



ASSESSMENT OF THE CAPACITY OF PRIMARY HEALTH CARE AGENCIES TO MANAGE THE PRIMARY HEALTH CARE FACILITIES IN SOUTH EASTERN NIGERIA

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ABSTRACT

The success of the Primary Health Care (PHCs) Centres in delivering health services at the community level is largely dependent on the effectiveness, efficiency, and management support being provided by the PHC Agencies. This study identified institutional capacity needs of selected PHC Agencies that will require urgent attention as a veritable means of the revitalisation of the PHC facilities and the capacity of these Agencies to operationalise the Basic Healthcare Provision Fund (BHCPF). A descriptive survey of the five State Primary Health Care Development Agencies (SPHCDA) in Southeast Nigeria. The respondents comprised all management staff of the SPHCDA in each of the five States. A standardized *Organisational Capacity Assessment Tool* (OCAT) was used for data collection. Approvals were obtained and preliminary consultations were done. OCAT was administered to managers at the Agencies and the findings were validated with the respondents. The findings showed that none of the Agencies attained a 50% organizational capacity score indicating poor organizational capacity. The main areas of common underperformance included: resource mobilisation, human resources for health, and service delivery. There is an overall weak organisational capacity of the key management body for PHC service provision in this part of the country. Human and institutional capacity development is crucial to the improvement of services and productivity of the PHC system. It is therefore important to periodically assess, identify issues and plan for capacity improvements in Agencies that manage crucial systems such as the SPHCA.

Keywords: BHCPF, BMPHS, Nigeria, OCAT, organizational capacity, primary health care, SPHCDA

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INTRODUCTION

Certainly, the advancement and preservation of the health of citizens of a country are crucial to sustained economic and social development (Abosedo and Sholeye, 2014). Several countries involve indices of primary healthcare quality or operation to assess their healthcare system (Al Saffer *et al.*, 2021). The health facilities especially the primary health care (PHC) facility and its management must be strategically positioned to support physical, mental, and social well-being and permit the people to lead a civilly and economically productive life (Abosedo and Sholeye, 2014). Primary healthcare (PHC) facilities across Nigeria are the entry points into the healthcare delivery system of the country. They are not only the closest healthcare facility to most residents but also, the facility of choice for vulnerable and poor citizens due to their cost-effectiveness. It is indeed a critical tier of the three-tier care system in Nigeria (FMOH-NHA, 2014). PHC is also important in making health systems more flexible to circumstances of crisis, more pre-emptive in the detection of early signs of epidemics, and more prepared to promptly act in response to surges in services demand (WHO, 2021).

Due to the prevailing poor state of PHC in Nigeria which are identified by insufficient coverage specifically in rural areas, high user fees and deficient health facility, the Nigerian President in October 2014 signed into law the National Health Act (NHAct) (Onwujekwe and Mbachu, 2015). A very important element of the NH Act is the establishment of the Basic Health Care Provision Fund (BHCPF), which seeks to expand PHC to all Nigerians by essentially increasing the capital for PHC services (Onwujekwe and Mbachu, 2015).

The implementation of the BHCPF involves various stakeholders at different levels of government. As provided by the National Primary Health Care Development Agency (NPHCDA) policy of Primary Health Care Under One Roof (PHCUOR), the management and sustainability of public PHC facilities in the country are carried out by a joint State Primary Health Care Development Agency (SPHCDA) and Local Government Health Authorities (LGHA) (HPI, 2014). The SPHCB/SPHCDA exists in every State of Nigeria and operates on the model and the 9-pillar guides of the NPHCDA.

The success of the PHC facilities in the States largely derives from the effectiveness, efficiency, and management support being provided by these Agencies (Nnaji *et al.*, 2010; Onwujekwe *et al.*, 2019; FMOH-NHP, 2016). The Government 2018 commenced the release of funds for the provision of a basic package of health services to Nigerians according to the universal health coverage of its citizens (FMOH-NBHCPF, 2020). These Agencies are expected to provide and manage a gateway of this fund as in the revised Operational Guidelines for the fund (FMOH-NBHCPF, 2020). The National Strategic Health Development Plan (NSHDP) provides for a significant role in many areas of care provision for the SPHCBs/SPHCDA (FMOH-NSHDP, 2018; Olawale and Janse van Vuuren, 2021) A preliminary report on the implementation of the Basic Health Care Provision Fund indicates that the Agencies may require to step up their game and calls have been made for attention on the workforce (Abdullahi *et al.*, 2020; Eweli *et al.*, 2021; Nwobodo *et al.*, 2022).

The BHCPF is meant for all citizens in Nigeria; however, the implementation guideline has criteria to be met by States before such States can be eligible to receive the funds. Some of the criteria as stipulated in the operational guideline

for the fund include management structure and functions of the PHC management Agencies that should be disbursing the funds to the PHC facilities (FMOH-NBHCPF, 2020).

This study, therefore, sought to; a) assess the institutional capacity of these Boards/Agencies, b) determine the extent to which they can provide the required technical and managerial support to the PHC facilities under their purview as well as the LG-level management of PHCs, namely the Local Government Health Authorities (LGHA) at each constituent LGA in the State in a bid to operationalise the BHCPF. The PHC system remains the weakest link in the healthcare delivery system of the country. The Organizational Capacity Assessment Tool (OCAT) used in this study was designed to measure the overall capacity of such an agency as the SPHCDA (SuNMaP, 2019). It assesses management capacity in several key areas namely governance, organizational management, program management, human resources management, and financial management.

METHODOLOGY

Study area

The study was conducted in the southeast region of Nigeria covering five States and the focus was on the State and Local Government's joint agency for the management of Primary Health Care services identifiable as the State Primary Health Care Development Agency (SPHCDA) or State Primary Health Care Board (SPHCB).

Study design

A descriptive survey research design was adopted for this study.

The population of the study

The study respondents comprised the 65 management staff of the Agencies including the Executive Secretaries (1x5), Directors of the Departments, and Heads of Units (12x5) for each of the five agencies. The number is of manageable size; hence, there was no need for sampling.

