

PRIMARY HEALTH CARE RENAISSANCE | THOUGHT LEADERSHIP BLOG SERIES

Why Nigeria's Primary Health Care Reforms Have Not Consistently Delivered Functional Services?

From Reform Initiatives to Functional Health Systems: Understanding the Missing Links

A Policy Reflection and Call for Transformative Action

By Dr. Abdullahi Jibril Mohammed (M.J Abdullahi).

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 (IHAT),

Founder: Integrated Healthcare Strategies and Analytics (IHSA) LTD, and

Founder: Health Development Academy.

Introduction: The Paradox of Reform Without Consistent Functionality

Nigeria's Primary Health Care (PHC) system has been the subject of numerous reforms, policy initiatives, institutional restructuring efforts and development investments over several decades. From the pioneering PHC initiatives of the late 1980s to the establishment of the National Primary Health Care Development Agency (NPHCDA), the introduction of Primary Health Care Under One Roof (PHCUOR), the Basic Health Care Provision Fund (BHCPF), and more recent revitalisation initiatives, the country has demonstrated sustained recognition of the importance of PHC.

Yet, despite these efforts, a fundamental question remains: Why have successive Primary Health Care reforms not consistently translated into functional, accessible, reliable and quality healthcare services for Nigerians?

This question is particularly important because the challenge is not necessarily the absence of policies, programmes, institutions or investments. Rather, it concerns the persistent gap between reform intentions, implementation processes, institutional performance and the actual experiences of people seeking healthcare.

Across Nigeria, health facilities have been constructed, renovated, equipped and commissioned. Health workers have been trained, commodities distributed, and programmes launched. However, many communities continue to experience shortages of skilled health workers, essential medicines,

functional equipment, reliable electricity, water, referral services and other basic requirements for effective healthcare delivery.

The central paradox: Nigeria has made considerable progress in developing PHC policies, programmes and infrastructure, but this progress has not consistently produced corresponding improvements in service functionality.

1. Reform Has Often Focused More on Inputs Than Functionality

One of the most persistent weaknesses in PHC reform has been the tendency to measure progress primarily through investments, activities and physical outputs rather than sustained improvements in service delivery.

The number of facilities constructed or renovated, equipment procured, personnel trained and funds disbursed frequently dominates implementation reports. These are important achievements, but they represent inputs and intermediate outputs rather than definitive evidence of functional healthcare services.

A renovated health facility without skilled personnel, essential medicines, functioning equipment or dependable operating hours cannot consistently meet the healthcare needs of its community. A facility may possess modern infrastructure but remain unable to provide basic maternal healthcare, childhood illness management, immunisation, hypertension screening or emergency stabilisation.

Functionality must therefore be understood as the ability of a health facility and its supporting system to consistently deliver an appropriate package of safe, effective, accessible, people-centred and quality services. This requires moving beyond counting facilities and activities towards assessing what services are actually available, whether they work, and whether people benefit from them.

2. Fragmented Governance and Institutional Responsibilities

Nigeria's federal structure creates important opportunities for decentralised healthcare governance. However, it also presents coordination challenges. Responsibilities for PHC policy, financing, infrastructure, human resources, service delivery and oversight are distributed across federal, state and local government institutions.

In practice, these responsibilities have not always been sufficiently harmonised. Different institutions may finance infrastructure, deploy personnel, procure medicines, supervise programmes or manage facilities without effective integration of their respective responsibilities. The result can be fragmented planning, overlapping mandates, inconsistent financing and weak operational accountability.

The Primary Health Care Under One Roof policy was designed to address important aspects of this fragmentation by promoting integrated PHC management under designated state-level

structures. However, adoption of an institutional framework does not automatically guarantee effective implementation.

Institutional restructuring without corresponding changes in authority, resources and management practices may produce administrative reform without functional transformation. The central challenge is ensuring that governance structures possess the capacity, authority and incentives to deliver results.

3. Inadequate Alignment Between Infrastructure and Operational Readiness

A recurring problem in PHC development is the weak alignment between capital investments and recurrent operational requirements. Infrastructure projects are often easier to identify, finance, implement and publicly demonstrate than the less visible investments required to sustain healthcare services.

Healthcare facilities depend on continuous operational inputs. Health workers must be available and adequately supported; essential medicines and supplies must be replenished; equipment requires maintenance; electricity and water systems must remain functional; and referral arrangements must operate reliably.

Where these recurrent requirements are not adequately planned and financed, infrastructure investments may yield limited or short-lived benefits. A facility that functions effectively immediately after commissioning may deteriorate within months if operational financing, maintenance arrangements and management responsibilities are unclear.

Should a PHC facility be considered successfully revitalised merely because construction and equipment installation have been completed, or only when it can demonstrate sustained service readiness and delivery? This question should reshape how revitalisation programmes are designed, financed, implemented and evaluated.

4. Persistent Health Workforce Challenges

No PHC reform can achieve sustained functionality without an adequate, competent, motivated and appropriately distributed health workforce. Nigeria's PHC system continues to face challenges involving workforce shortages, unequal geographical distribution, inadequate skills mix, limited supportive supervision, difficult working conditions and retention problems.

