

1ST ANNUAL PRIMARY HEALTH CARE LECTURE

Organised by the National Primary Health Care Development Agency
(NPHCDA)

**PRIMARY HEALTH CARE: REALITIES, CHALLENGES AND THE WAY
FORWARD**

By

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OUTLINE OF PRESENTATION

- I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)**
- II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE**
- III. IMPORTANCE/BENEFITS OF PRIMARY HEALTH CARE SYSTEM**
- IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA**
- V. RESULTS OF PHC IMPLEMENTATION IN NIGERIA**
- VI. CHALLENGES OF PHC IMPLEMENTATION IN NIGERIA**
- VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD**
- VIII. CONCLUDING REMARKS**

I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)-1

Emerging Issues

- Criticism of the vertical programmes' approach adopted in dealing with some diseases e.g. malaria
- Questioning of transplantation of hospital-based healthcare system to the developing countries
- Feeling that the Indian rural medicine model might be more relevant to poor countries
- Observation that a strict health sector approach is ineffective
- Growing realisation that other determinants of health (biology, environment & lifestyle) apart from health services might be important and also

I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)-2

Emerging Issues Contd.

that overall health of the population was less related to medical services than to the standard of living and nutrition

- The experience of the Church Medical Mission that the training of village health workers (VHWs), equipped with essential drugs and simple methods, was more effective at the grassroot level in developing countries
- Global popularity of the massive expansion of rural medical services in government clinics, especially “**barefoot doctors**” in China
- Widespread inequalities in health and health services all over the world
- Growing realisation of the need for an alternative approach to hospital-based and vertical approach to health service delivery

I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)-3

Key Events in the Alma Ata Story, 1970-1998

- 1970:** Adoption of Res. WHA 23:61 “ **Basic Principles for the Development of Health Services**”
- 1971:** WHO Executive Board chose “ **Methods of Promoting the Development of Basic Health Services**” as the subject for its organisational study (1971- 1973)
- 1972:** UNICEF/WHO Joint Committee on Health Policy (JCHP) chose to evaluate existing basic health services
- 1973:** Executive Board completed its organisational study
Dr. Halfdan Mahler took over as Director General of the World Health Organisation
- 1975:** “ **Alternative Approaches to Meeting Basic Health Needs in Developing Countries**” presented to WHO & UNICEF Executive Boards and an international conference agreed to by both organisations;
Dr. Newell, Director of WHO’s Division of Strengthening of Health Services, published his book **Health of the People**

I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)-4

Key Events in the Alma Ata Story, 1970-1998 (Contd)

- 1976:** (i) Executive Board and WHO Ad Hoc Group agreed to holding an International Conference on PHC in the Soviet Union
- (ii) Dr. H. Mahler, DG/WHO, proposed the goal of **HFA 2000** and this became an integral part of PHC
- 1976-1978:** Both WHO& UNICEF organised series of regional meetings to discuss **“alternative approaches”**
- 1977:** WHA specified that **“main target of government and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that would make them live a socially and economically productive life.”**
- 1978:** (i) International Conference on PHC at Alma Ata, 6-12 September, 1978 (**landmark event for PHC**)
- (ii) The goal/objective was further interpreted by the EB to mean an **“ acceptable level of health for all”** which came to be known as HFA/2000

I. BACKGROUND TO PRIMARY HEALTH CARE DEVELOPMENT (GLOBAL)-5

Key Events in the Alma Ata Story, 1970-1998 CONTD

- 1979:** Rockefeller Foundation- sponsored conference in Bellagio to address the numerous criticisms and reactions worldwide to the **comprehensive** PHC strategy as defined at Alma Ata a year earlier – concept of **selective** PHC strategy introduced
- 1988:** Riga Conference to globally review progress on PHC Declaration; PHC re-affirmed as the right approach.
- 2008:**
- (i) Celebration of 30 years of PHC policy
 - (ii) Both **World Health Report of 2008** and the report of the **Commission on the Social Determinants** of Health from the WHO provided contributions to the celebrations; reaffirmation of the relevance of PHC in terms of its vision and values in today's world.
 - (iii) International Conference on Primary Health Care and Health Systems in Africa, 28-30 April, 2008, Ouagadougou, Burkina-Faso

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (PHC)-1

Definition of PHC

- 'PHC is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part both of the country's health system of which it is the central function and the main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work, and constitute the first elements of a continuing health care process' (WHO Declaration of Alma Ata, 1978)

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (2)

Seven Key Features of PHC (As contained in the Definition of PHC)

	Features of PHC	Quotation from the Alma Ata Declaration
1	An element of the national health system	PHC... It forms an integral part of the country's health system. It is the first level of contact of individuals, the family, and the community with the national health system bringing healthcare as close as possible to where the people live and work
2	Focus on priorities	... essential health care
3	Scientific basis	... based on scientifically sound...
4	Culturally sensitive	... socially acceptable methods and technology
5	Equity	... made universally accessible to individuals and families in the country
6	Community participation	... through their full participation
7	Sustainability and self-reliance	... at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination
	Source: B.F.Marafa, Primary Health Care, Accessed at www.civ.edu/publications/studen	

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (3)

Basic Principles of Primary Health Care

1. Community Participation

- It is the hallmark of PHC
- It is a process by which individuals and families assume responsibility for their own health and those of the community
- It should involve identification of needs, development of strategy to meet identified needs, strategy implementation, monitoring and evaluation

2. Inter-sectoral Collaboration

- ‘**Production**’ of health is not something that the health sector alone can do; it involves efforts/inputs from **other sectors** including education, agriculture, livestock, finance, information, etc

3. Integration of health programmes

- Various components of primary health care need to be provided in a coordinated way and made available, to the community, including referrals.