Review of organisational statutes and mandates

The desk review of relevant materials relating to the SPHCDA in the selected states was conducted. These included their mandates/functions from their enabling Acts (respective laws for each Agency), the vision, mission, and core value statements, current organisational structure, systems, and processes including the functional relationship with its supervising ministry obtainable from the Operating Procedures, Plans, and Manuals or other management system documents as is available for the respective Agency.

Instrument development and field testing

The standardized Organizational Capacity Assessment Tool (OCAT) was adopted for this study (FMOH-NBHCPF, 2020). OCAT sought levels of capacity development of the institution (s) based on 11 management capacity domains namely (1) Governance and leadership(2) Finance and Operations (3) Human resources(4) Resource Mobilisation (5) M&E/KM (6) Program Management(7) Communication(8)Grants Mobilisation and Management (9)service delivery and Quality Assurance(10)Coordination & Collaboration and (11)Demand Creation approaches. The eleven

(11) domains included sub-domains within each domain that probed the extent of the capacity development of respective management structures and functions of the respective agencies. For instance, Governance and leadership have four sub-domains made up of (a) governing Board and Management in place (b) Management functions performance (c) strategic leadership, and (d) succession planning. These management capacity measures highlight functionality indicators as a guide. The indicators were weighted on a scale of 1-5 for various levels of functionality or performance. The OCAT questionnaire used in this study is modified after the OCAT tool was deployed in a related survey of a national health agency (SuNMaP, 2019).

Instrument administration

The administration of the survey tool was to top management staff of the respective State Agencies comprising the Executive Secretary, Directors, and other management staffers. In addition, a cross-section of the junior cadre staffers was interviewed. The tool was essentially a guided self-assessment in which scoring was conducted in a plenary and in which each score had a set of conditionalities. In all, 11 institutional capacities of both structure and functions were disposed of in eleven domains and 109 sub-domains were rated. Scoring was preceded by some detailed explanations of domains, sub-domains, and scoring criteria for each score scaled from 1-5 (based on a) poor, b) weak, c) fair, d) good and e) effective organisation indicators for the scale of 1-5 respectively).

Validation of findings with the respondents

The scores from the institutional review survey of the SPHCDA were validated in a plenary of staffers of respective Agencies. These scores are what have been used and analysed as the management capacity scores for each of the SPHCDA represented as tables and graphs in the results section of this study.

Official and ethical approvals to conduct the survey

Requisite approvals to conduct this survey were obtained from respective Agencies and their supervising authorities of the State Ministries of Health across the States. In this study, five Nigerian States were selected. For the sake of political correctness, these States are identified in this report as Nigerian States A-E respectively.

RESULTS

Overall management capacity assessment scores for the five SPHCDA

The consolidated assessment score of the five SPHCDA is summarised in Table 1. States A, C, and E scored 3 on a scale of 5 in terms of the Governance and Leadership domain whereas States B scored 2 out of 5 possible points on the same domain. However, State D scored 4 out of 5 on the same domain. In general, on governance and leadership management capacity, the SPHCDA rated themselves variously with an average of 3 out of 5 points. This will be considered a good or fair performance. The results of the consolidated domains ratings for the five agencies are presented in Table 1.

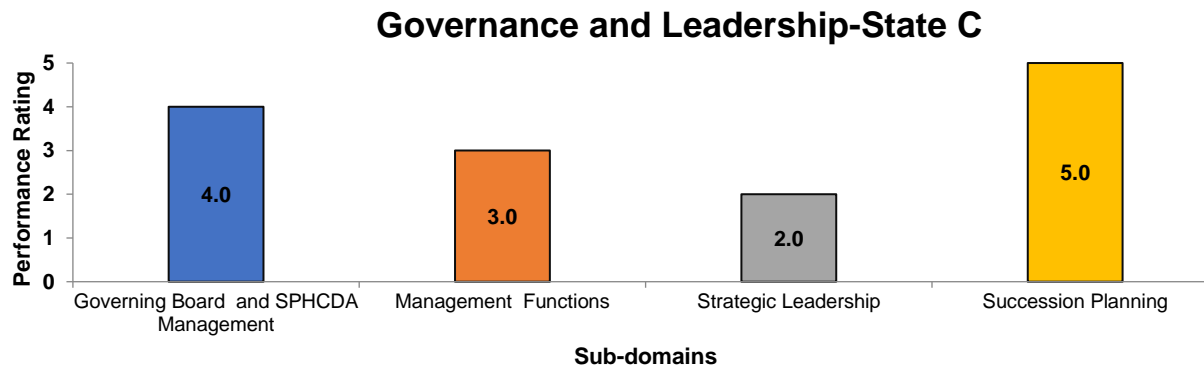
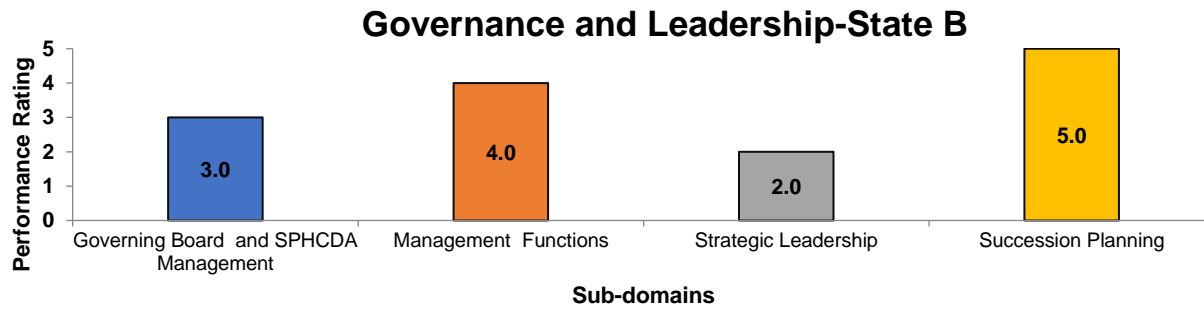
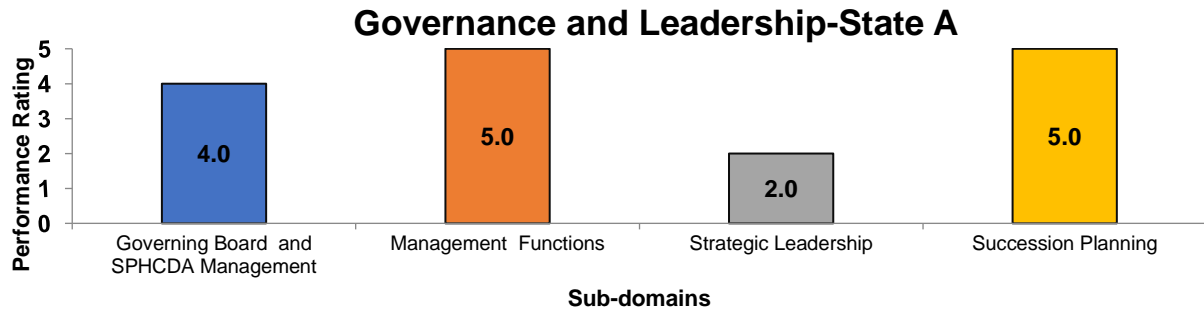
The table indicates that none of the five Agencies pooled a cumulative score or points of 50% or above for an effective organisation across all the management capacity measures.

