Putting Institutions at the Center of Primary Health Care Reforms: Experience from Implementation in Three States in Nigeria

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Abstract—Within the last two decades, the Nigerian government has committed to strengthening its primary health care system, through reforms addressing institutional restructuring, deepening decentralized governance, and the incorporation of an alternative health care financing strategy. One of these reforms prescribed the establishment of state primary health care agencies/boards (SPHCDBs) as an integral part of the national health system, with the principal responsibility “for the coordination of planning, budgeting, provision and monitoring of all primary health care services that affect residents of the state.” Central to this reform is the integration of primary health care (PHC) governance and management, popularly called primary health care under one roof. Another reform, piloting results-based financing, has been implemented since 2011 in three states under the Nigeria State Health Investment Project. This study assesses the implementation of the Primary Health Care Under One Roof (PHCUOR) policy as part of the broader PHC reforms, with a specific focus on how this policy has been strengthened through the Nigeria State Health Investment Project (NSHIP) in Adamawa, Nasarawa, and Ondo states, documenting the evolution of SPHCDB and PHC service delivery, with a focus on management, accountability, and incentives. The study shows that, in the above-mentioned states, significant milestones were achieved in the establishment of the SPHCDB, the strengthening of PHC systems, the improvement of accountability linkages, and an increase in service utilization. The authors therefore argue that integrated PHC systems through SPHCDBs, as enshrined in the PHCUOR guidelines, are a panacea for effective provision of primary health care and a potential game changer for health outcomes, especially when reinforced with a results-based financing approach.

INTRODUCTION

Sustainable Development Goal (SGD) 3 includes a target to “achieve universal health coverage (UHC), including financial
risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.\textsuperscript{11} Despite there not being a one-size-fits-all approach, there is widespread consensus that with the status quo it will not be possible to meet the goals of UHC.\textsuperscript{7} Therefore, there has been a call for health reforms, reappraisal of priorities, and pragmatically aligning health policies. In Nigeria, the efforts of government are geared toward the revitalization of primary health care (PHC), with a special focus on poor and vulnerable populations; an expansion of the insurance base; and the implementation of integrated primary health care systems, through the reduction of fragmentation of government institutions responsible for PHC governance and leadership.\textsuperscript{3}

Nigeria has a complex health care system, which is organized into a three-tier structure (federal, state, and local governments), each responsible for providing different health services—tertiary, secondary and primary, respectively.\textsuperscript{3} More specifically, the federal government is largely responsible for the provision of policy guidance, planning, and technical assistance; coordination of state-level implementation of the National health policy; and the establishment of health management information systems. In addition, it is responsible for disease surveillance, vaccine management, drug regulation, and training of health professionals, as well as the management of teaching, psychiatric, and orthopaedic hospitals, including some medical centers. On the other hand, at the state level, the responsibility for management of health facilities (HFs) is shared by the state ministries of health (SMoHs), state hospital management boards, and the local government areas (LGAs).\textsuperscript{4} Though states are responsible for secondary hospitals and for the regulation and technical support of PHC services, PHC has been the responsibility of LGAs providing health services through the ward health system.\textsuperscript{3} The 774 LGAs provide oversight for the operations of PHC facilities within their geographic areas and the provision of basic health services, community health, hygiene, and sanitation.\textsuperscript{4}

The Evolution of Primary Health Care in Nigeria

Nigeria’s National Health Policy of 2004 was developed according to the principles of social justice and equity, with PHC as its cornerstone.\textsuperscript{5} Since then, PHC in Nigeria has matured through three major attempts.\textsuperscript{6}

