

Case Study of an Emerging Domestic Resource Mobilization Strategy for Primary Healthcare in Nigeria

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Abstract

In Nigeria, the primary healthcare (PHC) system is critically underfunded, and the gaps in areas of infrastructure, commodity availability and human resource are increasingly exacerbated as foreign aid shrink globally. This challenge has prompted advocates and researchers in Nigeria to revisit the extant conversation on innovative domestic resource mobilization strategies. The "Adopt A PHC" (AAP) initiative is one of different piloted models long before the recent aid crisis. The approach is characterized by a systematic mobilization of local philanthropy investment to revitalize PHC facility infrastructure. However, a lack of documented evidence on its implementation has hindered its adoption and scale.

This retrospective case study investigates the pilot of the AAP initiative in the Federal Capital Territory, Abuja, drawing on key informant interviews with relevant stakeholders. Insights were synthesized from civil society actors who led the implementation, government program managers at the state and district levels, health workers as well as community members. Relevant quotes were analyzed thematically to profile the processes, enablers, barriers and opinions of the mapped stakeholder groups.

Findings reveal that AAP is positively perceived to support existing efforts to address PHC infrastructure gaps, leveraging Nigeria's strong culture of giving. It was enabled primarily through relationship-building competencies of civil society actors and the charitable culture among the Nigerian populace. However, barriers such as weak monitoring and coordination among stakeholders limited the potential for expansion and sustainability of the initiative after a successful pilot. Thus, a conceptual framework is extracted to map the ideal roles of involved stakeholder groups.

Introduction

Low access to primary healthcare persists in Nigeria (1), evident in the country's performance in various health indices (2). The poor performance of the health system is hinged on the poor strength of each of the pillars of health which all rely on funding. Due to inadequate health financing, it is reported that only about 20% of Nigeria's over 30,000 health facilities are functioning (3) while less than half of Nigerians can access public primary health services (4). Considering the economic and political landscape, prospects of optimal financing through government health expenditure to relieve the over 70% out-of-pocket health expenditure on Nigerians, remain elusive (5). Compounding the existing financing gaps are increasing global aid cuts by developed countries (6). These are projected to unsettle many health systems around the world (7–9), including Nigeria's (10).

Akintoyese et al. had proposed looking to alternative healthcare financing mechanisms such as voluntary and compulsory prepayment and foreign development assistance basket to meet pressing health financing challenges (11). This is as domestic resource mobilization become more imperative following significant reductions in foreign aid connected to the global recession that ensued from the COVID-19 pandemic and the Russian invasion of Ukraine in 2022 (12). Nigeria's economic underperformance, systemic corruption and the expanding armed conflict make it increasingly difficult for either the government to increase fiscal space for health or rely on prepayment by citizens to optimize primary healthcare (13), hence the need for innovative resource mobilization interventions. One notable intervention proposed by civil society and development practitioners in Nigeria is the "Adopt-A-PHC" initiative.

Nigeria, like the rest of the world, is not unfamiliar with philanthropic donations (14). While there is scarce information on Nigeria's domestic philanthropic funding basket, the 80 million USD contribution to COVID-19 response through the Coalition Against COVID-19 (CACOVID) facility in 2020 provides a pointer to the philanthropic capacity of Nigeria's private sector to health (14). Nonetheless, adoption of health facilities which entails more than donation but encompasses relationship and sustainability, is not yet a popular concept in Nigeria's development community. Similar to Adopt-A-Highway in the United States (15), Adopt-A-PHC involves a multi-stakeholder process of initiating and sustaining a long-term partnership between health facilities and individuals or organizations with the purpose of increasing financial support for primary healthcare (16). The initiative leverages existing philanthropic instruments such as personal donations and corporate social investments (CSIs) by private businesses, to raise domestic funds for primary healthcare initiative (17).

The micro or community level implementation Adopt A PHC is a recent model of the broader initiative (18). This flexible, small-scale model originated among civil society stakeholders in the Federal Capital Territory, Abuja, Nigeria (19). According to the manual developed by the authors, individuals and corporations are encouraged to direct their philanthropic donations or corporate social investments to the revitalization of frail health facilities (18, 20). In this model, a forum of potential adopters is established for each facility through strategic advocacy. As a result, the facility receives the financial and material patronage of the adopters in exchange for periodic administrative accountability such as submission of annual operational plan, financial report and impact report. The micro-adoption focuses on initiating a relationship between facilities and potential donors who, based on the performance and transparency of the facility, are encouraged to continue supporting. It is proposed as cheaper and flexible in that it gives donors the liberty to determine their level of support without disrupting service delivery at the facilities.