Table 1: Consolidated domain rating of surveyed Nigerian state primary health care development agencies

Domain (main)	State A	State B	State C	State D	State E
1) Governance and leadership	3	2	3	4	3
2) Finance and Operations	2	2	2	2	2
3) Human Resources	1	1	2	2	1
4) Resource Mobilisation	1	2	1	1	1
5) M&E/KM	1	2	3	2	1
6) Program Management	2	3	3	1	2
7) Communication	3	1	2	3	3
8) Grants Mobilisation and Management	2	2	2	2	2
9) Service Delivery and QA	2	2	1	2	2
10) Coordination & Collaboration	2	4	3	2	2
11) Demand Creation	2	3	2	2	2
Organisational Capacity (%)	38.2	43.6	43.6	41.8	38.2

Consideration of performances in management measure domains of concern

In this study, we are providing details of four management capacity measures in which performance at the Agency was less than or 2 out of five points across all the participating states. These considerations were therefore on 1) Governance, 2) HR Management, 3) Monitoring and Evaluation capacity, and 4) Resource mobilisation/ management capacity. The four domains had subdomains as indicated in figures 2-4. Briefly, Governance has 4 subdomains, HR Management has 6 subdomains, Service Delivery has 4 whilst M&E has 6 subdomains. An analysis of the various domains and their subdomains was conducted, and the results are shown in figures 1-4 (A-E) showing how respective State Agencies performed across the domains and subdomains. The subdomains serve to unbundle specific management capacity deficits for the agency. Governance with its four (4) sub-domains of the functionality of the Board/Management, including management functions, strategic leadership as well as succession planning. Human Resource has six (6) sub-domains that were assessed across the Agencies. These included staff numbers, staff mix, and training as well as performance management. M&E involved the assessment of six (6) sub-domains which included data management, data quality, data use, and knowledge management, etc. Service delivery has four (4) sub-domains assessed service delivery targets, standards, availability of Information, Education and Communication (IEC) materials as well as materials for service improvements and learning. Because of these, the respective performances of State A-E are summarised in the figures below:



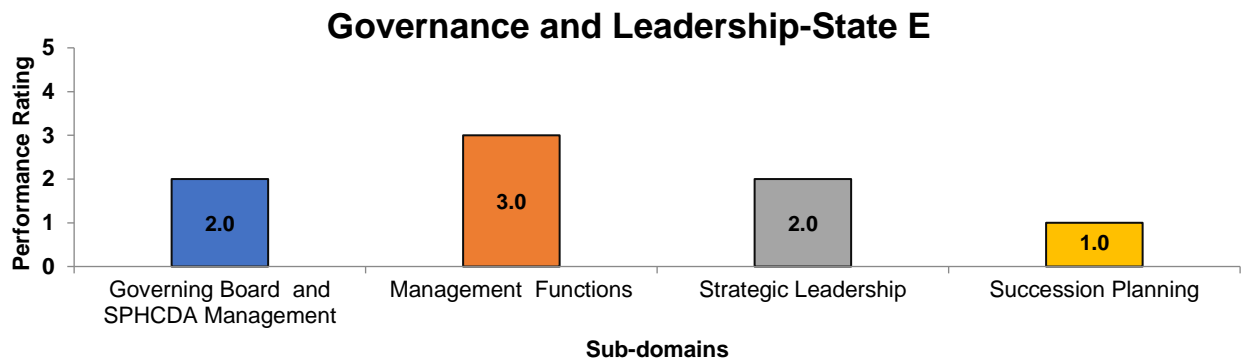
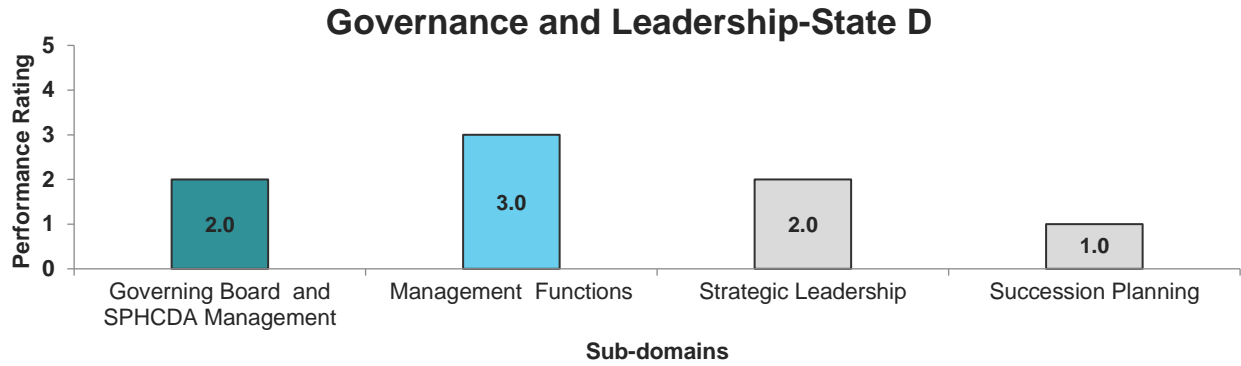
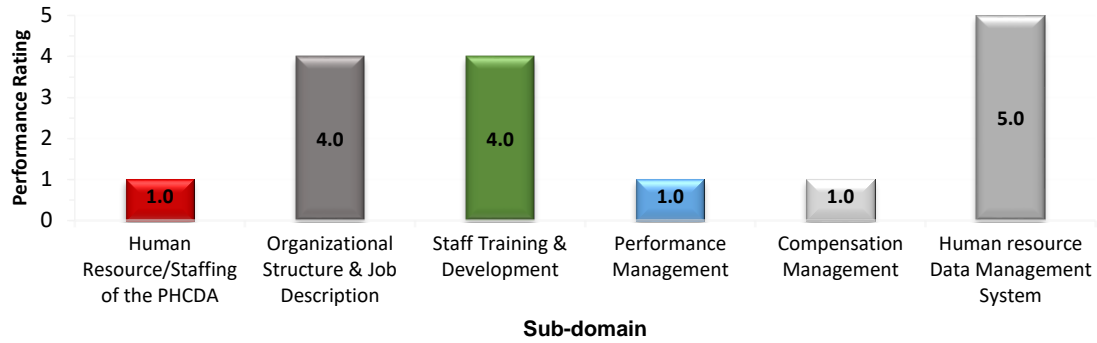