The first attempt was with the Basic Health Services Scheme (BHSS), as part of the Third National Development Plan (1975–1980), aimed at addressing poor utilization of health services.\textsuperscript{5,7} This plan marked a period of health system development with PHC as a cornerstone.\textsuperscript{6,7} The BHSS established “basic health units,” with a comprehensive health center in each LGA, backed up by four PHC centers and 20 health clinics with attached mobile clinics.\textsuperscript{7} A major drawback with this plan was that it focused on building and equipping new facilities and posting of health personnel; another drawback was the poor buy-in by states and noninvolvement of local communities; thirdly, there was poor budgetary allocation.\textsuperscript{7,8} The initiative thus became unsustainable for the government by the end of the third National Development Plan period.\textsuperscript{7,9}

Between 1986 and 1992, the late Professor Olikoye Ransome-Kuti, then minister of health, piloted a model PHC system in 52 LGAs that addressed all eight components of PHC.\textsuperscript{7,8} Within this period, PHC services provision, funding, and management were devolved to the LGAs.\textsuperscript{6,7} Careful application of the principle of active community participation was largely responsible for the health care successes noted during this period.\textsuperscript{7,9}

In 1992, the National Primary Health Care Development Agency (NPHCDA) was created, heralding the third attempt to make PHC accessible to the grassroots.\textsuperscript{7} The ward health system, which utilizes the electoral ward as the basic operational unit for PHC delivery, was established and, subsequently, the Ward Minimum Health Care Package was developed in 2001.\textsuperscript{7,9–11} However, five years down the line, service utilization and community response and participation were still below expectations.\textsuperscript{12} This has been attributed to instability in governance during the military era and the lack of visionary leadership and preparedness on the part of LGAs to shoulder all of the responsibilities associated with the management of PHC.\textsuperscript{6}

Despite these shortcomings, with the return to civilian rule in 1999, Nigeria’s PHC system began to witness a gradual turnaround. Notable achievements during the democratic dispensation include the revision of the national health policy (2004), with PHC strengthening as a key strategy; development of the blueprint for the revitalization of PHC in Nigeria (2004–2008); and PHC infrastructural development through the construction of new PHC facilities and refurbishing of existing ones.\textsuperscript{13,14}

Despite these achievements, the issue of fragmentation with respect to the provision of health services and management of staff, funds, and other resources remained a major problem for the management of PHC, prompting the need for yet another reform.\textsuperscript{7}

PHC Under One Roof

Fragmentation of PHC governance was characterized by a lack of clarity on stewardship and accountability. Institutional
responsibilities for the provision of PHC were assigned to different agencies of government at federal, state, and LGA levels. One such institution was the Local Government Service Commissions (LGSC), which regulated human resources (HR) for civil service grade levels seven and above, concurrently with the Ministry of Local Government (MoLG) PHC departments who managed grade levels one to six. Such fragmentation limited the states’ effectiveness in harmonizing HR plans and deployment and made the designation of the responsibility of discipline to specific institutions problematic. The SMoH was also involved in the management of PHC. On finance and budgeting, although PHC activities were appropriated by state governments and disbursed through state joint accounts, each of these multiple agencies had PHC budgets, with opportunity for duplication and misappropriation of funds. Similarly, there was no clear-cut mandate or delineation of responsibilities with regards to planning, service provision, and supervision. Simply put, there was no accountability.

In order to address the issues highlighted above, Nigeria committed to institutional restructuring, deepening decentralized governance, and the incorporation of an alternative health care financing strategy. Thus, in 2011, the National Council on Health adopted the “ Bringing PHC Under One Roof” (PHCUOR) guidelines for the integrated management of PHC level services to advance PHC reforms as stipulated in the Health Policy of 2004. The Nigeria National Health Policy of 2004—as revised in 2011—prescribed the establishment of SPHCDBs, primarily saddled with the responsibility “for the coordination of planning, budgeting, provision and monitoring of all PHC services that affect residents of the state.” The proposed PHCUOR policy was designed to ensure a unified structure across states and a coordinated management of PHC systems and services within states. Key elements of the policy called for specific structural changes hinged on the principle of “three ones”—one management body, one plan, and one monitoring and evaluation system: a single management body with control over services and resources (human and financial); an enabling legislative framework; decentralized authority, responsibility, and accountability with appropriate span of control; an integrated supportive supervisory system managed from a single source; the integration of all PHC services under one authority; and an effective referral system between/across different levels of care.

