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Strengthening Local Governance For Primary Healthcare: **Institutional Barriers And Reform Pathways In Rural Nigeria**

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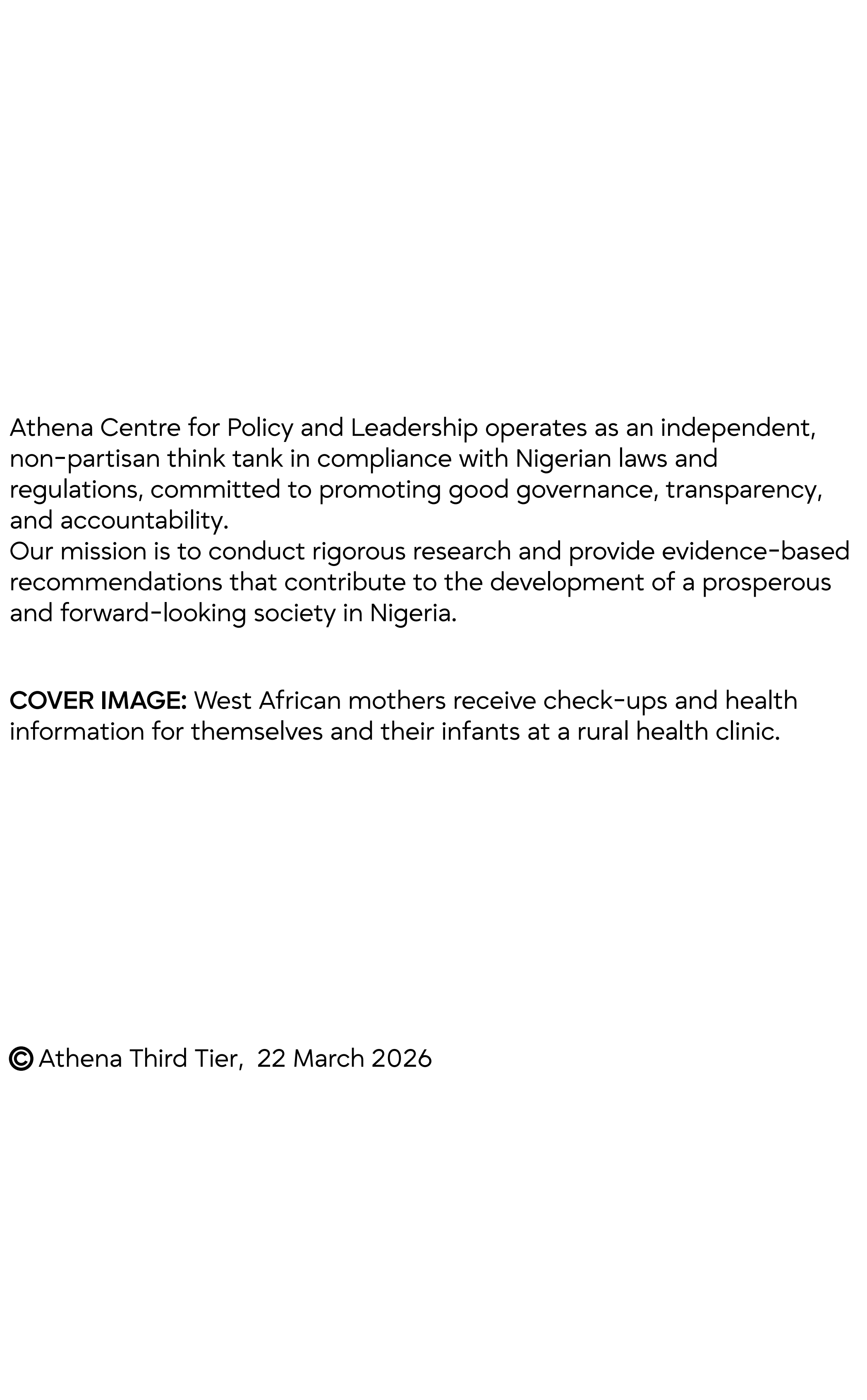

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COVER IMAGE: West African mothers receive check-ups and health information for themselves and their infants at a rural health clinic.

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Local governance structures, Local Government Authorities (LGAs), ward development committees, facility health committees, and traditional councils form the operational architecture through which Nigeria's Primary Health Care (PHC) system is intended to function. Yet these institutions now operate under misaligned mandates, weak supervisory authority, and limited discretion over financing. This misalignment has produced an environment where PHC facilities frequently lack the resources, managerial autonomy, and community engagement mechanisms required to deliver basic services consistently. The national picture of 34,000 PHC facilities with only 10–20 per cent fully functional reflects institutional mechanics rather than isolated operational deficits.

