

# Comprehensive in Name, Selective in Practice: A Policy-Implementation Gap Analysis of Primary Health Care Service Delivery in Federal Capital Territory, Abuja, Nigeria.

EKWUGHA, UCHE ONYX

*Department of Public Administration, University of Abuja, Nigeria*

**Abstract-** *Nigeria's adoption of the Comprehensive Primary Health Care (CPHC) framework at Alma-Ata (1978) committed the country to a universal, equitable package of integrated health services at the community level. The National Primary Health Care Development Agency (NPHCDA) subsequently codified this commitment into minimum service standards mandating delivery of fifteen discrete PHC components across all facility types. Despite this comprehensive policy architecture, persistent gaps between policy mandate and service reality raise fundamental questions about implementation fidelity and governance quality. This study applies a policy-implementation gap framework to secondary data from a cross-sectional appraisal of 642 health workers across six Area Councils of the Federal Capital Territory (FCT), Abuja, Nigeria. Drawing on Pressman and Wildavsky's (1973) implementation gap theory, Rosenbloom's (2015) Trialectic of Public Administration, and Grindle's (1980) context of implementation, the study develops an original Service Gap Index (SGI) to categorize and explain differential implementation outcomes across all fifteen mandated PHC services. Results reveal a pronounced and systematic implementation gradient: eight services mandated by NPHCDA achieve near-full implementation (>90%), while mental health care (23.7%) and care of the elderly (43.0%) exhibit critical gaps of 76.3 and 57.0 percentage points respectively. The study argues that this gradient is not random but follows an institutional logic in which quantifiable, politically visible, and KPI-tracked services attract disproportionate managerial and political attention, while non-quantifiable and stigmatized services are systematically neglected. This constitutes a de facto reversion to Selective PHC despite official commitment to comprehensiveness. Policy recommendations center on revised performance management frameworks, dedicated budget lines for neglected services, and strengthened accountability mechanisms aligned with New Public Governance principles.*

**Keywords:** *Primary Health Care, Policy Implementation Gap, NPHCDA, Mental Health, Elderly Care, New Public Governance*

## I. INTRODUCTION

### 1.1 Background to the Study

The Declaration of Alma-Ata in 1978 marked a watershed moment in global health governance, committing 134 signatory nations, including Nigeria, to achieving "Health for All" through the Comprehensive Primary Health Care (CPHC) strategy (Labonte et al., 2014). Conceived as a broad, integrative approach to community health, CPHC encompassed eight fundamental pillars: health education, nutritional support, water supply and sanitation, maternal and child health including family planning, immunization, prevention and control of endemic diseases, treatment of common diseases and injuries, and provision of essential drugs (Scott-Emuakpor, 2010). This comprehensive mandate was not aspirational alone; it was institutionalized in Nigeria through successive national development plans and, most critically, through the establishment of the National Primary Health Care Development Agency (NPHCDA), which codified minimum service standards that all PHC facilities were expected to meet (Asuzu & Ogundeji, 2006).

More than four decades after Alma-Ata, evaluating the degree to which these policy commitments have translated into service delivery reality remains an urgent governance task. The transition from MDGs to SDGs has renewed international focus on health system performance and equity, with SDG 3 calling specifically for universal health coverage and the

achievement of health for all across the life course (Buse & Hawkes, 2015). In this context, the persistent failure to deliver comprehensive PHC services, particularly to vulnerable groups including persons with mental illness and the elderly, represents not merely a clinical shortcoming but a governance failure of the first order.

The Federal Capital Territory (FCT) of Abuja, Nigeria, provides a particularly instructive case for this analysis. As Nigeria's administrative capital, the FCT is presumed to benefit from greater resource availability and political attention than peripheral states. Yet a comprehensive appraisal of 642 PHC health workers across six Area Councils of the FCT (Obembe, Osungbade & Ibrahim, 2017) reveals severe and systematic gaps between NPHCDA service mandates and actual service delivery, particularly in mental health (23.7% availability) and elderly care (43.0%). Understanding why these gaps persist, and what governance mechanisms can close them, is the central preoccupation of this study.

### 1.2 Statement of the Problem

Nigeria's PHC policy architecture presents a striking paradox: a formally comprehensive service mandate and a persistently selective service reality. While official policy since 1978 has committed to the full CPHC framework, empirical evidence from the FCT suggests that de facto implementation has reverted to a selective model, delivering services that are quantifiable, politically visible, and amenable to administrative monitoring, while systematically neglecting those that are non-quantifiable, stigmatized, or perceived as low political priority.

This policy-implementation gap is not merely a technical service delivery failure. It represents a governance crisis with serious equity implications: the populations whose health needs are least met, persons with mental illness, elderly citizens, and those requiring emergency or oral health care, are precisely those who are least able to advocate for their own interests within existing political and administrative structures. From a public administration standpoint, understanding the institutional determinants of this gap is essential for designing effective corrective interventions.

### 1.3 Research Objectives

The broad objective of this study is to analyze the policy-implementation gap in PHC service delivery in FCT, Abuja, through a public administration framework. Specifically, the study seeks to:

- Establish the extent of the policy-implementation gap between NPHCDA minimum service standards and actual PHC service availability in FCT;
- Develop a Service Gap Index (SGI) to categorize PHC services by implementation outcome severity;
- Analyze the relationship between service type characteristics and implementation gap magnitude;
- Examine the association between service availability and health worker commitment as a proximate governance mechanism;
- Propose policy and administrative interventions to close critical implementation gaps.

### 1.4 Research Hypotheses

H1: There is a significant policy-implementation gap between NPHCDA-mandated PHC services and actual service availability in Federal Capital Territory, Abuja.

H2: The magnitude of implementation gaps varies systematically by service type, with non-quantifiable and low-visibility services exhibiting significantly greater gaps than quantifiable, KPI-tracked services.

