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COM 401

INTRODUCTION TO PRIMARY HEALTH CARE

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Course code: COM 401

Course title: Introduction to Primary Health Care

Course credit load: 1 Unit

Series 1: Origin and Concepts of Primary Health Care

- **Part 1.1: The Origin of Primary Health Care**
  - Sub Part 1.1.1: The global health context before PHC
  - Sub Part 1.1.2: The Alma-Ata Declaration of 1978
  - Sub Part 1.1.3: Development of PHC in Nigeria
- **Part 1.2: Definition and Core Concepts of PHC**
  - Sub Part 1.2.1: Defining primary health care
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  - Sub Part 1.2.3: PHC as the first level of contact
- **Part 1.3: The Public Health Department and Its Role in PHC**
  - Sub Part 1.3.1: Organisation and functions of the public health department
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Introduction

Primary health care represents one of the most significant shifts in thinking about how health should be organised, delivered, and experienced at the community level. Before its emergence, health systems in many countries, including Nigeria, were largely structured around hospital-based curative services that reached only a small proportion of the population, leaving the vast majority without accessible, affordable, or appropriate care.

This Series traces the origins of primary health care from the global health context that made a new approach necessary, through the landmark Alma-Ata Declaration of 1978 that formally established PHC as an international framework, to its development and adoption in Nigeria. It then examines the core definitions and concepts that underpin PHC, and the role of the public health department within which PHC services are organised and delivered.

A thorough grounding in the origin and conceptual foundations of PHC is essential for understanding the principles, components, and service delivery approaches examined in the Series that follow.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 1.1** describe the global health context that gave rise to primary health care and explain the significance of the Alma-Ata Declaration (Linked to Part 1.1),
- **SLO 1.2** define primary health care and explain its core concepts, including Health for All and the first level of contact (Linked to Part 1.2), and
- **SLO 1.3** describe the organisation and functions of the public health department and explain PHC's position within the health system hierarchy (Linked to Part 1.3).

1.1 The Origin of Primary Health Care

1.1.1 The global health context before PHC

Prior to the emergence of primary health care as a formal framework, health systems in many low- and middle-income countries were characterised by a heavy reliance on **hospital-based, curative, specialist-oriented** services concentrated in urban areas and accessible to only a small, usually more affluent, segment of the population. Rural communities, where the majority of populations in countries such as Nigeria lived, were largely served by inadequate or non-existent health infrastructure, with preventable diseases such as malaria, diarrhoeal diseases, and vaccine-preventable infections causing enormous and avoidable death and disability.

The limitations of this hospital-centred model became increasingly apparent through the 1960s and 1970s, as evidence mounted that improving population health required addressing the **social, economic, and environmental determinants of health** rather than treating illness after it occurred. International bodies, including the World Health Organization, began pressing for a fundamental reorientation of health systems toward prevention, community-based services, and equitable access, setting the stage for the transformative declaration that would follow in 1978.

Fill in the blank: Prior to PHC, health systems relied on hospital-based, curative services concentrated in urban areas, leaving rural communities without accessible care and failing to address the social, economic, and _____ determinants of health.

1.1.2 The Alma-Ata Declaration of 1978

The **Alma-Ata Declaration** was adopted at the International Conference on Primary Health Care, held in Alma-Ata (now Almaty, Kazakhstan) in September 1978, jointly sponsored by the World Health Organization and UNICEF, with representatives from 134 governments in attendance. The Declaration articulated a radical and comprehensive vision for global health, establishing **Health for All by the year 2000** as its overarching goal and identifying primary health care as the key mechanism through which this goal would be achieved.

The Declaration defined PHC as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, at a cost the country and community could afford. It emphasised that health was a fundamental human right and that achieving it required coordinated action addressing not only medical care but also **education, food and nutrition, safe water, sanitation, and economic development**. The Alma-Ata Declaration remains the foundational international document for primary health care to this day.

Fill in the blank: The Alma-Ata Declaration of 1978 established _____ for All by the year 2000 as its overarching goal and identified primary health care as the key mechanism for achieving it.

1.1.3 Development of PHC in Nigeria

Nigeria's formal adoption of primary health care as a national policy followed the Alma-Ata Declaration, though efforts to expand community-based health services had begun earlier through various rural health programmes. A landmark moment came in 1987 with the **Local Government reform and the National Health Policy** which placed primary health care under the authority of local government councils, recognising that PHC delivery required decentralisation to the level closest to communities.

The **National Primary Health Care Development Agency (NPHCDA)** was subsequently established in 1992 as the apex body responsible for developing, coordinating, and monitoring PHC services throughout the country. Despite significant progress in establishing PHC infrastructure across Nigeria, persistent challenges including inadequate funding, shortages of trained health workers, poor facility maintenance, and inequitable distribution of services have continued to limit the full realisation of the PHC promise for the majority of Nigerians.

Fill in the blank: The National Primary Health Care Development Agency (NPHCDA) was established in 1992 as the apex body responsible for developing, coordinating, and _____ PHC services throughout Nigeria.

Figure 1.1: Key milestones in the international and Nigerian development of primary health care

Pilot questions 1.1

1. Describe the limitations of health systems before primary health care was formally adopted. (Linked to SLO 1.1)
2. State where and when the Alma-Ata Declaration was adopted and by how many governments. (Linked to SLO 1.1)
3. Explain the main vision articulated by the Alma-Ata Declaration. (Linked to SLO 1.1)
4. Describe two key events in the development of PHC in Nigeria after the Alma-Ata Declaration. (Linked to SLO 1.1)
5. Explain why PHC delivery was placed under local government authority in Nigeria. (Linked to SLO 1.1)

1.2 Definition and Core Concepts of PHC

1.2.1 Defining primary health care

The **Alma-Ata Declaration** defines primary health care as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, 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.

Several elements of this definition deserve emphasis. **Universally accessible** means PHC must reach all people, not only those who can afford to pay or who live near a health facility. **Socially acceptable methods and technology** means PHC must be delivered in ways that communities can understand, accept, and engage with. **Self-reliance and self-determination** underscores that communities are not passive recipients of externally delivered services but active agents in identifying, planning, and sustaining their own health care.

Fill in the blank: The Alma-Ata definition of PHC emphasises universal accessibility, socially acceptable methods, and self-reliance, placing communities as active agents rather than _____ recipients of externally delivered services.

1.2.2 Health for All and equity in health

The rallying concept of **Health for All** was not intended to mean the elimination of all disease or that all people would be equally healthy by the year 2000, but rather that health resources and essential health services would be **equitably distributed** so that every person, regardless of where they live or their economic status, would have access to a minimum standard of essential health care.

Equity in health is therefore a central organising principle of PHC, requiring that health systems actively reduce disparities in access and outcomes between populations, particularly between urban and rural populations, and between wealthier and poorer groups. Achieving equity requires not only building health facilities but also addressing the broader **social determinants** of health,

including education, income, water, sanitation, and nutrition, whose unequal distribution directly drives unequal health outcomes.

Fill in the blank: Health for All aimed at equitable distribution of essential health services, with equity in health requiring reduction of disparities and addressing broader social _____ of health.

1.2.3 PHC as the first level of contact

Primary health care is explicitly conceived as the **first level of contact** between individuals, families, and communities and the national health system, bringing health care as close as possible to where people live and work. This first-contact function is fundamental to the PHC model because it ensures that the most common and significant health needs of a community are addressed at the community level rather than requiring individuals to travel to distant, expensive, or overburdened hospital facilities.

As the first level of contact, PHC also plays a crucial **gatekeeping and referral function**, identifying cases that require a higher level of care and directing patients appropriately to secondary or tertiary facilities when needed, while retaining at the community level the large majority of health interactions that can be safely and effectively managed without specialist or hospital-based care. This rational organisation of health care by level is central to efficient and equitable health system functioning.

Fill in the blank: PHC is the first level of _____ between individuals and the health system, bringing care close to where people live and playing a gatekeeping and referral function for cases requiring higher-level care.

Concept	Meaning
Universal Accessibility	All people reached regardless of location or economic status
Health for All	Equitable distribution of essential services
Socially Acceptable Methods	Delivered in ways communities understand and accept
Self-Reliance	Communities as active agents in health care
First Level of Contact	Health care closest to where people live

Equity in Health	Active reduction of disparities in access and outcomes

Table 1.1: Key concepts of primary health care as defined by the Alma-Ata Declaration

Pilot questions 1.2

1. State the Alma-Ata definition of primary health care. (Linked to SLO 1.2)
2. Explain what is meant by universal accessibility in the context of PHC. (Linked to SLO 1.2)
3. Explain what Health for All actually means and does not mean. (Linked to SLO 1.2)
4. Explain the first-level-of-contact concept and its importance for the health system. (Linked to SLO 1.2)
5. Explain the gatekeeping and referral function of PHC. (Linked to SLO 1.2)

1.3 The Public Health Department and Its Role in PHC

1.3.1 Organisation and functions of the public health department

The **public health department** is the government administrative unit responsible for planning, organising, implementing, and overseeing public health services, including primary health care, within a defined geographical jurisdiction. In Nigeria, public health departments exist at the federal level, state level, and local government area level, each with responsibilities appropriate to its administrative tier.

Core functions of the public health department include **disease surveillance and control**, monitoring the occurrence and spread of communicable diseases and coordinating responses; **environmental health services**, overseeing sanitation, water quality, and food safety; **maternal and child health services**; immunisation programmes; and **health education and promotion**. The public health department also coordinates with other sectors, such as education, agriculture, and water supply, whose activities directly affect health outcomes.

Fill in the blank: Core functions of the public health department include disease surveillance, environmental health services, maternal and child health, immunisation, and health education and _____.

1.3.2 PHC within the health system hierarchy

Health systems are typically organised into **three tiers**: primary, secondary, and tertiary. **Primary care**, delivered through PHC facilities such as health posts, health centres, and primary health centres, provides essential preventive and curative services for the most common health problems, serving the community level. **Secondary care**, provided at general hospitals, offers more specialised services for cases referred from the primary level.

Tertiary care, provided at teaching hospitals and specialist centres, handles the most complex clinical conditions requiring highly specialised expertise and equipment. The public health department operates primarily at the primary care level, while maintaining referral linkages with secondary and tertiary institutions. A well-functioning health system depends on **effective integration** across all three tiers, with each level performing its appropriate role and supporting smooth patient movement when higher or lower levels of care are required.

Fill in the blank: Health systems are organised into three tiers: primary care (health centres), secondary care (general hospitals), and _____ care (teaching hospitals and specialist centres).

1.3.3 Linkages between PHC and higher levels of care

Effective **referral systems** are essential for ensuring that patients who present at PHC facilities with conditions beyond the capacity of that level of care are safely and promptly transferred to appropriate secondary or tertiary facilities. A functional referral system requires **clear referral protocols** specifying which conditions should be referred and under what circumstances, adequate **communication between facilities** to ensure the receiving facility is informed and prepared, and **reliable transport arrangements** to move patients safely.

Equally important is the **back-referral or counter-referral system** whereby patients treated at secondary or tertiary facilities are returned to their primary facility for follow-up care once the

acute phase of their condition has been managed. Strengthening these bidirectional linkages between PHC and higher levels of care is a persistent priority in Nigeria's health system, where breakdowns in referral communication and transport remain common causes of preventable adverse outcomes for referred patients.

Fill in the blank: Effective referral systems require clear protocols, adequate communication between facilities, and reliable transport; the _____ system returns patients to their primary facility for follow-up after treatment at higher levels.