4. Equity

- All primary health care resources and services should be made accessible and affordable **to all**

5. Appropriate Technology

- The technology (**methods of care, service delivery, procedures and equipment**) should be simple and scientifically sound. It should also be within reach of the individual/community

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (4)

Elements of Primary Health Care

- Health education
- Identifying and controlling prevailing health problems
- Food supply and proper nutrition
- Promotion of safe water and basic sanitation
- Maternal and child healthcare, including family planning
- Immunisation
- Prevention and control of endemic diseases
- Appropriate treatment of common diseases and injuries
- Promotion of mental health
- Provision of essential drugs

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (5)

Essential components of effective primary health care

- Well trained, multidisciplinary workforce
- Properly equipped and maintained premises
- Appropriate technology, including essential drugs
- Capacity to offer comprehensive preventive and curative services at community level
- Institutionalised systems of quality assurance
- Sound management and governance structures
- Sustainable funding streams aiming at universal coverage
- Functional information management and technology
- Community participation in the planning and evaluation of services provided
- Collaboration across different sectors – for example, education, agriculture
- Continuity of care
- Equitable distribution of resources

Source: Adapted from Stephen Gillam: Is the Declaration of Alma Ata still relevant to primary health care? BMJ, 8 March 2008, Volume 336 pp536-538

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (6)

Basic Requirements for a sound PHC (the 8A's and 4 C's)

1) Appropriateness

-Services provided are essential to meeting the population's needs

2) Adequacy

-Services provided are proportionate to what is required by the community

3) Affordability

-The cost of the services provided should be within the means and resources of the individual and the country

4) Accessibility

-Services provided must be 'reachable' (geographically, economically and culturally)

5) Acceptability

-Services provided must elicit adequate communication between health care providers and patients and must be trusted by patients

6) Availability

-People must be able to obtain the services they need as at when they need them

7) Assessibility

-People must be able to evaluate the services that are provided

8) Accountability

-It should be possible to review how the resources have been used to provide services

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (7)

Basic Requirements for a sound PHC (the 8A's and 4 C's) Contd

1) Completeness

-Adequate attention should be paid to all aspects of a medical problem – prevention, early detection, diagnosis, treatment, follow-up measures, and necessary rehabilitation

2) Comprehensiveness

-Care is provided for all types of health problems

3) Continuity

-The management of patient's care over time must be coordinated among providers

4) Community full participation

-Beneficiaries of services should be included in the identification of their health needs and how to meet such needs.

Source: Dr. B.A.G Hassan, Primary Health Care, accessed at www.comediubaghdad.edu/uploads/teaching/commed/batod-1pdf

II. ALMA ATA DECLARATION AND PRIMARY HEALTH CARE (8)

Different Perspectives on Primary Health Care

1. As a set of activities

- Outlined in the Alma Ata Declaration as health education; identifying and controlling prevailing health problems; food supply and proper nutrition; provision of safe water and basic sanitation; maternal & child health care, including family planning, immunisation; prevention and control of endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; provision of essential drugs

2. As a level of care

- PHC being that part of the healthcare system which people contact first when they have a health problem

3. As a strategy for organising health services

- PHC defined as accessible care, relevant to the needs of the population, functionally integrated, based on community participation, cost-effectiveness and characterized by collaboration between all sectors of society

4. As a philosophy that should permeate the entire healthcare system (the essence of PHC movement)

- A country can claim to practice PHC only if its entire healthcare system is characterised by social justice and equity, international solidarity, self- responsibility and an acceptance of the broad definition of health.

III. IMPORTANCE/BENEFITS OF EFFECTIVE PRIMARY HEALTH CARE SYSTEM (1)

1. Provision of a solid foundation for the national healthcare delivery system

The 3-tiers/levels of our national healthcare delivery system can be likened to the 3 major parts of a house or a building as follows:

- I. The primary healthcare system is like the **foundation** of the house/building on which the other parts of the house stand,
- II. The secondary healthcare system is like the **walls** of the house that connect the roof with the foundation of the house.
- III. The tertiary healthcare system is like the **roof** of the house.

Note

Just like there is a need for the 3 component parts of a building to be ‘welded’ together for the building to provide an effective shelter, so also there is a need for the 3 tiers of a national healthcare system to be effectively coordinated to provide relevant services to the population.

2. Ability to resolve 80% of the health needs of the people with their involvement and close to where they live and work

III. IMPORTANCE/BENEFITS OF EFFECTIVE PRIMARY HEALTH CARE SYSTEM (2)

Given the pattern of diseases in developing countries, including Nigeria, if the primary healthcare delivery system and the other two healthcare delivery systems are working and functioning well with **effective referral system** among the 3 tiers in place:

- i. The **primary healthcare system** should be able to resolve the health problems of at least 70% of the people (compared to the less than 20% of the population that it currently attends to in Nigeria)
 - ii. The **secondary healthcare system** should be able to resolve the health problems of 90% of the remaining 30% of the population which is about 27% of the population (unlike about 70% of the total population that the secondary healthcare delivery system currently sees).
 - iii. The **tertiary healthcare system should not see more than 3%** of the total population (unlike at least 10% of the population that the tertiary healthcare delivery system currently sees).
3. Effective PHC is central to improving health of all and reducing health inequalities among different groups
 4. Effective PHC system is likely to produce better health for the population at a lower cost
 5. Effective PHC system places stronger emphasis on health promotion and disease prevention
 6. Effective PHC strengthens the continuity of care and contributes to achieving a more integrated healthcare delivery system

III. IMPORTANCE/BENEFITS OF EFFECTIVE PRIMARY HEALTH CARE SYSTEM (3)

7. Effective PHC helps a country to make better use of highly qualified health professionals and specialized health services
8. Effective PHC plays a central role in the achievement of the Health MDGs, Universal Health Coverage, most of the 13 targets of the third Sustainable Development Goal (SDG) and **'can contribute to many of the 16 other SDGs'** (The Lancet, Vol 386, Nov.28, 2015 pp 119) in spite of the absence of reference to PHC in the SDGs and its target
9. Effective PHC is essential for reducing congestion of secondary and tertiary healthcare facilities
10. Effective PHC enhances early management of the health problems of the population.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (1)