Assessing PHCUOR Implementation
The PHCUOR policy guidelines call for specific structural changes in nine domains. The establishment of SPHCDBs to take over the management of PHC activities represented a pivotal institutional reform within the PHCUOR policy.

The NPHCDA developed a scorecard for monitoring the progress of implementation of PHCUOR as an accountability and advocacy tool to both governmental and nongovernmental stakeholders, for the purpose of facilitating decision making and the implementation of the PHCUOR policy nationwide. The scorecard is composed of nine weighted domains (see Table 1), reflecting the PHCOUR pillars. States are scored on each domain based on their responses and verifiable evidence.

Performance-Based Financing as a PHC Reform
In line with the aspirations of the federal government of Nigeria for PHC system strengthening, the World Bank provided an International Development Association credit of 150 million USD to implement the NSHIP. The NSHIP development objectives are to increase the delivery and use of high-impact maternal and child interventions, to improve the quality of care at selected health facilities in participating states, and to strengthen the institutions involved in the delivery and administration of PHC services. The participating states are Adamawa, Nasarawa, and Ondo, selected based on health indicators, political commitment to implementing performance-based financing (PBF), and their geographic spread.

NSHIP, effective in August 2013, utilizes results-based financing approaches, and its design is based on cardinal PHC reforms. It clearly stipulates that participating states should have functional SPHCDBs; it provides an alternative health care financing mechanism that ensures direct funding to health facilities based on performance; it strengthens budget preparation and execution; and it promotes accountability. NSHIP provides a veritable opportunity for implementation of PHCUOR and deepens fiscal decentralization. In fact, NSHIP states have established SPHCDBs; have LGA health authorities; have transferred the administration of HR to the SPHCDB; and control their budgets. The link between NSHIP and PHCUOR implementation is further described in the Findings and Discussion sections.

Methodology
This case study aims to assess the impact of reinforcing a nationwide institutional reform, PHCUOR, with institutional performance incentives administered through a results-based financing reform piloted in three states, under the NSHIP.

With this objective in mind, this case study draws from multiple sources:
Two political economy and institutional assessments (PEIA) commissioned by the World Bank in the three states in 2011\(^{23}\) and 2014\(^{24}\)—the first to assess whether PBF would work in that context and the second in preparation for the Saving One Million Lives—Program-for-Results (SOML—PforR) project. These used similar tools and could serve as before and after studies for the evolution of SPHCDBs in the three NSHIP states.

PHCUOR scorecard results from three rounds of assessment,\(^{20,21}\) whose findings were analyzed to evaluate achievements of the three NSHIP states within the PHCUOR reform. The results of the scorecards for the three NSHIP states were also compared with national averages.

Key informant interviews carried out in the NSHIP states in 2015 focused on the nine domains of PHCUOR, to qualitatively assess achievements of the PHCUOR reform in terms of the establishment of the SPHCDBs. Executives of the SPHCDBs, principal officers of the agency/board, the SMoH, the LGSC, LGA chairmen, executive secretaries of the health authorities, community leaders, nongovernmental organizations, health workers, and users of services were interviewed.
Service utilization data on coverage rates trends—between 2013 and 2015—for three key maternal and child health (MCH) indicators, reported in the NSHIP operational web portal.25

Data drawn from the National Nutrition and Health Survey, an annual population-based SMART survey26,27 that tracks performance of states on key MCH indices, to compare the performance of the three NSHIP states with the national average, in terms of changes in coverage rates between 2014 and 2015 of three MCH indicators.

It should be noted that the indicators used by NSHIP and the SMART Surveys have different definitions and are thus not fully comparable. However, the analyses of these two sources were used for different purposes: the former to showcase the evolution of service delivery in the NSHIP states and the latter to compare the states’ improvements with the national average.