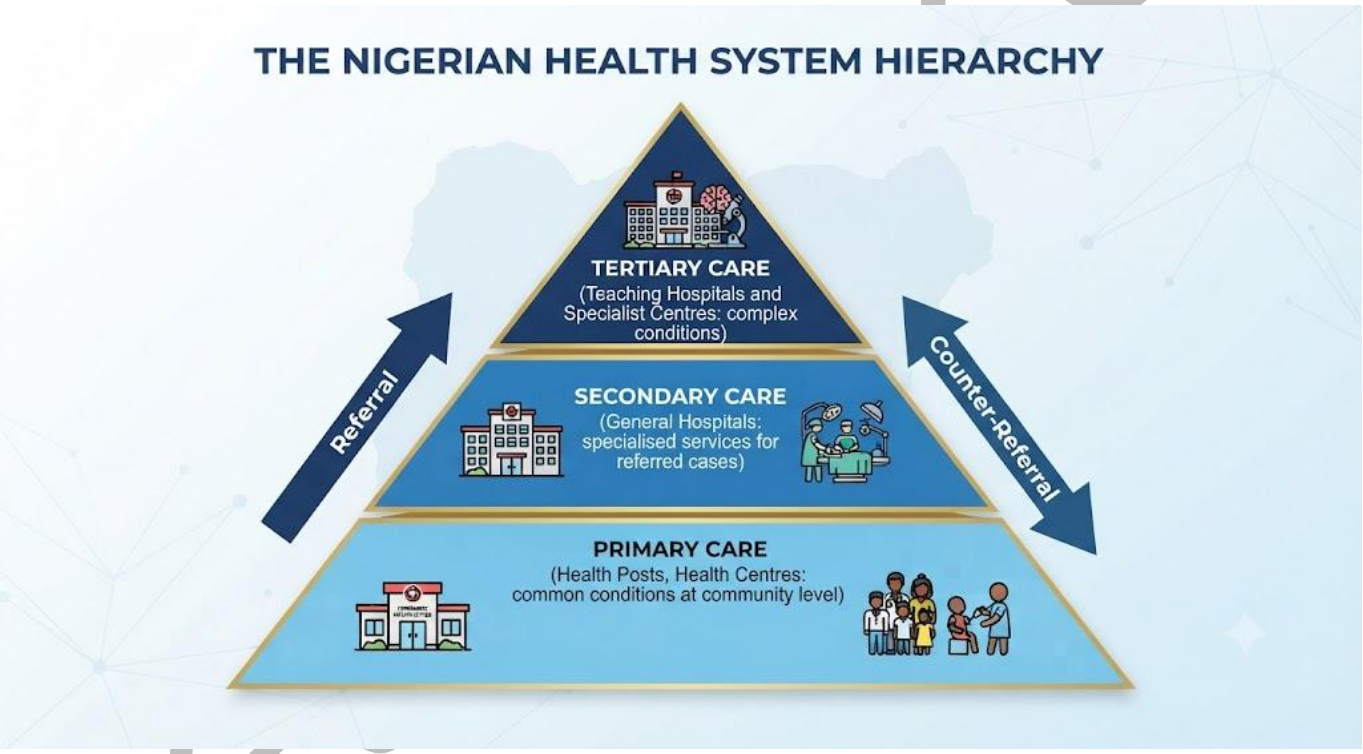

Figure 1.2: The three-tier health system hierarchy in Nigeria, with referral and counter-referral linkages

Pilot questions 1.3

1. Define the public health department and explain its role in primary health care. (Linked to SLO 1.3)
2. List five core functions of the public health department. (Linked to SLO 1.3)

3. Describe the three tiers of the health system and the level of care provided at each. (Linked to SLO 1.3)
4. Explain the referral system and state three requirements for it to function effectively. (Linked to SLO 1.3)
5. Define the counter-referral system and explain why it is important. (Linked to SLO 1.3)

Series Summary

This Series traced the origin and conceptual foundations of primary health care. Before PHC, health systems in many countries, including Nigeria, relied on hospital-based curative services concentrated in urban areas that were inaccessible to the majority of the population and failed to address the social, economic, and environmental determinants of health. The Alma-Ata Declaration, adopted in 1978 by 134 governments, established Health for All by the year 2000 as the overarching global health goal and identified PHC as the essential mechanism for achieving it, defining it as essential health care made universally accessible at a cost communities can afford, through their full participation. In Nigeria, the adoption of PHC was formalised through the 1987 National Health Policy, which placed PHC under local government authority, and the establishment of the National Primary Health Care Development Agency in 1992.

The core concepts of PHC include universal accessibility, socially acceptable methods, self-reliance, and equity in health, with the Health for All goal meaning equitable distribution of essential services rather than the elimination of all disease. PHC functions as the first level of contact between individuals and the health system, handling the most common health needs at the community level and performing an essential gatekeeping and referral function directing cases requiring more specialised care to secondary or tertiary facilities. The public health department, operating at federal, state, and local government levels, oversees disease surveillance, environmental health, maternal and child health, immunisation, and health education, and coordinates PHC within a three-tiered health system through effective referral and counter-referral linkages between primary, secondary, and tertiary care.

Glossary of Terms

- **Primary health care (PHC):** essential health care made universally accessible to individuals and families in the community through their full participation, at a cost the community and country can afford, as defined by the Alma-Ata Declaration.

- **Alma-Ata Declaration:** the international declaration adopted in 1978 at the International Conference on Primary Health Care in Alma-Ata, Kazakhstan, establishing Health for All and PHC as the global health framework.
- **Health for All:** the overarching goal of the Alma-Ata Declaration, meaning equitable distribution of essential health services so that every person has access to a minimum standard of care.
- **NPHCDA:** the National Primary Health Care Development Agency, established in Nigeria in 1992 as the apex body for developing, coordinating, and monitoring PHC services.
- **First level of contact:** the PHC principle that health services should be accessible at the community level as the first point of interaction between individuals and the health system.
- **Equity in health:** the principle requiring active reduction of disparities in health access and outcomes between populations, particularly between rural and urban, and poorer and wealthier groups.
- **Public health department:** the government administrative unit responsible for planning, organising, and overseeing public health services including PHC within a defined jurisdiction.
- **Referral system:** the organised process of transferring patients from a lower to a higher level of care when their condition exceeds the capacity of the current facility.
- **Counter-referral:** the return of a patient from a higher level of care to their primary facility for follow-up management after the acute phase of treatment.
- **Social determinants of health:** the social, economic, and environmental conditions that influence health outcomes, such as income, education, water, sanitation, and nutrition.
- **Decentralisation:** the transfer of authority and responsibility for health services from central to lower levels of government, such as placing PHC under local government control in Nigeria.

Concept Check Questions [Series 1]

Objective Questions

1. The Alma-Ata Declaration was adopted in _____, establishing Health for All and PHC as the global health framework. (Linked to SLO 1.1)
2. The National Primary Health Care Development Agency (NPHCDA) was established in Nigeria in _____. (Linked to SLO 1.1)
3. PHC is defined as essential health care made universally accessible at a cost the community can afford, through their full _____. (Linked to SLO 1.2)
4. Health for All means equitable distribution of essential services, not the elimination of all disease; equity requires addressing broader social _____ of health. (Linked to SLO 1.2)
5. PHC functions as the first level of _____ between individuals and the health system. (Linked to SLO 1.2)
6. The _____ system returns patients from higher-level facilities to their primary facility for follow-up care. (Linked to SLO 1.3)

Short-Answer Questions

7. Explain the main limitations of health systems before the emergence of primary health care. (Linked to SLO 1.1)
8. Explain what Health for All actually means in the context of the Alma-Ata Declaration. (Linked to SLO 1.2)
9. Describe the three tiers of the health system and the type of care provided at each level. (Linked to SLO 1.3)

Long-Answer Questions

10. Discuss the origin of primary health care, including the global health context, the Alma-Ata Declaration, and development of PHC in Nigeria. (Linked to SLO 1.1)
11. Define primary health care and evaluate the core concepts of universal accessibility, Health for All, and the first level of contact. (Linked to SLO 1.2)

Answers to Concept Check Questions [Series 1]

Objective Questions

1. 1978.
2. 1992.
3. Participation.

4. Determinants.
5. Contact.
6. Counter-referral.

Short-Answer Questions

7. Health systems before PHC relied on hospital-based, curative, specialist-oriented services concentrated in urban areas, inaccessible to rural majorities and to those who could not afford care, and failed to address the social, economic, and environmental determinants of health that drive most preventable disease.
8. Health for All means equitable distribution of essential health services so that every person, regardless of location or economic status, has access to a minimum standard of care; it does not mean the elimination of all disease or equal health outcomes for every individual.
9. Primary care is provided at health posts and primary health centres, delivering essential preventive and curative services for common health problems at the community level. Secondary care is provided at general hospitals, offering more specialised services for referred cases. Tertiary care is provided at teaching hospitals and specialist centres, handling the most complex conditions.

Long-Answer Questions

10. **Basic response:** Global context: hospital-based curative services concentrated in urban areas; rural majorities without access; social, economic, and environmental determinants unaddressed. Alma-Ata 1978: 134 governments; Health for All by 2000 goal; PHC as key mechanism; definition emphasising universal access, full participation, community affordability. Nigeria: 1987 National Health Policy placed PHC under local government; 1992 NPHCDA established as apex body; persistent challenges of funding, workforce, and equitable distribution remain.

    Value-added response: The historical trajectory from hospital-centred to community-centred health care reflects a fundamental recognition that most of the disease burden affecting low-income populations arises not from conditions requiring hospital specialist care but from preventable infections, nutritional deficiencies, and adverse environmental conditions that can be addressed far more effectively and affordably at the community level; this insight, enshrined in Alma-Ata, remains as relevant to Nigerian health policy

today as it was in 1978, given that the same inequities in access and determinants continue to drive the majority of preventable deaths.

11. **Basic response:** PHC definition (Alma-Ata): essential health care based on scientifically sound, socially acceptable methods; universally accessible; through full community participation; at affordable cost; spirit of self-reliance. Universal accessibility: all people regardless of location or economic status. Health for All: equitable distribution of essential services, not elimination of disease; requires addressing social determinants. First level of contact: closest to community; handles most common health needs; gatekeeping and referral function for cases beyond primary capacity.

    Value-added response: The three core concepts of universality, equity, and first contact are deeply interdependent rather than independent aspirations: universal accessibility cannot be achieved without equity (services nominally available but unaffordable or inaccessible to rural poor are not truly universal), and the first-contact principle can only fulfil its potential when PHC facilities have the capacity, staffing, and supplies needed to handle the health problems that people actually bring to them, which in turn requires the sustained financing and planning commitment that remains the most persistent challenge for PHC in Nigeria.

Answers to Pilot Questions [Series 1]

Part 1.1

1. Before PHC, health systems relied on hospital-based, curative, specialist-oriented services concentrated in urban areas, inaccessible to rural majorities and to those who could not afford care, and failed to address the social and environmental determinants of health.
2. The Alma-Ata Declaration was adopted in September 1978 at the International Conference on Primary Health Care in Alma-Ata, Kazakhstan, with 134 governments in attendance.
3. The Declaration established Health for All by the year 2000 as the overarching goal and identified PHC as the key mechanism for achieving it, defining PHC as universally

accessible essential health care delivered through full community participation at affordable cost.

4. Two key events are the 1987 National Health Policy and Local Government Reform, which placed PHC under local government authority, and the establishment of the NPHCDA in 1992 as the apex body for PHC development, coordination, and monitoring.
5. PHC delivery was placed under local government authority because effective PHC requires decentralisation to the level closest to communities, enabling services to be planned and delivered in response to local health needs.