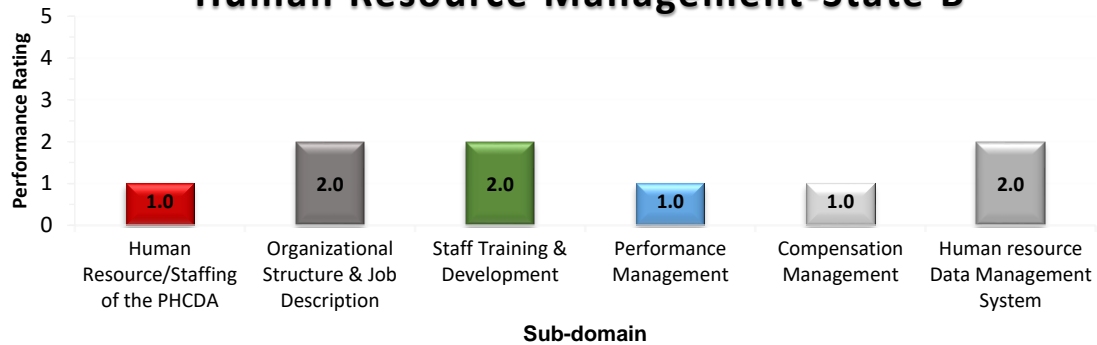
Figure 1A-E: Summary of performance of five SPHCDAs on governance

All the Agencies self-assessed themselves as being low in having strategic leadership in this domain. Three of the five States assessed their management as performing at about 60%. It would appear that the management and governance layout are in place, but they are not providing the critical leadership that is required to lead service delivery at this tier of the healthcare system. Three States have succession planning in having the requisite staff that could readily assume management and leadership functions, but the other two States appear to have a preponderance of junior cadre staff.