FINDINGS

Findings from the analyses described above are presented under three sub-headings.

Findings from the PEIA Studies

In 2011, the World Bank conducted a PEIA23 study in Adamawa, Nasarawa, and Ondo states. The study assessed the accountability relationships within the PHC system and found that (1) there was an absence of any effective accountability relationship between HFs and service users or communities—with HFs poorly staffed, lacking in equipment and essential drugs, with dilapidated structures and low service utilization; (2) there was a weak relationship between the HFs and LGA PHC departments and MoLG because of ineffective supervision; (3) the SMoH exercised no direct or indirect authority over the PHC system; and, lastly, (4) where there were fledging SPHCDBs, there were no major accountability relationships linking the SPHCDB with the NPHCDA. Therefore, the study concluded that the “major system reform envisaged that has the potential to improve accountability was the transfer of control of PHC functions from MoLG, LGA etc. to the new SPHCDBs.”23

Compared to the 2011 study, the 2014 analysis24 concluded that in the NSHIP states the process of transferring management of the PHC system to the SPHCDB had contributed to strengthening the accountability relationships throughout the system, specifically in the following ways:
- With a strong financial incentive for the PHC facilities to boost the provision of services, there was a visible accountability link from PHC facilities to facility users as the staff conduct outreach and take feedback to improve their services;
- Community relationship was strengthened through the ward development committee, which creates some accountability benefits, as well as encouraging stronger supervision from LG PHC departments.
- The transfer of PHC functions to the SPHCDB brought LGA PHC services under a more direct and focused management authority than was previously the case, and this improved the flow of funds.
- The establishment of the SPHCDB under the SMoH means that the latter now has a direct means of exerting strategic influence over PHC implementation, which it previously lacked—although there was still room for improving the relationship between the SPHCDB and the SMoH in all three states.
- The transfer of funds under NSHIP provides an accountability link between the SPHCDB and the NPHCDA, which was previously lacking. The NPHCDA now also provides direct technical assistance to the states in an organized manner.
- There is now no accountability relationship between the PHC system and the LGA. This is likely to have a positive result to the extent that it protects the PHC system from detrimental political interference (which has starved the PHC system of operational resources and led to overstaffing as well as inappropriate staffing) but may pose some challenges for effective coordination and ensuring LGA commitment where this is required to help improve health outcomes.24

Table 2 shows the changes observed in the structure and functions of the SPHCDBs in the three states.

Findings from the Analysis of the PHCUOR Scorecards and Key Informant Interviews

In the first scorecard assessment, carried out in 2012, all three states outperformed their zonal averages. Adamawa State had a composite score of 57% (north-east zone average was 52%), Nasarawa State had a score of 59% (north-central zone average was 34%), and Ondo State scored 91% (south-west average was 57%). The third scorecard assessment, carried out in 2015, was based on modified and more in-depth indicators. Among the states, Adamawa and Ondo still outperformed their respective zone averages (59% versus 52% and 66% versus 38%, respectively). Nasarawa State, on the
other hand, scored 35%, versus its zonal average of 39%.19,20

The section below describes the assessments in depth.

Governance and Ownership

At the assessment of the first scorecard (S1), none of the three states had appointed governing boards or established accountability structures. However, by the second scorecard (S2) administration, there were guidelines for governing boards and appointments of the boards in Adamawa and Ondo. By the third scorecard (S3) assessment, all three states had appointed leadership for the SPHCDB. In most cases, SPHCDB executives report directly to the governor and the state executive council through the commissioners of health, except in Adamawa State, where the executive reports directly to the governor. These clear lines of accountability have been a catalyst for sustained high-level political support, as well as support of the technical cadres. Similarly, the buy-in of stakeholders such as the chairmen of the Association of Local Governments, nongovernmental organizations/community-based organizations, faith-based organizations, and political and traditional leaders, through a consultative process, has facilitated the establishment of the agencies. The community is represented on the boards of all three SPHCDB.20,21