Part 1.2

1. PHC is defined as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, at a cost the community and country can afford.
2. Universal accessibility means PHC must reach all people regardless of where they live or their economic status, not only those who can afford to pay or who live near a health facility.
3. Health for All means equitable distribution of health resources and essential services so that every person has access to a minimum standard of care; it does not mean the elimination of all disease or that all people will be equally healthy.
4. PHC as the first level of contact means health services are brought as close as possible to where people live and work, ensuring the most common health needs are addressed at the community level without requiring travel to distant or expensive hospital facilities.
5. The gatekeeping function means PHC identifies cases that require a higher level of care and directs patients appropriately to secondary or tertiary facilities, while retaining at the community level the majority of health interactions that do not require specialist care.

Part 1.3

1. The public health department is the government administrative unit responsible for planning, organising, and overseeing public health services including PHC within a defined jurisdiction, operating at federal, state, and local government levels in Nigeria.

2. Five core functions are disease surveillance and control, environmental health services, maternal and child health services, immunisation programmes, and health education and promotion.
3. Primary care at health posts and health centres provides essential preventive and curative services for common problems. Secondary care at general hospitals provides more specialised services for referred cases. Tertiary care at teaching hospitals handles the most complex clinical conditions.
4. The referral system transfers patients from a lower to a higher level when their condition exceeds primary capacity. Three requirements are clear referral protocols, adequate communication between facilities, and reliable transport arrangements.
5. The counter-referral system returns patients from higher-level facilities to their primary facility for follow-up care once the acute phase is managed; it is important for continuity of care and for reducing unnecessary burden on secondary and tertiary facilities.

References and Attributions [Series 1]

Textual References

- World Health Organization and UNICEF. (1978). Declaration of Alma-Ata. Geneva: WHO.
- Federal Ministry of Health Nigeria. (1988). National Health Policy and Strategy to Achieve Health for All Nigerians. Abuja: FMOH.
- National Primary Health Care Development Agency. (2010). Ward Minimum Health Care Package. Abuja: NPHCDA.
- Park, K. (2017). Park's Textbook of Preventive and Social Medicine (24th ed.). Jabalpur: Banarsidas Bhanot.

Figures, Plates, Tables, and Boxes

- Figure 1.1: Key milestones in the development of primary health care. AI generation prompt: "Create a clean horizontal timeline illustration titled Key Milestones in the Development of

Primary Health Care, showing five chronological labelled events: 1978 Alma-Ata Declaration (Health for All goal, PHC international framework); 1987 Nigeria National Health Policy and Local Government Reform (PHC under local government); 1992 NPHCDA Established (apex PHC coordination body); 2000 Health for All Target Year; 2001 Abuja Declaration (African nations commit 15 percent of budget to health); use a clean professional infographic timeline style." Suggested OER search string: "primary health care timeline history Alma-Ata 1978 Nigeria".

- Table 1.1: Key concepts of primary health care. AI generation prompt: "Create a clean two-column table titled Key Concepts of Primary Health Care and Their Meaning; columns Concept and Meaning; six rows: Universal Accessibility (all people reached regardless of location or economic status), Health for All (equitable distribution of essential services), Socially Acceptable Methods (delivered in ways communities understand and accept), Self-Reliance (communities as active agents in health care), First Level of Contact (health care closest to where people live), Equity in Health (active reduction of disparities in access and outcomes); use a clean professional table design with alternating row shading." Suggested OER search string: "primary health care concepts table Alma-Ata definition equity".
- Figure 1.2: The three-tier health system hierarchy in Nigeria. AI generation prompt: "Create a clean three-tier pyramid diagram titled The Nigerian Health System Hierarchy; top tier labelled Tertiary Care (Teaching Hospitals and Specialist Centres: complex conditions); middle tier labelled Secondary Care (General Hospitals: specialised services for referred cases); bottom tier labelled Primary Care (Health Posts, Health Centres: common conditions at community level); add bidirectional arrows between tiers labelled Referral pointing upward and Counter-Referral pointing downward; use a clean professional infographic pyramid style." Suggested OER search string: "health system hierarchy three tiers Nigeria referral pyramid diagram".

Course code: COM 401

Course title: Introduction to Primary Health Care

Course credit load: 1 Unit

Series 2: Principles, Components, and Services of PHC

- **Part 2.1: Principles of Primary Health Care**
    - Sub Part 2.1.1: Equitable distribution
    - Sub Part 2.1.2: Community participation and intersectoral collaboration
    - Sub Part 2.1.3: Appropriate technology and use of available resources
- **Part 2.2: Components of Primary Health Care**
    - Sub Part 2.2.1: The eight essential components of PHC
    - Sub Part 2.2.2: The components in the Nigerian context
    - Sub Part 2.2.3: Interrelationship among the components
- **Part 2.3: PHC Services**
    - Sub Part 2.3.1: Preventive PHC services
    - Sub Part 2.3.2: Promotive and curative PHC services
    - Sub Part 2.3.3: Rehabilitative services and integration of PHC service delivery

Introduction

Understanding what primary health care is requires not only knowing its definition and history but also grasping the principles that shape how it must be delivered, the specific components that together constitute a comprehensive PHC system, and the range of services through which those principles and components are put into practice at the community level. These three dimensions, principles, components, and services, together give PHC its operational form.

This Series examines the internationally recognised principles of PHC, including equitable distribution, community participation, intersectoral collaboration, and appropriate technology, before turning to the eight essential components that form the minimum content of a PHC system. It then examines how these components translate into the actual preventive, promotive, curative, and rehabilitative services delivered at the primary health care level in Nigeria.

Mastering this material enables learners to move beyond an abstract understanding of PHC toward a concrete grasp of what a functioning PHC system should actually look like in practice and what services it should be capable of delivering to the communities it serves.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 2.1** enumerate and explain the principles of primary health care (Linked to Part 2.1),
- **SLO 2.2** enumerate and describe the eight essential components of primary health care (Linked to Part 2.2), and
- **SLO 2.3** describe the preventive, promotive, curative, and rehabilitative services provided at the PHC level (Linked to Part 2.3).

2.1 Principles of Primary Health Care

2.1.1 Equitable distribution

Equitable distribution is the foundational principle of PHC, reflecting the Alma-Ata Declaration's commitment that essential health care must be accessible to all people regardless of their geographical location, economic status, or social circumstances. In the Nigerian context, achieving equitable distribution requires intentional allocation of health resources, including facilities, trained personnel, essential medicines, and equipment, to underserved rural and peri-urban communities that have historically received disproportionately less than urban centres.

Equity does not mean identical services everywhere but rather that the **level of need** in a community guides resource allocation, ensuring that populations with greater health burdens and fewer existing resources receive proportionally greater attention. Monitoring equity requires tracking health indicators disaggregated by geography, income, gender, and other relevant characteristics, so that persistent disparities can be identified and targeted for correction.

Fill in the blank: Equitable distribution means health resources are allocated according to the level of _____ in each community, ensuring underserved populations receive proportionally greater attention.

2.1.2 Community participation and intersectoral collaboration

Community participation is both a principle and a practical requirement of PHC, reflecting the conviction that communities are not passive recipients of externally provided health services but active agents who must be engaged in identifying their own health problems, planning responses, and sustaining health programmes over time. Participation ranges from simple consultation, in which communities provide input that informs externally designed programmes, to genuine **community control**, in which communities take real decision-making authority over health matters affecting them.

Intersectoral collaboration recognises that health is determined by factors across multiple sectors beyond health care, including education, agriculture, water and sanitation, housing, and

economic development, and that PHC cannot succeed in isolation from coordinated action in these related sectors. Effective PHC therefore requires active collaboration between health workers and professionals in these other sectors, acknowledging that a school that teaches hygiene, a water authority that provides safe drinking water, and an agricultural extension that improves nutrition all contribute directly to the health outcomes that PHC aims to improve.

Fill in the blank: Intersectoral collaboration recognises that health is determined by factors across multiple sectors including education, agriculture, water and sanitation, housing, and _____ development.

2.1.3 Appropriate technology and use of available resources

Appropriate technology in PHC refers to the use of methods, equipment, and materials that are scientifically sound, adapted to local conditions and culture, acceptable to the communities using them, and affordable within the country's and community's available resources. The principle explicitly rejects reliance on sophisticated, expensive, or imported technologies that may be effective in high-income settings but are unsustainable, inaccessible, or culturally inappropriate in the communities most in need of PHC services.

Use of available resources extends this principle to human resources as well, recognising that community health workers, traditional birth attendants, and other community-based practitioners, trained to deliver specific PHC services within defined competency limits, represent a critical resource for expanding PHC reach without requiring the large numbers of formally trained professionals that many countries lack. This principle underpins the approach of task shifting, examined further in Series 4, whereby specific health tasks are delegated to less specialised workers who have been trained to perform them safely and effectively.

Fill in the blank: Appropriate technology in PHC is scientifically sound, adapted to local conditions, culturally acceptable, and _____ within available resources; it underpins the use of community health workers to extend PHC reach.

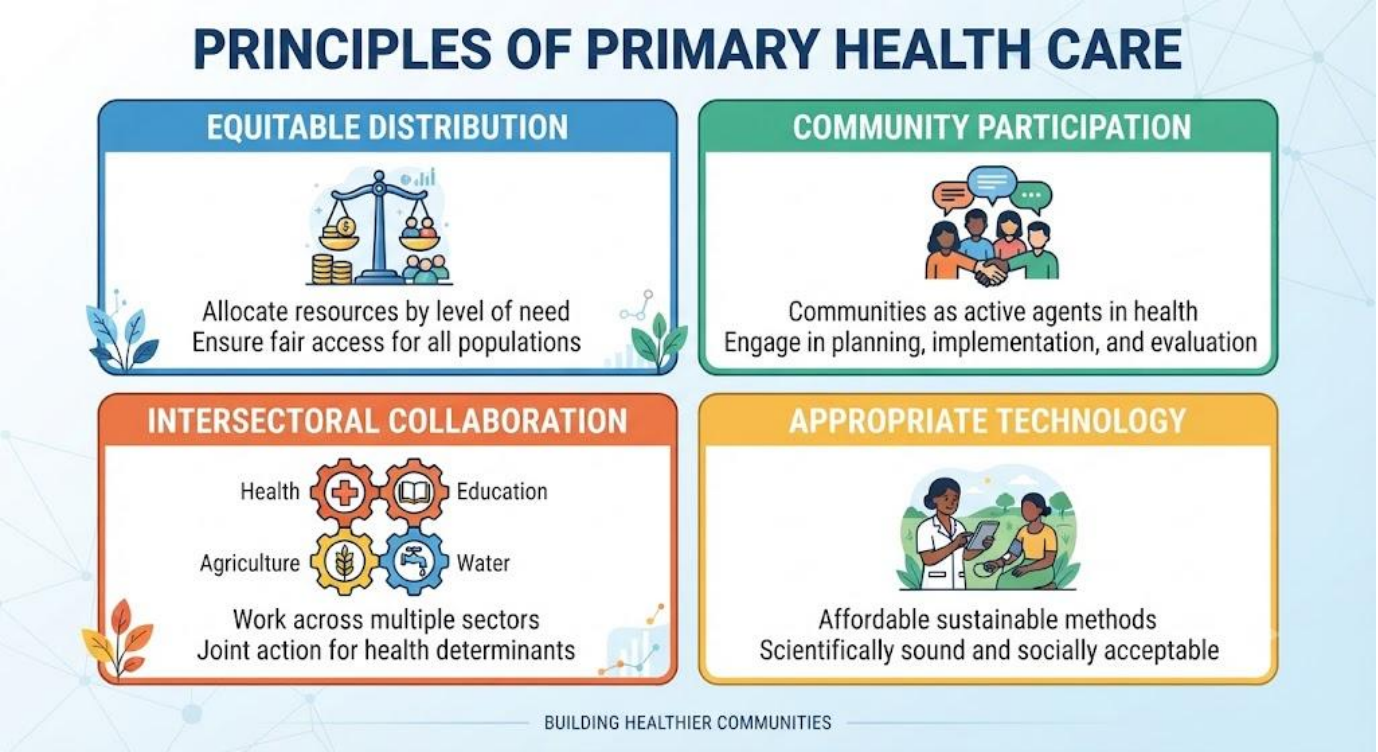

Figure 2.1: The four key principles of primary health care as established by the Alma-Ata Declaration

Pilot questions 2.1

1. Explain the principle of equitable distribution in PHC. (Linked to SLO 2.1)
2. Distinguish between community consultation and community control as levels of participation. (Linked to SLO 2.1)
3. Explain why intersectoral collaboration is essential for PHC success. (Linked to SLO 2.1)
4. Define appropriate technology in the context of PHC. (Linked to SLO 2.1)
5. Explain how the principle of appropriate technology supports the use of community health workers. (Linked to SLO 2.1)

2.2 Components of Primary Health Care

2.2.1 The eight essential components of PHC

The Alma-Ata Declaration identified eight **essential components** that together constitute the minimum content of a comprehensive PHC system. These are: (1) **education concerning prevailing health problems** and methods of preventing and controlling them; (2) **promotion of food supply and proper nutrition**; (3) **adequate supply of safe water and basic sanitation**; (4) **maternal and child health care**, including family planning.