Rural and underserved communities are particularly vulnerable. Even where facilities exist, the absence of appropriately trained personnel may prevent them from providing essential services.

Workforce challenges are not limited to staffing numbers. They also involve competencies, deployment practices, motivation, performance management, professional development and institutional support. A facility may have health workers on its nominal establishment but still experience service gaps because of absenteeism, inappropriate deployment, insufficient clinical competencies or inadequate supervision.

Workforce reform must move beyond recruitment targets to address the broader conditions necessary for effective service delivery. This requires a comprehensive approach linking workforce planning, recruitment, deployment, competencies, incentives, supervision, retention and accountability to defined service delivery requirements.

5. Financing Has Not Always Been Sufficiently Predictable or Linked to Performance

Sustainable PHC functionality requires adequate, timely, predictable and efficiently managed financing. Although Nigeria has introduced important financing mechanisms, including the Basic Health Care Provision Fund, persistent challenges remain in resource adequacy, fund flow, financial management and expenditure accountability.

The existence of a financing mechanism does not necessarily guarantee that resources reach frontline facilities when needed or are used effectively. Delays in fund releases, fragmented financing arrangements, inadequate operational allocations and weak expenditure tracking can undermine service delivery.

Financial performance is sometimes assessed primarily by the amount allocated, released or spent rather than the services delivered and outcomes achieved. A stronger financing approach would connect resource allocation and expenditure to clearly defined service readiness, quality, utilisation and accountability indicators.

Financing should be sufficiently equitable to address structural disadvantages while creating incentives for improved service delivery, responsible resource management and continuous quality improvement. The important question is not simply how much money has been invested in PHC, but what measurable and sustainable improvements those investments have produced.

6. Weak Integration of Essential Health Services

Primary Health Care is intended to provide comprehensive, continuous, coordinated and people-centred services. However, many interventions have historically been organised around specific diseases, programmes, funding streams or development priorities.

Immunisation, maternal and child health, nutrition, malaria, tuberculosis, HIV, noncommunicable diseases and other interventions may operate through separate planning, financing, reporting and supervision arrangements. While targeted programmes have contributed substantially to health improvements, excessive fragmentation can weaken integrated service delivery.

A patient attending a PHC facility should not encounter a collection of disconnected programmes. The facility should function as an accessible entry point into a coordinated health system.

Integrated PHC requires harmonised clinical pathways, coordinated workforce deployment, shared information systems, effective referral arrangements and continuity of care. Without these

elements, individual programmes may achieve important results while the overall health system remains fragmented.

7. Weak Monitoring, Verification and Accountability for Results

A major limitation of many reform initiatives is the gap between reported implementation achievements and independently verified service delivery performance. Monitoring systems frequently emphasise activities completed, resources utilised and outputs delivered. These measures are necessary, but they do not provide a complete picture of functionality.

A more meaningful performance assessment should examine whether facilities are consistently open, skilled personnel are available, medicines are stocked, equipment is operational, essential services are delivered, referrals are completed and patients receive acceptable care. It should also assess whether services are equitable, affordable, safe and responsive to community needs.

Independent verification is particularly important because administrative reports may not fully reflect conditions experienced by patients. This creates a strong case for combining routine health information systems with facility assessments, supportive supervision, independent verification, community monitoring and social accountability mechanisms.

Reported progress must be tested against operational reality and the lived experiences of healthcare users. The ultimate measure of reform success should not be the number of activities completed, but the extent to which people can reliably access quality healthcare.

8. Limited Community Ownership and Citizen Participation

Primary Health Care was founded on principles that include community participation, equity, intersectoral collaboration and appropriate technology. Yet, community participation has not always been sufficiently institutionalised as an effective mechanism for planning, oversight and accountability.

Communities may be consulted during project initiation or mobilised for specific health campaigns without being meaningfully involved in monitoring facility performance and influencing service improvements. Where communities have limited information about available services, funding, staffing standards or their healthcare entitlements, their ability to demand accountability is constrained.

Ward Development Committees, community-based organisations, civil society groups and patient representatives can contribute to identifying service gaps, monitoring performance, strengthening feedback mechanisms and supporting local problem-solving. These mechanisms must be empowered with appropriate information, participation opportunities and institutional responsiveness.

Citizen engagement should not be treated as a ceremonial component of PHC development. It should become an integral part of how healthcare services are governed, assessed and improved.

9. Policy Discontinuity and Weak Institutionalisation of Reforms

Reform initiatives are sometimes associated with particular administrations, leadership teams, development partners or funding cycles. Changes in leadership or political priorities may result in shifts in implementation emphasis, institutional arrangements or programme direction.

New initiatives may be introduced before earlier reforms have been fully implemented, evaluated or institutionalised. This can create repeated cycles of policy formulation, programme launches and implementation adjustments without sufficient consolidation of lessons and achievements.

Sustainable reform requires institutional continuity beyond individual leadership tenures. Policies must be supported by enduring legal frameworks, operational standards, financing commitments, institutional capacities and accountability arrangements.