Whilst a promising approach, there has been no systematic documentation of the processes and outcomes of this approach since its implementation in 2022. The aim of this paper, thus, is to fill knowledge gap around this emerging domestic resource mobilization approach. This study investigates the implementation of the Adopt-A-PHC initiative in the Federal Capital Territory, Nigeria, by documenting its implementation processes, identifying lessons learned regarding impact, challenges, and enablers, and gathering stakeholder recommendations to inform best practices for its expansion.

Methodology

This study employed a retrospective case study approach (21), using qualitative and archival data to document the implementation of the Adopt A PHC domestic finance mobilization for primary healthcare in FCT, Nigeria. Key informant interviews (KIIs) and in-depth interviews (IDIs) were conducted with purposively selected participants who represent various stakeholders involved in the implementation. Stakeholder groups include government PHC program managers at all levels (national, state and district or local government area), community leaders, philanthropies, civil society organizations, facility management and others. Participants were selected based on their ability to provide a first-hand account of the implementation of the initiative, espouse the policy and programmatic environment in the present day as well as proffer solutions to equitably scale the initiative to more communities.

Data Collection

A total of 9 interviews were held with 35 participants in Table 1: two with program managers (one each at state and district levels); four with civil society and community-based organizations; one with community leaders and representatives; one with a philanthropist; and one health workers. The data collection tool was designed to collect data along the study objectives as follows, documenting the history and processes of the pilot implementation in the FCT; understanding the perceptions of the stakeholders on the impact and drivers of this initiative; and obtaining recommendations needed to iterate the initiative and institutionalize best practices.

Table 1
Data Collection Plan

Respondent cadre	Interview type	No. of interviews	No. of Respondents
State PHC Manager	FGD	1	8
District PHC Managers	FGD	2	8
Community Leaders and representatives	FGD	1	8
Philanthropies/Private Sector	IDI	1	1
Civil Society and Community based organizations	KII	4	4
Health workers	FGD	1	6
Total		10	35

Data Analysis

Interviews with consenting participants will be audio-recorded, transcribed verbatim, and analyzed using a hybrid approach combining deductive and inductive thematic analysis. The qualitative data will be organized and examined using Dedoose software. Identified themes will be captured and illustrated with quotes from the transcripts, ensuring anonymity to protect participants' confidentiality.

Ethical Considerations

To ensure the research met ethical standards, we obtained expedited approval from the Federal Capital Territory Health Research Ethics Committee prior to data collection. Before participating, each study participant gave informed oral consent after being read a standard script in either English or their local language. This script outlined the study's purpose, ensured confidentiality, guaranteed protection from harm, and requested permission for audio recording of interviews. The recordings were solely used for transcription, maintaining the integrity and confidentiality of the data collected.

Result

Awareness of ADOPT A PHC

Interviewees described the ADOPT-A-PHC initiative as originating from collaborative efforts between health partners, civil society and the private sector. One respondent noted that in her experience it was a donor-funded project. Respondents clarified that adoption is meant to be a broad partnership, not only by private firms but also

by citizens and community groups. As one interviewee explained, “partners come from different fields, they come to adopt the PHC”.

- "In terms of the origin, it's difficult to say where it originated from because there are a lot of ideas and people are doing things at different levels. So, but the specific one that I was part of, worked with... was under a project supported by USAID IHP." - CSO Representative
- "The little I know is that partners come from different fields, they come to adopt the PHC." – State Program Manager
- " When you also mean ADOPT-A-PHC, it does not necessarily mean it needs to be adopted solely by a private sector. Citizens can actually still adopt PHCs. So, when you look at that conversation from the name, it means Adopt PHC. And if you look at that meaning of adopt, it means that take something, to your care, bring something under your care, to be nurtured." - CSO Representative

Imperatives for Direct Philanthropy Financing to Primary Healthcare

Respondents highlighted that persistent underfunding and poor conditions at PHC facilities make external support urgent. One interviewee pointed out the FCT has peculiar legal constraints that hamper primary health care financing. This observation is likely related to the special status of the FCT which differs generally from other states in exercise of financial autonomy. Respondents tie the financial limitations to the deplorable state of many PHCs across the city, reportedly lacking waste disposal management, prone to flooding and lacking in clean water. One state program manager said that working under such conditions “reduces the morale of the health workers.” As a result, patients routinely experience very low-quality care and many families bypass PHCs altogether. However, stakeholders agreed that because PHCs serve basic community needs, regardless of government inadequacies, it is a shared responsibility.