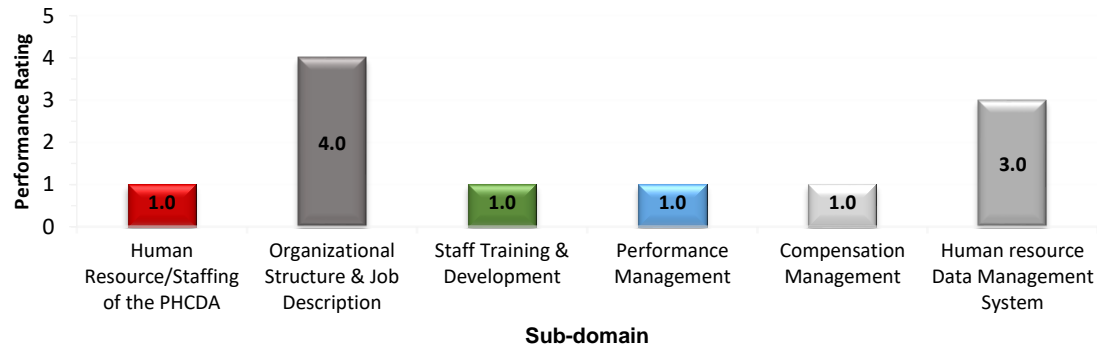
Human Resource Management-State A



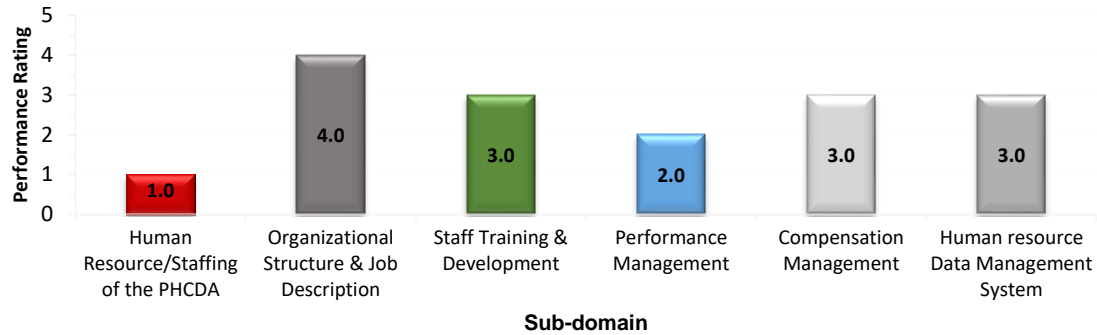
Human Resource Management-State B



Human Resource Management-State D



Human Resource Management-State C



Human Resource Management-State E

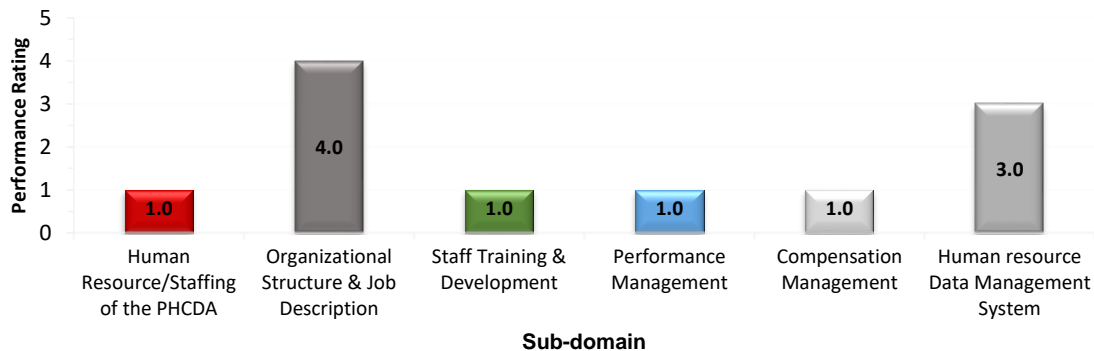
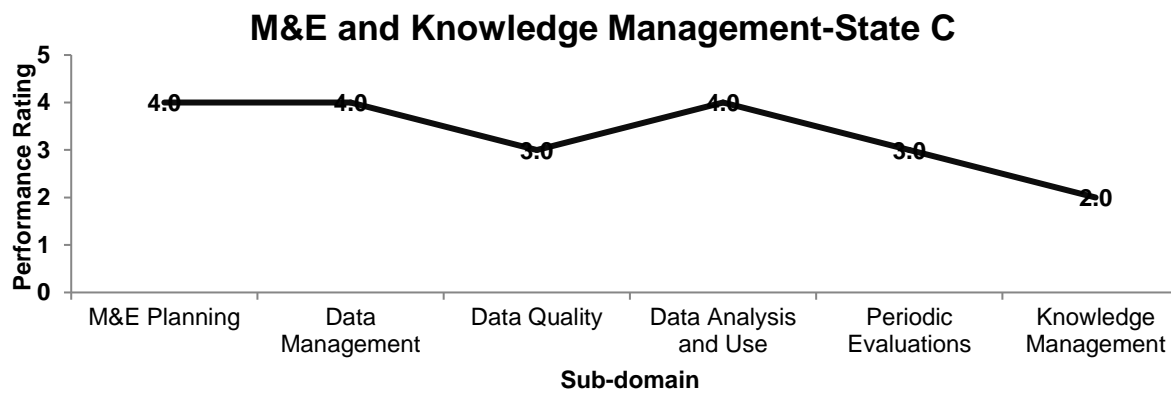
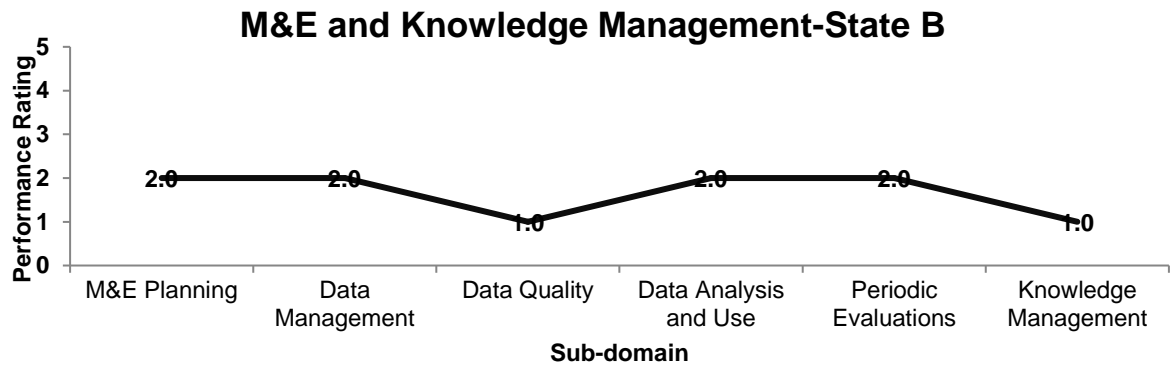
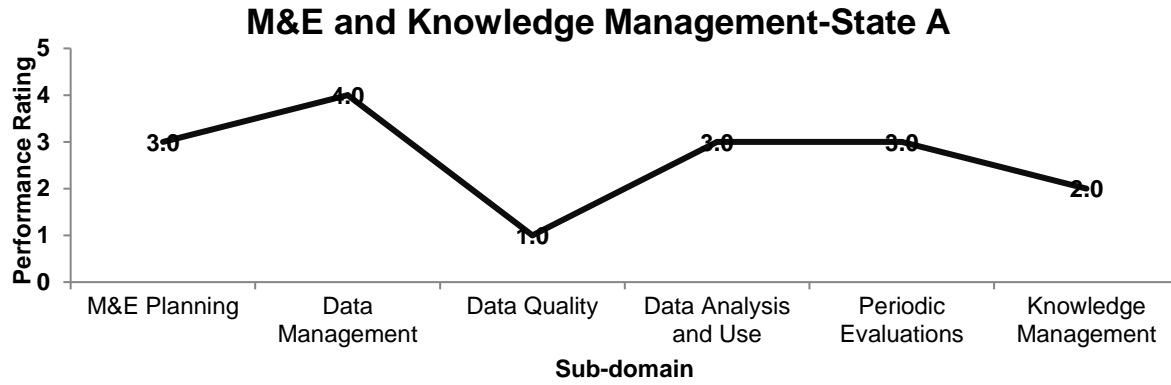