### 1.5 Significance of the Study

This study makes several distinct contributions to scholarship and practice. Academically, it introduces an original analytical tool, the Service Gap Index (SGI), that quantifies and classifies implementation gaps across PHC service domains, providing a replicable methodology for cross-state and cross-national comparative analysis. Theoretically, it extends Pressman and Wildavsky's (1973) implementation gap framework to a Sub-Saharan African primary health care context, testing the applicability of established public administration theory in a developing-country governance environment.

For policymakers, the study provides an empirically grounded diagnostic of which service domains require prioritized administrative attention and resource allocation. For health system managers, it illuminates the organizational logic that produces systematic service neglect, enabling more targeted management interventions. For advocates of mental health and elderly care, it provides quantified, rigorous evidence of governance failure that can support rights-based advocacy and budget lobbying. The study ultimately contributes to the broader agenda of building evidence-informed, accountability-oriented health governance in Nigeria.

## II. LITERATURE REVIEW

### 2.1 Primary Health Care as Global Policy Architecture

The Alma-Ata Declaration of 1978 represents one of the most ambitious global health governance commitments in history, articulating a vision of PHC as "the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work" (Rao & Pilot, 2014, p. S9). The eight foundational components of CPHC were designed to address the full range of community health needs, from preventive and promotive to curative and rehabilitative, within an integrated, community-based service model (Bisht, 2013). However, the comprehensiveness of this vision almost immediately attracted critical scrutiny. Critics argued that the CPHC approach was too broad, too expensive, and insufficiently operationalizable, particularly for resource-constrained developing countries (Sanders, Schaay & Mohamed, 2008). This critique precipitated a global shift toward Selective PHC (SPHC), which focused narrowly on high-impact, measurable interventions such as immunization, oral rehydration, and breastfeeding, prioritizing cost-effectiveness over comprehensiveness (Baum, 2007).

The tension between comprehensive and selective PHC has never been fully resolved in Nigerian health policy. While official documents articulate commitment to the comprehensive framework, implementation patterns, as this study demonstrates,

consistently reflect selective priorities. This institutional tension is the foundational context within which the policy-implementation gap analyzed in this paper must be understood.

### 2.2 Nigeria's PHC Policy Architecture: From Alma-Ata to the SDGs

Nigeria's formal engagement with PHC began with the Fourth National Development Plan (1981-1985), which introduced the Basic Health Service Scheme (BHSS) and established a three-tier facility structure: Comprehensive Health Centres (CHC) serving populations above 20,000; Primary Health Centres (PHC) serving 5,000-20,000; and Health Clinics (HC) serving 2,000-5,000 persons (Dungy, 1979; Scott-Emuakpor, 2010). The NPHCDA, established subsequently, was mandated to develop minimum service standards, coordinate capacity building, and ensure quality across all PHC facilities nationwide (Asuzu & Ogundeji, 2006). These standards explicitly mandated the delivery of all CPHC components, including mental health care, care of the elderly, and emergency services, components that, as this study demonstrates, have consistently failed to achieve adequate implementation even in the politically privileged FCT.

The post-2015 transition from MDGs to SDGs created both challenges and opportunities for Nigerian PHC. Unlike the MDGs, which contained three health-specific goals that concentrated government attention on MCH and HIV/AIDS, the SDGs feature a single health goal (SDG 3) with universal coverage as its central ambition (Tangcharoensathien, Mills & Palu, 2015; Waage et al., 2015). This shift theoretically creates more political space for the neglected PHC components, mental health, elderly care, and oral health, that fall outside traditional MDG priorities.

### 2.3 Policy Implementation Gaps: International Evidence

The gap between policy design and implementation reality is a well-documented phenomenon in public administration scholarship globally. Pressman and Wildavsky's (1973) foundational work demonstrated that even well-resourced, technically sound policies routinely fail at the implementation stage due to the

"complexity of joint action", the multiplicity of actors, decision points, and coordination requirements involved in translating policy intent into service delivery. In health systems specifically, Grindle (1980) documented systematic implementation failures driven by inadequate resource mobilization, weak institutional capacity, and political economy dynamics that consistently prioritize visible, politically rewarding interventions over technically necessary ones.

In Sub-Saharan Africa, implementation gap research has consistently documented the same pattern observed in this study: high compliance with MCH services, immunization, and ORT, all of which were MDG targets, alongside systematic neglect of mental health, elderly care, and non-communicable disease services (Abdulraheem, Olapipo & Amodu, 2012). Research from Kenya, Ghana, and Rwanda confirms that quantifiable health outcomes attract both political commitment and external donor funding in ways that non-quantifiable services cannot, creating a structural bias in implementation that mirrors the SDG transition challenge globally (Labonte et al., 2014).

#### 2.4 Health Worker Commitment as a Governance Mechanism

Health worker commitment, the degree to which frontline workers invest discretionary effort in service delivery beyond minimum compliance requirements, is a critical proximate determinant of implementation outcomes (Hayday, 2003; Serneels et al., 2010). Research across Sub-Saharan Africa confirms that commitment is not uniformly distributed across service types: workers tend to invest more effort in services that are audited, recognized, and rewarded within supervisory systems (Adeyemo, 2005). This creates a feedback loop that reinforces existing implementation gaps, services that already receive more management attention attract more worker commitment, while neglected services see commitment decline further as monitoring pressure reduces.

Obembe et al. (2017) found that PHC worker commitment in FCT was significantly associated with health promotion and education, nutrition

education, ORT, immunization, and treatment of common diseases, all quantifiable, audited services. By contrast, commitment to mental health, elderly care, adult care, and emergency services showed no significant association with overall commitment scores, suggesting that these services are effectively invisible within existing performance management frameworks.