- "The FCT budget system... do not actually favor the healthcare system because... the implementation of the PHC has been faced with so many issues and we've not been able to strike because the area council chairmen have not actually got off the constitutional procedure regarding the area councils and the FCT." – CSO Representative
- "In fact, at the point in time there were so many outcries about people not receiving quality care from these people. And then that has actually made a strong, good number of people to migrate to secondary and tertiary facilities... making the PHC become redundant." – CSO Representative
- "Yes, the government is responsible for all of this. But government cannot do it alone. And it's about individuals lives... And this is a PHC that actually serves as the first level of care we need to ensure that it is well equipped." – CSO Representative
- "If... there is only one toilet, there is no water, there is no power for you to work with... the health workers will not be able to give the best of themselves... it's kind of reduces the morale of the health workers too." – State Program Manager
- "There was a heap of dustbin around that is just a step... We got there, the centre... whenever it rained, then there were the patients admitted. Patients will be standing. They were collecting water in drums." – Philanthropy Representative

Prospects of AAP

Interviewees were generally positive about AAP's prospects and noted that it fits well with Nigeria's strong culture of giving. Several said the initiative is "quite laudable" because it brings together public, private and community actors. One stakeholder pointed out that "Nigerians are actually givers" and that with active citizen engagement, nationwide PHCs revamp is "achievable." Participants cited examples of how rampant Nigerians engage in charitable giving on social media (called "giveaway"), noting that showcasing a PHC's needs online could attract such donations. They saw a potential multiplier effect in which successful adoption stories could ignite a widespread momentum. At the same time, a few cautioned not to overstate AAP's impact. One health advocate noted that without broader funding and policy reforms, the impact of AAP will be very minimal in the grand scheme of Nigeria's health financing gap. Another CSO representative cautioned that AAP could encourage a new kind of government dependency and that implementers should avoid concentration of facility adoption in some facilities at the loss of others.

- "When we have a conversation around adopting PHCs, it's quite laudable because it integrates partnership and collaboration between the public sector and the private sector and the citizens." - CSO Representative
- "Nigerians are actually givers... So for the PHCs to be well equipped... I think it is achievable and is doable with serious citizens engagement... we can have a fully furnished, functional PHC... it is possible." - CSO Representative
- "I think Adopt-A-PHC is good... But I don't want to overestimate the potential contribution... I believe that health systems, especially primary health care, we need more public funding and efficient utilization of resources in that area." - CSO Representative
- "People send money... on Instagram... because somebody has a need... and then you bring in what has been done by somebody, it's going to go a long way." – District Program Manager
- "I feel it's sustainable, because for us in Nigeria, if you do something that is good, another person will want to come and also do it." – District Program Manager

Implementation Approaches and Tools

Stakeholders described a phased implementation led by a civil society coalition. First, a coalition of CSOs (called FCT Accountability Mechanism) organized a comprehensive baseline assessment of 62 focal PHCs, each in every political ward in the FCT. A scorecard was produced and became the primary advocacy tool. One respondent explained that the assessment cut across the six pillars of the health system, and the scorecard highlighted gaps and recommendations. In parallel, the team held stakeholder meetings at city and district levels to explain the project's goals and gather feedback routinely.

Next, the coalition targeted potential adopters. Instead of broad solicitations, they used a "relationship-based" outreach strategy. Key staff identified specific corporate and philanthropic contacts through personal networks, contacted them by phone or email, and presented the evidence from the scorecards. Once philanthropists indicated interests, they selected facilities from the scorecard and conducted site visits, identified areas of intervention and cost it. Adopters signed memorandum of understanding (MoU) with the authorities, witnessed by the CSOs, before commencement of intervention. The pilot adoption by an FCT-based restaurant focused on upgrading the infrastructure, such as building perimeter walls, removing heap of community refuse, installing water taps and lighting bulbs, replacing roof sheets and fixing toilets. Besides health agencies, community

structures and some other government departments related to water, power, works and women affairs were reportedly engaged for support.