The existence of the new organizations establishes clear lines of accountability across the tiers of the health system (state and LGA), reinforcing the SMoH’s regulatory role and ensuring a clear delineation of key governance functions. However, there are still some limitations, among which is with the governing boards of the SPHCDB not yet being fully functional. This could be a limitation in engendering ownership; full representation of interests of different constituencies including the LGAs, communities, and women; and, ultimately, social accountability. Nonetheless, this has not precluded the operations of the agencies and increasing oversight of PHC operations, though more can be done.20,21

| S/N | Functions of SPHCDA/B | Adamawa | Nasarawa | Ondo |
|-----|-----------------------|---------|----------|------|
| 1   | Political commitment for the PHC reform | ✓       | ✓        | ✓✓✓  |
| 2   | Legislation           | ✓✓✓     | ✓        | ✓    |
| 3   | Progress in transferring of functions and finances | ✓        | ✓        | ✓    |
| 4   | Budget                | ✓✓✓✓    | ✓✓✓      | ✓✓✓  |
| 5   | Planning              | ✓        | ✓        | ✓    |
| 6   | Service delivery      | ✓        | ✓        | ✓    |
| 7   | Supervision           | ✓        | ✓        | ✓    |
| 8   | Health management information systems, data management and use | ✓        | ✓        | ✓    |
| 9   | Health system integration | ✓✓✓      | ✓        | ✓✓   |
| 10  | Spillover effect      | ✓✓✓✓    | ✓✓✓      | ✓✓✓  |

TABLE 2. Qualitative Assessment of Structure and Functions of SPHCDBs in the Three NSHIP States Between 2011 and 2014. The number of ticks for each point are a comparative measure across the three states describing the level of accomplishment of each point. Source: Adapted from Refs. 22, 23, and 30
Legislation

By the time of the administration of S2, all three states had passed legislation for the establishment of the SPHCDB and implementation of PHCUOR, with acts that detail their funding, composition, roles, functioning, and management procedures, as well as their board and LGA counterparts.\textsuperscript{20,21} This was fast-tracked as a prerequisite for engagement in the PBF pilot at a time when less than ten states in the country had put in place this legal framework. Yet, there is still a need to complete the process. The PHCUOR assessment, in fact, found that, though the legislative processes happened early and quickly, three to five years after their establishment the boards still do not have fully documented operational guidelines.\textsuperscript{20,21}

Minimum Service Package

Benefiting from the minimum package of activities designed for the PBF pilot, the three states have made progress in defining a minimum service package that meets requirements as set out by the NPHCDA. Although the PHCUOR assessments suggest that it is yet to be adopted at full scale by the state,\textsuperscript{20,21} it exists and is delivered by at least one PHC center in every political ward and one general hospital in each LGA. More recently, private providers have also adopted this suite of services under a PBF pilot for urban centers. It is also noteworthy that this progress is at significantly more advanced stages than other states in the country. It may indeed be the first adequately documented instance in Nigeria in which PHC facilities deliver a dedicated suite of services that speak to the national disease burden, cost effectiveness of interventions, and achievement of Sustainable Development Goals. It is also a real game changer because it presents an opportunity to minimize duplication of donor funds at the state level.\textsuperscript{20,21}

Repositioning

At the time of administration of the S2, all three states had made some progress in repositioning, although there remained some lack of clarity in sub-state structures and some political difficulty in realigning them to their new roles. By the S3 administration, in all three states, repositioning had occurred to a significant degree, with new roles carved out for the SMoH and LGA Primary Health Care Authorities (PHCAs) with regard to PHC management. Furthermore, clarity has been provided regarding the new expectations for the LGSC and MoLG with their new formation as LGA PHCA—their principal function being that of supportive supervision and assessing the quality of care provided.\textsuperscript{20,21} This function is aided by the role carved out for them in the PBF system, which has significantly supported the lower level management structure by designating monitoring (collection of data), supervision (quality checks), capacity strengthening for HFs, and a secretarial function for the local governance structure as the role of the LGA PHCA. By instituting the purchaser–provider–regulator split in PBF, the SMoHs within the NSHIP are also clear on their role in policy setting, strategic direction, and regulating technology, drugs, and commodities for health, thereby ensuring good quality care, and the SPHCDB maintains a governance and oversight function.