PHC Development in Nigeria: Important Milestones

- 1975:** Establishment of the National Basic Health Services Scheme (BHSS)
- 1978:** Alma Ata Declaration
- 1985:** African Health Ministers' re-affirmation to the Alma Ata Declaration through the adoption of the **Three-Phased Health Development Scenario** (TPHDS)
- 1986:** Adoption of PHC in Nigeria in 52 LGAs as models (funded and managed by FGN)
- 1987:** Adoption of the **Bamako Initiative** by African Health Ministers
- 1988:** Launch of Nigeria's first comprehensive National Health Policy based on Primary Health Care. **(Its formulation was highly influenced by TPHDS)**
- 1986-90:** Establishment of Schools of Health Technology
 - Expansion of PHC to all LGAs
 - Achievement of Universal Child Immunization Target of over 80%
 - Devolution of responsibility for PHC to LGAs
- 1991:** Review of Nigeria's efforts toward the implementation of PHC by a WHO High Level Review Team
- 1992:** Establishment of the National Primary Healthcare Development Agency (NPHCDA) on the recommendation of the WHO High Level Review Team

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (2)

PHC Development in Nigeria: Important Milestones (Contd)

1993: Beginning of the collapse of PHC in Nigeria

1997: Establishment of the National Programme on Immunization (NPI)

2001: Report on **Needs Assessment Survey to Determine the Status of PHC in Nigeria**

2001: Development of the National Reproductive Health Policy and Strategy

Establishment of the Ward Health System & Launch of the Ward Minimum Health Package

Launch of the National Policy on Food & Nutrition

2004: Development of the **National Economic Empowerment & Development Strategy (NEEDS)**

Approval of the Revised National Health Policy

Development and Implementation of the Health Sector Reform Programme (2003-2007)

Launch of the National Plan for Action on Food & Nutrition

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (3)

PHC Development in Nigeria: Important Milestones Contd

2005: Launch of the National Policy on Infants & Young Child Feeding

Launch of the Formal Sector Programme of the National Health Insurance Scheme

2006: Launch of the National Child Health Policy

Launch of the Accelerated Child Survival & Development: Strategic Framework & Plan of Action

Launch of the Roadmap for Accelerating the Achievement of MDGs Related to Maternal & Newborn Health

2007: Approval of the Integrated Maternal Newborn & Child Health (IMNCH) Strategy

Merger of the NPI with NPHCDA

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (4)

PHC Implementation in Nigeria: Important Milestones (Contd)

2009: National Health Conference with the theme **‘Primary Health Care in Nigeria: 30 years after Alma Ata’**

Launch of the **Midwives Service Scheme (MSS)**- Skilled Birth Attendant focused

2010: Launch of the National Strategic Health Development Plan (NSHDP) 2010-2015

Launch of the Nigeria’s State Health Investment Project (NSHIP) – includes Skilled Birth Attendant Component

2011: Launch of the President Jonathan’s Transformation Agenda

2012: Launch of the SURE-P MCH (includes Skilled Birth Attendant component)

Launch of the Save One Million Lives (SOML) Initiative (which is now an umbrella for MSS, and SURE-P MCH)

2014: National Health Bill signed into law (National Health Act)

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (5)

Phases of PHC Implementation in Nigeria

Phase I : Basic Health Services Scheme, 1975 – 1980

- Third Development Plan Period
- Period of the initiation of health system development with PHC as the cornerstone
- Although there was no clear policy framework, there was a **National Health Implementation Plan for Basic Health Services Scheme** (BHSS) with a semi-autonomous Implementation Agency headed by Professor Olukoye Ransome-Kuti
- BHSS was designed to : (i) increase the proportion of the population receiving health services from 25% to at least 40%, and (ii) offer a platform to correct imbalances in the provision of health services between preventive/curative, and urban/rural areas
- BHSS was based on the concept of a **Basic Health Unit** (BHU) per Local Government Area with about 150,000 people. Note: A BHU was to comprise – 1 comprehensive health care center, 4 primary health care centers; 20 primary health clinics; and five mobile clinics

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (6)

Phases of PHC Implementation in Nigeria (Contd)

Phase I : Basic Health Services Scheme 1975 – 1980 (Contd)

- With BHSS, new categories of PHC workers (Community Health Workers/ Assistants/Supervisors) were to be trained in 19 Schools of Health Technology and Community Health Officers to be trained in Teaching Hospitals to man the new health facilities
- BHSS failed for many reasons: poor commitment of FMOH bureaucrats due to their having a different agenda; poor budgetary allocation to the scheme; non-involvement of the community; the concept of BHSS in each LGA was politicized; the principles of PHC were not applied; refusal of the new cadres of health staff to work in rural areas; the Schools of Technology did not equip trainees with the skills to set up PHC systems; enormous quantities of sophisticated equipment purchased contrary to the principles of self reliance and appropriate technology; lack of policy framework, etc.
- **‘Most of the buildings were not complemented. Medical equipment was delivered but remained unused for many years (if ever). Individuals and companies were paid for equipment that were never delivered and for work that was never done. No primary health care service was being delivered in any part of the country’ (Ransome-Kuti, 1998).**

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA(7)

Phases of PHC Implementation in Nigeria (Contd)

Phase II : BHSS Evolving to PHC, 1980 - 1985

- Fourth Development Plan Period
- The Plan was the first Plan to underscore the need for a shift from curative to preventive healthcare
- Overarching philosophy of the Plan was to ‘ **put in place a comprehensive healthcare system that offers promotional, protective, restorative and rehabilitative services to an increasing proportion of the population**’
- Essentially, the BHSS was to be used to actualize the objectives of the Plan with respect to the health sector during the period but they (the objectives) were never realized by the end of the period.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA(8)

Phases of PHC Implementation in Nigeria (Contd)

Phase III: PHC Development Period (1986-1992)

- Professor Olikoye Ransome-Kuti's tenure as Health Minister
- The first comprehensive National Health Policy (**National Health Policy and Strategy to Achieve Health for All Nigerians**) was developed and launched in 1988; the policy, among other things, defined the health roles and responsibilities of each level of government (**the Policy, however, had no legal backing!**)
- The era witnessed second attempt (after the first failed attempt, the BHSS) at the implementation of PHC based on the Alma Ata Declaration.
- Creation of PHC Directorate in the Federal Ministry of Health and the organization of the country into four(4) zones
- In 1986, 52 LGS were selected to be developed as models for primary health care services with each selected LG paired with a College of Medicine/School of Health Technology to provide LG with technical assistance and act as practice areas for students to acquire necessary skills to provide health services at the community level
- Village Health Services and Village Health Committees were set up in 52 LGAs and ; Village Health Workers were selected and trained.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA(9)

Phases of PHC Implementation in Nigeria(Contd)

Phase III : PHC Development Period 1986 – 1992 Contd.