- "So, we had our questionnaire, we collected data in all the Ward Local PHC, 62 of them in the FCT. The CSOs led these activities at the various area councils. Of course, we engaged through the CSOs, the community leaders and the local area council health authorities with the data that we got, used it to develop a scorecard that kind of ranked the various area councils in terms of performance using defined indicators in line with the six building blocks of the health system, and also produced a policy brief and some kind of health financing analysis within the FCT... On our part, we used this to push for ADOPT-A-PHC." – CSO Representative
- "So, after that research, we developed a scorecard... So that scorecard was the basis for advocacy for engaging these individuals... I would say that was a major tool that we used to engage these persons." – CSO Representative
- "For the approach, instead of reaching out blindly... we had targeted some specific persons based on relationship... We have people that have access to some philanthropists... So, we leveraged relationship very strongly in approaching this philanthropist." – CSO Representative
- "...the government is aware too that these partners are coming and they know they have to issue a Memorandum of Understanding for those partners." – State Program Manager

Barriers and Obstacles in implementing AAP

Access to facilities was an early challenge, with one case where one facility manager denied civil society representatives the consent to conduct the baseline assessment. Limited timeframes also posed a major constraint, as the project was short-lived and had to deliver within tight schedules. During the intervention phase, incomplete construction projects and security issues, such as theft undermined progress. Sustaining engagement was another difficulty, because as the project wound up, civil society follow-up weakened till it reached a halt. Broader systemic barriers included unstable leadership in FCT health administration, trust deficit in government-led efforts, incomprehensive engagement and weak monitoring system.

- "Somewhere along the line we had access restrictions to one of the PHCs. We didn't get consent, but that was just like an isolated case." – CSO Representative
- "The only issue with that was the fact that of course it was project based. And after the project ended, there was no funding to continue the engagement." – CSO Representative
- "Some just go directly without us knowing and we also have issue of overlapping supports in which... some [facilities] might be left along." – District Program Manager
- "The fence. Yes. Because we still have challenges of the jumping the fence into the compound to commit their atrocities." – Community Representative

Enablers and Levers for Implementing AAP

Several enabling factors supported AAP's implementation. Relationship between non-profit actors and business owners emerged as a key lever, with implementers deliberately identifying individuals and organizations who are passionate about healthcare. Existing community structures such as Ward Development Committees (WDCs) provided local entry points. The use of the scorecard and advocacy briefs strengthened engagement with government and philanthropists by presenting clear data on gaps and needs. Presence of advocacy and

communication division within the city's health board also played a supportive role. Respondents highlighted the cooperation of health workers and community members, whose hospitality and involvement enhanced trust and ownership. While the project focused on activating domestic resources for PHCs, participants referred to the catalytic role that the USAID played in terms of funding.

- "Leveraging relationships, we tried to reach out to individuals that probably had their own establishment, passionate about healthcare." – CSO Representative
- "I remember that with the scorecard we also developed like an advocacy tool, like a brief, which we used to engage stakeholders across board. I remember that because we actually did for AMAC. So we engaged the chairman of AMAC. Beyond engaging the chairman of AMAC we actually conducted periodic meetings where we saw what the gaps were and we identified what steps we needed to take in order to fill those gaps." – CSO Representative
- "People were hospitable, the community people were hospitable... we took the community people along, and so we are like family." – Philanthropy Representative
- "So, the first thing is the cooperation from the community and the facility staff and even AMAC... I think that is one of the things that makes it to be a success." – Health Worker
- "During the implementation collaborations in the past, there has always been the advocacy. We have the advocacy, communication and social division at the board. They have always been involved. So, they layer between both the government, the implementing partners and the community. So, they go all out to sensitize and to ensure that people, all these people have been carried along even for activities." – State Program Manager

Monitoring Practices, Tools and Challenges

Monitoring practices included periodic follow-up visits mostly by the adopters and civil society actors. Having revealed the lack of an integrated and sophisticated monitoring system for philanthropy at any level of PHC administration, health workers reported that they use letters and lists from donors to register the contributions they receive.

- "And they always come with a list of everything they come with." – Health Worker
- "Indicators were not specific... Adopt a PHC was just one of the deliverables of what we did over the six-month period." – CSO Representative
- "Every time they will bring letter. You know, letter is just as a register also. But if you go to the form and you will see it, you will see all those people that have come. And they always come with a list of everything they come with." – Health Worker
- "Monitoring part which I said was not really strong as a result of the duration of the project." – CSO Representative

Principles and Motivations

Civil society actors explained that their working principles included alignment with adopters' organizational goals and interests, recognizing that not every cause resonates equally with potential partners. Another principle was the recognition that adoption complements, but cannot replace, government's central role in health system financing and governance. Engagement with communities was seen as essential, as respondents emphasized

the importance of consulting local leaders and facility staff before interventions. There was also indication of flexibility for adopters to choose areas they cared about most.

Respondents described motivations as both organizational and personal. For organizations, adoption aligned with existing social responsibility commitment. Healthcare was seen as relatable, since most people have personal experiences with its challenges, making it easier for adopters to connect with the initiative. Recognition was seen as another motivator, whether in form of public acknowledgment through government mention, branding opportunities, or planned celebratory events. However, the adopter in this pilot claimed to have been driven by empathy, evidenced by their aversion to any public recognition since the adoption.