This progress has not come without challenges or resistance. However, collaborators witnessing the formation of the SPHCDB have begun to understand their role and how best to leverage their positions. For instance, in both Adamawa and Nasarawa, the state agencies for the control of AIDS are increasingly recognizing the role of the SPHCDBs and synergizing their efforts to ensure coordination in delivery. Similar relationships are being reported with the ministries of budget and planning (former Millennium Development Goal offices) and the like.

Systems Development

This domain is related to the development of procedures for financial management, program reporting, monitoring and evaluation, and data management. The drive toward this goal has been greatly supported by PBF implementation. At the administration of S2, however, there was little development of procedures, and only Ondo State had a costed strategic plan. By the third administration, however, Adamawa State had developed an operational plan.\textsuperscript{20,21}

The SPHCDB submit their annual work and procurement plans to the NPHCDA as a yearly obligation under the PBF project. The agencies have thus been encouraged to think through the broad range of functions they are expected to perform across administrative and technical domains. This includes the strengthening of financial management systems to enable payment of performance bonuses to HFs. Likewise, the strengthening of technical capacity within the agency has been a paramount activity, driven by the need to strengthen core agency functions such as data review and analysis, supervision and training of HR, provision of equipment, and coordination of logistics for supply chains for nonessential commodities linked to vertical programs. The latest PHCUOR assessment suggests that there is room to further strengthen this by developing operational guidelines that allow processes to be ingrained within the organizations.\textsuperscript{20,21}

Through the support of the NSHIP project, all three states have developed a strategic plan for health (2016) that looks
at building on the experiences of implementing a PBF system alongside other key programs and leveraging them in the long term for better sector results.

Operational Guidelines

Under this domain, PHCUOR implementation guidelines ought to be domesticated at the state level. Based on this, state personnel should be trained and oriented on the new institutional arrangements.20,21 This provides clarity on lines of accountability and reporting. In all three states, PHC transfer guidelines have been domesticated as a first step to the PHCUOR transfer. As aforementioned, the third scorecard assessment revealed that the policy has not made provisions for HR management, monitoring and evaluation, and accounting procedures. This has been most evident in Ondo State and might account for some challenges the state has had in implementing PBF, ensuring separation of functions, and giving autonomy to PHC under SPHCDB ownership.

Human Resources

At the time of the S2 administration, it was assessed that all three states had made tremendous progress in HR. According to the PHCUOR implementation guidelines, Human Resources for Health (HRH), which were formerly health staff of the LGA, are to be brought entirely under the management of the SPHCDB.19,20 This includes the recruitment of personnel, payment of salaries, development of job descriptions for key staff positions (health facility managers), deployment, and capacity building. Among the three states, only Adamawa and Nasarawa States have fully transferred the management of HRH to its state agency. In Ondo State, the lack of transfer of HRH has been a limitation to full oversight, supervision, autonomy, and incentivizing of health workers, although this is significantly far more progressed than in non-NSHIP states.20,21 Under the NSHIP, management of HRH has been significantly driven by an indicator linked to disbursements to the states, whereby states earn funds for preparing staff profiles and maintaining hiring restrictions for nontechnical cadres. This is a critical first step to eventual redistribution of HRH across functioning facilities. Health workers themselves are direct beneficiaries of performance bonuses based on their productivity, which represents a huge augmentation to salaries paid to them by the states or LGA (as the case may be) and promotes service delivery.

