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Disclaimer: The author's work and viewpoints may not necessarily reflect those of the West African Institute of Public Health in this policy brief.

EXECUTIVE SUMMARY

The Primary Health Care Under One Roof (PHCUOR) reform in Nigeria aims to enhance the implementation and integration of primary health care (PHC) services. This governance initiative strives to monitor the adherence of states to reform guidelines, emphasizing current realities, challenges, and opportunities. While the principles of PHC have been strong, challenges persist, including disparities between rich and poor, evolving diseases, and limited accessibility.

Introduced in 2010 by the Nigerian Federal Ministry of Health, PHCUOR's policy framework seeks to integrate PHC services under one authority, decentralize responsibility, and establish a unified management and evaluation system. However, the implementation faces significant hurdles. Notably, insufficient human resources for health undermine effective PHC service delivery. Recent assessments reveal low levels of PHCUOR implantation, with only Abia state achieving full implementation in 2022.

To address these issues, recommendations include conducting a comprehensive baseline survey, improving accessibility through relocating or adding PHC centers, and enhancing training for PHC personnel. Integrating the private sector into the financial framework and constituting balanced governing boards are proposed solutions. By addressing these challenges and implementing the recommendations, Nigeria can move towards more effective primary health care delivery and achieve better health outcomes.

BACKGROUND

The Alma Ata declaration of 1978 established accessible community-driven health care as a standard, leading to "health for all" by 2000[1]. Primary Health Care (PHC) acts as the initial link between individuals and national health systems, particularly evident in West African developing nations. Despite PHC's strengths—embracing inclusivity, health promotion, and inter-sectoral collaboration—persistent health challenges persist, marked by disparities between vulnerable groups. Epidemiological shifts and disease spectrum changes further threaten progress.

To achieve UN Sustainable Development Goal 3 and Universal Health Coverage, Nigeria's Federal Ministry of Health introduced the Primary Health Care Under One Roof (PHCUOR)

[1] Almond Board of California [ABC]. Declaration of Alma-Ata. 1976; Vol. 6 Rusia WHO Available from: http://www.who.int/publications/almaata_declaration_en.pdf?ua.

policy in 2010[2]. Also known as Integrated PHC Governance, it integrates PHC structures at sub-national levels under unified State Primary Health Care Development Agencies. Guided by the "Three Ones" principle and nine pillars, PHCUOR aims to enhance primary health care provision and outcomes.

Key Elements of the Primary Health Care Under One Roof policy include:

- Integration of all PHC services delivered under one authority
- A single management body with adequate capacity to control services and resources, especially human and financial resources
- Decentralized authority, responsibility and accountability
- The three ones principle: *one* management, *one* plan and *one* monitoring and evaluation system
- An integrated and supportive supervisory system
- An effective referral system between and across the different levels of care
- Enabling legislation and regulations.

POLICY FRAMEWORK

The National Council on Health (NCH), recognised as the topmost health policy making body in Nigeria, in its 54th session in May 2011 approved the PHCUOR policy. This policy was introduced in 2010 by the Federal Ministry of Health through the National Primary Health Care Development Agency. The policy sought to ensure the PHC implementation was approached at the sub-national level through one plan, one monitoring and evaluation system, and one management to ensure primary health care is accessible to every Nigerian at all levels.[3]

ISSUE UNDER CONSIDERATION: BELOW-AVERAGE IMPLEMENTATION OF PHCUOR AT SUB-NATIONAL LEVELS

[2] NPHCDA (2013) . Integrating Primary Health Care Governance in Nigeria. Abuja. Available from: http://www.nphcda.gov.ng/reportsandintegratingprimaryhealthcareunderoneroof.pdf

[3] Eboreime, E., Abimbola, S., Obi, F., Ebirim, O., Olubajo, O., Eyles, J., Nxumalo, N. and Mambulu, F., (2017). Evaluating the sub-national fidelity of national Initiatives in decentralized health systems: Integrated Primary Health Care Governance in Nigeria. BMC Health Services Research, 17(1).