The remaining four components are: (5) **immunisation against major infectious diseases**; (6) **prevention and control of locally endemic diseases**; (7) **appropriate treatment of common diseases and injuries**; and (8) **provision of essential drugs**. Together these eight components represent the full spectrum of health action required at the community level, spanning prevention, treatment, health promotion, and addressing the environmental and nutritional foundations of health.

Fill in the blank: The eight PHC components include health education, nutrition, safe water and sanitation, maternal and child health, immunisation, endemic disease control, treatment of common diseases, and provision of essential _____.

2.2.2 The components in the Nigerian context

In Nigeria, the eight PHC components have been operationalised through specific national programmes and services delivered at the primary health care level. **Immunisation** is delivered through the National Programme on Immunisation (NPI), now the Routine Immunisation programme, targeting vaccine-preventable diseases including polio, measles, diphtheria, tetanus, and hepatitis B. **Maternal and child health** is delivered through antenatal care, postnatal care, skilled birth attendance, and child nutrition programmes.

Prevention and control of endemic diseases is addressed through the National Malaria Elimination Programme, tuberculosis control, and neglected tropical disease control initiatives, among others. **Essential drug management** at the PHC level involves ensuring the consistent

availability of a defined list of essential medicines at health centres through the essential drug supply system, while the **drug revolving fund** mechanism, examined in Series 5, attempts to ensure financial sustainability of drug supply through community cost-sharing arrangements.

Fill in the blank: In Nigeria, immunisation is delivered through the _____ programme, while endemic disease control includes malaria elimination, tuberculosis control, and neglected tropical disease management.

2.2.3 Interrelationship among the components

The eight PHC components are not independent silos but **deeply interrelated**; progress in one frequently depends on and reinforces progress in others. For example, improving **nutrition** strengthens immune function, making immunisation more effective and reducing susceptibility to the common infections that the treatment component addresses. Provision of **safe water and sanitation** directly reduces the incidence of diarrhoeal disease, one of the leading killers of children, reducing the burden on both the treatment and maternal and child health components.

Health education multiplies the impact of every other component by increasing community awareness of preventive measures, appropriate care-seeking behaviour, and the importance of completing treatment courses. Recognising these interrelationships is practically important for PHC planning: resource constraints that force prioritisation among components should be guided by an understanding of which components have the greatest multiplicative effect on others within the specific disease burden profile of the community in question.

Fill in the blank: The PHC components are deeply interrelated; health _____ multiplies the impact of every other component by increasing community awareness and appropriate care-seeking behaviour.

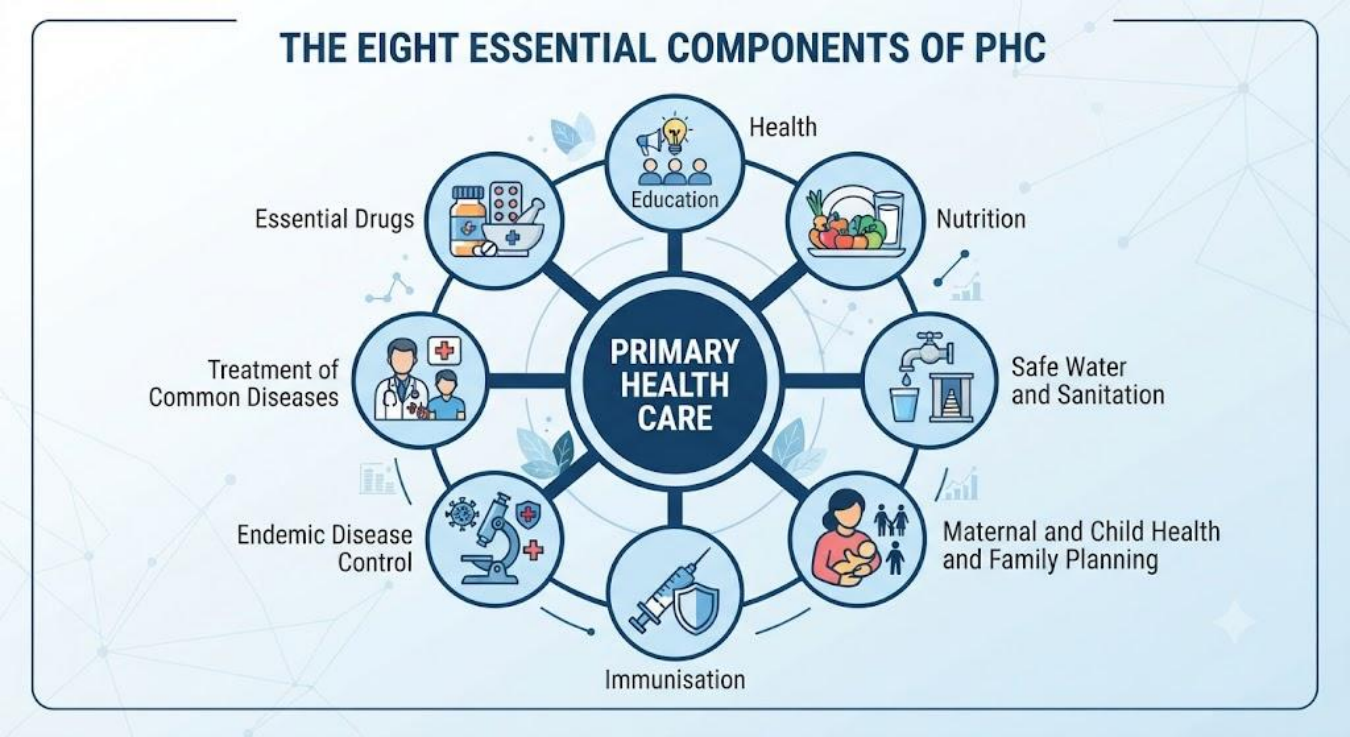

Figure 2.2: The eight essential components of primary health care as a wheel, illustrating their interrelationships

Pilot questions 2.2

1. List the eight essential components of primary health care. (Linked to SLO 2.2)
2. Describe how the immunisation component is delivered in Nigeria. (Linked to SLO 2.2)
3. Explain the interrelationship between the nutrition component and the immunisation component. (Linked to SLO 2.2)
4. Explain how safe water and sanitation reduces burden on other PHC components. (Linked to SLO 2.2)
5. Explain why health education multiplies the impact of every other PHC component. (Linked to SLO 2.2)

2.3 PHC Services

2.3.1 Preventive PHC services

Preventive services aim to stop disease and injury from occurring in the first place, representing the most cost-effective category of health intervention. At the PHC level, preventive services include **immunisation** against vaccine-preventable diseases; **antenatal care** visits that identify and manage pregnancy complications before they become emergencies; **health education** on disease prevention, hygiene, nutrition, and family planning; and **environmental health measures** such as vector control, promotion of safe water, and sanitation improvement.

Prevention also includes **specific protection measures** such as distribution of insecticide-treated bed nets for malaria prevention, chemoprophylaxis for certain high-risk groups, and school health programmes that include regular deworming. In Nigeria, preventive services at the PHC level are intended to address the leading causes of morbidity and mortality in the community, particularly among the most vulnerable groups, including children under five, pregnant women, and older adults.

Fill in the blank: Preventive PHC services include immunisation, antenatal care, health education, environmental health measures, and specific protection measures such as distribution of insecticide-treated bed _____.

2.3.2 Promotive and curative PHC services

Health promotion services go beyond prevention of specific diseases to strengthen individuals' and communities' overall capacity for health. They include **nutrition counselling and supplementation**, growth monitoring of children under five, **family planning** information and services, and broader community health education programmes that build health literacy and support informed decision-making about health behaviours.

Curative services at the PHC level address illness and injury that has already occurred, providing **basic diagnostic and treatment services** for common conditions including malaria,

diarrhoeal diseases, respiratory infections, skin conditions, minor wounds and injuries, and selected chronic conditions such as hypertension and diabetes that can be safely managed at the primary level. The emphasis at the PHC level is on **simple, proven, affordable treatments** using medicines from the essential drugs list, rather than complex or expensive interventions more appropriate for higher levels of care.

Fill in the blank: Curative services at the PHC level address common conditions including malaria, diarrhoeal diseases, and respiratory infections using simple, proven, affordable treatments from the essential _____ list.

2.3.3 Rehabilitative services and integration of PHC service delivery

Rehabilitative services aim to restore the maximum possible function to individuals who have experienced disease, injury, or disability, supporting their reintegration into family and community life. At the PHC level, rehabilitation includes **physiotherapy exercises** and guidance provided to patients recovering from stroke, injury, or disability; **nutritional rehabilitation** for children recovering from severe malnutrition; and **support and referral** for persons with mental health conditions, visual impairment, or hearing loss that can be partially addressed through community-based interventions.

Effective PHC service delivery integrates all four categories, preventive, promotive, curative, and rehabilitative, rather than delivering each in isolation. A well-run PHC facility uses every patient contact as an opportunity to deliver **integrated care**: a child brought for treatment of diarrhoea is also checked for vaccination status, growth monitored, and the mother counselled on oral rehydration therapy, breastfeeding, and hygiene, ensuring that a single visit addresses multiple health dimensions simultaneously and maximises the value of the community's engagement with the health system.

Fill in the blank: Effective PHC service delivery integrates preventive, promotive, curative, and rehabilitative services, using every patient contact as an opportunity to deliver _____ care across multiple health dimensions.