The timing of these constraints has gained renewed relevance. First, Basic Health Care Provision Fund (BHCPF) disbursements have become increasingly vulnerable to fiscal tightening, exposing PHC facilities to irregular fund flow at a moment when operational costs are rising. Second, post-COVID surveillance fragility has heightened the need for reliable facility-level reporting and community-embedded detection systems, precisely where local governance is weakest. Third, inflation and declining household purchasing power have pushed more Nigerians toward out-of-pocket expenditure for basic care, making the reliability of local public PHC services more consequential for rural communities.

Rural Nigeria, home to an estimated 107 million people, depends almost entirely on PHC for maternal, newborn, and child health, routine immunisation, and essential surveillance functions. Yet rural LGAs face the most acute shortages of health workers, the most inconsistent supply chains, and the least effective supervisory structures. Workforce concentration in urban areas at approximately 75 per cent leaves many rural facilities operating below minimum staffing norms. Traditional authority structures, which historically reinforced accountability, now have unclear mandates within the contemporary PHC governance framework.

This policy brief examines these institutional constraints as mechanisms, not failures. It argues that Nigeria's PHC system is constrained by gaps in mandate clarity, financing predictability, operational autonomy, and community-level accountability. These constraints limit the ability of local institutions to act, even when individual officials or facility managers have the will to enforce standards. The analysis integrates evidence from facility assessments, national surveys, and comparative governance systems to clarify where authority is blocked, how incentives accumulate, and what reform levers remain viable within existing institutional arrangements.

The stakes relate to system intelligence, continuity of service, and citizen trust. Without strengthening the governance mechanisms closest to communities, PHC reforms will continue to show policy intent at higher levels without corresponding operational expression at the frontline.

1 The Institutional Failure Behind The Issue

Nigeria's PHC governance challenge is not the absence of reform frameworks but the inability of local institutions to execute authority due to structural, administrative, and fiscal constraints. This section identifies the specific institutional mechanics, the "binding constraints", that shape performance at the local level.

1. Mandate Fragmentation and the Binding Constraint of Payroll Authority

The most consequential constraint in local PHC governance is the lack of consolidated payroll and personnel control at the LGA level. In most states, LGAs do not have exclusive authority over:

a. hiring and deployment
b. sanctioning absenteeism
c. approving leave schedules
d. verifying attendance
e. implementing performance corrections.

Instead, responsibility is split between State PHC Boards (SPHCBs), Local Government Service Commissions, and LGA health authorities. As a result, even when an LGA health officer identifies absenteeism or poor performance, they cannot sanction or reassign the staff member. This renders supervision largely observational and limits the effectiveness of any accountability mechanism.

2. Facility Managers Operate Without Operational Discretion

Officers-in-charge (OICs) of PHC facilities lack predictable operational budgets and have no delegated financial authority. They cannot fund minor repairs, secure fuel for cold-chain refrigerators, or purchase basic consumables. Even BHCPF facility-level funds often require multiple approvals and face delays in release. This removes managerial agency at the point of service delivery.

3. Traditional and Community Governance Structures Are Weakly Integrated

Traditional councils, lineage chiefs, women's coalitions, age-grade associations, and facility committees historically performed oversight functions. However, the introduction of formal PHC governance structures did not clarify their roles or integrate them into supervisory loops. Without formal mandates or reporting obligations, these actors operate in parallel rather than within PHC governance chains.

4. Supervisory Chains Lack Sanction Logic

LGA health teams conduct supervisory visits, but such visits often end at documentation. Without payroll control or sanction authority, supervision becomes a compliance task rather than a corrective mechanism. This produces a governance loop where:

a. supervisors identify gaps
b. reports are filed
c. no consequence follows.

This undermines the credibility of the supervisory system and weakens facility responsiveness.

5. Local Supply Chain Weakness and Control Limitations

While national and state systems procure vaccines and medicines, LGAs bear responsibility for last-mile distribution and cold-chain maintenance. Yet they lack:

a. Dedicated logistics budgets
b. Functional transport systems
c. Procurement authority for emergency replenishment

Local managers cannot act when cold-chain equipment fails or when fuel is needed for generators. These constraints translate directly into sporadic immunisation availability and frequent stockouts.

6. Data Systems Without Local Verification Capacity

Facilities submit routine data into DHIS2, but LGA Monitoring and Evaluation units rarely conduct validation due to transport, staffing, or administrative limitations. As a result, data flows upward without systematic local verification. This weakens surveillance accuracy and compromises state-level planning.