The durability of reform depends on how deeply its principles and operating systems become embedded in institutions, not merely on the commitment of their original champions.

10. Insufficient Attention to the Wider Health System

Primary Health Care cannot function effectively in isolation. Its performance depends on broader health-system arrangements, including referral hospitals, diagnostic services, supply chains, transportation, health information systems, emergency response and health financing.

A PHC facility may appropriately identify a high-risk pregnancy or a patient requiring specialist care, but the value of that intervention is diminished if referral transportation is unavailable, communication systems are weak or the receiving hospital cannot provide timely treatment. Interruptions in central medicine supply systems may also compromise otherwise well-managed facilities.

PHC reform must therefore be conceived as part of wider health-system strengthening. The objective should be to position PHC as the foundation of an integrated national health system, supported by functional referral networks and coordinated institutional arrangements.

11. What Does the Evidence Tell Us?

The National Health Facility Survey 2023 provides important evidence of persistent service readiness challenges. Among the findings reported for primary healthcare facilities were average essential medicine availability of 34.3%, functional basic medical equipment in 29.9% of public PHCs, and limited readiness to provide selected noncommunicable disease services. The survey also highlighted gaps in healthcare workforce availability and clinical training.

These findings reinforce a critical reality: improvements in physical infrastructure do not automatically translate into comprehensive service readiness. They demonstrate why functionality must be measured across several interdependent dimensions rather than through isolated infrastructure or programme indicators.

Although survey findings must be interpreted in relation to their methodology, facility categories and measurement periods, the broader policy message remains compelling. Nigeria's PHC challenge is not simply about expanding the number of facilities. It is about ensuring that existing and newly revitalised facilities can consistently deliver the services for which they were established.

12. From Repeated Reforms to Primary Health Care Renaissance

The persistence of these challenges does not mean that previous reforms have failed entirely. Important progress has been achieved in policy development, institutional arrangements, immunisation, healthcare financing, infrastructure expansion, community mobilisation and service delivery. Many reforms have established foundations upon which future improvements can be built.

However, their uneven results suggest that Nigeria requires more than another cycle of isolated interventions. It requires a fundamental shift in how Primary Health Care reform is conceptualised, implemented, monitored and sustained.

A renaissance is not simply a return to earlier PHC principles or the introduction of another reform programme. It is a call to renew the vision of PHC, rethink its institutional and operational arrangements, and reposition it as the functional foundation of Nigeria's national health system.

13. A New Standard for Measuring Reform Success

A critical element of PHC Renaissance should be the establishment of a more rigorous and transparent approach to defining and measuring functionality. Instead of treating facility renovation or programme implementation as the endpoint of reform, Nigeria should adopt a multidimensional functionality framework.

Such a framework should assess the availability, reliability and quality of essential services; workforce readiness; medicines and equipment; infrastructure and utilities; referral effectiveness; financial management; patient experience; and community accountability. It should distinguish between facilities that are physically available, those that are operationally ready, and those that consistently deliver quality healthcare.

The framework should also incorporate regular verification of reported performance. A particularly valuable measure would be a Citizen-Verified Improvement Rate, reflecting the proportion of documented service delivery improvements that are independently confirmed through patient and community feedback.

The objective is not to create additional reporting burdens, but to make existing monitoring and accountability systems more meaningful, integrated and responsive. The central performance question should become: Are Primary Health Care services becoming more functional, reliable, accessible and responsive to the people who depend on them?

Conclusion: The Missing Link Is Functional Transformation

Nigeria's experience demonstrates that sustained policy attention, institutional reforms and infrastructure investments, while necessary, are insufficient on their own to guarantee functional Primary Health Care.

The recurring challenge lies in the incomplete translation of reform initiatives into coordinated institutional performance, reliable operational systems, accountable service delivery and measurable improvements in people's health experiences.

This is not an argument against previous reforms. Rather, it is an argument for building more deliberately upon their achievements, correcting persistent weaknesses and strengthening the systems required to sustain results.

Nigeria does not necessarily need to begin again. It needs to consolidate what has worked, confront what has not, and establish a stronger connection between policy ambition, institutional accountability, operational readiness and service delivery outcomes.

The next generation of PHC reforms must therefore be judged less by the scale of announcements, infrastructure projects or programme activities, and more by the reliability, quality and equity of healthcare services available to communities.

The true success of Primary Health Care reform is not what government builds, purchases, launches or reports. It is what the health system can consistently deliver—and what citizens can independently verify and experience.

Questions for National Reflection and Dialogue

Why do some PHC facilities remain poorly functional despite repeated investments in infrastructure and equipment?

What institutional, financing and management reforms are necessary to ensure sustained service readiness?

How can government and development partners move from measuring activities and outputs to verifying actual improvements in healthcare delivery?

What role should communities, civil society organisations and patients play in monitoring PHC functionality?

How can Nigeria institutionalise a national PHC functionality framework that promotes accountability, continuous improvement and sustainability?

These are not merely technical questions. They are fundamental questions of governance, leadership, public accountability and national development.

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