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AFRICAN RENAISSANCE

Revitalising Primary Healthcare Through Local Management Reforms in Kano State, Nigeria

Revitalising Primary Healthcare through Local Management Reforms in Kano State, Nigeria

Key takeaways:

Kano State showed that improvements in health facilities do not always require additional capital investment; meaningful gains can also be achieved by supporting facilities to optimise existing budgets through targeted capacity building.

Kano State health facilities were able to mitigate the constraints of centralised hiring policies by engaging temporary staff, thereby strengthening local control over recruitment and ensuring that staffing needs were met in a timely manner.

Reform objectives:

The primary aim of the intervention in Kano State was to enable primary healthcare (PHC) facilities to meet the Minimum Service Package (MSP) standards. This is a set of national standards developed by the Nigerian government to bolster Primary Health Care (PHC) and advance Universal Health Coverage The intervention was mainly implemented by the Kano State Primary Health Care Management Board (KSPHCMB) and the Clinton Health Access Initiative (CHAI) which provided essential technical assistance to the KSPHCMB.

Context:

A 2021 assessment in Kano revealed that less than 1% of facilities met the standards for the national Minimum Service Package (MSP). The Minimum Service Package consists of a priority set of health interventions and investments that should be provided in PHC centres at little or no cost to clients. The MSP outlines the minimum requirements for three key areas of facility performance:

- Inputs: Infrastructure, utilities, equipment, commodities, and human resources for health.
- Processes: The organisational structure and management of the facility.
- Outputs: The actual availability of services to the community.

In the Kano State intervention, the MSP focused on critical pillars including infrastructure, commodities, supplies, and the health workforce. To address these MSP gaps, the Kano State Primary Health Care Management Board (KSPHCMB), with technical support, adopted a delivery-based approach focused on optimising existing resources. Key changes included:

- Establishment of the MSP Monitoring Team (MSPMT) to coordinate implementation, resource mobilisation, and provide continuous mentoring and supervision to facilities.

- The system transitioned from a top-down model to a bottom-up prioritisation model. Facility managers were trained in financial management, including the use of cashbooks, budgeting, and the development of Quarterly Business Plans (QBPs).
- Multidisciplinary teams which included facility staff, local government representatives, and Ward Development Committees (WDCs) were engaged to identify specific bottlenecks and co-develop six-monthly improvement plans.
- Facilities were empowered to use their Basic Health Care Provision Fund (BHCPF) disbursements to address their specific needs, such as hiring skilled temporary staff and fixing infrastructure like water connections and alternate power sources.
- A new policy standardised the recruitment and remuneration of temporary staff, who make up 60% of Kano's PHC workforce, enabling facilities to better hire and retain skilled workers.

Achievements:

The intervention in Kano State led to significant improvements in infrastructure, workforce availability, and service utilisation across the 49 focal facilities. Average antenatal care visits more than doubled, while the number of midwives and nurses increased fourfold through the use of budgetary allocations to support temporary hires. In addition, the proportion of facilities providing 24-hour services rose by 26%, and more than 90% of all facilities had access to a backup generator. Further improvements are presented in the table below.

Comparison of Baseline vs. Endline Metrics

Category	Metric	Baseline (May 2021)	Endline (April 2023)
Financial and Management	Staff trained in financial management	79.6%	87.8%
	Routine development of business plans	57.1%	100%
	Community (WDC) involvement in plans	63.3%	100%
Infrastructure and Utilities	Facilities providing 24-hour services	53.1%	79.6%
	Water connected to service units	16.3%	49.0%
	Facilities with backup generators	61.8%	91.8%
	Facilities meeting MSP room count (15+)	65.3%	89.8%
Health workforce	Mean number of skilled HCWs	11.14	20.80
	Mean number of nurses/midwives	1.33	5.67
	Mean total facility staff	24.16	37.24
Service availability	Overall Tier 1 services provided	84%	91%
	Newborn care services	76%	92%
	Labor and delivery services	74%	89%
	Functional tracer equipment available	77%	83%
Utilisation	Average monthly ANC attendance	172.61	429.70

Policy recommendations

1. Health systems should empower frontline facility managers to identify their own service delivery bottlenecks and co-develop improvement plans. This can include strengthening managers' foundational financial management capacities, including budgeting and cashbook use, to support more effective prioritisation and use of available resources.
2. To address human resource shortages, systems should implement policies that standardise the recruitment and remuneration of temporary staff, allowing facilities to hire and retain skilled workers at their convenience.
3. Significant improvements in infrastructure and staffing can be achieved by enhancing the allocative efficiency of current funds rather than waiting for massive new state investments.
4. Health systems should ensure that local actors are meaningfully engaged in the development of facility business plans so that interventions are better aligned with community priorities, service delivery realities, and local needs.
5. Governments should strengthen supply chain management by introducing real-time stock visibility and forecasting systems that connect health facilities directly to central procurement agencies, alongside minimum stock threshold alerts to reduce persistent stockouts of essential medicines.
6. Policymakers should recognise that improving facility readiness alone may be insufficient to increase uptake of some services, including facility-based deliveries. Health systems should therefore invest in identifying and addressing the cultural and social barriers that continue to discourage care-seeking.

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Method: The study used a longitudinal before-and-after design assessing 49 purposively selected primary healthcare facilities in Kano State over two years, collecting data at baseline and endline through interviews, physical observation, and review of facility records, with paired sample t-tests and McNemar tests used to compare changes in infrastructure, health workforce, service availability, utilization, and quality of care indicators.

Evidence: Abubakar, A. A., Abba, A., Fasawe, O., Hussaini, T., Umar, N., Bukari, A., Ugochi, G., Kabara, A., Bassey, E., Gaya, I. N., Pasipanodya, B., Brady, E., Novignon, J., Sunusi, B., Ibrahim, M. A., Denavit, C., Wiwa, O., Yerima, A., & Gulma, K. (2025). Improving facility-level performance in primary healthcare system through strengthening management and financial resource utilization in Kano State, Nigeria. SSM - Health Systems, 5, 100080. https://doi.org/10.1016/j.ssmhs.2025.100080

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