Fig 2A-E: Summary of the performance of five SPHCDA on human resource management

The staffing number/staff mix sub-domain was reported as being 20% of what it should be by all five Agencies. There was a near absence of staff performance management as well as compensation management including incentivisation or motivation to work across the five SPHCBS/SPHCDA. However, four of the five Agencies have clearly defined organisational structures and job descriptions for all staff. The breakdown of the individual Agencies' performances for respective sub-domains on HRH is as in figure 2A-E. There were many service areas in which the right staff or the right number were not available. The National Task Shifting policy appears to be of limited value in many situations in the surveyed states.



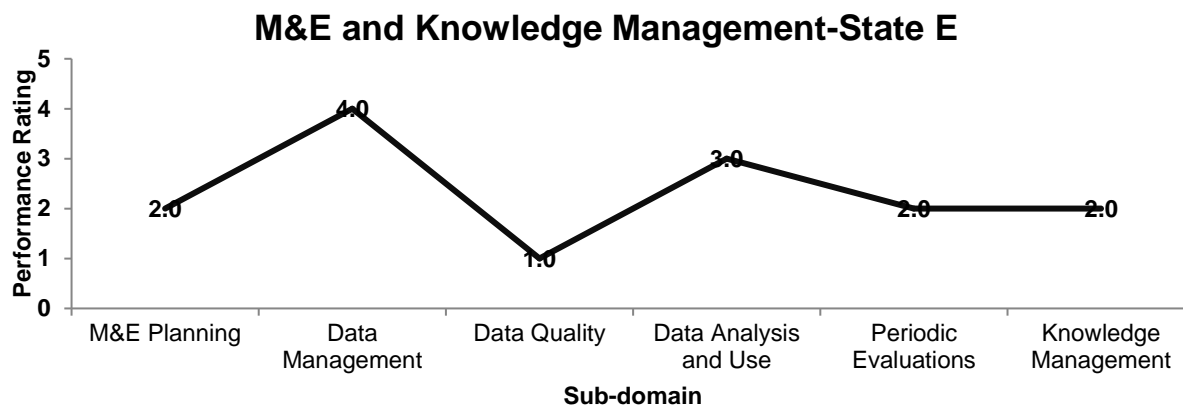
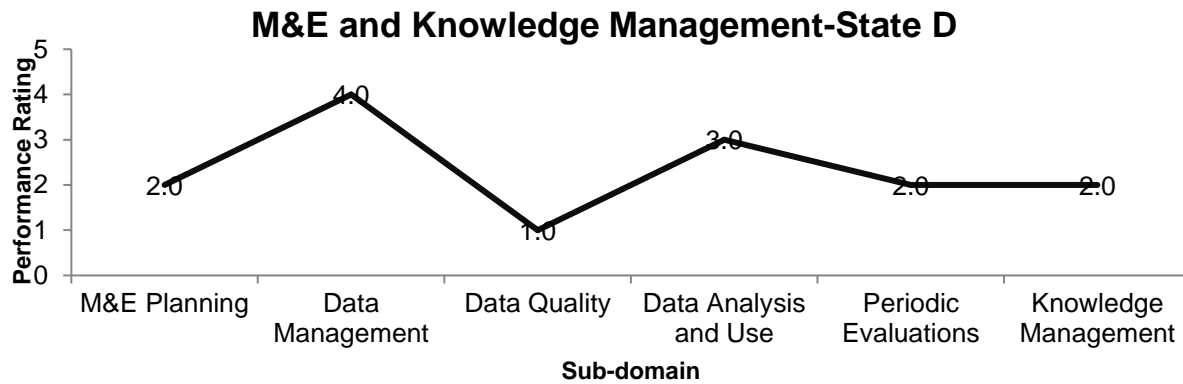
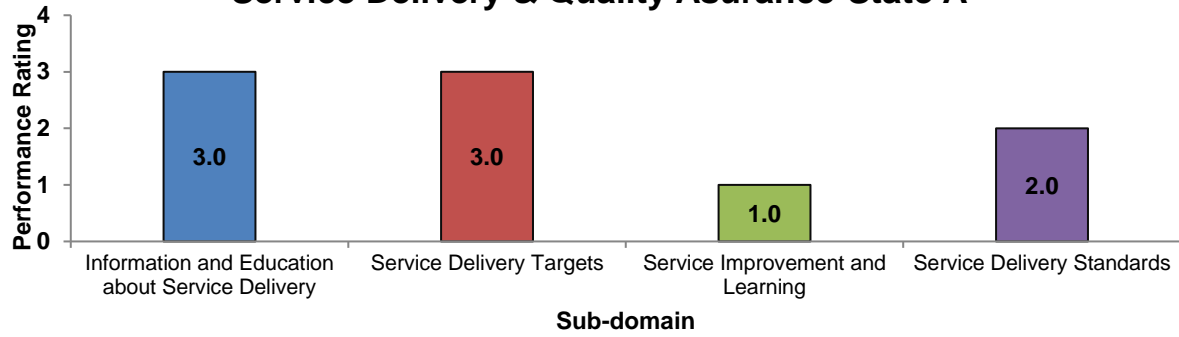


