Review Article

Primary Health Care Under One Roof (PHCUOR) in Nigeria in Retrospect: Successes and Challenges and the Possible Way Forward

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ABSTRACT

Primary Health Care (PHC) was the grass-root management approach to achieving the goal of "Health for all by the year 2000." It is the first level care model of the National Health System where it is strategically positioned to be the first point of contact for the health challenges of individuals and families in the communities. Over the years, Nigeria has made several attempts to implementing PHC, however the fragmentation the health system is experiencing in the provision of health services and management of resources has caused a major setback. In an attempt to resolve these challenges facing the Nigerian health care system, the policy of bringing primary health care under one roof (PHCUOR) was adopted. This paper reviews the successes and challenges of the PHCUOR reform agenda, with a view to proffer a way forward for successful implementation.

Keywords: Health For All, Nigerian Health System, PHCUOR, Primary Health Care,

INTRODUCTION

The goal "Health for all by the year 2000" was declared following the meeting of Alma Ata (presently Almaty) in Kazakhstan on Primary Health Care (PHC) in 1978. PHC was subsequently accepted and adopted as a grass-root management approach to achieving this goal.[1] It is meant to provide quality health care services (including preventive, curative and rehabilitative services) for all people in a community, without any discrimination. The primary health care system is a channel through which individuals and families in the community are connected to the first level care of the national health system where many uncomplicated health challenges are to be solved.[2]

Several attempts have been made in Nigeria at implementing the Alma Ata declaration from 1978 till date and this has had PHC to go through various phases of fragmentation at different levels of our health system. One of the attempts is the creation of Basic Health Services Scheme (BHSS) as part of the Third National Development Plan (1975–1980), aimed at addressing poor utilization of health services. This plan marked a period of health system development with PHC as a cornerstone.[3] The BHSS established "basic health units," with comprehensive health center in each LGA, backed up by four PHC centres and 20 health clinics with attached mobile clinics to serve 150,000 citizens.[3] However, the system failed because local communities were not involved, and the initiative became unsustainable for the government at the end

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of the third National Development Plan Period, as also, there was poor budgetary allocation.[4]

Another attempt was established between 1986 and 1992 by late Professor Olikoye Ransome-Kuti, the then Minister of Health. He made use of a model that was piloted in 52 LGAs with implementation of all eight minimum core components of PHC.[4] The notable achievements of this dispensation were the attainment of 80% immunization coverage for fully immunized under-5 children, use of oral rehydration therapy by nursing mother, and exclusive breastfeeding among others. These were accrued to the principle of active community participation put to practice during this era.[4,5]

The creation of the National Primary Health Care Development Agency (NPHCDA) in 1992 marked the beginning of another attempt to ensure continuity and sustainability of PHC agenda. This attempt makes use of the ward health system and utilizes the electoral ward as the basic operational unit for PHC delivery.[4,5] During this period, Ward Minimum Health Care Package (WMHCP) which outlines a set of cost-effective health interventions was developed according to the nation's burden of disease, and priority diseases of national importance. However, the NPHCDA achievements only became prominent following the return of democratic governance in 1999, thereby restoring the lost gains of this "glorious" era in Nigeria's PHC story, when the agency was able to establish itself as the pillar of primary health care in Nigeria.

Among the notable achievements during the democratic dispensation were: reactivation of routine immunization, revision of the national health policy (2004), with PHC strengthening as a key strategy; development of the blueprint for the revitalization of PHC in Nigeria (2004–2008); and PHC infrastructural development through the construction of new PHC facilities and refurbishing of existing ones.[6] However, while the issue of service utilization and community response and participation were resolved to some extent, the issue of fragmentation with respect to the provision of health services and management of staff, funds, and other resources remained a major problem in the management of PHC. This gives birth to another reform called Primary Health Care Under One Roof (PHCUOR)[7] which is also known as Integrated PHC Governance because it entails integrating all PHC services and management under one authority. This program was initiated in 2005 with the support of the UK Department for International Development (DFID) project funding and the Partnership for Transforming Health System (PATHS 2005-2008) and adopted in Nigeria in 2011.

IMPLEMENTATION OF PHCUOR IN NIGERIA

In an attempt to proffer solution to some of the challenges facing health care system, such as fragmented and multiple structures of health system, weak/low capacity of Local Governments responsible for PHC, infrastructural decay, inadequacy in human resources, lack of essential equipment and essential medicines and other supplies, the National Council on Health in May 2011 during its 54th health meeting approved the policy of bringing primary health care under one roof (PHCUOR).[7] The policy was backed by the National Health Act of 2014 which creates a Basic Health Care Provision Fund (BHCPF), a sustainable healthcare financing, as a means of making health accessible to every citizen in the nation.