Service Category	Examples
Preventive	Immunisation, antenatal care, bed nets, health education
Promotive	Nutrition counselling, growth monitoring, family planning
Curative	Malaria treatment, oral rehydration therapy, wound care
Rehabilitative	Physiotherapy, nutritional rehabilitation
Integrated	Single visit delivering services across all four categories

Table 2.1: The four categories of PHC services with examples and the principle of integrated delivery

Pilot questions 2.3

1. List four preventive PHC services. (Linked to SLO 2.3)
2. Explain the difference between preventive and promotive health services. (Linked to SLO 2.3)
3. Describe three curative services provided at the PHC level. (Linked to SLO 2.3)
4. Define rehabilitative services and give two examples relevant to PHC in Nigeria. (Linked to SLO 2.3)
5. Explain what integrated care at the PHC level means and why it is important. (Linked to SLO 2.3)

Series Summary

This Series examined the principles, components, and services that give PHC its operational form. The four key principles, equitable distribution, community participation, intersectoral collaboration, and appropriate technology, guide how PHC must be organised and delivered to fulfil its promise: resources allocated by level of need rather than administrative convenience; communities engaged as active agents rather than passive recipients; health sectors coordinating with education, agriculture, water, and other determinants of health; and technologies selected for scientific soundness, cultural acceptability, and affordability rather than sophistication. The eight essential components, health education, nutrition, safe water and sanitation, maternal and child health, immunisation, endemic disease control, common disease treatment, and essential drugs provision, constitute the minimum content of a comprehensive PHC system and are deeply interrelated, with progress in any one component supporting and multiplying progress in others.

The Series concluded by examining the four categories of services through which the PHC system is actually delivered to communities. Preventive services, including immunisation, antenatal care, health education, and environmental health, stop disease before it occurs. Promotive services, including nutrition counselling, growth monitoring, and family planning, strengthen overall health capacity. Curative services address the most common illnesses and injuries using simple, affordable treatments from the essential drugs list. Rehabilitative services support recovery of function after disease or injury. Effective PHC integrates all four, treating every patient contact as an opportunity for comprehensive engagement across these dimensions simultaneously, ensuring that the community gains maximum health value from each interaction with the primary health care system.

Glossary of Terms

1. **Equitable distribution:** the PHC principle requiring health resources to be allocated according to community need, ensuring underserved populations receive proportionally greater attention.
2. **Community participation:** the active involvement of communities in identifying health problems, planning responses, and sustaining health programmes, ranging from consultation to community control.
3. **Intersectoral collaboration:** coordinated action between the health sector and other sectors, including education, agriculture, water and sanitation, and housing, whose activities directly affect health outcomes.
4. **Appropriate technology:** methods, equipment, and materials used in PHC that are scientifically sound, adapted to local conditions, culturally acceptable, and affordable within available resources.
5. **Task shifting:** the delegation of specific health tasks to less specialised but trained community health workers, extending PHC reach without requiring large numbers of formally trained professionals.
6. **Essential components of PHC:** the eight areas of health action established by the Alma-Ata Declaration as the minimum content of a comprehensive PHC system.
7. **Essential drugs:** a defined list of medicines selected for their safety, efficacy, and affordability, intended to be consistently available at all PHC facilities.
8. **Preventive services:** health interventions aimed at stopping disease or injury from occurring, including immunisation, antenatal care, health education, and environmental health measures.
9. **Promotive services:** health interventions that strengthen individuals' and communities' overall capacity for health, including nutrition counselling and family planning.
10. **Curative services:** health interventions that address illness or injury after it has occurred, providing basic diagnosis and treatment for common conditions.

11. **Rehabilitative services:** health interventions that restore the maximum possible function to individuals who have experienced disease, injury, or disability.

Concept Check Questions [Series 2]

Objective Questions

- The PHC principle requiring health resources to be allocated according to community need is called _____ distribution. (Linked to SLO 2.1)
- _____ collaboration recognises that health is determined by factors across multiple sectors, including education, agriculture, and water. (Linked to SLO 2.1)
- The eight PHC components include health education, nutrition, safe water, maternal and child health, immunisation, endemic disease control, common disease treatment, and provision of essential _____. (Linked to SLO 2.2)
- In Nigeria, immunisation is delivered through the _____ Immunisation programme. (Linked to SLO 2.2)
- Preventive PHC services include immunisation, antenatal care, health education, and distribution of insecticide-treated bed _____. (Linked to SLO 2.3)
- Curative services at the PHC level use simple, affordable treatments from the essential _____ list. (Linked to SLO 2.3)

Short-Answer Questions

- Explain the principle of appropriate technology in PHC. (Linked to SLO 2.1)
- Explain the interrelationship between the safe water and sanitation component and other PHC components. (Linked to SLO 2.2)
- Explain what integrated care at the PHC level means and why it is important. (Linked to SLO 2.3)

Long-Answer Questions

- Enumerate and explain the principles of primary health care. (Linked to SLO 2.1)
- Enumerate the eight essential components of PHC and describe the four categories of PHC services. (Linked to SLOs 2.2 to 2.3)

Answers to Concept Check Questions [Series 2]

Objective Questions

1. Equitable.
2. Intersectoral.
3. Drugs.
4. Routine.
5. Nets.
6. Drugs.

Short-Answer Questions

7. Appropriate technology refers to methods, equipment, and materials that are scientifically sound, adapted to local conditions and culture, culturally acceptable, and affordable within available resources; it rejects sophisticated imported technologies that are unsustainable or inaccessible and supports use of community health workers to extend PHC reach.
8. Safe water and sanitation directly reduces incidence of diarrhoeal disease, reducing burden on the treatment and maternal and child health components; it also supports better nutrition outcomes by reducing parasitic infections, reinforcing the nutrition component, illustrating the deeply interrelated nature of all eight PHC components.
9. Integrated care means using every patient contact to deliver preventive, promotive, curative, and rehabilitative services simultaneously; a child brought for treatment of diarrhoea also has vaccination status checked, growth monitored, and the mother counselled on hygiene and nutrition, maximising health value from a single visit.

Long-Answer Questions

10. **Basic response:** Equitable distribution: resources allocated by level of need, not administrative convenience; monitor by geography, income, gender. Community

participation: communities as active agents from consultation to community control; essential for sustainability. Intersectoral collaboration: health determined by education, agriculture, water, sanitation, housing; PHC requires coordinated action across these sectors. Appropriate technology: scientifically sound, locally adapted, culturally acceptable, affordable; supports task shifting and community health worker deployment.

Value-added response: The four principles together reflect a fundamental reorientation of health thinking from health care as a professionally-delivered, facility-based technical service to health as a shared social responsibility requiring community agency, cross-sector coordination, and resource allocation driven by need rather than by historical patterns; without all four operating simultaneously, PHC risks becoming simply a cheaper version of the hospital-centred model it was designed to replace, rather than the genuinely transformative approach to community health that the Alma-Ata vision intended.

11. **Basic response:** Eight components: health education; nutrition; safe water and sanitation; maternal and child health and family planning; immunisation; endemic disease control; common disease treatment; essential drugs. Four service categories: preventive (immunisation, antenatal care, health education, bed nets, environmental health); promotive (nutrition counselling, growth monitoring, family planning); curative (malaria, diarrhoea, respiratory infections, hypertension, simple injuries using essential drugs list); rehabilitative (physiotherapy, nutritional rehabilitation, support for mental health and sensory impairment).

    Value-added response: The alignment between the eight components and the four service categories is not coincidental: the components specify what health areas must be covered, while the service categories specify how the health system responds within each area at different stages of the disease and health cycle, from promotion through prevention, treatment, and recovery; a PHC system that delivers all four service categories across all eight components represents the fullest operational expression of what the Alma-Ata Declaration envisioned.

Answers to Pilot Questions [Series 2]

Part 2.1

6. Equitable distribution means health resources are allocated according to the level of need in each community, ensuring underserved rural and peri-urban populations receive proportionally greater attention rather than being disadvantaged relative to urban centres.
7. Consultation involves communities providing input that informs externally designed programmes, while community control involves communities taking real decision-making authority over health matters, representing a more genuine form of participation.
8. Intersectoral collaboration is essential because health is determined by factors in multiple sectors beyond health care, including education, water, sanitation, agriculture, and housing; PHC cannot succeed if action is confined to the health sector alone.
9. Appropriate technology refers to methods, equipment, and materials that are scientifically sound, adapted to local conditions and culture, culturally acceptable, and affordable within available community and country resources.
10. Appropriate technology supports community health workers by recognising that tasks can be safely performed by trained community members without requiring the sophisticated equipment or extensive training of formally qualified professionals, extending PHC reach sustainably.

Part 2.2

11. The eight components are: health education concerning prevailing problems; promotion of food supply and nutrition; safe water and sanitation; maternal and child health and family planning; immunisation; prevention and control of endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

12. Immunisation is delivered through the Routine Immunisation programme, targeting vaccine-preventable diseases including polio, measles, diphtheria, tetanus, and hepatitis B, with health centres serving as the primary delivery point.
13. Improved nutrition strengthens immune function, making immunisation more effective; a well-nourished child mounts a stronger immune response to vaccines, meaning the nutrition and immunisation components reinforce each other directly.
14. Safe water and sanitation reduces incidence of diarrhoeal diseases, relieving burden on the curative treatment component; it also reduces parasitic infections that impair nutrient absorption, supporting the nutrition component, illustrating how a single component benefits multiple others.
15. Health education increases awareness of preventive measures, appropriate care-seeking, and treatment adherence, making every other component more effective; without health education, communities may not utilise immunisation services, may not adopt sanitation improvements, or may not complete treatment courses.

Part 2.3

1. Four preventive services are immunisation, antenatal care, health education on disease prevention and hygiene, and distribution of insecticide-treated bed nets for malaria prevention.
2. Preventive services stop disease from occurring, such as immunisation preventing measles, while promotive services strengthen overall health capacity, such as nutrition counselling improving resilience; prevention targets specific diseases while promotion builds general health foundations.
3. Three curative services are treatment of malaria using artemisinin-based combination therapy, oral rehydration therapy for diarrhoeal disease, and basic wound care and management of minor injuries.
4. Rehabilitative services restore maximum possible function after disease or injury. Two examples are physiotherapy exercises for patients recovering from stroke, and nutritional rehabilitation for children recovering from severe malnutrition.

5. Integrated care means every patient contact is used to deliver preventive, promotive, curative, and rehabilitative services simultaneously; it is important because it maximises the health value of each community engagement and ensures patients benefit from the full range of PHC without requiring multiple separate visits.

References and Attributions [Series 2]

Textual References

6. World Health Organization and UNICEF. (1978). Declaration of Alma-Ata. Geneva: WHO.
7. Federal Ministry of Health Nigeria. (1988). National Health Policy and Strategy to Achieve Health for All Nigerians. Abuja: FMOH.
8. National Primary Health Care Development Agency. (2010). Ward Minimum Health Care Package. Abuja: NPHCDA.
9. Park, K. (2017). Park's Textbook of Preventive and Social Medicine (24th ed.). Jabalpur: Banarsidas Bhanot.

Figures, Plates, Tables, and Boxes

10. Figure 2.1: The four key principles of primary health care. AI generation prompt: "Create a clean four-panel infographic titled Principles of Primary Health Care, with four equal boxes in a two-by-two grid: Panel 1 Equitable Distribution (scales of justice icon, allocate resources by level of need); Panel 2 Community Participation (group of people icon, communities as active agents in health); Panel 3 Intersectoral Collaboration (interlocking sectors icon showing health, education, agriculture, water); Panel 4 Appropriate Technology (community health worker with simple tools icon, affordable sustainable methods); use a clean professional infographic style with consistent colour scheme." Suggested OER search string: "primary health care four principles diagram equitable community participation".
11. Figure 2.2: The eight essential components of PHC as a wheel diagram. AI generation prompt: "Create a clean wheel diagram titled The Eight Essential Components of PHC, with a central circle labelled Primary Health Care surrounded by eight equally spaced outer circles connected by spokes, labelled: Health Education, Nutrition, Safe Water and Sanitation, Maternal and Child Health and Family Planning, Immunisation, Endemic Disease Control, Treatment of Common Diseases, Essential Drugs; add connecting lines between adjacent outer circles to

illustrate interrelationships; use a clean professional infographic wheel style." Suggested OER search string: "eight components primary health care wheel diagram Alma-Ata".