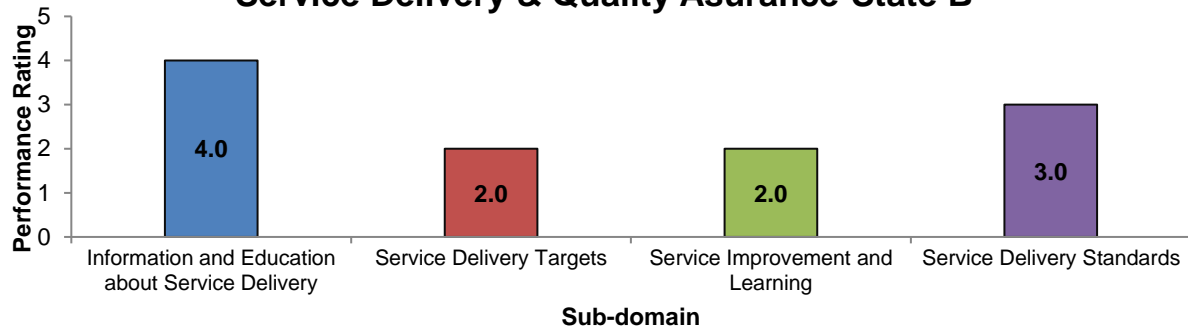
Fig 3A-E: Summary of the performances of five SPHCDAs on monitoring and evaluation

As in figure 4A-E, data quality is reportedly the least performing indicator of this capacity measure with about 20% performance in four of the five Boards. Periodic evaluations and management of the information are reportedly at about 40%. This can explain quite a several weaknesses in other crucial functions of the SPHCDAs in the surveyed States. With poor-quality data, lack of evaluations, and information management, it will be hard to manage and improve plans and service delivery outcomes.

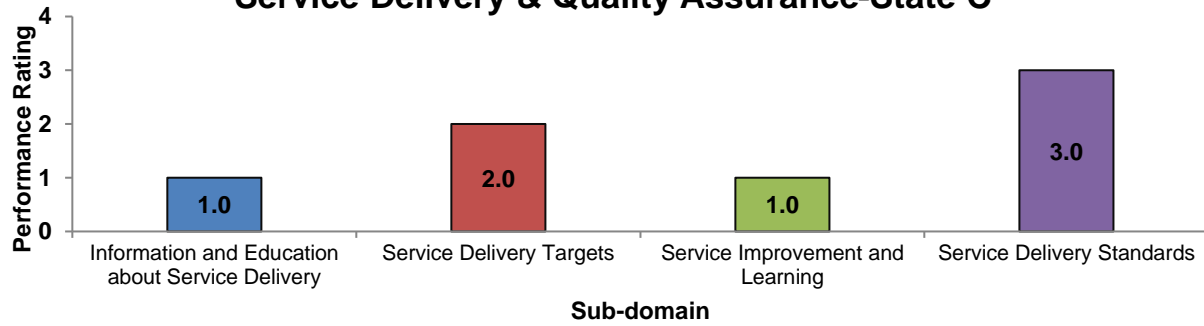
Service Delivery & Quality Assurance-State A



Service Delivery & Quality Assurance-State B



Service Delivery & Quality Assurance-State C



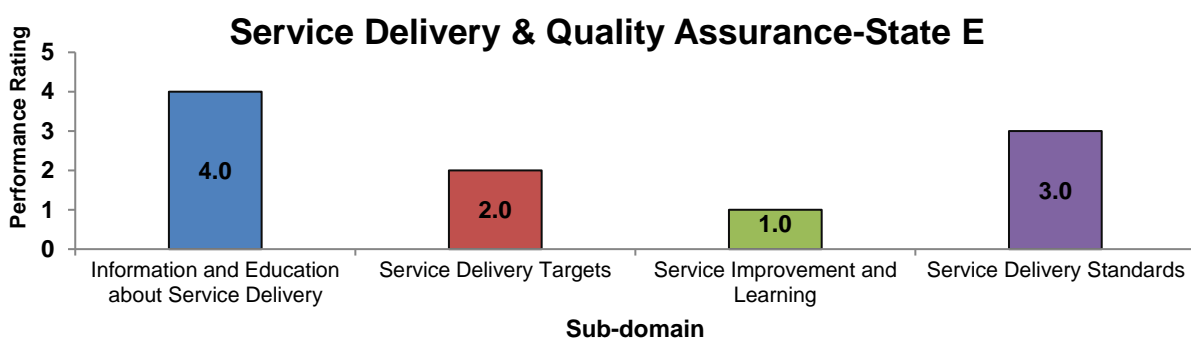
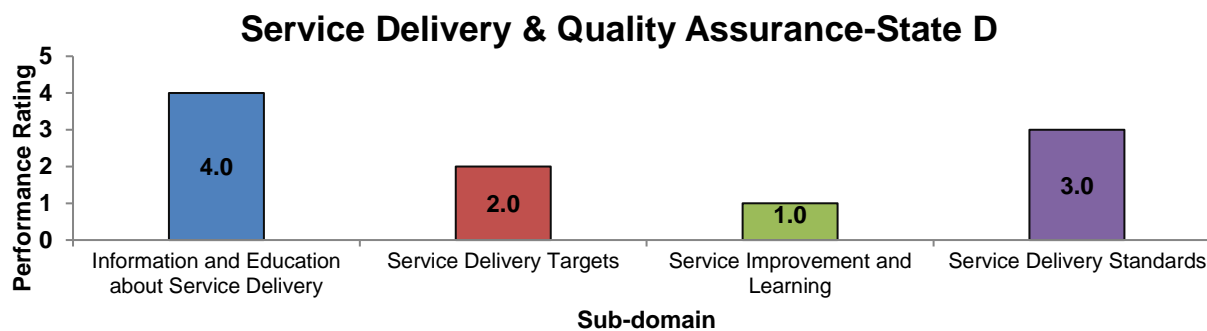


Figure 4A-E: Summary of the performances of five SPHCDA on the service delivery domain

Service delivery domains consisted of five sub-domains. Of the five sub-domains assessed, the least performing by most Agencies were a) service delivery targets, b) service improvement and learning capacities (40% and 20% respectively) as summarised in Figure 4 A-E. Service delivery standards were reportedly high at about 60% across the Boards. This is explained by the availability of many NPHCDA-led OG/SOPs/Protocols/Service Guides/algorithms developed in the context of the Primary Health Care Under One Roof (PHCUOR) policy.