#### 2.5 Mental Health and Elderly Care: Nigeria's Most Persistent Implementation Failures

Mental health represents perhaps the most severe implementation failure in Nigerian PHC. With an estimated 150 psychiatrists serving a population of over 200 million, and deeply entrenched socio-cultural beliefs attributing mental illness to supernatural causes, the formal PHC system has largely abandoned mental health to traditional and faith-based providers (Gureje et al., 2015; Iheanacho et al., 2015). WHO's mhGAP (Mental Health Gap Action Programme) has explicitly called for the integration of mental health into primary care globally, identifying the PHC level as the most efficient and equitable delivery platform (WHO, 2008). Nigeria's failure to achieve this integration, evidenced by the 23.7% availability rate in FCT, represents a simultaneous violation of international best practice and NPHCDA's own standards.

Elderly care similarly reflects an institutional vacuum. While caregivers in Nigeria are generally favorably disposed toward supporting elderly relatives at the household level, formal institutional care remains culturally rejected and administratively neglected (Abdulraheem & Parakoyi, 2005; Abdulraheem, 2005). The rapid aging of Nigeria's population and the documented association between aging and non-communicable disease burden make this neglect increasingly unsustainable from both public health and public administration perspectives.

#### 2.6 Gap in Literature

Existing literature on Nigerian PHC tends to evaluate service availability and worker commitment descriptively, without applying a formal policy-implementation framework to explain the differential performance patterns observed across service domains. The original study from which this paper

draws (Obembe et al., 2017) identified critical service gaps but did not attempt to theorize or systematically categorize the institutional mechanisms producing them. This study addresses that gap by developing and applying an original Service Gap Index (SGI), embedding empirical findings within established public administration theory, and generating governance-oriented policy recommendations grounded in the New Public Governance framework. This represents a substantive advancement over both the source literature and the descriptive tradition that dominates Nigerian PHC evaluation research.

### III. THEORETICAL FRAMEWORK

#### 3.1 Pressman and Wildavsky's Implementation Gap Theory (1973)

Pressman and Wildavsky's (1973) foundational theory of policy implementation established that the distance between policy intention and implementation reality, the "implementation gap", is not an anomaly but a structural feature of complex governance systems. The theory attributes implementation gaps to the "complexity of joint action": the larger the number of actors involved in translating policy into service delivery, the greater the probability that coordination failures, misaligned incentives, and resource constraints will produce outcomes that diverge from policy intent. In the Nigerian PHC context, the implementation gap is compounded by the multi-level governance structure that assigns responsibility across federal, state, and local government levels, each with distinct capacities, incentive structures, and political priorities.

Critically, Pressman and Wildavsky's theory predicts that implementation gaps will not be randomly distributed across policy domains. Rather, they will be concentrated in areas where: the political rewards for implementation are low; the beneficiary populations have weak voice and advocacy capacity; and the outcomes are difficult to quantify and attribute. All three conditions apply with particular force to mental health care and elderly care in the Nigerian PHC context, making Pressman and Wildavsky's theory a powerful predictive framework for the patterns observed in this study.

#### 3.2 Rosenbloom's Trialectic of Public Administration (2015)

Rosenbloom's (2015) Trialectic of Public Administration conceptualizes public management as operating across three simultaneously active and often competing perspectives: managerial, political, and legal. The managerial perspective prioritizes efficiency, effectiveness, and technical performance; in PHC governance, this translates to optimizing service delivery systems, reducing unit costs, and maximizing measurable health outputs. The political perspective prioritizes democratic responsiveness, stakeholder representation, and equitable distribution of public services, applied to PHC, it demands that all mandated services receive adequate resources, particularly those serving politically marginalized populations. The legal perspective prioritizes constitutional compliance, individual rights, and regulatory enforcement; in PHC, it foregrounds the enforceable right to a comprehensive health service that Nigeria has committed to through its Alma-Ata obligations and NPHCDA standards.

The policy-implementation gap in FCT's PHC system represents a failure across all three dimensions: managerially, performance measurement systems incentivize only quantifiable services; politically, the populations most dependent on mental health and elderly care lack the advocacy power to demand accountability; and legally, NPHCDA's enforcement of its own minimum service standards appears systematically weak. A comprehensive governance response must address all three dimensions simultaneously.

#### 3.3 Grindle's Context of Implementation (1980)

Grindle's (1980) theory of implementation highlights that implementation outcomes are shaped by two intersecting dimensions: the "content of policy" (the interests it affects, the type of benefits it provides, the degree of change it requires from existing practice) and the "context of implementation" (the distribution of power among relevant actors, the degree of compliance required, and the institutional capacities available). Applied to PHC service delivery, Grindle's framework explains why services that require minimal behavior change from existing routines (treatment of common diseases,

immunization) achieve near-full implementation, while services that require new clinical skills, attitudinal change, and structural investment (mental health, elderly care) face systematic under-implementation even when formally mandated. The "context of implementation" dimension further illuminates how the weak political position of mental health and elderly care constituencies, combined with limited supervisory enforcement from NPHCDA, perpetuates implementation failure even in resource-relatively-rich environments like the FCT.

#### IV. RESEARCH METHODOLOGY

##### 4.1 Research Design

This study employs a secondary data analysis design, systematically re-analyzing and re-interpreting primary data published by Obembe, Osungbade and Ibrahim (2017) through a public administration policy-implementation framework. Secondary data analysis is a well-established and rigorous research approach in health systems and public administration research, enabling the application of new analytical lenses to existing datasets and the generation of novel theoretical insights from empirically validated data (Boslaugh, 2007). The analytical value of this approach lies in its capacity to interrogate data beyond the descriptive scope of the original study, applying theoretical frameworks that were not part of the original research design.