- ❖ The implementation of PHC in selected LGAs involved a planning process with the following components:
 - baseline surveys, situation analysis and programmes formulation;
 - provision of N500,000 seed money and facilitators by the Federal Government;
 - setting up of village health system followed by the training of volunteer health workers,
 - establishment of essential drug scheme and drug revolving fund in line with the Bamako Initiative and;
 - pursuance and strengthening of monitoring and evaluation
- ❖ PHC services provision, funding and management was devolved onto the Local Government from 1990- 1992
- ❖ PHC system strengthened by Bamako Initiative activities in 1988 when PHC facilities had seed stock of drugs to operate Drug Revolving Funds (DRFs) jointly administered with their Community Development Committees.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (10)

Phases of PHC Implementation in Nigeria(Contd)

Phase III: PHC Development Period 1986-1992 Contd

- Nigeria made tremendous progress in the implementation of the LGA-focused PHC, with extensive expansion in PHC infrastructure, establishment of Community Health Workers training institutions (Schools of Health Technology), and production of large number of community health workers.
- PHC implementation in Nigeria was reviewed by a WHO High Level Analytical Team and Nigeria's efforts was highly commended in 1991
- National Primary Health Care development Agency (NPHCDA) was established in 1992 as recommended by the WHO High Level Analytical Team as a way of institutionalizing PHC implementation in Nigeria.
- A key achievement during the period was the **attainment of 80% immunization coverage for fully immunized U5 children** which was largely attributable to active community participation
- Other indicators of PHC's success during the period were : DP3 coverage increased from 10% (1984) to 56% (1990), OPV 3 coverage from 10% (1984) to 55%(1990) and measles coverage from less than 10% (1984) to 85% (1990)

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (11)

Phases of PHC Implementation in Nigeria (Contd)

Phase IV: Period of PHC Collapse (1992-1998)

- PHC success was however short-lived largely due to the withdrawal of donors' support to PHC because of the unpopular regime of Abacha with no corresponding increase in political commitment to PHC by the 3-tiers of government during the period 1993-1999. **Note: WHO, DFID, and UNICEF continued to support NPHCDA and the process of PHC devolution**
- Other factors that contributed to the collapse of PHC during the period were:
 - instability in governance;
 - lack of visionary leadership;
 - low staff morale;
 - lack of preparedness on the part of LGAs to shoulder all the responsibility associated with the devolution of PHC

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (12)

Phases of PHC Implementation in Nigeria(Contd)

Phase IV: Period of PHC Collapse (1992-1998) Contd

- Evidence of the collapse of the national health system included:
 - (i) the ranking of the performance of Nigeria's health system in the 187th position out of 191 Member States of the WHO in 2000.
 - (ii) very poor health indicators
 - Only 14% of children fully immunised
 - 41% of children with zero immunisation
 - Neonatal mortality rate, 52/1000 live births
 - Post natal mortality rate, 47/1000 live births
 - Infant mortality rate, 100/1000 live births
 - U 5 mortality rate 187/1000 live births
 - Maternal mortality, 1000/100,000 live births.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (13)

Phases of PHC Implementation in Nigeria(Contd)

Phase IV: Period of Collapse of PHC (1999-2008)

- Petroleum Trust Fund (PTF) and its intervention in supporting the establishment of Drug Revolving Funds in PHC facilities (1995- 1999)
- Establishment of the National Programme on Immunisation (1997) as a parastatal of the Federal Ministry of Health but the purchase of vaccines for the country was done by the pet project of the First Lady, Maryam Abacha, **the Family Support Programme.**
- On NPI and the purchase of vaccines during the period, Professor Oyewale Tomori noted ‘... **Thus, the NPI was established, ostensibly to ensure every Nigerian child got due vaccines at the right time, but it turned out to be a programme where the undue process became due, and where disease eradication or control became a system for ‘incentuous’ avenue for amassing ‘ blood’ money. The beneficiaries, ministry workers, civil servants, political party agents and their types went away with illegally acquired money, while parents of children succumbing to vaccine preventable diseases mourned their losses’ (Tomori, 2013)**

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (14)

Phases of PHC Implementation in Nigeria(Contd)

Phase V: Initial PHC Revival Period (1999-2008)Contd

- Return to civilian government (1999)
- Enactment of NHIS Decree (1999)
- Debt Relief/Debt Relief Grants & National Virtual Poverty Fund and the earmarking of a significant portion of the DRG to health, including PHC
- Nationwide construction of new model PHC centres by FG (plus provision of equipment and seed stock of drugs) and rehabilitation of existing ones
- Revision of National Health Policy (2004) with PHC as strategy
- Development and implementation of NEEDS and Health Sector Reform Programme (2003-2007) with great attention to PHC
- Development of the National Health Bill (2004) which was later approved by FEC and remitted to NASS
- Merger of NPI & NPHCDA (2007)

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (15)

Phases of PHC Implementation in Nigeria Contd

Phase V: Initial PHC Revival Period (1999-2008)Contd

- Development and implementation of many health policies including those related to PHC
- Development of the Blueprint for the Revitalisation of PHC in Nigeria (2004-2008)
- Implementation of the Health Systems Development Projects (funded by the World Bank and the African Development Bank)
- Professor Olikoye Ransome-Kuti brought on-board as the Chairman of NPHCDA in order to re-invigorate the Agency and PHC in Nigeria
- Establishment of the Ward Health System and the development of the Ward Minimum Health Care Package (WMHCP)- 2001
- With the introduction of Ward Health System, the LGA-District/village structure for implementing PHC was replaced by the LGA-Ward-community/village structure to provide a nationally acceptable targeted area of operation with clearly defined boundary, political representation and population
- PHC Infrastructural Development through the construction of new PHC facilities and refurbishing of existing ones (HSDP, Debt Relief Grants/MDGs)

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (16)