DISCUSSIONS

This study appears to be the first study to identify the institutional capacity needs of State PHC Development Agencies that will require urgent attention. The managerial capacity of SPHCDA over PHC centers is crucial to the delivery of quality PHC services and fundamental to improving health outcomes. In this study, OCAT assessed the 11 domains of management capacity and analysed the breakdown of four key domains or management capacity measures namely HR, Governance, M&E, and Service Delivery. Each of these domains has a further 4-6 sub-domains that were analysed to guide the discussions and recommendations.

The results indicate an overall weak organisational capacity of the key management body for primary health care service provision in the southeast region of the country. Of the five Agencies surveyed, none of them attained a 50% organisational capacity score on this OCAT tool. As shown in Table 1, the best-performing SPHCDA and the least-performing scored 46 and 38 percent respectively using the same tool and assessors. The main areas of common

underperformance by all of the five agencies that are however crucial management functions included a) resource mobilisation (RM), b) human resource for health (HRH), and c) service delivery (SD) which is the expected output of the entirety of the system. It would appear therefore that a combination of weak RM and HRH in these agencies negatively impacts service delivery and therefore health outcomes and outputs of the crucial PHC system the Agencies are expected to manage. With a generally weak M&E system as indicated in table 1, it is unlikely the Agencies have quality and valid databases to effectively plan, adjust the plan and make progress towards an improved PHC system in the concerned States. It is difficult to project that the situations in States A-E is common across the other thirty-one SPHCDA in the country; but even at that, such situations may obtain in those other States. The findings of weak to poor to fair management capacities in domains such as SD, HR, and RM are significantly telling on the capacity of the SPHCDA to manage the PHC system and the all-important BHCPF disbursements. In any case, the Fund is expected to catalyse improvements in the system, but this will only be possible if the Fund is effectively applied by effectively organised SPHCDA.

This breakdown of the 11 domains in which the assessments were based indicated various capacity deficits. A weak organisational capacity affects performance as capacity is the engine that drives performance and facilitates an organisation to reach its objectives and attain its comprehensive mission (Weber and Smith, 2019; Rehman *et al.*, 2019). Kress *et al.* (2016) identified that Nigeria compared to peer African countries (i.e., Senegal, Kenya, Tanzania, and Uganda), ranks second lowest in all primary healthcare performance initiative (PHCPI) indicators despite having high levels of health worker density and health facility density which were often considered to be the main cause of shortfall in PHC systems.

It was apparent that despite the existence of statutory governing bodies as well as management processes, there was a dearth of strategic leadership and direction from the Management and the Governing Board of the Agencies. As ordinary as this may seem, none of the Agencies had a strategic plan. In addition, it appears all activities are carried out without recourse to State-specific dynamics and peculiarities including the political climate. Strategic planning is a very useful and valid tool for any organisation that has been related to increasing organisational performance (George and Sahay, 2018).

M&E is crucial for development and service improvements. Data quality and use were sub-domains in which the SPHCDA underperformed the most. It is therefore difficult to improve services when evidence-based plans and programmes are difficult to put in place. Knowledge management is non-existent in all the Boards. This is indicative of a potential weak accountability and performance management capacity.

The lack of strategic planning and direction or leadership linked to poor data potentially weakened the availability of service targets and pursuit of the service delivery targets and thus poor service delivery outcomes. Service standards are indeed at about 60%, but this is largely attributable to the many operational guidelines and service protocols that the National equivalent of the SPHCDA has supported them to develop and put into use. The periodic assessments which the NPHCDA carries out based on its 9 pillars of which service delivery is one also contributed to the rating of service standards. Service delivery learning and improvements capacity of the Agencies is weak, possibly due to the ready-made support of the NPHCDA or extant capacity deficits of the SPHCDA. The Agencies are not as at yet

readied for managing public health emergencies as designed. There are reports of some unholy activities in several segments of the care system impacting care delivery (3) and budgeting is a big issue (2) with the potential to negatively impact services in the times of BHCPF and many ongoing reforms.

The human Resource for the Health domain had six sub-domains that were assessed. The results indicate that capacity deficit of the right number and mix of HRH was the most prevalent issue across the five states. Again, staff performance management was reportedly operating at about 20% in most of the SPHCDA. If the SPHCDA is not on sound footing on its own, the HRH performance management process will be difficult to put in place. HR Management assessment also showed a near absence of incentives and compensation. The staff of the PHC system under such situations will scarcely inspire staff to meet the ever-increasing demands of this tier of the healthcare delivery system.

In general, human and institutional capacity development is crucial to the improvement of services and productivity of the PHC system. It is therefore important to periodically assess, identify issues and plan for capacity improvements in agencies that manage crucial systems such as the SPHCDA. In this survey, we establish that a) there are capacity deficits in the PHC management agencies in some States, b) these deficits cut across regular organisational processes and procedures of SPHCDA, c) these deficits are more in some aspects of the processes or system such as staff performance management deficit component of HRH, and d) these capacity gaps can be addressed and should, indeed, be addressed to better position the crucial SPHCDA across the country to better manage service delivery in the thousands of PHC facilities and programmes across Nigeria.

There is an indication of concern about the capacity of the SPHCDA in the southeast region of Nigeria to deliver on their mounting responsibilities of providing quality primary health care services and health outcomes. Their effectiveness, efficiency, and capacity to discharge their supervisory role are crucial to delivering the desired health outcomes. The Agencies were reportedly underperforming in their capacity to manage and supervise PHC service delivery in the region. Supervision as a management tool has been described as the strongest managerial tool at the PHC level (Nwobodo, 2016).

CONFLICT OF INTEREST

The authors declare no conflict of interest to this study.

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AUTHORS' CONTRIBUTIONS

EN, AO, and UE conceptualized the study and design. EN, UE, GU, DCI, and NN contributed to manuscript writing and revision. AO, UE, GU, and NN contributed to data collection. All authors contributed to data analysis, manuscript writing, and its revision and gave final consent for the version to be published.

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