- "So, number one is they had their own organizational goals and objectives. And so, the first thing was that it aligned with their own goals. Number two is almost everybody can relate with healthcare, so it aligned with their interests. They were able to see what the gaps are, they were able to see what the recommendations and they were able to choose which of the building blocks that aligns with them." – CSO Rep
- "The fact that their names were mentioned to the government and that's like an incentive The recognition of the fact that this person actually did this." – CSO Rep
- "She was really ready to just dig the hole and then put the blood and sweat in building a structure that we call a primary head just because of her heart. Her heart is warm to the less privileged and the very vulnerable group." – Philanthropy Representative

Result and Impact

Participants reported some AAP interventions during the pilot, including repaired sewage systems, fencing, lighting, roofing and enhanced aesthetic. These changes were linked to results such as including better service delivery, increased health seeking behaviour, and greater comfort for health workers. Stakeholders, including health workers and the community, expressed happiness and excitement about the developments.

- "But with the new look, many people now know that this is a hospital and you can get quality services. So, we have more patronage done when it was open. Especially on delivery. You know, like before, when women came, you are. You are in labor and it was raining, rain will be falling on you. But now they know they are safe. There will be nothing like that." – Health worker
- "So, we are more comfortable working now in a cleaner environment." – Health worker
- "But in terms of impact, the people are excited. The community is happy. The patients that come around, the children, the women and all men that come around to get medical attention, are very, very excited that this happened to them." - Philanthropy Representative

Monitoring and Accountability Recommendations

Respondents emphasized that robust monitoring and accountability systems are critical for the expansion of Adopt A PHC. Stakeholders noted risks of corruption if adoption efforts proceed without transparency, as government funds could be diverted while adopters contribute resources. Mechanisms such as equitable adoption procedures, routine checks and active involvement of vocal community stakeholders were proposed to optimize impact and reduce misuse. A CSO representative opined that Adopt A PHC presents a higher moral ground for citizens to hold government more responsible for PHC.

- "I was going to mention corruption, because if we don't have transparency. And so, if a private person or individual or company organization or a group of people decide to adopt a PHC, right? And a corrupt officer somewhere feels okay because this money is going on, that same money has been approved for the same intervention at that PHC, then you find out that money will be diverted and then reported... So, we also need to put mechanism in place to ensure that we limit corruption. So, it's opportunity for us to strengthen accountability and transparency regarding this adopting a PHC." – CSO Representative
- " So, one of the things we need to look into that in as much as we want things to work, we also need to go out there and ensure that in our support we are able to hold that the government is able to deliver all its responsibility." – CSO Representative
- "Identify critical stakeholders, critical community members... who can actually do the monitoring, who can actually ensure that whatever resources is being provided for is being used." – CSO Representative
- "Maybe quarterly you can come back for physical check-ups, come around for some sort of feedback." – District Program Manager

Implementation Process Recommendations

Respondents recommended clearer processes for implementation, with emphasis on capacity building and communication. Facilities and staff were seen as needing support to maintain adopter relationships, document impacts and prepare reports. Communication protocol was debated among district program managers, particularly on who, between the facility and the district health authority, should communicate what information to adopters considering the chain of command and technical capacities. They resolved that whilst a measure of communication must exist between facility managers and adopters, official routine communication should be carried out by a designated desk at the district level.

With respect to the pilot, district managers considered the coordination as weak, and recommended that district health authorities should have been engaged in their role as direct managers of PHC facilities and data. This data, they argued, is critical to identifying the most crucial needs of the facilities. Furthermore, program managers encouraged adopters to be transparent with their level of support at the planning stage to help manage expectations and efficiently allocate resources. Stakeholder engagement was identified as requiring greater community involvement and education in clear, simple language, ensuring buy-in from residents and leaders. Resource mobilization should be spread equitably, avoiding duplication at some facilities while others remain neglected.

- "If we have a toolkit... to help the facility to continue to stay in touch with the adopter's community, so they such that you're able to have teach the facility how to send them emails of reports, how to do impact reports, because those are the things that maintain relationship with funding." – District Program Manager
- "I also want to throw more light that when I mentioned one thing is being moved. So, most of the information you seek you actually get through the headquarters... But if it gets to collecting data that you are going to use for informed decision making, or maybe review of your policies, or that you might need to have an insight on how well the project is faring, then each you get those data through the headquarters, because it goes through series [of data processes] - District Program Manager
- "People may just have good minds... They just go and buy some things that they feel that the PHC will need and just give it to them. And all of that needs to be well coordinated and effectively directed towards meeting actual needs." - District Program Manager

- "One thing that came out so strongly is the fact that community needs to be involved, to be made aware, understand what is supposed to be and understand what need in order for their PHCs to work very well." – CSO Representative

Policy Recommendations

Most recommendations were made by CSO representatives who suggested that government should play a more formalized role in AAP expansion. Institutionalizing a national or state-level framework or protocol to guide adoption processes was also recommended. Federal involvement was considered necessary for scaling, with state and local governments working under a coordinated framework. Platforms that bring together government agencies, civil society, and private actors were generally encouraged to align efforts.