12. Table 2.1: The four categories of PHC services with examples. AI generation prompt: "Create a clean two-column table titled PHC Service Categories and Examples; columns Service Category and Examples; five rows: Preventive (immunisation, antenatal care, bed nets, health education), Promotive (nutrition counselling, growth monitoring, family planning), Curative (malaria treatment, oral rehydration therapy, wound care), Rehabilitative (physiotherapy, nutritional rehabilitation), Integrated (single visit delivering services across all four categories); use a clean professional table design with alternating row shading." Suggested OER search string: "PHC service categories preventive promotive curative rehabilitative table".

Course code: COM 401

Course title: Introduction to Primary Health Care

Course credit load: 1 Unit

Series 3: Community Participation, Ownership, and Mobilisation

- **Part 3.1: Community Participation in PHC**
  - Sub Part 3.1.1: The concept and meaning of community participation
  - Sub Part 3.1.2: Levels and forms of community participation
  - Sub Part 3.1.3: Barriers to effective community participation
- **Part 3.2: Community Ownership of Health Programmes**
  - Sub Part 3.2.1: The concept of community ownership
  - Sub Part 3.2.2: Building and sustaining community ownership
  - Sub Part 3.2.3: Community ownership in the Nigerian PHC context
- **Part 3.3: Community Mobilisation for PHC**
  - Sub Part 3.3.1: The concept and purpose of community mobilisation
  - Sub Part 3.3.2: Approaches and strategies for community mobilisation
  - Sub Part 3.3.3: Community mobilisation and the village health committee

Introduction

Among all the principles of primary health care, community participation stands out as perhaps the most distinctive and most frequently misunderstood. The Alma-Ata Declaration did not simply call for the delivery of health services to communities but insisted that communities be active participants in defining, planning, implementing, and evaluating those services. This represents a fundamental shift from viewing communities as objects of health care to viewing them as subjects and agents of their own health.

This Series examines community participation as both a concept and a practice, exploring what genuine participation means, the different levels at which it can occur, and the practical barriers that often prevent it from being realised. It then examines the related concept of community ownership, how it is built and sustained, and how it has been applied in the Nigerian PHC system. Finally, it turns to community mobilisation, the practical process through which communities are organised and energised to take action for their collective health.

Together, these three interconnected concepts represent the human and social foundation upon which effective and sustainable PHC depends, without which even well-resourced health programmes will fail to achieve their potential.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 3.1** explain the concept of community participation, describe its levels and forms, and identify barriers to its realisation (Linked to Part 3.1),
- **SLO 3.2** define community ownership, describe how it is built and sustained, and explain its application in the Nigerian PHC context (Linked to Part 3.2), and
- **SLO 3.3** define community mobilisation, describe its strategies and approaches, and explain the role of the village health committee (Linked to Part 3.3).

3.1 Community Participation in PHC

3.1.1 The concept and meaning of community participation

Community participation in PHC refers to the active and meaningful involvement of community members in all stages of the health care process, from identifying health problems and setting priorities to planning, implementing, and evaluating health programmes. It is important to distinguish genuine community participation from superficial or **tokenistic** forms of engagement, in which community members are consulted or informed about decisions already made by health professionals or government officials without having real influence on outcomes.

True community participation is built on the recognition that communities possess **local knowledge, resources, and capacities** that formal health systems cannot replicate, and that health programmes designed and implemented without drawing on these assets are less likely to be appropriate, accepted, and sustained. It also reflects the fundamental principle that people have both the right and the responsibility to participate in decisions affecting their own health and the health of their communities.

Fill in the blank: Community participation refers to the active and meaningful involvement of community members in all stages of health care, from identifying problems to planning, implementing, and _____ health programmes.

3.1.2 Levels and forms of community participation

Community participation can occur at different **levels of intensity and influence**, ranging from passive receipt of information at the lowest level, through consultation where communities are asked for their views, to active collaboration where communities are joint decision-makers, and finally to full community control where communities independently manage their own health services. Most PHC programmes in practice operate somewhere in the middle of this spectrum, aspiring to collaboration without always achieving full community control.

In terms of form, community participation in PHC may be **individual**, such as a person attending a health education session or bringing a child for immunisation, or **collective**, such as a

community group organising a sanitation improvement activity. Collective participation is generally more powerful than individual participation because it builds shared commitment, distributes effort across the community, and creates community-level accountability structures that can sustain health actions beyond the life of any single programme.

Fill in the blank: Community participation ranges from passive information receipt through consultation and collaboration to full community _____; collective participation is more powerful than individual participation.

3.1.3 Barriers to effective community participation

Several categories of barrier commonly prevent community participation in PHC from being genuine and effective. **Health worker attitudes** constitute a significant barrier when health professionals regard community members as ignorant recipients of expert care rather than as partners with valuable knowledge, leading to practices that exclude community input rather than actively soliciting it. **Gender and power dynamics** within communities often mean that women, who carry the primary responsibility for household health in many Nigerian communities, have limited voice in community-level decision-making processes.

Structural barriers include the time costs of participation for communities with demanding economic and subsistence activities that leave little time for health meetings or community activities. **Disillusionment** from previous negative experiences with health programmes that sought community input without acting on it also substantially reduces participation in subsequent initiatives. Overcoming these barriers requires deliberate strategies including flexible scheduling of participation activities, targeted outreach to marginalised groups such as women and young people, and demonstrated follow-through on community input.

Fill in the blank: Barriers to community participation include health worker attitudes, gender and power dynamics, structural time constraints, and _____ from previous negative experiences with programmes that ignored community input.

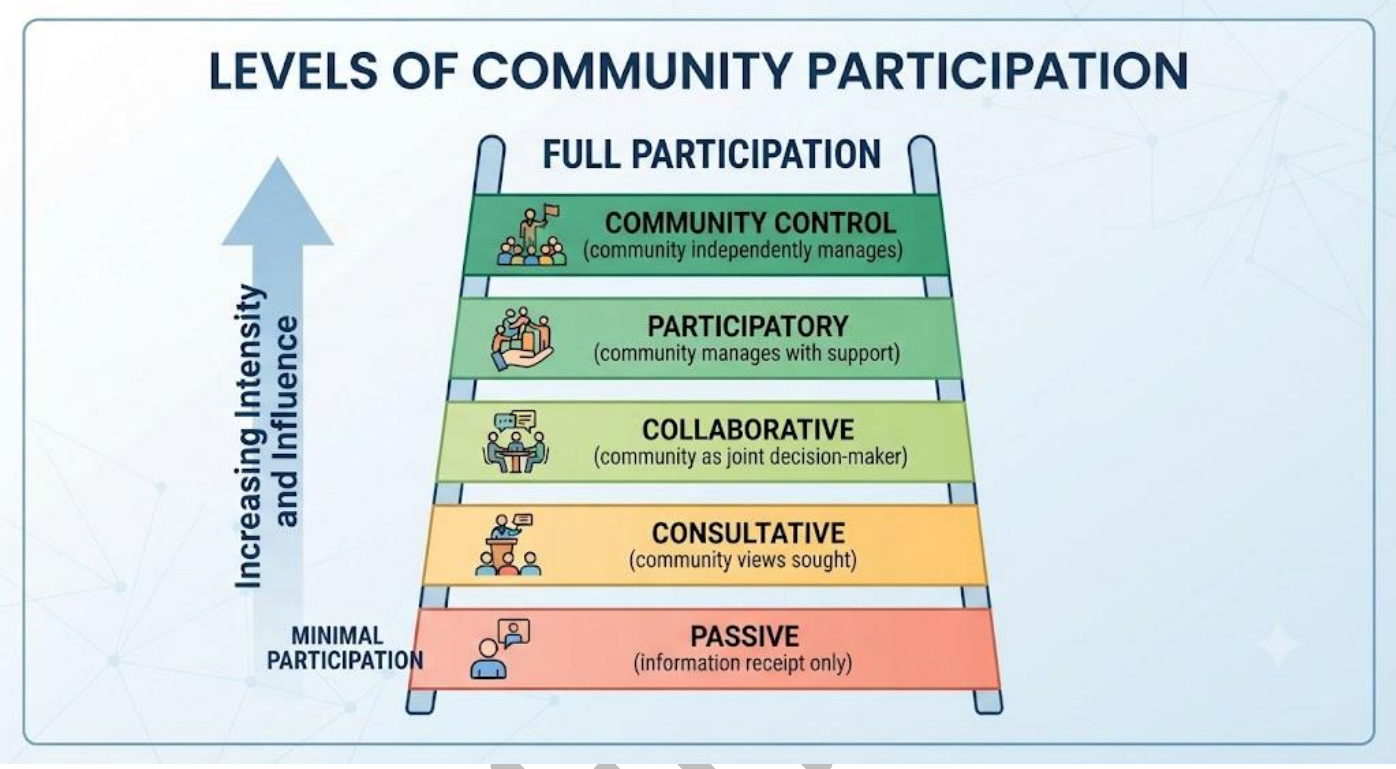

Figure 3.1: The ladder of community participation, from passive information receipt to full community control

Pilot questions 3.1

1. Define community participation in PHC and distinguish it from tokenistic engagement. (Linked to SLO 3.1)
2. Explain why communities possess assets that formal health systems cannot replicate. (Linked to SLO 3.1)
3. Describe the levels of community participation from the lowest to the highest. (Linked to SLO 3.1)
4. Explain why collective participation is generally more powerful than individual participation. (Linked to SLO 3.1)
5. Identify three barriers to effective community participation in PHC. (Linked to SLO 3.1)

3.2 Community Ownership of Health Programmes

3.2.1 The concept of community ownership

Community ownership refers to the degree to which a community regards a health programme as its own, taking responsibility for its continuation, protection, and adaptation rather than viewing it as an external intervention to be passively received or even resisted. A community that genuinely owns a health programme will take steps to maintain it when external support is reduced or withdrawn, will adapt it to changing local circumstances, and will hold service providers accountable for its quality.

Community ownership is closely related to but distinct from community participation: **participation** refers to the process of involvement, while **ownership** refers to the resulting sense of responsibility and investment in the outcome. A community can participate superficially in a programme without developing any sense of ownership if their participation was not genuine or did not influence programme design; conversely, genuine participation consistently built over time tends to generate strong ownership.

Fill in the blank: Community ownership refers to the degree to which a community regards a programme as its own, distinct from participation: participation is the process of involvement while ownership is the resulting sense of _____ and investment.

3.2.2 Building and sustaining community ownership

Building community ownership requires deliberate strategies throughout the programme cycle, not only at the entry and inception stage. Involving the community in **problem identification and needs assessment** from the very beginning creates a foundation of relevance, ensuring the programme addresses needs the community itself regards as important rather than needs determined externally. **Transparent communication** about programme plans, budgets, and decision-making processes builds trust and demonstrates that the programme is genuinely accountable to the community.

Sustaining ownership over the long term requires **building local capacity** so that community members can perform programme functions themselves rather than depending on external technical assistance for every activity. **Celebrating community achievements** and publicly acknowledging the contributions of community volunteers and leaders reinforces the sense that the programme belongs to and is driven by the community. Conversely, actions that undermine ownership include making major programme decisions without consulting the community, failing to follow through on commitments, and replacing community-controlled elements with externally managed ones.

Fill in the blank: Building community ownership involves problem identification from the start, transparent communication, and building local capacity; sustaining it requires celebrating achievements and avoiding _____ that replace community-controlled elements.