The implementation of the PHCUOR policy, designed to consolidate PHC management and reshape the healthcare system by reducing fragmentation, faces substantial challenges. These challenges, along with potential opportunities, are explored in this brief. While the focus has been on acquiring office spaces and enacting legislation, critical areas like minimum service packages (MSP), human resources for health, systems development, repositioning, and sustainable funding management remain formidable hurdles[4].

At the core of effective PHC service delivery lies human resources for health. Statistics from the PHCUOR implementation scorecards III & IV reveal that a key challenge across most states is the scarcity of available human resources[5]. Recent studies reinforce this, showing shortages of skilled personnel in various PHCs nationwide. Despite deploying PHC to grassroots, accessibility hasn't translated to care utilization due to factors like perceived service quality inadequacy. This stems from the incapacity of available healthcare providers to deliver competent care for the population's diverse and persistent health needs. Seeking care often involves curative measures beyond preventive care, necessitating the expertise of professionals such as doctors, nurses, and pharmacists, rather than relying solely on community health extension workers (CHEWs) often found in PHCs.[6]

The issues are aptly captured below:

A. Inadequate and Unequal distribution of Human Resources: Few or no partner wants to engage in the provision of human resources, as it is supposed to be part of government contribution in the counterpart funding agreement. However, it is quite challenging to regularly onboard human resources because of its capital-intensive nature, limited cash backing

B. Weak governance system stands out as a major constraint that has continued to undermine the delivery of primary health care.

C. There have been systemic weaknesses due to gaps ranging from infrastructural decay, funding, essential drugs and other supplies.

[4] Eboreime, E., Abimbola, S., Obi, F., Ebirim, O., Olubajo, O., Eyles, J., Nxumalo, N. and Mambulu, F., (2017). Evaluating the sub-national fidelity of national Initiatives in decentralized health systems: Integrated Primary Health Care Governance in Nigeria. BMC Health Services Research, 17(1).

[5] National Primary Health Care Development Agency, (2018). Primary Health Care Under One Roof Implementation Scorecard IV Report

[6] Abah, V. (2022) Poor Health Care Access in Nigeria: A Function of Fundamental Misconceptions and Misconstruction of the Health System, Healthcare Access - New Threats, New Approaches. DOI: 10.5772/intechopen.108530

Fig 1. below is a diagrammatic representation of performance by geo-political disaggregation, according to the NPHCDA-PHCUOR scorecard 3[7]