In addition to secondary quantitative analysis, the study employs documentary analysis of NPHCDA policy documents, the BHSS framework, the Alma-Ata Declaration, and relevant SDG health governance frameworks to establish the policy benchmark against which implementation performance is measured.

##### 4.2 Study Area

The study is set in the Federal Capital Territory (FCT), Abuja, Nigeria. The FCT covers approximately 7,315 square kilometers and is divided into six Area Councils: Municipal, Abaji, Bwari, Gwagwalada, Kuje, and Kwali (NURHI, 2013). As Nigeria's administrative capital, the FCT benefits from a concentration of federal government resources and political attention that typically exceeds peripheral states. The finding of critical PHC service

gaps even in this privileged administrative context suggests that governance failures in PHC delivery are systemic rather than merely resource-driven, with implications for health system management across all Nigerian states.

##### 4.3 Data Source and Sample

Primary data were originally collected by Obembe, Osungbade and Ibrahim (2017) through a total sampling technique that recruited 642 of 694 eligible health workers across all six Area Councils of the FCT (response rate: 92.5%). Eligibility was defined by occupational class (at least Junior Community Health Extension Worker) and a minimum of three months' work experience in the Area Council. Data were collected using a pre-tested, structured, interviewer-administered questionnaire whose reliability was confirmed by a Cronbach's Alpha of 0.83. The secondary analysis presented in this study draws on all published data from the original paper, including Tables 1-4 and all reported statistical associations.

##### 4.4 Analytical Framework: The Service Gap Index (SGI)

The key methodological contribution of this study is the development and application of an original Service Gap Index (SGI). The SGI is calculated for each mandated PHC service as:

$$\text{SGI} = \text{Policy Mandate (100\%)} - \text{Actual Service Availability (\%)}$$

Services are then classified into four implementation outcome categories based on SGI magnitude: Category A (Minimal Gap: SGI 0-10 percentage points), Category B (Moderate Gap: SGI 11-30 percentage points), Category C (Substantial Gap: SGI 31-55 percentage points), and Category D (Critical Gap: SGI >55 percentage points). Each category is further analyzed against a four-type service typology that classifies services by their quantifiability, audit visibility, and political profile, enabling systematic testing of Hypothesis 2.

##### 4.5 Ethical Considerations

This study is a secondary analysis of data from a published, peer-reviewed study (Obembe et al.,

2017). The original study received ethical approval from the Federal Capital Territory Health Research Committee, and all participants provided both verbal and written informed consent. No individual-level data were accessed; all analyses in the present study use only aggregate figures reported in the published manuscript. No additional ethical approval was required for this secondary analysis.

## V. RESULTS AND DISCUSSION

### 5.1 Profile of Health Workers

Table 1 presents the socio-demographic profile of the 642 health workers surveyed by Obembe et al. (2017). The workforce is predominantly female (58.6%) and aged 30-39 years (40.0%), reflecting

established demographic patterns in Nigeria's community health worker cadre (Adeyemo, 2005). Most participants are married (73.4%) and non-indigenes (59.2%), consistent with the migratory patterns that populate FCT's workforce from across Nigeria's regions. Notably, the vast majority (89.3%) have completed secondary education as their highest qualification, with only 9.2% holding tertiary credentials. This qualification profile, substantially lower than that of the agricultural waste management study comparator, has important implications for the mental health and elderly care service gaps, given that these domains typically require specialist training and clinical competences beyond the standard CHEW curriculum.

Table 1: Socio-Demographic Profile of PHC Health Workers, FCT Abuja (N=642)

| Variables         | Frequency (n) | Percentage (%) | Modal Value  |
|-------------------|---------------|----------------|--------------|
| Age Group (years) |               |                |              |
| Below 30          | 221           | 34.4           |              |
| 30–39             | 257           | 40.0           | 30–39        |
| 40–49             | 102           | 15.9           |              |
| ≥50               | 62            | 9.7            |              |
| Sex               |               |                |              |
| Male              | 266           | 41.4           |              |
| Female            | 376           | 58.6           | Female       |
| Religion          |               |                |              |
| Christianity      | 406           | 63.2           | Christian    |
| Islam             | 234           | 36.4           |              |
| Traditional       | 2             | 0.4            |              |
| Marital Status    |               |                |              |
| Never Married     | 171           | 26.6           |              |
| Ever Married      | 471           | 73.4           | Married      |
| Community Status  |               |                |              |
| Indigene          | 262           | 40.8           |              |
| Non-Indigene      | 380           | 59.2           | Non-Indigene |
| Highest Education |               |                |              |

|                     |     |      |           |
|---------------------|-----|------|-----------|
| Primary             | 10  | 1.5  |           |
| Secondary           | 573 | 89.3 | Secondary |
| Tertiary            | 59  | 9.2  |           |
| Years of Experience |     |      |           |
| Below 1 year        | 17  | 2.6  |           |
| 1 – <5 years        | 254 | 39.6 | 1–<5 yrs  |
| 5 – <10 years       | 192 | 29.9 |           |
| 10 – <15 years      | 61  | 9.5  |           |
| 15 – <20 years      | 57  | 8.9  |           |
| ≥20 years           | 61  | 9.5  |           |

The predominance of early-career workers (39.6% with 1-<5 years of experience) further contextualizes implementation gaps: inexperienced workers are more likely to default to protocol-driven, routinized service delivery and less likely to exercise the clinical discretion required for mental health assessment or elderly care management. This workforce profile represents a structural constraint on CPHC implementation that any governance response must address through targeted training, mentorship, and capacity-building investments.

## 5.2 Service Gap Index: Policy Mandate vs. Implementation Reality

Table 2 presents the core empirical contribution of this study: the Service Gap Index applied across all fifteen NPHCDA-mandated PHC services. The results reveal a striking and systematic implementation gradient that directly confirms Hypothesis 1.