3.2.3 Community ownership in the Nigerian PHC context

The Nigerian PHC system has formal mechanisms designed to foster community ownership, most notably the **Village Health Committee** and the **Ward Health Committee**, which provide structured forums through which community members are involved in the governance, planning, and oversight of PHC services in their area. These committees are intended to give communities formal representation in PHC decision-making and to serve as the institutional basis for community ownership.

In practice, the effectiveness of these committees in generating genuine community ownership has varied considerably across different local government areas, depending on factors including the quality of their composition, whether they reflect the diversity of the community including women and marginalised groups, the regularity and quality of their engagement with PHC facility management, and the degree of genuine decision-making authority they actually exercise. Where these committees function well, they represent an important Nigerian expression of the PHC principle of community participation.

Fill in the blank: The Nigerian PHC system has formal ownership mechanisms including the Village Health Committee and the _____ Health Committee, providing structured forums for community involvement in PHC governance.

Key Actions	What to Avoid
Involve community in problem identification	Avoid defining problems externally
Maintain transparent communication	Avoid making major decisions without consultation
Build local capacity	Avoid replacing community functions with external management
Celebrate community achievements	Avoid ignoring community contributions

Table 3.1: Key actions for building and sustaining community ownership and corresponding pitfalls to avoid

Pilot questions 3.2

1. Define community ownership and distinguish it from community participation. (Linked to SLO 3.2)
2. Explain why involving communities in problem identification is essential for building ownership. (Linked to SLO 3.2)
3. Describe three strategies for building community ownership of a health programme. (Linked to SLO 3.2)
4. Describe the formal mechanisms for community ownership in the Nigerian PHC system. (Linked to SLO 3.2)
5. Identify two factors that determine the effectiveness of Ward and Village Health Committees. (Linked to SLO 3.2)

3.3 Community Mobilisation for PHC

3.3.1 The concept and purpose of community mobilisation

Community mobilisation is the process of organising and energising a community to take collective action in pursuit of a shared health goal, channelling the latent capacities, resources, and social ties of a community toward specific, purposeful health activities. It is the active, organisational dimension of community participation, converting individual willingness to engage into coordinated collective action.

The purpose of community mobilisation in PHC extends beyond any single health campaign or programme; effective mobilisation builds **social cohesion** and collective health agency that persist beyond the immediate programme, strengthening the community's long-term capacity to identify and respond to health challenges independently. In the Nigerian context, community mobilisation has been central to the success of large-scale public health campaigns such as the **National Immunisation Days** for polio eradication, where mobilising communities to bring all children forward for vaccination depended critically on organised, community-rooted engagement rather than simply making vaccine available.

Fill in the blank: Community mobilisation organises and energises a community for collective health action, building social cohesion and collective health _____ that persist beyond any single programme.

3.3.2 Approaches and strategies for community mobilisation

Effective community mobilisation typically begins with identifying and engaging **community champions**: respected individuals within the community, such as religious leaders, traditional rulers, women group leaders, or respected elders, whose active endorsement and personal advocacy can powerfully influence broader community engagement. These champions serve as credible intermediaries between health programmes and communities who may initially be suspicious or indifferent.

Other effective mobilisation strategies include **peer education and peer support networks** that leverage existing social relationships to spread health messages and encourage participation, **community health education events** such as health talks at markets, churches, mosques, or schools that reach community members during their normal activities, and **social mobilisation through mass media**, including local radio, public address systems, and, increasingly, social media platforms, to extend reach beyond what face-to-face strategies alone can achieve.

Fill in the blank: Community mobilisation strategies include engaging community champions, peer education networks, health education events, and social mobilisation through mass _____ to extend reach.

3.3.3 Community mobilisation and the village health committee

The **Village Health Committee (VHC)** is the primary institutional structure through which community mobilisation for PHC is organised in Nigeria. The VHC is a community-level committee typically comprising representatives of different segments of the community, including community leaders, women, youth, and health workers, tasked with coordinating community involvement in PHC planning, service monitoring, and health action.

The VHC serves several key functions in mobilising communities for PHC: it **identifies community health needs** and communicates them to the PHC facility management; it **organises community members** to participate in health activities such as immunisation campaigns, environmental sanitation exercises, and health education sessions; it **monitors the quality and coverage of PHC services** and advocates for improvement; and it **manages community health funds** where community financing mechanisms are in operation. An active and representative VHC is one of the most reliable indicators of a well-functioning, community-rooted PHC system.

Fill in the blank: The Village Health Committee identifies community health needs, organises participation in health activities, monitors service quality, and manages community health _____ where community financing is in operation.

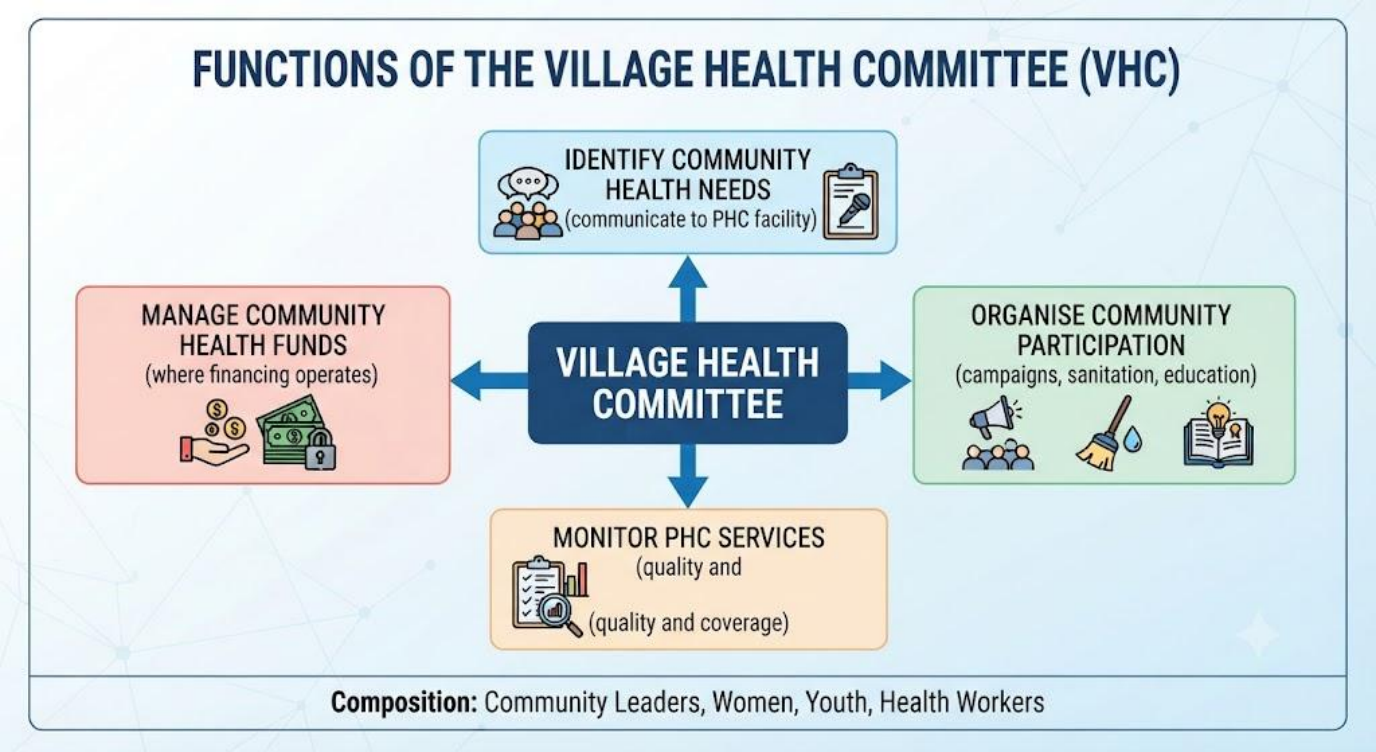

Figure 3.2: The composition and four key functions of the Village Health Committee in the Nigerian PHC system

Pilot questions 3.3

1. Define community mobilisation and explain its purpose in PHC. (Linked to SLO 3.3)
2. Distinguish between community mobilisation and community participation. (Linked to SLO 3.3)
3. Explain the role of community champions in mobilisation strategies. (Linked to SLO 3.3)
4. Describe three strategies for effective community mobilisation in PHC. (Linked to SLO 3.3)
5. Describe the composition and four key functions of the Village Health Committee. (Linked to SLO 3.3)

Series Summary

This Series examined the three interconnected concepts of community participation, community ownership, and community mobilisation that together form the human and social foundation of primary health care. Community participation is the active and meaningful involvement of community members in all stages of the health care process, distinguished from tokenistic engagement by the genuine influence communities have over health decisions; it ranges across levels from passive information receipt through consultation and collaboration to full community control, with collective forms of participation more powerful than individual engagement, and with barriers including health worker attitudes, gender inequities, time constraints, and disillusionment requiring deliberate strategies to overcome. Community ownership is the sense of responsibility and investment that results from genuine participation, distinct from participation as a process; it is built through involving communities in problem identification, transparent communication, and capacity building, and sustained through celebrating achievements and avoiding actions that transfer control back to external actors.

In the Nigerian PHC context, Ward and Village Health Committees provide the formal institutional mechanisms for community participation and ownership, with their practical effectiveness depending on their composition, regularity of engagement, and genuine decision-making authority. Community mobilisation is the organised, collective action dimension of community participation, converting individual willingness into coordinated community activity for health; it is achieved through engaging community champions, peer education, health education events, and mass media, and is organised at the community level primarily through the Village Health Committee, which identifies health needs, organises participation in campaigns and activities, monitors service quality, and manages community health funds. Together, these three concepts describe the shift from communities as objects of health care delivery to communities as active agents of their own health, which the Alma-Ata Declaration identified as central to PHC's transformative vision.

Glossary of Terms

1. **Community participation:** the active and meaningful involvement of community members in all stages of the health care process, from problem identification through planning, implementation, and evaluation.
2. **Tokenistic participation:** superficial engagement in which community members are consulted or informed about decisions already made without having genuine influence on outcomes.
3. **Community ownership:** the degree to which a community regards a health programme as its own and takes responsibility for its continuation, adaptation, and protection.
4. **Community mobilisation:** the process of organising and energising a community to take collective action in pursuit of a shared health goal.
5. **Village Health Committee (VHC):** the community-level committee in Nigeria tasked with coordinating community involvement in PHC planning, service monitoring, and health action.
6. **Ward Health Committee:** a committee at ward level in Nigeria providing a structured forum for community involvement in PHC governance above the village level.
7. **Community champion:** a respected community member whose active endorsement and advocacy powerfully influences broader community engagement with health programmes.
8. **Peer education:** a mobilisation strategy that leverages existing social relationships to spread health messages and encourage participation among community members.
9. **Social mobilisation:** the use of communication channels including radio, public address systems, and social media to extend health mobilisation reach beyond face-to-face methods.

10. **Community agency:** the capacity of a community to independently identify health challenges and take organised action to address them.
11. **National Immunisation Days:** large-scale polio vaccination campaigns in Nigeria that relied critically on community mobilisation to bring all eligible children forward for vaccination.