Phases of PHC Implementation in Nigeria Contd

Phase VI: Further Revitalisation of PHC Period (2009 to Date)

- Further intensification of efforts to achieve the Health MDGs
 - The development and implementation of the National Strategic Health Development Plan (2010-2015)
 - The enactment of the National Health Act
 - Official declaration by the WHO of the halting of polio virus transmission in Nigeria
 - **Development and implementation of many Strategic interventions to revitalise PHC since 2010 include the following:**
- (1) **MDG/NHIS/MCH Project**
- Initiated in October 2008 to improve the worsening maternal and child health indicators in Nigeria and thereby accelerate progress towards achieving MDGs 4 & 5 by significantly reducing financial barriers to access to care for the vulnerable groups
 - The project provides free primary health services to all registered women and children under 5 years of age, and secondary maternal services through capitation payments (at the primary level) and fee-for-service (at the secondary level) to accredited providers in selected LGAs of the country.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (17)

Phases of PHC Implementation in Nigeria Contd

Phase VI: Further Revitalisation of PHC Period (2009 to Date)Contd

- The project has been implemented in 2 phases – phase I covered 6 states (Sokoto, Niger, Gombe, Oyo, Imo and Bayelsa) and phase 2 covered 6 other states (Katsina, Jigawa, Yobe, Bauchi, Ondo and Cross River). Six (6)LGAs were selected in each of the 12 states except Ondo where 12 LGAs were covered.
- The source of funding for the project is the Debt Relief Grants (DRGs) through MDG Funds and the Federal Government of Nigeria (FGN) Appropriation.
- Expectation was that the implementation of the project would be scaled up to the remaining states and LGAs successfully
- It has been reported that the project has led to increased enrolment and utilisation of health services, elimination of high out-of-pocket expenses and improved motivation of staff in the facilities
- Considering the fact that the MDGs are time-bound, the NHIS-MCH Project has been designed to scale up benefitting-states' counterpart funding as the MDG funding scales down in 2015.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (18)

Phases of PHC Implementation in Nigeria Contd

Phase IV: Further Revitalisation of PHC Period (2009-Date)Contd

(2) National Midwifery Service Scheme (NMSS) – 2009

- A collaborative effort between the 3 tiers of government to facilitate an increase in the use of Skilled Birth Attendants (SBAs)
- Involves hiring newly graduated, unemployed or retired midwives temporarily in rural areas in all 36 states and FCT, with emphasis on underserves areas
- Recruited midwives are posted for one year (with possibility of renewal) to select PHCs with the intent of ensuring 24-hr provision of MCH services and access to SBAs at all births.
- Programme involves NPHCDA signing MOUs with State and Local Governments.

(3) SURE-P MCH

- The Subsidy Re-investment & Empowerment Programme (SURE-P) was created in 2012 following large-scale protests about the fuel subsidy reduction in Nigeria
- Programme meant to re-invest fuel subsidy funds into infrastructure and safety net programmes with MCH being one of them
- The SURE-P MCH programme is designed to increase access to maternal and child health services through a number of supply- and demand-side interventions which includes the following components: health facility staffing and renovations; supply chain for essential maternal health commodities; conditional cash transfers (CCT) for ANC, facility delivery, and post natal care attendance; and community mobilization through village health workers and leadership commitment.

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (18)

Phases of PHC Implementation in Nigeria Contd

Phase IV: Further Revitalisation of PHC Period (2009-Date)Contd

- SURE-P MCH dually managed by a federally- level implementing unit affiliated with NPHCDA and a presidentially approved oversight committee responsible for approving fund allocation and monitoring implementation
- States are engaged through State-level Steering Committees and agreements to contribute to SURE-P health workers' salaries

(4) Saving One Million Lives (SOML)

- President Jonathan committed to SOML initiative in 2012
- SOML initiative is country-driven and country-led but is implemented with several partners including some development partners, philanthropists, and civil society organisations
- SOML is comprised of 8 components: improving maternal new-born and child health; improving routine immunisation coverage achieving polio eradication; elimination of mother-to-child transmission of HIV; scaling up access to essential medicines and commodities, malaria control; improving child nutrition, strengthening logistics and supply chain management; and improving innovation and use of technology to improve health services
- The programme's component targeting improved MNCH is focused on developing an integrated package of interventions at 5000 PHCs to increase SBA utilisation rates to 80% by 2015

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (19)

Phases of PHC Implementation in Nigeria Contd

Phase IV: Further Revitalisation of PHC Period (2009-Date)Contd

(5) PHC Under One Roof (PHCUOR)

- Nigeria devolved PHC services to the LGAs in late 1980s
- NPHCDA was established in 1992 to represent Federal Government's support to PHC with mandate to: provide technical support to PHC development, planning, management and programme implementation; mobilise resources at the national and international levels for PHC; support the M & E of PHC; promote human resources for PHC development; promote PHC systems research; support states and LGs in their immunisation programmes
- PHC implementation in Nigeria has, however, been fragmented with the involvement of a multitude of different organs & bodies (FMOH, NPHCDA, SMOH, SHMB, SPHCDA/B, Local Government Service Commission, Local Government Council, Local Government Health Department/ Local Government PHC Authority, and Development Partners)
- Fragmentation (with respect to provision of services, management of staff, funds, and other resources) has been the most significant problem facing the country's PHC implementation.
- PHCUOR is a new attempt to ensure a unified state level structure that should be responsible for coordinating the management of PHC system and services

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (20)

Phases of PHC Implementation in Nigeria Contd

Phase IV: Further Revitalisation of PHC Period (2009-Date)Contd

6. Basket Funding:

- Basket funds are a mechanism for pooling funds from various sources, typically governments, donors and the private sector to support priorities and ensure adequate resources allocation for agreed upon program areas.
- In Nigeria, selected states established basket funds to address barriers to primary health care financing, resulting from inconsistent prioritisation of health, weak budget implementation, and lack of transparency and accountability in the use and allocation of public resources.
- Early experiences from two states in Nigeria, Zamfara and Kano, indicate that basket funds help ensure the availability of funds to implement primary health care plans, and also enhance accountability while creating transparency in how, when and where funds are disbursed.
- With time and evidence of success, basket funds have the potential to address primary healthcare financing in Nigeria