Overall Institutional Logic

Local institutions are unable to enforce standards because they lack the authority, resources, and enforcement instruments required to translate reform frameworks into action. The inability to sanction, deploy, finance, or verify becomes the central institutional constraint shaping PHC performance.

Healthcare workers organize patient records at a local health clinic.

2 What The Evidence Reveals

Evidence from national surveys, independent assessments, and programme reports demonstrates that Nigeria's PHC performance challenges are rooted in institutional conditions at the local level rather than isolated operational gaps. This section presents verifiable, time-specific indicators using Endnotes standards, consolidating findings from facility functionality studies, public expenditure reviews, workforce analyses, and utilisation data.

1. Facility Functionality and Service Availability

Nigeria has approximately 34,000 PHC facilities, but external assessments consistently show that only 10–20 per cent meet minimum functionality standards. Functionality assessments typically cover power supply, water access, cold-chain readiness, essential drugs, and staffing. These assessments demonstrate that facilities in rural LGAs experience disproportionately lower functionality due to weak supervisory presence and the absence of facility-level operating budgets.

The lack of functionality is not equally distributed; remote LGAs in states such as Yobe, Taraba, Niger, and Bayelsa show the lowest levels of service readiness. This is consistent with the finding that poorly functioning facility committees and weak integration of traditional structures correlate with lower operational reliability.

2. Financing Patterns and Local-Level Predictability

Nigeria's public health expenditure averaged 0.6% of GDP in 2023, placing PHC financing under chronic pressure. Although the BHCPF provides statutory allocations, the timeliness of disbursement remains inconsistent, with documented delays in quarterly facility-level payments. This directly undermines operational continuity in PHC facilities.

For facility managers, the central financing challenge is not only the quantum of funds but also the lack of authority to make expenditures once funds arrive. Many facilities have waiting periods of 30–180 days between fund disbursement and local approval, weakening managerial discretion and responsiveness.

3. Workforce Distribution and Local Availability

Approximately 75 per cent of Nigeria's health workforce is estimated to be located in urban areas, leaving rural LGAs with limited staff availability. Rural PHC facilities often have only one or two community health extension workers, many of whom undertake dual roles. Staff absenteeism at the PHC level has been consistently documented in facility surveys.

Crucially, LGAs do not hold consolidated payroll authority. This prevents them from enforcing attendance norms even when absenteeism is identified. As a result, rural facilities experience unpredictable service availability despite official staffing lists indicating full deployment.

4. Maternal, Child Health, and Routine Immunisation

Nigeria's Maternal Mortality Ratio (MMR) remains above 1,000 per 100,000 live births. Facility-level gaps, such as limited 24-hour coverage, unreliable transport for referrals, and low community mobilisation, are major contributors. These gaps correspond directly to weak local governance capacity.

Routine immunisation coverage for Diphtheria, Tetanus Toxoid, and Pertussis (DTP3) remains below global benchmarks, with stagnation observed in 2023–2024. Cold-chain reliability at the local level and inconsistent community engagement contribute significantly to this pattern.

5. Community Demand and Perceived Facility Reliability

Household surveys consistently indicate that communities often rely on traditional birth attendants and patent medicine vendors because these actors are predictable, proximate, and culturally embedded. Communities interpret PHC reliability through experience, irregular staffing, stockouts, or negative encounters, which shape utilisation behaviour.

Overall Evidence Logic

The data present a coherent pattern: functionality, staffing, financing, and utilisation are weakest where the local authority is constrained, and community governance structures are inactive. This reinforces the central thesis that local institutional mechanics, not national policy design, are decisive for PHC performance.

KEY INDICATOR SUMMARY TABLE

INDICATOR & LATEST ESTIMATE	STATUS & KEY INSIGHTS
PHC facilities nationwide	Baseline, Extensive
Fully functional PHCs: 10 - 20%	Very Low, Major Deficit
Public health expenditure: 0.6% of GDP	Officially underfunded
Rural population: 107 million	Large undeserved population
Workforce in urban areas: 75%	Significant Imbalance, Urban Bias
Maternal Mortality Ratio: 1,000/100,000	Dangerously High
DTP3 coverage: Below global targets	Insufficient Immunisation
Reliable Power/Water: 30% in rural LGAs	Crititcal Infrastructure Gaps
BHCPF on time: Inconsistent (state variation)	Weak Financial Management

3 Why The System Sustains The Constraints

Nigeria's PHC system remains constrained due to a self-reinforcing incentive equilibrium operating at local, sub-national, and community levels. This equilibrium explains why facilities remain underperforming even when policies and resources are in place.