The initiative is a reform agenda to improve primary health care implementation at sub-national level integrating all PHC services under one authority, thereby reducing fragmentation in the management and delivery of PHC services in Nigeria. The policy is guided by a set of principles and nine pillars. These principles include integration of all PHC services delivered under one authority, a single management body with adequate capacity to control services and resources and decentralized authority.[8] Other principles include the principle of "three ones" which means: one management, one plan, and one Monitoring & Evaluation (M&E) system, an integrated supportive supervisory system managed from a single source, an effective referral system across the different levels of care and enabling legislation and regulations.[8] The nine pillars are governance and ownership, legislation, minimum service package (MSP), repositioning, PHC systems development, operational guidelines, human

resources, sustainable funding, and infrastructure establishment.

Under this policy, every state in the federation is to establish an administratively autonomous and self-accounting PHC Board (SPHCB) to coordinate PHC implementation at all levels in each state. Each state decides the method and extent of operations of the board taking into account local circumstances.[7] Likewise, LGA PHC departments are to transform into Local Government Health Authorities (LGHAs) to manage PHC at the sub-state levels. At present, all 36 states and the FCTs have established their State PHC Boards which are at different level of functionality. However, not all the states in the federation have implemented the PHCUOR as directed by the federal government.[9]

The performance assessment on the implementation of PHCUOR in 36 States and FCT, based on nine pillars using score cards showed that if implemented well, PHCUOR still remain the best way to providing quality health at grassroots. This study, therefore, describes the successes and challenges of PHCUOR since inception by reviewing of existing publications, with a view to identifying way forward for successful implementation.

THE SUCCESSES OF PHCUOR IN NIGERIA

Improvement has been recorded in the PHC system since adoption of PHCUOR in 2011. This is more pronounced in the states where the implementation of PHCUOR was piloted with other programs funded by partners as it provides an alternative health care financing mechanism that ensures direct funding to health facilities based on performance; strengthening budget preparation and execution; and promoting accountability.[10,11]

The most notable success is in the provision of physical resources for operations of the established agencies and renovation of the existing infrastructures across the 36 states to meet the requirement of the National Health Bill. Another success is the repositioning of human resources and recruitment of man power at different levels. While many states have demonstrated marked achievement in this area, there is still shortage of human resources in some places, but there has been a significant improvement compared to the past.[12] Implementation of PHCUOR has also improved the quality of health services delivered to the poor and vulnerable, at the grassroots, thus moving the nation forward towards the attainment of UHC. There is better monitoring and supervision of services, and it has also promoted equity and increased access to affordable high-quality services.[9]

Decentralization of health services has assisted in shift of power from politicians to stakeholders, such as health managers with clarity of roles and responsibilities in management of key resources. Furthermore, creation of Ward Development Committees (WDCs) strengthened the community relationship with sense of belonging - improving community participation - and foster stronger supervision.[12,13] There is increased confidence and use of services by the community, especially in rural areas where access to secondary and tertiary institution may not be visible. This has led to some level of changes in the nation's maternal and child health indices.[13]

The revitalization of routine immunization with support of partners leads to increase routine immunization coverage as evidenced by household survey data. The transfer of staffs and funds provides an accountability link between the SPHCDB and the NPHCDA, which was previously lacking. The NPHCDA also provides direct technical assistance to the states in an organized manner.[11] PHCUOR has also facilitated partnership with different organizations. One of these is the performance-based financing loan provided to three pilot states by World Bank in 2013 in form of International Development Association credit loan to implement the Nigerian Social Health Investment Project (NSHIP).[10] This program helped to improve quality of health care delivery in participating state and increase the delivery and use of high-impact maternal and child intervention, while strengthening the PHC services.

THE CHALLENGES OF PHCUOR IN NIGERIA

There have been challenges hampering the full implementation of PHCUOR policy in different

states, especially in the following pillars - policy governance, weak legislation, minimum service package, Repositioning, Human resources, sustainable funding, despite the recorded successes. These problems are governance, weak legislation, poor funding, inadequate man power and poor stake holder buy-in.[14] Considering the governance system of the established SPHCDB, it has been unsatisfactory in some states. Some are yet to establish the Local Government Health Authority according to the Act, while WDC are not actively involved in the planning, implementation and evaluation of primary healthcare services despite being part of the board.[1]

SPHCDB have been developed and backed by law as required, however, the legislative aspect is still deficient in some States, with no regulation for operationalization of SPHCDB. Legislation provides long-term vision while regulation gives details of action required to make the vision a reality.[13] Not only does lack of this prevents the health managers from implementing what is required of them, it also prevents them from taking sole responsibility.