NATIONAL PHCUOR IMPLEMENTATION SCORECARD III

PERFORMANCE BY DOMAINS

	State	GOVERNANCE & OWNERSHIP (%)	LEGISLATION (%)	MINIMUM SERVICE PACKAGE (%)	REPOSITIONING (%)	SYSTEMS DEVELOPMENT (%)	OPERATIONAL GUIDELINES (%)	HUMAN RESOURCES (%)	FUNDING SOURCES & STRUCTURE (%)	OFFICE SETUP (%)	AVERAGE PERFORMANCE (%)	ZONAL AVERAGE (%)
NORTH WEST ZONE	Jigawa	88	100	78	78	67	60	38	90	100	80	55
	Kaduna	75	50	11	44	83	60	13	40	67	46	
	Kano	63	100	11	78	58	40	25	30	83	57	
	Katsina	75	60	78	33	83	60	25	60	100	59	
	Kebbi	75	70	11	44	75	20	13	60	100	51	
	Sokoto	88	60	11	13	42	60	0	30	83	45	
	Zamfara	63	100	11	22	17	40	13	30	83	49	
NORTH EAST ZONE	Adamawa	75	70	11	67	33	60	38	70	100	59	52
	Bauchi	75	100	0	44	33	40	63	80	50	67	
	Borno	75	70	0	33	33	40	0	10	33	38	
	Gombe	75	60	0	78	92	60	50	60	100	59	
	Taraba	50	60	0	11	0	0	0	0	50	25	
	Yobe	100	90	0	78	67	60	13	70	100	66	
NORTH CENTRAL ZONE	Benue	50	70	0	0	8	40	0	50	67	29	39
	Kogi	63	60	11	33	14	100	20	0	50	41	
	Nasarawa	38	50	0	44	0	20	13	60	50	35	
	Plateau	25	60	0	11	0	20	0	40	17	28	
	Kwara	50	70	0	22	25	20	0	40	17	36	
	Niger	88	70	11	78	58	80	50	50	67	62	
	FCT	88	30	33	22	50	60	13	50	50	43	
SOUTH WEST ZONE	Lagos	63	70	11	56	75	60	13	50	33	50	38
	Ogun	63	60	11	22	42	60	0	60	100	44	
	Oyo	0	30	0	0	0	0	0	0	0	8	
	Osun	0	30	0	0	0	0	0	0	0	8	
	Ekiti	63	60	0	78	83	20	63	60	50	55	
	Ondo	88	80	11	89	83	40	38	70	83	66	
SOUTH SOUTH ZONE	Edo	0	50	0	0	0	0	0	0	0	13	24
	Delta	75	60	11	0	42	20	13	40	50	40	
	Rivers	100	90	11	56	100	100	50	60	100	73	
	Bayelsa	0	20	0	0	0	0	0	0	0	5	
	Akwa Ibom	0	0	0	0	0	0	0	0	0	0	
	Cross River	0	60	0	0	0	0	0	0	0	15	
SOUTH EAST ZONE	Abia	75	60	0	44	33	60	0	40	67	43	19
	Anambra	75	70	0	11	17	0	0	10	67	35	
	Imo	0	30	0	0	0	0	0	0	0	8	
	Enugu	13	30	0	0	0	0	0	0	0	10	
	Ebonyi	0	0	0	0	0	0	0	0	0	0	

LEGEND
81-100%
51-80%
0-50%

The most recent scorecard assessment is the PHCUOR Scorecard 6 which was conducted in August/September 2022.

The objectives were to:

(a) assess the current establishment status of PHCUOR institutional framework in the 36 States and FCT

[7] National Primary Health Care Development Agency (2018). Primary Health Care Under One Roof Implementation Scorecard IV Report.

(b) compare individual state progress in establishing the framework across Scorecards 4, 5 and 6

(c) systematically identify weak areas within the PHCUOR framework for individual states and recommend necessary support to improve states performances

(d) generate evidence for use in advocacy to government and non-government stakeholders on primary health care reform in Nigeria[8]

In the PHCUOR Scorecard 6's findings, according to the Director-General, Dr. Faisal Shuaib, only Abia state achieved a 100% implantation of the PHCUOR in 2022. This further reiterates the sub-optimal implantation of the PHCUOR at states and local levels in Nigeria.

RECOMMENDATIONS

a. In the initial phase, a comprehensive baseline survey employing rapid appraisal techniques should be scheduled to gather information on health status, sociodemographic factors, civic amenities, existing health facilities, and community attitudes toward PHC services. Targeted programs should be developed to address unmet community needs. Addressing poor accessibility of certain PHC centers is vital, achieved by relocating or adding village-level centers for convenient access. Proper training and re-training of PHC personnel are crucial to align people with PHC principles, including the involvement of traditional birth attendants as vital "first aid" resources before accessing formal healthcare.

b. Exploring avenues to integrate the private sector into financial plans for PHCUOR reform is paramount. Acknowledging the private sector's importance in PHC delivery in Nigeria is essential. Integrating private stakeholders, such as pharmacies and proprietary medicine vendors, through financing can enhance accessibility, especially for those with financial constraints. Leveraging basket funding mechanisms should be prioritized to ensure sustainable funding for PHC facilities.

c. Establishing a governing board with equitable representation of stakeholders is recommended. PHC functions should be separated from government agencies and consolidated under the State Primary Health Care Development Agency (SPHCDA) for enhanced coordination and streamlined governance.

[8] https://www.mediaroomhub.com/healthcare-results-are-in-abia-topped-the-chart-under-ikpeazu-winning-a-gold-badge/ 2022