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (21)

Phases of PHC Implementation in Nigeria

Phase VI: Further Revitalisation of PHC Period (2009-Date)Contd

(7) **National Health Act (NHA)**

- The National Health Bill passed onto National Assembly in 2004 went through many alterations before it became an Act in 2014
- The Act creates a “ **Basic Health Care Provision Fund**” , a big boost to PHC, which is to be financed through a FG grant of not less than 1% of the Consolidated Revenue Fund and any other third party funding sources available. 50% of the Fund will be managed and disbursed by NHIS for the provision of a minimum healthcare package to all Nigerians . NPHCDA will be responsible for disbursing the remaining 50% of the funds through the SPHCDA/Bs, including the FCT to LG and Area Council Health Authorities.
- The NPHCDA-managed funds will be disbursed as follows:
 - (a) 40% shall be used to purchase essential drugs, vaccines and consumables
 - (b) 30% shall be used for the provision and maintenance of facilities, laboratory, equipment and transportation;
 - (c) 20% shall be used for the development of human resources for PHC; and
 - (d) 10% shall be used for Emergency Medical Treatment

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (22)

Phases of PHC Implementation in Nigeria Contd

Phase VI: Further Revitalisation of PHC Period (2009-Date)Contd

- These funds shall be disbursed directly to LGAs unless a specific state government chooses to be over at least 25% of the total cost of delivering the services listed above.
- As an incentive for compliance and accountability, NPHCDA is compelled by law not to give out money to any LGA if it is not satisfied that the money earlier disbursed was applied in accordance with the provision of the ACT.
- **The substantial financial investment in human resources, infrastructure, equipment, transportation, drugs, etc. at PHC level that the implementation of the National Health Act will bring about will be a big boost to PHC implementation. But the success or failure will depend on the institutional readiness of the SPHCDA/B and the timely release of money into the fund**

IV. REALITIES OF PHC IMPLEMENTATION IN NIGERIA (23)

Phases of PHC Implementation in Nigeria Contd

Phase VI: Further Revitalisation of PHC Period (2009-Date)Contd

(8) The Nigeria State Health Investment Project (NSHIP)

- The Project was initiated by the World Bank in collaboration with FMOH, State and Local officials to make more targeted improvements to MCH services to improve their impact
- The Project is designed to achieve meaningful results by both building upon lessons learnt from MSS (and other MCH programs) and incentivizing results where implementation occurs (i.e. at PHC facility level)
- The Project is based on the premise that mechanisms intended to improve quality of healthcare must be introduced at health care facility and have a direct link with pregnant women themselves. Accordingly, the Project has been designed to strengthen accountability and introduce a set of incentives to improve care quality at PHC facilities.
- The Project's primary objective is to increase the delivery and use of high impact MCH interventions and improve quality of care at selected health facilities in Adamawa, Nasarawa and Ondo and selected LGAs in these states.
- NSHIP has two components: **results-based** financing for outputs at health facilities and PHC departments and **technical assistance**

V. RESULTS OF PHC IMPLEMENTATION IN NIGERIA (1)

General Results

- **Poor health outcomes(poor health status indicators) still prevail- see following Table**
- Difficulty in meeting health-MDGs and UHC
- Perpetuation of health inequalities
- Retention of a high proportion of the population in poverty
- Low utilisation of PHC services
- By-passing of PHC facilities to secondary/tertiary health facilities
- Over-burdening of secondary and tertiary health facilities with health conditions that can and , indeed, should be treated at PHC facilities.

V. RESULTS OF PHC IMPLEMENTATION IN NIGERIA (2)

Specific Results				
	Indicator	2003	2008	2013
1	Percentage of currently married women age 15-49 who are currently using contraception (any method)	13	15	15
2	Ante natal care attendance by skilled provider during pregnancy for most recent births	58	58	61
3	Delivery in a health facility	33	35	36
4	Delivery assistance by skilled provider	35	39	38
5	Trends in vaccination coverage			
	- BCG	48	50	51
	- DPT 3	21	35	38
	- Polio 3	29	39	54
	- Measles	36	41	42
	- ALL	13	23	25
	- None	27	29	21
6	Trends in child mortality			
	- Neonatal mortality	48	40	37
	- Infant mortality	100	75	31
	- Post neonatal mortality	52	157	44
	- Child mortality	112	35	69
	- U5 mortality	201	88	128
7	Trends in maternal mortality	About 1000/100,000 (UNICEF/WHO)	545/100,000	576/100,000
8	Trends in nutritional status (% of underweight children)	24	23	29
Source: NHDS (2003, 2008 & 2013				

VI. CHALLENGES OF PHC IMPLEMENTATION INN NIGERIA (1)

Governance and Leadership

- Inadequate political commitment to PHC development
- Lack of clear definition of roles and responsibilities of the various levels of government with respect to health in general, and to PHC, in particular
- LGA, the weakest tier of government and with limited resources and capacity, 'allocated' the function of managing PHC, the most critical component of the national health system
- Corruption/fraud/mismanagement of resources and lack of accountability & transparency
- Fragmentation of PHC
- Lack of coordination of PHC activities of different stakeholders- the Federal Government, the State Governments , the Local Governments, the Development partners, the Non-Governmental Organisations, etc.
- Little attention paid to inter-sectoral collaboration which is supposed to be one of the pillars of PHC

VI. CHALLENGES OF PHC IMPLEMENTATION IN NIGERIA (2)

Service Delivery

- Inequitable access (physical) to services between people in the rural/remote/hard-to-reach areas and the urban areas
- Basic amenities(like water, electricity, accommodation, good access road, etc) lacking in most health facilities, particularly in rural areas
- Lack of logistic facilities (eg transport) to facilitate taking services to remote areas and dealing with emergencies
- Quality of services generally poor due to lack of or inadequate resources (human, financial, material etc), poor attitude of staff, poor facility management, etc
- Low confidence of the population in PHC services and hence low utilisation leading to the by-passing of PHC facilities to secondary and tertiary health facilities
- Non- provision of minimum package of health services that is made universally accessible
- Many facilities do not offer comprehensive PHC services and are not opened 24/7
- Limited or lack of participation/involvement of the community in the PHC movement and, hence, absence of community ownership which affects utilisation