- "The federal government needs to be involved and then from there we can have other states stakeholders carried along in that framework and then we can then scale it to other states. And I'm sure the document should have a very strong evidence component how to generate data. So, we may already have existing data on six building blocks. You know, working closely with the primary care Development agency, if they have current research that was done maybe in just few months, we can use that as evidence to show the gaps for ADOPT-A-PHC." – CSO Representative
- "ADOPT-A-PHC is an idea that is going to work. If we have a framework that guides this at the federal level, Federal Ministry of Health and then the state ministries of health, then it can then be scaled. So, my recommendation would be that we develop that framework." – CSO Representative
- "So that platform should be targeted for advocacy to say, okay, we have a framework on this. The framework may need to be reviewed to meet current realities." – CSO Representative
- "I've not seen FCT having a framework [that] actually guides the procedure of how to adopt a PHC within the FCT. So having a document, having a clear procedure, on how a PHC can be adopted in FCT strategy, clear strategy terms and conditions, things that need to be done." – CSO Representative
- "At that broad stakeholder's engagement meeting, the review can be done and then we have a stronger framework for implementation." -CSO Representative

Adopter Acquisition and Retention Recommendations

Respondents emphasized the need to deliberately target individuals or groups with an interest in community health. Incentives were viewed as crucial: stakeholders recommended tax reliefs, certifications, titles, and public recognition as ways to encourage participation. In terms of messaging, a respondent recommended that highlighting the impacts of small contributions rather than ambitious demands can inspire and retain adopters. Clear communication of the benefits and progress achieved through adoption was seen as essential for retention. Almost all respondents noted that recognition, both formal and informal, can sustain adopter interest, alongside proper maintenance and feedback on their contributions.

- "A good number of private sectors asking is that what is there for them... when we have a clear CSR framework of saying okay, if you do this, these are level of incentive you have. Okay, if you're using the amount of profit for this, you're going to have this tax waiver." – CSO Representative
- "They deserve a title. They give them title. So, we recognize titles as an incentive. Title is very important. Yes, these are the two things. Yes, we need to recognize them and appreciate them." – District Program Manager

Sustainability and Expansion Recommendations

Broad stakeholder engagement meetings were suggested to update existing implementation frameworks. Exit planning was mentioned as a neglected but vital step to transition adoption management from civil society to government structures. District health program managers advocated for the training of health workers and program managers as crucial to sustainability. A CSO representative called for more resilience on the part of implementers, regretting that more would have been achieved if momentum had been sustained. In any case, having exit plan to complement all adoption programs is seen as essential for smooth transition of adoption management.

- "We must not now shift government responsibility to citizens in a way that cities are becoming a little bit overburdened. And because they already been taxed ... we must ensure that government does its part." – CSO Representative
- "If only the momentum was actually kept alive, I think we would have even recorded more success." – CSO Rep
- "In project management, before we talk about the sustainability and all those things, you begin to also plan for exit... when it's [time] to hand over to government." – District Program Manager
- "For sustainability to work, there need to be training." – District Program Manager

Discussion

Adopt-A-PHC is viewed with optimism among the participants as a source of additional funding for healthcare (22) with a potential to advance health equity (23). More so, Nigeria tends to have pressing imperatives such as dilapidating infrastructure, shrinking human resource, scarce commodities and overall poor quality which experts have tied to insufficient funding landscape for healthcare (4, 24). Whilst these needs are not more argument for health philanthropy as they are for general increase in health investment, philanthropy has managed to be a historic part of health financing conversation across the world, including in resource-rich settings such as the United States and China (25, 26). For instance, despite the high volume of government health spending in a country like the US, one study records that private health philanthropy accounts for as high as 7 to 10 per cent of total health spending which go into health promotion, research and direct health services (27). In China, analysis of local health philanthropy shows clear divergence from global health initiatives due to their priority for tackling affordability and commodity availability issues (26).