The S3 administration, being a more robust and granular questionnaire, reveals some weaknesses, such as lack of clear plans for rationalization of HRH, lack of clear capacity strengthening plans for health workers, and, in Ondo State, that HRH audits are yet to be completed.20,21 This may in some way be feeding into Ondo State’s low performance in PBF (which is the poorest of the three states).

Funding

The most progress has been made in this domain over time by all three states. At their embryonic stages, the three states had take-off grants. Nasarawa State has made the most progress with the establishment of a pooled fund for PHC activities, including funding the operations of the agency, as required by this domain. Indeed, the decentralization of services without adequate fiscal decentralization has resulted in PHC operations being patchy and inconsistent. Funding has been made available for the agencies in all three cases, though in some instances not necessarily commensurate with operational plans.19,20 The sustainability of the sources of funds for PHC also remains in question. A significant proportion of this funding comes through development assistance for programs supported by donors. Nonetheless, this has provided a starting point and platform for the development of the agencies and their incremental strengthening over time. It is, however, pertinent for states to begin to look inward toward sustainably funding PHC.

Office Setup

Considerable progress has been made in the provision of physical resources for operations of the established agencies.20,21

Findings from the Analysis of NSHIP Operational Data and SMART Surveys

Between 2013 and 2015, all three states recorded very significant increases in service utilization for the three focus indicators (Figures 1-3) in terms of coverage rates. For instance, the average coverage for institutional normal deliveries in the project states increased from 2% in 2013 to 33.1% in 2015.25 In the same period, the average coverage for utilization of modern family planning methods increased from 1.04% to 21.3%,25 and the average coverage for completely vaccinated children increased from 1.4% to 49.2%.25 When comparing the three NSHIP states’ performance with the national average, through coverage rates presented in the 2014 and 2015 SMART surveys (Table 3), we see that the NSHIP states outperformed the national average in both skilled birth attendance and contraceptive prevalence rate.26,27 However, in terms of DPT3/Penta 3 coverage, only
Ondo and Nasarawa States performed better than the national average, and Adamawa suffered a decrease in coverage higher than that experienced at the national level.\textsuperscript{26,27} This may be attributable, in part, to the influx of displaced persons from neighboring states affected by the insurgency.

**DISCUSSION**

Positive results from a more integrated management of the PHC system have been found in the three NSHIP states, demonstrating the importance of institutions. It has been shown that with the appropriate organizational incentives and direct incentives to workers, a new culture of effective and efficient client-oriented service delivery can be established, resulting in improved service utilization.

This study demonstrated that implementation of the NSHIP reinforced the emergence of PHC accountability in Nigeria, as envisioned in the PHCUOR policy. According to the *World Development Report* of 2004,\textsuperscript{28} accountability is a relationship of power among actors that has five features: delegation, finance, performance, and information about

![Population Coverage of Normal Delivery](image1)

**FIGURE 1.** Population Coverage of Normal Delivery

![Population Coverage of Family Planning Methods Utilization](image2)

**FIGURE 2.** Population Coverage of Family Planning Methods Utilization
performance and enforceability. In the health sector, ideally, citizens have voice over politicians, and policy makers have compacts with organizational providers, who in turn manage frontline providers. The strengthening of core management systems is of central importance for any sustainable impact, but this needs to be linked to an adequate flow of operational funds for service delivery and supervision, which would be achieved only through sufficient political commitment. In fact, the latter varies significantly between the three NSHIP states, and its pattern is mirrored in differences in service utilization performance, as presented in the findings.

It could be argued that the strict implementation of PBF, as an alternative health care financing strategy, contributed to the success recorded. On the one hand, that may be true because of an injection of much-needed funds at every level of the health system and because of the autonomy that comes with PBF, which allows institutions, all the way down to the PHC facilities, to take managerial decisions, including how to allocate funds, thus avoiding the inefficiencies of central bureaucracy. On the other hand, implementing PBF in the pre-PHCUOR, fragmented PHC system would have been a recipe for disaster. The PHCUOR and PBF reforms have therefore mutually reinforced each other, jointly strengthening the (NSHIP states’) health system as a whole.