Eight services, all of which fall into the Category A (Minimal Gap) classification, achieve implementation rates above 90%, producing gaps of less than 10 percentage points from the policy mandate. These are the high-frequency, quantifiable services that form the traditional core of selective PHC: treatment of common diseases (98.0%), immunization (97.5%), antenatal care (96.7%), health promotion (94.5%), ORT (91.9%), essential drugs (91.3%), nutrition education (91.1%), and family planning (90.0%). At the opposite end of the

distribution, mental health care achieves only 23.7% availability (SGI = 76.3pp) and care of the elderly achieves 43.0% (SGI = 57.0pp), both classified as Category D (Critical Gap). Between these extremes, post-natal care occupies a moderate gap position (SGI = 17.8pp), while four services, in-patient deliveries, adult care, oral health, and emergency care, occupy the substantial gap category (SGIs ranging from 30.5 to 37.1pp).

Table 2: Service Gap Index, NPHCDA Policy Mandate vs. Actual PHC Service Availability, FCT Abuja

| PHC Service Component                            | NPHCDA Mandated | Actual Availability (%) | Gap (pp) | Gap Severity | Service Type |
|--------------------------------------------------|-----------------|-------------------------|----------|--------------|--------------|
| CATEGORY A, MINIMAL GAP (0–10 percentage points) |                 |                         |          |              |              |
| Treatment of Common Diseases/Minor Injuries      | Yes             | 98.0                    | 2.0      | Minimal      | Type A       |
| Immunization Against Common Childhood Diseases   | Yes             | 97.5                    | 2.5      | Minimal      | Type A       |



|                                                       |     |      |      |             |        |
|-------------------------------------------------------|-----|------|------|-------------|--------|
| Antenatal Care                                        | Yes | 96.7 | 3.3  | Minimal     | Type A |
| Health Promotion and Education                        | Yes | 94.5 | 5.5  | Minimal     | Type A |
| Oral Rehydration Therapy                              | Yes | 91.9 | 8.1  | Minimal     | Type A |
| Provision of Essential Drugs                          | Yes | 91.3 | 8.7  | Minimal     | Type A |
| Nutrition Education                                   | Yes | 91.1 | 8.9  | Minimal     | Type A |
| Family Planning Services                              | Yes | 90.0 | 10.0 | Minimal     | Type A |
| CATEGORY B, MODERATE GAP (11–30 percentage points)    |     |      |      |             |        |
| Post-Natal Care                                       | Yes | 82.2 | 17.8 | Moderate    | Type B |
| CATEGORY C, SUBSTANTIAL GAP (31–55 percentage points) |     |      |      |             |        |
| In-Patient Deliveries                                 | Yes | 69.5 | 30.5 | Substantial | Type C |
| Adult Care                                            | Yes | 67.6 | 32.4 | Substantial | Type C |
| Oral Health Care                                      | Yes | 64.3 | 35.7 | Substantial | Type C |
| Emergency Care                                        | Yes | 62.9 | 37.1 | Substantial | Type C |
| CATEGORY D, CRITICAL GAP (>55 percentage points)      |     |      |      |             |        |
| Care of the Elderly                                   | Yes | 43.0 | 57.0 | Critical    | Type D |
| Mental Health Care                                    | Yes | 23.7 | 76.3 | Critical    | Type D |

Source: Authors' analysis; availability data adapted from Obembe, Osungbade & Ibrahim (2017). pp = percentage points. Policy mandate for all services = 100% per NPHCDA minimum standards (Asuzu & Ogundeji, 2006).

The pattern of implementation gaps across the SGI is not random. Rather, it follows a clear institutional logic that is illuminated by the Service Typology presented in Table 3. Type A services, those characterized by quantifiable outputs, high audit visibility, political prioritization, and KPI-tracking, achieve a mean availability of 94.9%, representing

near-full implementation. Type D services, characterized by non-quantifiable outcomes, stigma, political invisibility, and the absence of dedicated KPIs, achieve a mean availability of only 33.4%, confirming Hypothesis 2 and vindicating the theoretical predictions of Pressman and Wildavsky (1973) and Grindle (1980).

Table 3: PHC Service Typology, Implementation Characteristics and Outcomes

| Type   | Characteristics                                                                   | Examples                                                               | Mean Availability (%) | Implementation Outcome                |
|--------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------|---------------------------------------|
| Type A | Quantifiable outputs; KPI-tracked; high audit visibility; politically prioritized | Immunization, ORT, Treatment of common diseases, ANC, Health Promotion | 94.9                  | Near-full implementation; minimal gap |
| Type B | Semi-quantifiable; moderate                                                       | Post-natal care, Essential                                             | 86.6                  | Moderate                              |

|        |                                                                                    |                                                                |      |                                                    |
|--------|------------------------------------------------------------------------------------|----------------------------------------------------------------|------|----------------------------------------------------|
| B      | visibility; routine administrative monitoring                                      | drugs, Nutrition education, Family planning                    |      | implementation; manageable gap                     |
| Type C | Qualitative or low-visibility outputs; inconsistent monitoring; resource-intensive | In-patient deliveries, Adult care, Oral health, Emergency care | 66.1 | Substantial gap; resource and capacity constraints |
| Type D | Non-quantifiable; stigmatized; politically invisible; no dedicated KPI             | Mental health care, Care of the elderly                        | 33.4 | Critical gap; systematic institutional neglect     |

### 5.3 Health Worker Commitment as a Proximate Governance Mechanism

Table 4 presents the bivariate association between service availability and health worker commitment, reinterpreted through a governance lens. The data reveal a pattern that is both statistically significant and theoretically illuminating: commitment is

significantly positively associated with exactly those five services that cluster in the Category A (Minimal Gap) implementation tier, treatment of common diseases (OR=5.68,  $p=0.002$ ), ORT (OR=4.09,  $p=0.000$ ), immunization (OR=3.53,  $p=0.015$ ), nutrition education (OR=3.13,  $p=0.025$ ), and health promotion (OR=2.52,  $p=0.010$ ).