1. Provider Incentive Equilibrium

Facility staff operate under limited supervision, irregular remuneration, and constrained operational autonomy. In this context, absenteeism becomes rational rather than negligent. Staff often engage in supplementary income activities, including private practice or informal drug sales, because the formal system provides neither predictable income nor consistent oversight.

Similarly, bureaucratic shortcuts, such as retrospective completion of facility registers or supervision reports, become administrative norms, allowing facilities to meet documentation requirements without corresponding service provision. This equilibrium stabilises low accountability: neither staff nor supervisors have sufficient incentives to shift behaviour.

2. The Sub-National Incentive Logic

A critical but often overlooked factor is the political economy of state-level decision-making.

a. **Elections in Nigeria are rarely won on PHC performance but** on broader patronage networks, political mobilisation, and party structures.
b. **PHC functions are perceived as cost centres**, offering limited political returns compared to visible infrastructure projects.
c. **State executives retain control through fragmented mandates**, which allow political appointment of facility staff, selective release of funds, and discretion in PHCUOR implementation.
d. **Weak PHC offers political flexibility**: staff posting, payroll control, and facility upgrades become instruments of local negotiation rather than system optimisation.

Thus, even when state actors acknowledge poor PHC performance, political incentives do not align with enforcing strong, rule-based local governance.

3. LGA-Level Governance Dynamics

Local Government Areas (LGAs) have limited fiscal autonomy and rely heavily on state-level allocations. Without predictable funds or authority over payroll, LGAs cannot enforce supervision or reward performance. LGA chairmen, operating under electoral pressures and constrained tenure, may allocate resources to politically salient needs rather than system strengthening.

Additionally, decentralised procurement systems create opportunities for local patronage, influencing stock distribution, staff transfer decisions, and facility upgrades.

4. Community and Informal Market Actors

In many rural areas, informal providers, traditional birth attendants (TBAs), patent medicine vendors

(PMVs), and herbal practitioners occupy central roles in community health-seeking behaviour. Their responsiveness and embeddedness reduce pressure on PHCs to improve performance. Community trust becomes fragmented, leaving facility committees with limited influence.

5. Data and Surveillance Incentive Distortion

Data flows upward regardless of local verification. LGAs lacking transport or personnel often submit unverified data to meet reporting deadlines. This reduces the incentive to improve accuracy and masks local performance gaps.

Overall Political Economy Logic

The system sustains its constraints because:

a. Providers lack incentives to improve
b. LGAs lack the authority to enforce performance
c. States lack the electoral motivation to prioritise PHC
d. Communities rely on alternative providers
e. Bureaucracies adapt through compliance-oriented documentation rather than service-oriented delivery.

Reform must therefore focus on institutional incentives, not behavioural exhortation or facility-level troubleshooting.

The Adebayo Alata Primary Health Care Centre in Ogbomoso, Nigeria, stands as a critical outpost for essential medical services in the community.

4 Comparative Insights

Countries that have strengthened primary healthcare systems under resource constraints did so by reconfiguring authority, incentives, and verification mechanisms at the local level, rather than by expanding infrastructure or increasing programme volume.

India's ASHA programme demonstrates variation: states with robust local supervision delivered higher performance; those without timely incentives or supervisory structures underperformed. Local incentive coherence was the decisive factor.

Rwanda institutionalised performance-linked financing grounded in *local verification*. Community committees validated facility outputs, and district teams cross-checked reports before fund release. The key institutional lesson was not financing alone but a verification authority located close to communities.

Ghana's CHPS compounds worked best where traditional leaders had formalised roles in facility oversight, enabling consistent community mobilisation. This illustrates the importance of clear community governance mandates.

Ethiopia's Health Extension Programme succeeded because health extension workers were salaried, supervised through district structures, and embedded in community institutions. The programme demonstrated that local supervisory clarity and payroll control are essential.

Brazil's Family Health Strategy emphasised municipal management authority over staffing, team deployment, and digital registration, strengthening local accountability loops. Brazil's experience shows that local governments must control human resources and data to achieve continuity.

Across contexts, reforms succeeded where the following occurred:

1. Local institutions had clear authority and defined mandates,
2. Financing was predictable and linked to verified outputs,
3. Workforce incentives aligned with local supervisory capacity, and
4. Community governance structures were formally integrated into PHC oversight.

These lessons reinforce that Nigeria's PHC performance will shift only when local governance, not federal policy design, becomes the anchor of reform.