In Nigeria, virtually all participants agree on the viability of the AAP at community (or micro) level if evidence, strategic messaging, accountability and incentives are in place. This notion is rooted in available evidence from a global think tank on philanthropy. The African Philanthropy Forum ranked Nigeria highest in the concentration of financial donors, being 89% of the population in 2024 with up to 2.83% of their gross income (28). While most donations, even to healthcare are reportedly under-recorded, findings from (OECD) study on philanthropy demonstrate that donations from 12 top domestic philanthropists in Nigeria match at least 10% of foreign assistance in health sector (29). These data points, though require further research, support the assumption that Nigeria has a large generosity base that needs only to be harnessed to augment government efforts in the area of healthcare access.

From the study, participants distinguish AAP as an initiative to systematically tap into domestic philanthropy to address immediate material challenges within the local health service delivery. Evidence of such systematic approach for community-based philanthropy, led by civil society organizations, is scarce in literature. Some closely related and more researched concepts are corporate social responsibility (CSR) (25, 30, 31) and community health partnerships (11, 32). While CSR and corporate philanthropy emphasize the social obligations of businesses to society (31), community health partnerships explore the inherent link between community stakeholders and their shared health system in terms of problems and opportunities. Participants in this study referred to these familiar concepts as levers for the AAP to work, so long as the word “adoption” is understood in principle rather than legally. The implementers envisioned “adoption” as a collective community ownership, rather than an exclusive type, which is a generally encouraged approach for healthcare delivery by the World Health Organization (33) and others (34, 35).

Through the conceptual flow in Fig. 1, AAP is seen to build on existing concepts of CSR and community health partnership. By pluralizing the sources of support between businesses and community members, the concentrated powers of traditional CSR system (36) are ostensibly dispersed. At the same time, the systematic approach of AAP creates platform for an orderly participation of community stakeholders. These features and others culminate in the logic of AAP. Other features are the roles of the various stakeholders – government, civil society, health workers, community members and philanthropists. AAP is intended to be institutionalized within Nigeria’s health financing landscape, hence the important role of government. Expected roles include creating incentives for facility adopters and enforcing quality standards for AAP interventions. One of the mentioned incentives, also used in other climes is tax credits which is supported within Nigeria’s corporate income tax law but not well-known or leveraged (37). In countries where tax opportunities are harnessed, Organization for Economic Co-operation and Development (OECD) recorded non-profit contributions of near 5% of the GDP to development purposes (38).

Generating buy-in through strategic communication to community members and businesses, alongside necessary technical assistance is expected from civil society partners. In addition, civil society partners work with communities and health workers to promote accountability (23) and strengthen resource mobilization and stewardship capacities (39), respectively. Such synergistic efforts have previously been recorded in a previous program in Niger state, Nigeria, where ‘community-oriented resource persons’ or CORPs were mobilized to donate material and technical resources to local health facilities (40). An estimated USD 123,062 was contributed this way in support of malaria, pneumonia and diarrhoea management among under-five children. From Nigeria to Bangladesh (41), mobilizing additional funding for health voluntary contributions by community members and private sector is associated with improved service delivery and community ownership. AAP is designed to increase replicability and predictability of organized local philanthropy for health through its conceptual framework.

Responses from this study support AAP’s conceptual aspirations, although the pilot implementation fell short in areas such as monitoring, transitioning and sustainability. CSO respondents blamed the short period of the project while government representatives blamed inadequate planning on the part of the CSO implementers. The most envisaged risks in expanding adoption are the likelihood of government dependency and corruption. Reconciling adoption plans and existing government infrastructure can mitigate future risks. Notwithstanding, members and health workers of Kabusa community, FCT, are “happy” to now have a renovated health facility with

adequate lighting, sturdy roofing [see Fig. 2], running water, conducive toilet facilities, parameter fencing and flowing drainage.

Conclusion

This retrospective case study successfully documented the implementation of the "Adopt A PHC" initiative, an emerging model for domestic resource mobilization in Nigeria's primary healthcare sector. The research situated AAP within the context of Nigeria's philanthropic culture and the urgent need for alternative financing, providing a critical analysis of its pilot phase. The findings confirm AAP's potential to systematically organize local philanthropy to address tangible PHC deficits, as evidenced by improved infrastructure and increased community satisfaction in the pilot facility. Central to this study is the development of a conceptual framework that synthesizes the operational logic of AAP, clarifying the distinct yet interconnected roles of various stakeholders: government as a regulator and incentivizer; civil society as a facilitator and accountability agent; communities as stewards; and adopters as resource partners. This framework provides a actionable blueprint for replicating and scaling the initiative.