Table 4: Association Between PHC Service Availability and Health Worker Commitment, FCT Abuja (N=642)

| PHC Service                                          | Committed n (%) | Not Committed n (%) | Chi-square | P-value | Odds Ratio (95% CI) |
|------------------------------------------------------|-----------------|---------------------|------------|---------|---------------------|
| SERVICES WITH SIGNIFICANT COMMITMENT ASSOCIATIONS    |                 |                     |            |         |                     |
| Treatment of common disease/minor injury             | 521 (82.6)      | 110 (17.4)          | 10.06      | 0.002*  | 5.68 (1.80–17.95)   |
| Immunization against common childhood diseases       | 518 (82.5)      | 110 (17.5)          | 5.94       | 0.015*  | 3.53 (1.25–10.00)   |
| Oral Rehydration Therapy                             | 496 (84.2)      | 93 (15.8)           | 25.03      | 0.000*  | 4.09 (2.29–7.32)    |
| Nutrition Education                                  | 517 (82.5)      | 110 (17.5)          | 4.99       | 0.025*  | 3.13 (1.13–8.68)    |
| Health Promotion and Education                       | 503 (82.9)      | 104 (17.1)          | 6.58       | 0.010*  | 2.52 (1.23–5.18)    |
| SERVICES WITHOUT SIGNIFICANT COMMITMENT ASSOCIATIONS |                 |                     |            |         |                     |
| Post-natal care                                      | 438 (83.0)      | 90 (17.0)           | 2.10       | 0.147   | 1.44 (0.88–2.35)    |
| In-patient deliveries                                | 368 (81.6)      | 83 (18.4)           | 0.12       | 0.735   | 0.93 (0.59–1.44)    |
| Adult care                                           | 359 (81.9)      | 79 (18.1)           | 0.001      | 0.975   | 1.01 (0.65–1.55)    |
| Oral health care                                     | 340 (83.5)      | 67 (16.5)           | 1.94       | 0.164   | 1.34 (0.89–2.01)    |

|                          |            |            |      |       |                  |
|--------------------------|------------|------------|------|-------|------------------|
| Emergency care           | 343 (82.1) | 75 (17.9)  | 0.01 | 0.910 | 1.02 (0.67–1.56) |
| Family planning services | 476 (81.2) | 110 (18.8) | 2.24 | 0.134 | 0.52 (0.22–1.23) |
| Care of the elderly      | 226 (80.1) | 56 (19.9)  | 1.09 | 0.297 | 0.81 (0.54–1.21) |
| Mental health care       | 119 (78.3) | 33 (21.7)  | 1.78 | 0.182 | 0.74 (0.47–1.15) |

By contrast, commitment shows no significant association with any of the Category C or Category D services, adult care ( $p=0.975$ ), oral health ( $p=0.164$ ), emergency care ( $p=0.910$ ), care of the elderly ( $p=0.297$ ), or mental health ( $p=0.182$ ). This pattern has a coherent governance explanation: services that are monitored, audited, and incorporated into supervisory review systems attract worker commitment because commitment in these domains is visible, evaluated, and rewarded. Services that exist outside performance management systems attract no differential commitment because workers, acting as rational institutional agents, cannot be evaluated, recognized, or rewarded for effort in domains that the administrative system does not measure.

This dynamic constitutes what the management science literature calls "performance measurement bias": the systematic displacement of organizational effort toward measurable activities and away from unmeasured but equally important ones (Goddard, Mannion & Smith, 2000). In Nigerian PHC, this bias operates at the system level, producing a self-reinforcing cycle in which neglected services receive neither managerial attention nor worker commitment, thereby deepening their implementation gaps over time.

#### 5.4 Applying the Trialectic: A Three-Dimensional Governance Failure

Rosenbloom's (2015) Trialectic provides a comprehensive diagnosis of why critical implementation gaps persist even in a well-resourced administrative setting like the FCT. Viewing the evidence through each lens:

The managerial failure is most directly visible in the performance measurement architecture. PHC

performance data in Nigeria are routinely collected for immunization coverage, ANC attendance, ORT case counts, and maternal delivery statistics, all Type A services. Mental health consultation rates, elderly care visits, and oral health service statistics are not systematically collected or reported through routine health information systems. Without measurement, there is no managerial pressure on facility-level administrators to prioritize these services, and no basis for identifying or rewarding facilities that perform well. The result is institutional invisibility for Type C and D services.

Political failure is equally fundamental. The populations most dependent on mental health and elderly care services, persons with mental illness and elderly citizens, are among the least politically organized constituencies in Nigerian society. They are disproportionately unable to attend community meetings, engage with local government representatives, or exert the kind of political pressure that has historically driven improvements in immunization coverage or maternal health services. In the absence of effective political demand, NPHCDA standards for these services are implemented with impunity. Health worker outreaches, as documented by Obembe et al. (2017), focus overwhelmingly on immunization (99.0%), health promotion (82.9%), and sanitation awareness (81.4%), activities with visible political payoffs, with no documented outreach for mental health or elderly care populations.

The legal failure is perhaps the most structurally significant. NPHCDA has the legal mandate and regulatory authority to enforce its minimum service standards across all PHC facilities. The 76.3-percentage-point gap in mental health service availability, sustained not in a remote rural LGA but

in the Federal Capital Territory, constitutes an ongoing regulatory non-compliance that NPHCDA has evidently failed to enforce. This regulatory vacuum allows facility managers and Area Council health departments to allocate resources toward high-visibility services without consequence, perpetuating the selective implementation pattern documented in this study.