Furthermore, repositioning still remains a major issue. Primary health care workers in other ministries are yet to be transferred to SPHCDB in some states, while incomplete repositioning occurs in terms of transfer of salaries from ministry of LGA to SPHCDB. This creates barrier to effective monitoring and coordination of PHC staffs. Likewise, specific programs, such as Malaria control, TB control are yet to be transferred in many States. The delay in repositioning could be attributed to lack of funding, and unwillingness of politicians to release management to the boards, or the unwillingness of the SPHCDB to take full responsibility. The recent yearly scorecard assessment done on nine pillars revealed that Legislation, repositioning and MSP scored least.[15]

Without human resources, revitalization of PHC to achieving universal health coverage is difficult. It requires adequate number of competent, highly-skilled and motivated health care workers which are not available in many primary health facilities across the country. This problem continues as partners are unwilling to take sole responsibilities of human resources because of its capital-intensive nature. They always want government to provide human resources. Transferring of health staff from one ministry to the other are problematic, some of the current employers are not willing to release their staff while the PHC is not ready to absorb them. While lack of implementation plan for managing issues relating to staff distribution is the major problem in some state such as Nasarawa, political undertones associated with mal-distribution of staff, presence of ghost workers and imbalance between professional and non-professional health care workers further worsen the human resources challenges.[10,16]

Funding is another area of great concern. In many states, SPHCDBs are not properly funded. Since finance system of SPHCDB still remains the responsibilities of States and partners, it needs to be adequately budgeted for in the State budget. For example, in Niger, there is lack of commitment and fulfillment of 15% counterpart support from ministry of LGA and chieftaincy despite a dedicated budget line and tracking mechanism for released fund for PHC activities according to 2015 scorecard.[16] Poor accountability of how allocated funds are utilized by PHC board also contributed to loss of commitment of policy makers and politicians.[13]

PHCUOR IN NIGERIA: THE POSSIBLE WAY FORWARD

Political will and commitment at all levels, especially federal level and state level are the major strengths in achieving PHCUOR. Understanding the budget implications involved in successful running of the policy is essential. All stakeholders should be engaged from planning stage, and the implications, challenges and benefits of PHCUOR made known to them since this gives them sense of ownership. Amendment of State PHCB law to facilitate full movement of PHCs department, programs and staff in the state Ministry of Health (MOH), Ministry of Local Government, and all LGA to the State PHCB should be done in States where it is yet to be fully done.

Training and re-training of PHC workers is another way of improving on PHCUOR implementation. This acquaints them with all the components of the new management concept for PHC service delivery and helps the PHC workers to understand the new roles and job descriptions involved in the new PHCUOR for effective PHC service delivery. The roles and responsibilities of stakeholders (governing body and management team) at all level should be well clarified for effective coordination and provision of PHC service, supervision, monitoring, management, maintenance of facilities, and human resource function. These include recruitment, discipline, deployment, and training.

Establishment of Human resources committee who are technically sound and politically inclined to address all the issues, related to human resources should be the first step in solving human resources problem. Auditing of existing man power to know the available manpower to serve as a basis for subsequent work such as recruitment of new staff and restructuring of staff within the system could go a long way in solving some of these issues. Educating and encouraging those workers who are not interested in moving to new agency is paramount. This could be achieved through frequent communication and advocacy. Recruitment exercise at state and local level should be free from political influence; as this ensures employment of competent personnel and uphold the credibility of structures.

Sustainability of PHCUOR funding could be achieved through development and implementation of viable and achievable annual operational plans by PHC state board, backed by the BHCPF. Moreover, there is need to implement an effective monitoring and evaluation process with necessary indicators showing outputs, outcomes and impact as well develop an independent audit process to ensure the quality of PHC is being maintained and set goals are being achieved. This will improve the engagement and commitment of political leaders and policy maker while improving accountability. Training and retraining of health managers, especially to understand the process of procurement for timely ordering of supplies and equipment is necessary, as this will improve availability of resources and supplies and reduce the frequent out of stock syndrome.

In conclusion, it is evident that PHCUOR is the way to ensuring quality and responsive implementation of PHC in Nigeria, which despite the present challenges need to be bought into, fully implemented and continually strengthened, towards achievement of the goal of health for all.

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Conflict of Interest

The authors have no conflict of interest to declare.

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