VI. CHALLENGES OF PHC IMPLEMENTATION IN NIGERIA (3)

Health Financing

- Local and state governments' over-dependence on statutory allocation from the Federal Government
- Low priority accorded to health at all levels, especially at LG and SG levels, and hence gross underfunding of PHC
- Available financial resources barely meet recurrent (personnel) expenditure with little or nothing to support the actual provision of services
- No clearly defined policy on the financing of PHC services
- Most patients rely on out-of-pocket payments to access PHC services because of very low coverage with prepayment schemes like the national health insurance scheme and community-based health insurance scheme and/or publicly provided PHC services

VI. CHALLENGES OF PHC IMPLEMENTATION IN NIGERIA (4)

Human Resources for Health

- Nigeria has one of the largest supplies of health workers in Africa but there are disparities in their distribution between the rural and urban areas, between and within geopolitical zones, states and local government areas
- Understaffing of many of the PHC facilities
- Poorly motivated staff- poor work environment (lack of equipment, drugs, other supplies; poor physical infrastructure, etc), poor conditions of service, non regularity of salary payment, lack of social amenities (particularly for those that work in rural areas), little or no provision for continuing education, inadequate supervision and logistic support,
- Poor management of health workers- poor retention of health workers, migration of health workers
- Production of many cadres of health workers not relating to needs- underemployment/unemployment of some categories of health workers
- Lack of/non-enforcement of standards for staffing PHC facilities

VI. CHALLENGES OF PHC IMPLEMENTATION IN NIGERIA (5)

Health Information System (HIS)

- Very weak capacity (human, infrastructure/equipment) for HIS at sub-state level (LGA, facility)
- Late collection/production and reporting of routine data
- HIS activities are grossly underfunded
- Lack of basic data, a great constraint to PHC planning, implementation, monitoring and evaluation
- Absence of health systems research activities within the context of PHC implementation

Medicines, Vaccines, Other Supplies and Technologies

- Lack of basic equipment in most PHC facilities and/or inadequate maintenance of existing equipment
- Poor management of the drug supply system and, hence frequent drug 'stock outs'
- Collapse of the system of drug revolving funds

VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD (1)

Governance and Leadership

- Clear definition of roles and responsibilities of the 3 tiers of government with respect to health in general, and PHC, in particular, through **Constitutional review**
- Effective implementation of the provisions of the **National Health Act**, especially on issues related to PHC
- Development of a **new National Health Policy** (and not a mere revision of the 2004 National Health Policy
- A successful **war against corruption , fraud and abuse of office** at all levels of government
- Establishment of State Primary Health Care Development Boards/Agencies and their effective functioning
- Effective implementation of **Primary Health Care Under One Roof** (PCHUOR)
- Development and implementation of a **Roadmap/Strategic Plan for the Revitalisation of PHC** by NPHCDA/SPHCDA
- Review and finalisation of the **Minimum Standards for Primary Health Care in Nigeria**, followed by its adoption by the National Council of Health (NCH) and its strict implementation by the NPHCDA/SPHCDA
- Effective **inter-sectoral collaboration** for health
- Accordance of greater priority to health, in general and to PHC, in particular, by political leaders at all levels
- Greater empowerment and involvement of communities and civil society organisations in health (PHC)

VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD (2)

Health Services

- Successful implementation of the National Health Act, especially its provisions on the minimum basic health package
- Successful implementation of the Primary Health Care Under One Roof (PHCUOR) concept
- Sustained support for the scaling up and coordination of the existing health initiatives (eg Midwives Service Scheme, SURE-P MCH, Nigeria State Health Investment Project etc.)
- Expansion of PHC health services coverage through infrastructural development
- The piloting and scaling up of **performance-based financing** which has the potential of improving the quality of PHC services as well as access to utilisation of the services
- Adequate staffing, equipping and provision of logistic support to each Ward's primary health centre so that it can provide quality health services 24/7 and also undertake outreach activities to remote areas
- Strict enforcement of/ adherence to the Minimum Standards for PHC in Nigeria once it is finalised and adopted by the National Council on Health
- Development and distribution of Standard Operating Procedures (SOPs) and guidelines for quality delivery of PHC services accompanied by relevant training of relevant health staff on the use of the SOPs

VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD (3)

Health Financing

- Successful implementation of the National Health Act, especially as it relates to the setting up and management of the Basic Health Care Provision Fund
- High and sustained political commitment to PHC implementation by all level of government – increased budgetary allocation
- Scaling up the implementation of the national health insurance scheme (by among other things, reviewing the NHIS Act and making health insurance mandatory) and community-based health insurance schemes
- Exploration of some innovative health financing mechanisms
- Introduction of ‘basket funding’ for PHC at State/LGA level
- Strengthening the financial management (including budget tracking) capacity at LGA/facility levels in order to improve the efficiency of PHC fund utilisation as well as enhancing transparency/accountability in the use of such funds
- Any new revenue allocation formula among the 3 tiers of government should increase the allocation made to the LGAs but at the same time the Constitution should be amended to compel local government's to allocate a well-defined % of their budget on the provision of PHC services
- Undertaking the development of a PHC sub-account of the National Health Account and using that as part of the evidence to develop and implement on a policy on the sustainable financing of PHC in Nigeria

VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD (4)

Human Resources for Health

- Successful implementation of the National Health Act, especially the aspects that deal with human resources for health
- Scaling up the implementation of such initiatives such as MSS and ensuring that NYSC doctors, pharmacists, nurses and midwives, medical laboratory scientists etc. are not only posted to the rural areas but also that they are well monitored
- Successful implementation of the approved Task Shifting Policy
- Finalisation and approval of the National HRH Policy and HRH Strategic Plan and its successful implementation
- Enforcement (after approval) of the **Minimum Standards for PHC in Nigeria** as it relates to health workers

VII. PHC IMPLEMENTATION IN NIGERIA: THE WAY FORWARD (5)

Health Information System

- Successful implementation of the National Health Act as it relates to the health management information system
- Strengthening of institutional and human capacity at the LG and health facility levels to collect, transmit, analyse and use the results of the analysis
- Promotion of the undertaking of health systems research/operational research at the LGA/facility levels and the utilisation of the results of such research to improve the management of PHC services at the local level

Medicines, Vaccines, Other Supplies and Technology

- Successful implementation of the National Health Act as it relates to essential drugs and other supplies
- Greater budgetary allocation to PHC, especially for non-personnel recurrent expenses, so that PHC facilities can be better equipped
- Revitalisation of drug revolving funds scheme at facility level and undertaking of bulk purchasing of drugs and medical supplies at the state level for distribution to the LGAs' PHC facilities
- Strengthening the supply chain management capacity at State/LG/Facility levels
- Enforcement of the **Minimum Standards for PHC in Nigeria** with regards to health infrastructure and service provision (minimum requirement of medical equipment) and essential drugs.