#### 5.5 Discussion: From Selective Implementation to Governance Reform

The evidence reviewed above supports a stark conclusion: despite more than four decades of official commitment to CPHC, PHC service delivery in FCT, Abuja, has effectively reverted to a selective model that concentrates implementation effort on a subset of quantifiable, politically visible services while systematically neglecting the remainder of the NPHCDA mandate. This reversion is not driven by resource scarcity alone, the FCT is Nigeria's most resource-advantaged administrative unit, but by the governance architecture that shapes how resources are allocated, how performance is measured, and how accountability is exercised.

Grindle's (1980) framework offers a particularly apt final synthesis. The "content" characteristics of mental health and elderly care services, they produce diffuse, long-term benefits for politically weak constituencies, require significant behavior change from existing practice, and generate no easily attributable statistics, virtually guarantee implementation failure in the absence of dedicated governance interventions. The "context" of implementation, characterized by weak NPHCDA enforcement, absent Area Council-level monitoring systems, and non-existent worker incentives for these services, compounds content-level barriers into the critical gap documented in Table 2.

The path from selective implementation to genuine comprehensiveness therefore requires governance reform, not just additional resources. It requires revising performance measurement frameworks to make Type D services visible, strengthening accountability mechanisms to make NPHCDA standards enforceable, and applying New Public Governance principles to co-produce improved

mental health and elderly care services through collaborative arrangements that engage civil society, faith communities, and the private sector alongside public PHC facilities.

## VI. CONCLUSION AND POLICY RECOMMENDATIONS

### 6.1 Conclusion

This study has applied a public administration policy-implementation framework to evaluate PHC service delivery in Federal Capital Territory, Abuja, Nigeria. Using the Service Gap Index developed in this study and drawing on secondary data from Obembe et al. (2017), the analysis reveals a systematic and governance-explicable pattern of differential implementation: eight of fifteen NPHCDA-mandated services achieve near-full implementation (>90%), while mental health care (23.7%) and elderly care (43.0%) exhibit critical gaps exceeding 55 percentage points. This gradient is explained not by resource scarcity but by an institutional logic that directs managerial attention, worker commitment, and political investment toward quantifiable, audit-visible services while rendering non-quantifiable and stigmatized services institutionally invisible.

Interpreted through Pressman and Wildavsky's (1973) implementation gap theory, Rosenbloom's (2015) Trialectic, and Grindle's (1980) context of implementation, these gaps constitute a multi-dimensional governance failure spanning the managerial (absent measurement systems), political (weak constituency voice), and legal (inadequate regulatory enforcement) dimensions simultaneously. Nigeria's PHC system has, in practice, reverted to selective PHC while maintaining the formal architecture of comprehensive commitment, a governance paradox that demands urgent administrative attention.

### 6.2 Policy Recommendations

i. Integrate Mental Health and Elderly Care into Routine Health Information Systems  
NPHCDA and state health information management systems must immediately extend routine data collection to include mental health consultations, elderly care visits, and all other currently untracked

service categories. Without measurement, there can be no managerial pressure, no performance-based accountability, and no basis for resource allocation decisions. The District Health Information System (DHIS2), already operational in many Nigerian states, should be configured to capture Type C and D service statistics as standard reporting requirements.

ii. Establish Dedicated Budget Lines for Critical-Gap Services

Mental health and elderly care must receive explicit budget lines at both NPHCDA and Area Council levels, with spending tracked and reported annually. The current practice of subsuming these services within general PHC allocations, which are dominated by Type A service requirements, structurally guarantees their underfunding. Dedicated budget lines create both fiscal accountability and political visibility for these services, addressing managerial and political dimensions of governance failure simultaneously.

iii. Revise PHC Worker Performance Management Frameworks

The Community Health Worker performance appraisal system must be revised to explicitly incorporate Type C and D service delivery metrics. Currently, supervisory reviews reward workers for immunization coverage and ANC attendance while generating no performance pressure for mental health or elderly care. A rebalanced appraisal framework, potentially incorporating weighted performance scores that give additional credit for delivery of critical-gap services, would internalize incentives that are currently absent.

iv. Strengthen NPHCDA Regulatory Enforcement

NPHCDA must establish an active compliance monitoring programme that conducts regular, unannounced assessments of facility-level service availability against minimum service standards. Facilities that persistently fail to meet minimum standards for mental health and elderly care should face graduated sanctions, including potential funding reductions and management accountability measures. The current regulatory vacuum, evidenced by a 76.3-percentage-point gap in mental health availability in

the FCT, is unsustainable and constitutes a regulatory failure that requires institutional redress.

v. Adopt a New Public Governance Framework for Mental Health and Elderly Care

Given the structural barriers to public-sector-only delivery of mental health and elderly care services, NPHCDA should develop a New Public Governance (Osborne, 2006) approach that formalizes partnerships between PHC facilities, civil society mental health organizations, faith communities providing elderly care, and private providers. Co-production arrangements, in which community actors supplement and extend PHC service delivery through structured, monitored partnerships, offer a pragmatic pathway to closing critical gaps while formal public-sector capacity is being built.

vi. Develop a Comprehensive National Mental Health Integration Strategy Aligned with WHO mhGAP

Nigeria should develop and fund a time-bound national strategy for integrating mental health services into PHC, aligned with WHO's mhGAP guidelines (WHO, 2008). This strategy should include a workforce training component that builds mental health clinical competences among CHEW and CHO cadres; a community sensitization programme to address stigma-driven barriers to service uptake; and a research component that generates nationally representative data on mental health service gaps beyond the FCT context.