However, the pilot also exposed critical challenges, particularly in monitoring, government dependency risks, and the lack of a sustainability plan for the post-pilot phase. Another key limitation of this research is its qualitative nature and inability to provide quantitative measurements of AAP's fiscal impact or its potential to replace foreign aid. Nevertheless, the documented viability and stakeholder buy-in justify further investigation. Future research should focus on quantifying contributions, assessing long-term impacts, and refining the conceptual framework.

Declarations

Ethics, Consent to Participate, and declarations: Ethical approval was sought and obtained from the Federal Capital Territory's Health and Human Services Secretariat, with approval number: FHREC/2025/01/174/11-06-25. Data was collected and used in accordance with all guidelines by the review board. Consents to participate were obtained from all participants.

Consent to Publish: Not applicable

Clinical Trial Number: Not applicable

Data Availability statement: The authors do not have the permission of the participants to share full transcripts of their interviews publicly. However, expanded quotations or redacted transcripts can be provided based on a need-to-know request.

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Conflict of Interests: None

Author Contribution

CO and OOA conceptualized the research idea and designed the instruments. All authors collected data, OO transcribed while OOA analyzed with supervision from CO. PFB proofread the final manuscript after all authors had revised it.

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Figures

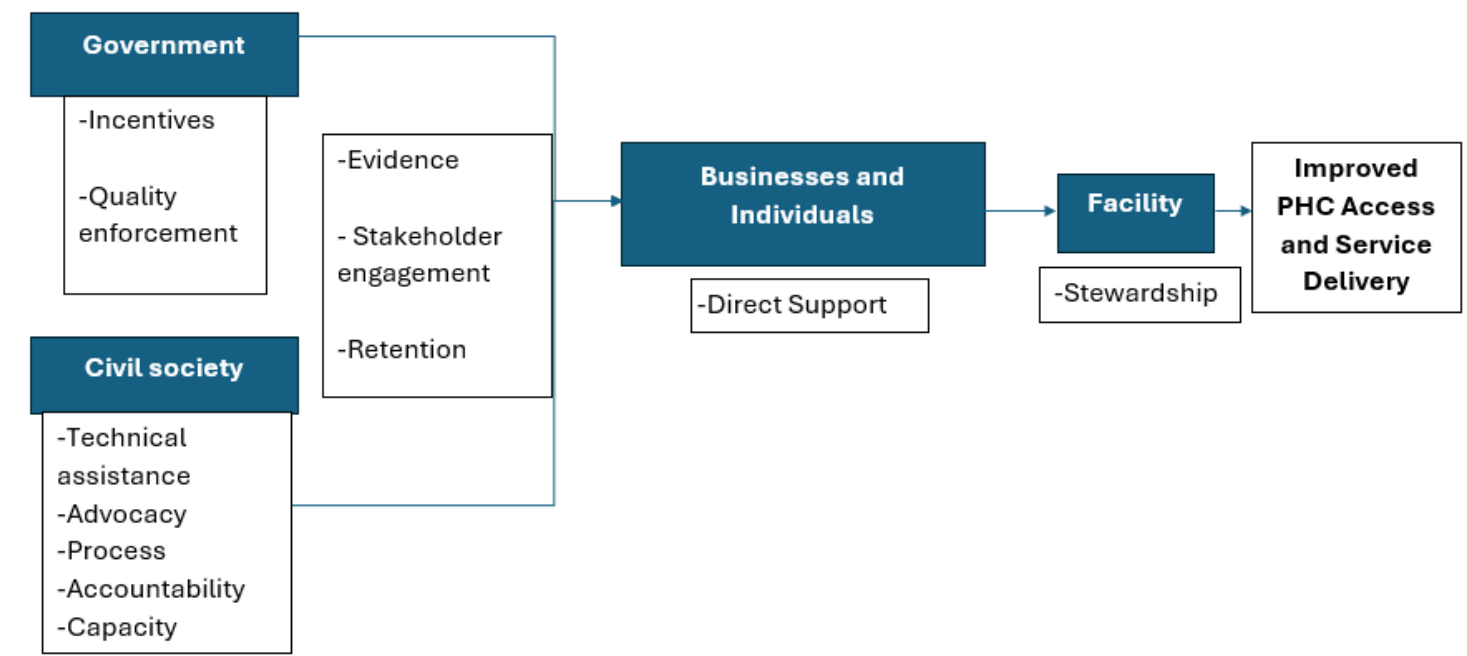


Figure 1
Conceptual Framework for the Micro-level Adopt A PHC



Figure 2

A photo collage of the renovation process [on the left] and the completed roofing [on the right], being one of the areas of intervention by the adopter