieved.

Closing the Gap Between Policy and Implementation

Nigeria has developed important policies and reform frameworks for strengthening PHC. Yet one persistent weakness remains the gap between policy intention and implementation reality.

Closing that gap requires a clear line of sight:

Policy → Financing → Implementation → Facility Performance → Patient Experience → Health Outcomes.

Every major PHC intervention should be traceable across this chain.

If funds are released, what changed at facility level?

If workers are recruited, did service availability improve?

If medicines are supplied, did patients actually receive them?

If facilities are renovated, are they functional?

If performance indicators improve, do communities independently confirm those improvements?

This is where governance and accountability become meaningful.

Accountability Must Follow the Resources

Increased PHC financing must be accompanied by stronger accountability.

It is not enough to know how much money was budgeted or released.

We must know where the resources went, what they were intended to achieve, whether they reached intended facilities and populations, what services were delivered and what measurable improvements resulted.

Every naira invested in Primary Health Care should have a visible pathway to improved services and better health outcomes.

From Administrative Accountability to Public Accountability:

Traditional health-sector accountability is predominantly vertical: facilities report upward through Local Government, state and national structures.

That remains necessary.

But the PHC Renaissance requires accountability in several directions:

Upward accountability — to supervisory and financing institutions.

Horizontal accountability — between institutions and oversight mechanisms.

Professional accountability — to standards, ethics and professional obligations.

Downward accountability — to patients, communities and citizens.

Social accountability: through citizen participation, civil society scrutiny and independent verification.

Together, these create a stronger accountability ecosystem.

Restoring Trust Through Leadership, Governance and Accountability

Trust is not built through communication campaigns alone.

People trust health institutions when their repeated experiences demonstrate competence, fairness, responsiveness and integrity.

The relationship is therefore clear:

Leadership provides direction.

Governance establishes responsibility and order.

Integrity safeguards the system.

Accountability connects responsibility to results.

Participation gives citizens a voice.

Verification establishes credibility.

Responsiveness turns feedback into action.

Performance builds confidence.

Confidence strengthens trust.

A New Accountability Compact for Primary Health Care

Nigeria's PHC Renaissance should establish a stronger accountability compact among government, managers, health workers, communities, civil society and development partners.

Government must provide stewardship, financing and an enabling environment.

Managers must translate resources into functional services.

Health workers must provide competent, ethical and respectful care.

Communities must participate and provide feedback.

Civil society should track commitments, independently verify implementation and amplify citizen experience.

Development partners should align support with nationally owned priorities and measurable results.

Every actor must know what they are responsible for, what they are expected to deliver, how performance will be measured and what happens when commitments are not fulfilled.

Shared responsibility must never become diluted accountability.

Closing Reflection

Primary Health Care is the foundation of the health system.

But strong foundations require more than facilities, equipment, medicines and health workers.

They require institutions that work, leaders who provide direction, governance systems that clearly allocate responsibility and accountability mechanisms that ensure commitments translate into results.

Nigeria's Primary Health Care Renaissance will therefore depend not only on how much we invest, but on how well we lead, how effectively we govern, how responsibly we manage resources and how consistently we hold ourselves accountable for results.

The defining accountability question must remain:

Are citizens actually experiencing the improvements we claim to be making and can those improvements be independently verified?

If the answer cannot be demonstrated at facility and community levels, transformation remains incomplete.

The renaissance we seek must ultimately become visible in the everyday experience of citizens, in accessible services, functional facilities, equitable care, responsive institutions, responsible leadership, respectful treatment and restored public trust.

Good leadership makes reform possible.

Good governance makes reform work.

Accountability makes responsibility real.

Verification makes results credible.

And credible results build trust.

That is when reform becomes transformation.

Primary Health Care Renaissance Platform

Reimagining PHC. Inspiring Transformation. Improving Health Outcomes.

The Primary Health Care Renaissance Platform promotes dialogue, evidence, leadership and accountability towards transforming Primary Health Care as the foundation of Nigeria's health system.

For updates, collaborations and inquiries, you can reach me by email at

abdullahionly@yahoo.com or ihatnigeria@gmail.com

You can also reach us through the following contact:

Tel: +234 803 617 0644,

WhatsApp: +234 913 348 8988.

Facebook: ihatnigeria

Instagram: ihatnigeria

twitter: @ihatnigeria

Youtube: ihatnigeria