5 Policy Pathways For Reform

(Structured across four governance pillars)

A. Restore Local PHC Governance and Operational Credibility

Core Actions

1. **Clarify and standardise supervisory mandates** connecting SPHCBs to LGA Health Authorities to Facility Officers-in-Charge, specifying who can issue directives, conduct supervision, and escalate sanctions.
2. **Delegate facility-level operating authority:** permit OICs to approve expenditure up to a defined limit (e.g., N50,000–N100,000) for cold chain fuel, minor repairs, or consumables.
3. **Formally integrate traditional leaders and facility committees** into monthly supervisory reporting, with defined roles.

KPIs

- 80% of LGAs publish supervisory schedules quarterly.
- 70% of PHC facilities receive operational funds within 30 days of disbursement.
- 60% of facility committees meet monthly and submit structured reports.

Verification Mechanism

- A quarterly review conducted by SPHCB Monitoring Units
- Random verification by NPHCDA technical teams.

Sanction Logic

- LGAs missing supervisory KPIs for two consecutive quarters face withholding of 10–15% of BHCPF LGA sub-allocations.
- Facility OICs failing to submit verified reports face suspension of facility-level discretionary funds until compliance.

Budget Linkage

- BHCPF disbursement tied to verified supervisory documentation uploaded through DHIS2 modules.

B. Align Incentives and Enforcement at Facility and LGA Levels

Core Actions

1. **Link BHCPF facility payments to validated service outputs** (e.g., verified immunisation sessions, maternal health visits).
2. **Introduce performance-linked supervision allowances** for LGA teams based on verified activity.
3. **Create a structured escalation pathway:** non-performing facilities flagged for remedial support, followed by sanctions.

KPIs

- 75% of facilities submit monthly DHIS2 data with 10% error margin.
- 90% of scheduled LGA supervisory visits completed and verified.

Verification Mechanism

- Data quality audits (DQAs) led quarterly by state M&E units.
- Community observers (traditional leaders or committee members) sign off on immunisation sessions.

Sanction Logic

- Withhold the next quarter's BHCPF tranche for LGAs with repeated verification gaps.
- Flag OICs with repeated absenteeism violations for disciplinary action by the SPHCB.

Budget Linkage
Performance-based fraction (10–15%) of BHCPF tied to verification of service delivery.

C. Strengthen Local Surveillance and Data Integrity

Core Actions

1. Deploy district/LGA verification teams to validate facility registers monthly.
2. Digitise every facility's OPD, immunisation, and labour registers using low-bandwidth DHIS2 tools.
3. Integrate facility committees into data verification through community scorecards.

KPIs
- 85% of facilities achieve timely DHIS2 reporting.
- 70% concordance between DHIS2 and physical registers.

Verification Mechanism
Quarterly triangulation: DHIS2 × facility registers × community scorecards.

Sanction Logic
- Facilities with 25% data discrepancy placed under supervised reporting status (daily oversight for 30 days).
- Persistent discrepancies → reduction of facility operational fund allocation.

Budget Linkage
- DHIS2 timeliness and concordance metrics directly linked to facility-level BHCPF disbursement.

D. Rebuild Community Trust Through Formalised Local Governance

Core Actions

1. Reactivate facility health committees with formalised roles, TORs, and reporting templates.
2. Co-develop demand-generation strategies with traditional authorities, focusing on maternal health, immunisation, and outbreak surveillance.
3. Institutionalise community scorecards published quarterly.

KPIs
- 60% of facilities publish quarterly community scorecards.
- 50% increase in ANC1 and facility birth attendance within 24 months in targeted LGAs.

Verification Mechanism
- SPHCB reviews community scorecards; spot checks by civil society organisations.

Sanction Logic
- Facilities without active committees for two quarters lose discretionary funding.
- LGAs failing to implement community engagement plans face partial BHCPF retention.

Budget Linkage
Community-governance indicators form part of the BHCPF performance-triggered tranche.

6 Conclusion

Local governance remains the most decisive determinant of PHC performance in rural Nigeria. Current institutional constraints, fragmented mandates, limited payroll authority, unpredictable financing, weak local supervision, and low community integration continue to shape service availability and reliability. Unless these constraints are addressed, the operational capacity of PHC facilities will remain inconsistent, regardless of federal or state reform frameworks.

Strengthening PHC requires reinforcing the institutions closest to the point of service delivery: LGAs, facility management, traditional governance structures, and community committees. Where these actors have authority, resources, and verifiable accountability mechanisms, PHC reliability improves. Where they do not, reforms remain procedural rather than functional.

By aligning incentives, clarifying mandates, strengthening verification, and linking financing to local performance, Nigeria can create an institutional environment in which PHC reforms produce sustained operational gains. The viability of Nigeria's health system, its surveillance capacity, community trust, and rural service continuity, depends on how effectively local governance is strengthened in the years ahead.

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