VIII. CONCLUDING REMARKS(1)

- Given the high burden of infectious diseases and the related morbidity and mortality in Nigeria and the fact that about 70% of the population live in rural areas, making PHC the cornerstone of our national health system a step in the right direction
- The first comprehensive National Health Policy (**National Health Policy to Achieve Health for All Nigerians, 1988**), the Revised National Health Policy (2004), the Health Sector Reform Programme (2004-2007), the health component of the National Economic Empowerment & Development I (2003-2007) and the National Strategic Health Development Plan (2010-2015) were all rooted in primary health care
- Primary Health Care Development has gone through many phases in Nigeria since 1975. Except for the period 1985-1992, PHC has, however, not had the desired impact of providing an acceptable foundation to our national health system. Health outcomes have continued to be poor and we have failed to achieve the health-related MDGs and also to achieve on time some other internationally-set health targets like eradication of polio
- PHC will continue to be relevant to our journeys towards achieving Universal Health Coverage as well as to achieving the 3rd Sustainable Development Goal by 2030,

VIII. CONCLUDING REMARKS (2)

- In my presentation, I have tried to identify, some (and certainly not all) the challenges that we have faced in implementing PHC over the last 40 years and I have also highlighted some of the things we need to do (using the WHO building blocks of health system framework) to meaningfully build a PHC system that will provide a solid foundation for our national health system in the coming years
- Among the ‘menu’ of things to do to move the country forward in the implementation of PHC are:
 - fight against corruption, fraud, and abuse of office at all levels of government;
 - clear clarification of the roles and responsibilities of the 3 levels of government with regards to health, in general, and PHC in particular;
 - political commitment of all levels of government to health;
 - implementation of the National Health Act;
 - establishment of State Primary Health Care Board and implementation of the Primary Health Care Under One Roof (PHCUOR) initiative;
 - development and implementation of Roadmap/Strategic Plans for the revitalisation of PHC by NPHCDA and SPHCDA

VIII. CONCLUDING REMARKS (3)

- finalization and approval by the **Minimum Standards for PHC in Nigeria**;
 - finalization of the national policies on health financing (with more attention to PHC) and human resources for health and the development and implementation of the corresponding strategic plans;
 - donors' increased and coordinated support to health, especially to PHC; and
 - greater voice of the people on issues related to health and good governance
- A strong and effective PHC will be crucial to our journeys towards universal health coverage, attainment of the targets of the recently set Sustainable Development Goals, especially the third goal, and consequently make our people healthy so that they can be well-positioned to drive the engine of economic growth.

VIII. CONCLUDING REMARKS (4)

- In conclusion, I will like to make the following charges/appeals (on your behalf?) to:
- ❖ **PMB**
- **Fight the good fight** against corruption, fraud, abuse of office at all levels of government very doggedly – this is high on the list of ‘changes’ that we expect from your government
- Remember the **‘Abuja target’** of at least 15% of government total expenditure allocated to health (2001) and incrementally move towards achieving this target within the next 8 years
- Explore with relevant organs of government some innovative ways of financing health services, especially primary health care

VIII. CONCLUDING REMARKS (5)

❖ National Assembly

- Keep the 'Abuja target' very much in mind while reviewing the annual budget proposals from the executive arm of government
- Play your part in the implementation of the 2014 National Health Act by ensuring that at least 10% of the Consolidated Federal Revenue is allocated annually to fund the Basic Health Care Provision Fund
- Amend the 1999 NHIS Act to, among other things, make health insurance mandatory
- In the further review of the 1999 Constitution, clearly spell out the roles and responsibilities of all the 3 levels of government on health matters

VIII. CONCLUDING REMARKS (6)

❖ State Governments/Governors

- Accord health a high priority in your political agenda and incrementally strive towards achieving the 'Abuja target' over the next 8 years
- **'loosen your hands'** on the Joint State/Local Government Account
- Provide more financial support to the implementation of PHC through the State Primary Health Care Board

❖ Local Government

- Accord health a high priority in your political agenda and incrementally strive towards achieving the 'Abuja target' over the next 4 years

❖ Development Partners

- Provide more medium- to long-term support to health, especially primary health care, through 'basket funding'

VIII. CONCLUDING REMARKS (7)

❖ Federal Ministry of Health

- Develop and implement a policy on inter-sectoral action for health at all levels, especially at LGA level.
- Review and finalize the national policies on health financing and human resources for health and develop/implement the corresponding strategic plans
- Develop a new National Health Policy with appropriate orientations (including PHC)

❖ National Primary Health Care Development Agency

- Finalise and implement the **Minimum Standards in PHC in Nigeria**
- Support the construction of a PHC sub-account of the National Health Account and use that as part of the basis for the development and implementation of a comprehensive policy on PHC financing in Nigeria
- Explore the role of the private sector in the effective implementation of PHC in the years ahead
- Build on your achievements over the last few years in strengthening the PHC system in Nigeria

VIII. CONCLUDING REMARKS (8)

❖ Labour Unions

- Review your stand on your members' contribution to the National Health Insurance Scheme (**it is one of the reasons why health insurance coverage remains abysmally low**)

❖ Civil Society Organisations & the Media

- Lead the health-advocacy vanguard as well as the anti-corruption & abuse-of-office crusade vigorously and sustainably.

**VIII. CONCLUDING REMARKS
CONTD**

Thank you