In order to ensure sustainability, however, political commitment will still need to be reinforced. First of all, both at federal and state levels, fiscal space must be made for PHC expenditures, because currently there is a significant level of substitution with project funds, as opposed to using them to complement allocated government funds. Secondly, there needs to be a systematic strengthening of HR management capacity to address the existing misallocation of health workers and excess of unskilled staff throughout the PHC system.

The reforms have also provided a new accountability link between state (SPHCDBs) and national (NPHCDA) levels, as well as facilitating NPHCDA’s role in providing regular technical assistance to the SPHCDB. This is a novelty that may significantly change the way the Nigerian health sector works and is already being implemented in the nationwide

| State     | Skilled Birth Attendance | Contraceptive Prevalence Rate | DPT 3/Penta 3 Coverage |
|-----------|--------------------------|-------------------------------|------------------------|
|           | 2014  | 2015  | Difference | 2014  | 2015  | Difference | 2014  | 2015  | Difference |
| Adamawa   | 19.4  | 26    | 6.6        | 8.5   | 22.8  | 14.3       | 51.6  | 45.4  | –6.2       |
| Nasarawa  | 55.8  | 70.9  | 15.1       | 14.1  | 21.4  | 7.3        | 39.4  | 38.4  | –1         |
| Ondo      | 55.5  | 67.1  | 11.6       | 20.4  | 30    | 9.6        | 67.3  | 75.3  | 8          |
| National Average | 48.02 | 54.51 | 6.50       | 15.83 | 19.95 | 4.12       | 53.3  | 50.27 | –3.03      |

**TABLE 3.** Comparison of Project States’ Performance with National Average on the SMART Surveys of 2014 and 2015.
The same strategy has been envisioned for the basic health care provision fund within the 2014 Health Act, whereby states will apply for federal funds to invest in PHC under the condition of having a fully functional SPHCDB.²⁹

**CONCLUSION**

This case study has highlighted that significant milestones have been achieved in Nigeria’s PHC reform journey. It has shown that the consolidation of PHC functions and services under the SPHCDB can contribute to broader health system achievements, though it is not a sufficient condition, because the implementation of the reform was fast-tracked due to the NSHIP and inherent principles of PBF. The challenges identified call for regular strategic and programmatic reviews as the country builds sustainable institutions. The lingering questions are the following: How can Nigeria ensure sustainability of the reform? How will this kind of progress be ensured in other non-NSHIP states? We are optimistic that the SOML—PforR project, implemented nationwide, will be able to translate institutional strengthening into improved service utilization indicators. In conclusion, this case study has shown that integrated PHC systems through SPHCDBs, as enshrined in the PHCUOR guidelines, are a panacea for effective provision of PHC and a potential game changer for health outcomes because institutions matter.

**DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST**

The authors acknowledge the potential conflict of interest related to this case study, given that they are all involved to some extent in the implementation of the NSHIP. They have tried to address this by including in the study other sources of data, external to the NSHIP, to triangulate results (e.g., SMART surveys, PEIA studies, and PHCUOR scorecards).

**AUTHOR CONTRIBUTIONS**

O.Od. developed the concept note and prepared the first draft and the first section on the findings and finalized the write-up. N.I. provided policy guidance and critique to the first and final drafts. R.T.G. developed the Key Informant Interview guide and drafted the second part of the findings. V.M. conducted the Key Informant Interviews and edited the final draft. M.A. conducted the Key Informant Interviews. O.Ol. provided guidance on the operations of SPHCDB and NSHIP at the state level. B.B. and O.F. drafted the third part of the findings. R.A. drafted recommendations and references. A.J. G.M. provided oversight.

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