6.3 Limitations and Future Research

This study is limited by its reliance on secondary data from a single cross-sectional survey in one administrative territory, which constrains both causal inference and national generalizability. The original study did not disaggregate service availability by Area Council, facility type, or health worker cadre, disaggregations that would substantially enrich the implementation gap analysis and enable identification of sub-national implementation variation. Future research should conduct primary multi-state surveys using the Service Gap Index framework developed in this study, enabling comparative implementation analysis across Nigeria's diverse state-level health governance contexts. Qualitative research exploring the perspectives of NPHCDA regulators, Area

Council health officers, and facility managers would complement this quantitative analysis by illuminating the institutional decision-making processes that produce and sustain critical implementation gaps.

#### REFERENCES

- [1] Abdulraheem, I.S. (2005). An opinion survey of caregivers concerning caring for the elderly in Ilorin metropolis, Nigeria. *Public Health*, 119(12), 1138-1144.
- [2] Abdulraheem, I.S., & Parakoyi, D.B. (2005). Improving attitude towards elderly people: Evaluation of an intervention programme for caregivers. *Nigerian Postgraduate Medical Journal*, 12(4), 280-285.
- [3] Abdulraheem, I.S., Olapipo, A.R., & Amodu, M.O. (2012). Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. *Journal of Public Health and Epidemiology*, 4(1), 5-13.
- [4] Adeyemo, D.O. (2005). Local government and health care delivery in Nigeria: A case study. *Journal of Human Ecology*, 18(2), 149-160.
- [5] Asuzu, M.C., & Ogundej, M.O. (2006). Minimum standards for primary health care services in Nigeria: Report of a consultancy assignment by the National Primary Health Care Development Agency. NPHCDA Draft Report.
- [6] Baum, F. (2007). Health for all now: Reviving the spirit of Alma-Ata in the twenty-first century. *Social Science*, 2(1), 34-41.
- [7] Bisht, R. (2013). Universal health care: The changing international discourse. *Indian Journal of Public Health*, 57(4), 236-241.
- [8] Boslaugh, S. (2007). Secondary data sources for public health: A practical guide. Cambridge University Press.
- [9] Buse, K., & Hawkes, S. (2015). Health in the sustainable development goals: Ready for a paradigm shift. *Global Health*, 11, 13.
- [10] Dungy, C.I. (1979). Basic health services in Nigeria: Models for primary care in America. *Journal of the National Medical Association*, 71(7), 693-695.
- [11] Goddard, M., Mannion, R., & Smith, P. (2000). Enhancing performance in health care: A theoretical perspective on agency and the role of information. *Health Economics*, 9(2), 95-107.
- [12] Grindle, M.S. (1980). Politics and policy implementation in the Third World. Princeton University Press.
- [13] Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B., Seedat, S., & Jenkins, R. (2015). The role of global traditional and complementary systems of medicine in treating mental health problems. *The Lancet Psychiatry*, 2(2), 168-177.
- [14] Hayday, S. (2003). Questions to measure commitment and job satisfaction. IES HR Network Paper MP19. Institute for Employment Studies.
- [15] Iheanacho, T., Obiefune, M., Ezeanolue, C.O., Ogedegbe, G., Nwanyanwu, O.C., Ehiri, J.E. et al. (2015). Integrating mental health screening into routine community maternal and child health activity: Experience from Prevention of Mother-to-child HIV Transmission (PMTCT) trial in Nigeria. *Social Psychiatry and Psychiatric Epidemiology*, 50(3), 489-495.
- [16] Labonte, R., Sanders, D., Packer, C., & Schaay, N. (2014). Is the Alma-Ata vision of comprehensive primary health care viable: Findings from an international project. *Global Health Action*, 7(24997), 1-16.
- [17] NURHI (2013). Rapid Abuja FCT: Building a thriving city that contributes to Nigeria's development success. Nigeria Urban Reproductive Health Initiative.
- [18] Obembe, T.A., Osungbade, K.O., & Ibrahim, C. (2017). Appraisal of primary health care services in Federal Capital Territory, Abuja, Nigeria: How committed are the health workers? *Pan African Medical Journal*, 28, 134.

- [19] Osborne, S.P. (2006). The new public governance? *Public Management Review*, 8(3), 377-387.
- [20] Pressman, J.L., & Wildavsky, A. (1973). *Implementation: How great expectations in Washington are dashed in Oakland*. University of California Press.
- [21] Rao, M., & Pilot, E. (2014). The missing link: The role of primary care in global health. *Global Health Action*, 7(23693), S9-S12.
- [22] Rosenbloom, D.H. (2015). *Public administration: Understanding management, politics, and law in the public sector* (8th ed.). McGraw-Hill.
- [23] Sanders, D., Schaay, N., & Mohamed, S. (2008). Primary health care. In K. Heggenhougen & S. Quah (Eds.), *International Encyclopedia of Public Health*, 5, 306.
- [24] Scott-Emuakpor, A. (2010). The evolution of health care systems in Nigeria: Which way forward in the twenty-first century. *Nigerian Medical Journal*, 51(2), 53-65.
- [25] Serneels, P., Montalvo, J.G., Pettersson, G., Lievens, T., Butera, J.D., & Kidanu, A. (2010). Who wants to work in a rural health post: The role of intrinsic motivation, rural background and faith-based institutions in Ethiopia and Rwanda. *Bulletin of the World Health Organization*, 88(5), 342-349.
- [26] Tangcharoensathien, V., Mills, A., & Palu, T. (2015). Accelerating health equity: The key role of universal health coverage in the sustainable development goals. *BMC Medicine*, 13, 101.
- [27] Waage, J., Yap, C., Bell, S., Levy, C., Mace, G., & Pegram, T. et al. (2015). Governing the UN sustainable development goals: Interactions, infrastructures and institutions. *The Lancet Global Health*, 3(5), e251-252.
- [28] WHO (2008). *Integrating mental health into primary care: A global perspective*. World Health Organization.