Concept Check Questions [Series 3]

Objective Questions

- Community participation is the active and meaningful involvement of community members in all stages of health care, from problem identification to planning, implementing, and _____ programmes. (Linked to SLO 3.1)
- Community participation ranges from passive information receipt, through consultation and collaboration, to full community _____. (Linked to SLO 3.1)
- Community _____ refers to the sense of responsibility and investment that results from genuine participation. (Linked to SLO 3.2)
- The formal community ownership mechanism in the Nigerian PHC system includes the Village Health Committee and the _____ Health Committee. (Linked to SLO 3.2)
- Community _____ is the process of organising and energising a community to take collective action for a shared health goal. (Linked to SLO 3.3)
- The Village Health Committee identifies health needs, organises participation, monitors services, and manages community health _____. (Linked to SLO 3.3)

Short-Answer Questions

- Identify three barriers to effective community participation in PHC and suggest one strategy to address each. (Linked to SLO 3.1)
- Explain why community ownership is important for the sustainability of PHC programmes. (Linked to SLO 3.2)
- Describe the composition and functions of the Village Health Committee. (Linked to SLO 3.3)

Long-Answer Questions

- Discuss the concept of community participation in PHC, including its levels, forms, and barriers. (Linked to SLO 3.1)

- Evaluate the concepts of community ownership and community mobilisation and their practical expression in the Nigerian PHC system. (Linked to SLOs 3.2 to 3.3)

Answers to Concept Check Questions [Series 3]

Objective Questions

1. Evaluating.
2. Control.
3. Ownership.
4. Ward.
5. Mobilisation.
6. Funds.

Short-Answer Questions

7. Health worker attitudes (strategy: train health workers in community-centred approaches); gender and power dynamics (strategy: targeted outreach to women and marginalised groups); disillusionment from previous negative experiences (strategy: demonstrate genuine follow-through on community input).
8. Community ownership is important for sustainability because a community that regards a programme as its own will maintain it when external support is reduced or withdrawn, adapt it to changing local circumstances, and hold providers accountable, whereas a programme perceived as externally owned tends to collapse once external support ends.
9. The VHC typically comprises community leaders, women, youth, and health workers. Its four key functions are identifying community health needs and communicating them to PHC management, organising community participation in health activities such as campaigns and sanitation exercises, monitoring the quality and coverage of PHC services, and managing community health funds.

Long-Answer Questions

10. **Basic response:** Definition: active and meaningful involvement in all stages from problem identification through planning, implementation, and evaluation; distinct from tokenistic consultation. Levels: passive (information receipt), consultative (views sought), collaborative (joint decision-making), participatory (community manages with support), community control (full independence). Forms: individual (attending sessions) versus collective (group actions); collective builds shared commitment and accountability. Barriers: health worker attitudes; gender and power dynamics; structural time constraints; disillusionment from past negative experiences. Strategies: flexible scheduling, targeted outreach, demonstrated follow-through.

    Value-added response: The distinction between genuine and tokenistic participation is not merely academic but has direct practical consequences: programmes that consult communities without giving them real influence consume community time and goodwill without generating ownership, and when they fail to respond to community input, they actively damage future participation by reinforcing the experience that participation does not matter; genuine participation, by contrast, builds the trust and ownership that sustain programmes through the inevitable periods of resource constraint and external support reduction that characterise the long-term trajectory of most Nigerian health programmes.

11. **Basic response:** Community ownership: degree to which community regards programme as its own; related to but distinct from participation (process versus resulting responsibility). Building: problem identification involvement, transparent communication, local capacity building. Sustaining: celebrating achievements, maintaining community-controlled elements. Nigerian context: Village Health Committees and Ward Health Committees as formal mechanisms; effectiveness varies with composition, engagement quality, and genuine decision-making authority. Community mobilisation: organising collective health action; purpose includes building lasting social cohesion and health agency. Strategies: community champions, peer education, health education events, social mobilisation through

media. VHC functions: identifying needs, organising participation, monitoring services, managing funds.

Value-added response: The Village Health Committee represents the institutional expression of both community ownership and mobilisation in Nigeria, but its practical effectiveness illustrates a fundamental tension in PHC governance: committees created by government decree are not automatically community-driven, and top-down creation of community structures can paradoxically undermine genuine ownership if communities perceive the committee as a government mechanism rather than a community institution; building committees that genuinely reflect community priorities requires sustained investment in their capacity, genuine respect for their decisions, and willingness to allow communities to shape their own structures rather than conforming to externally imposed templates.

Answers to Pilot Questions [Series 3]

Part 3.1

6. Community participation is the active and meaningful involvement of community members in all stages of health care, from problem identification through planning, implementation, and evaluation. Tokenistic engagement, by contrast, consults or informs communities about decisions already made without giving them real influence.
7. Communities possess local knowledge about their own health problems, resources, and cultural context that formal health systems cannot replicate; programmes designed without this knowledge are less appropriate, accepted, and sustainable than those co-designed with communities.
8. The levels from lowest to highest are passive (information receipt only), consultative (community views are sought), collaborative (community is a joint decision-maker),

participatory (community manages with external support), and community control (community independently manages).

9. Collective participation is more powerful because it builds shared commitment across many individuals, distributes effort so no single person bears the full burden, and creates community-level accountability structures that can sustain health actions beyond the life of any individual or single programme.
10. Three barriers are health worker attitudes that regard communities as recipients rather than partners, gender and power dynamics that exclude women from decision-making, and disillusionment from previous experiences where community input was sought but not acted upon.

Part 3.2

11. Community ownership is the degree to which a community regards a health programme as its own and takes responsibility for its continuation, protection, and adaptation. It differs from participation in that participation is the process of involvement, while ownership is the resulting sense of responsibility and investment.
12. Involving communities in problem identification from the very beginning creates a foundation of relevance, ensuring the programme addresses needs the community itself regards as important; communities that help define the problem are far more likely to feel invested in addressing it.
13. Three strategies are involving communities in problem identification and needs assessment, maintaining transparent communication about plans, budgets, and decisions, and building local capacity so communities can perform programme functions themselves.
14. The formal mechanisms are the Village Health Committee at the village level and the Ward Health Committee at the ward level, both providing structured forums for community involvement in PHC governance, planning, and oversight.

15. Two factors are whether the committee composition reflects community diversity including women and marginalised groups, and whether the committee exercises genuine decision-making authority rather than simply rubber-stamping decisions made by health workers or government officials.

Part 3.3

1. Community mobilisation is the process of organising and energising a community to take collective action in pursuit of a shared health goal; its purpose is to convert individual willingness into coordinated action and to build lasting social cohesion and health agency.
2. Community participation refers to the involvement of communities in health decision-making and programmes, while community mobilisation is specifically the organised, collective action dimension, converting participation into coordinated community-level health activity.
3. Community champions are respected individuals whose active endorsement powerfully influences broader community engagement; they serve as credible intermediaries between health programmes and communities who may be initially suspicious or indifferent.
4. Three strategies are engaging community champions whose endorsement influences community-wide engagement, peer education networks that leverage social relationships to spread messages, and community health education events at markets, churches, or mosques that reach people during normal activities.
5. The VHC typically comprises community leaders, women, youth, and health workers. Its four functions are identifying community health needs and communicating them to PHC management, organising community participation in health activities, monitoring the quality and coverage of PHC services, and managing community health funds.

References and Attributions [Series 3]

Textual References

6. World Health Organization and UNICEF. (1978). Declaration of Alma-Ata. Geneva: WHO.
7. National Primary Health Care Development Agency. (2010). Ward Minimum Health Care Package. Abuja: NPHCDA.
8. Laverack, G. (2007). Health Promotion Practice: Building Empowered Communities. Maidenhead: Open University Press.
9. Park, K. (2017). Park's Textbook of Preventive and Social Medicine (24th ed.). Jabalpur: Banarsidas Bhanot.

Figures, Plates, Tables, and Boxes

10. Figure 3.1: The ladder of community participation levels. AI generation prompt: "Create a clean vertical ladder diagram titled Levels of Community Participation, showing five rungs from bottom to top: Passive (information receipt only), Consultative (community views sought), Collaborative (community as joint decision-maker), Participatory (community manages with support), Community Control (community independently manages); add an upward arrow on the left side labelled Increasing Intensity and Influence; label the top Full Participation and bottom Minimal Participation; use a clean professional infographic style." Suggested OER search string: "community participation ladder levels diagram PHC primary health care".
11. Table 3.1: Building and sustaining community ownership. AI generation prompt: "Create a clean two-column table titled Building and Sustaining Community Ownership: Actions and Pitfalls; columns Key Actions and What to Avoid; four rows:

Involve community in problem identification (avoid defining problems externally), Maintain transparent communication (avoid making major decisions without consultation), Build local capacity (avoid replacing community functions with external management), Celebrate community achievements (avoid ignoring community contributions); use a clean professional table design with a green column for actions and a red column for pitfalls." Suggested OER search string: "community ownership health programme building sustaining table strategies".

12. Figure 3.2: Functions of the Village Health Committee. AI generation prompt: "Create a clean central hub diagram titled Functions of the Village Health Committee (VHC), with a central box labelled Village Health Committee connected by arrows to four surrounding boxes: Identify Community Health Needs (communicate to PHC facility), Organise Community Participation (campaigns, sanitation, education), Monitor PHC Services (quality and coverage), Manage Community Health Funds (where financing operates); add a composition note below: Community Leaders, Women, Youth, Health Workers; use a clean professional infographic style." Suggested OER search string: "Village Health Committee functions diagram Nigeria PHC community".

Course code: COM 401

Course title: Introduction to Primary Health Care

Course credit load: 1 Unit

Series 4: Management of PHC Programmes and Health Planning Cycle

- **Part 4.1: Organisation and Management of PHC Programmes**
  - Sub Part 4.1.1: Organisation structure of PHC programmes
  - Sub Part 4.1.2: Supervision and evaluation of PHC programmes
  - Sub Part 4.1.3: Manpower development and training for PHC
- **Part 4.2: Management Skills and Techniques**
  - Sub Part 4.2.1: Supervision, delegation, and task shifting
  - Sub Part 4.2.2: Motivation in PHC management
  - Sub Part 4.2.3: Leadership concepts in PHC
- **Part 4.3: The Health Planning Cycle**
  - Sub Part 4.3.1: Definition and importance of health planning
  - Sub Part 4.3.2: Steps in health planning
  - Sub Part 4.3.3: Monitoring, evaluation, and feedback in the planning cycle

Introduction

Effective primary health care depends not only on the right principles and components but also on competent management and systematic planning. Even well-designed PHC programmes with adequate resources will underperform if they lack clear organisational structures, skilled supervision, capable leadership, and a rational planning process that responds to evidence and community needs.

This Series examines how PHC programmes are organised and managed at the facility and district levels, the key management skills required including supervision, delegation, motivation, and leadership, and the systematic process of health planning through the planning cycle. Together, these management and planning competencies equip health workers to move from delivering individual PHC services to effectively directing and sustaining entire PHC programmes.

Mastery of these management concepts is essential for any health worker who aspires to a supervisory or coordinating role in the Nigerian PHC system, from PHC facility officers to local government area health officers and beyond.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 4.1** describe the organisation structure, supervision, evaluation, and manpower development of PHC programmes (Linked to Part 4.1),
- **SLO 4.2** describe management skills and techniques used in PHC, including supervision, delegation, task shifting, motivation, and leadership (Linked to Part 4.2), and
- **SLO 4.3** define health planning, enumerate the steps in the health planning cycle, and describe monitoring and evaluation as part of the cycle (Linked to Part 4.3).

4.1 Organisation and Management of PHC Programmes

4.1.1 Organisation structure of PHC programmes

PHC programmes in Nigeria operate within a defined **organisational structure** that spans from the federal level through the state and local government area levels to the community level. At the federal level, the **National Primary Health Care Development Agency (NPHCDA)** sets national policy, standards, and guidelines and coordinates national PHC programmes. At the state level, the **State Primary Health Care Board or Agency** adapts national policy to state contexts, manages state resources for PHC, and supervises local government area activities.

At the **local government area (LGA) level**, the LGA health department is directly responsible for managing PHC services within its jurisdiction, including facility oversight, staff management, and supply chain coordination. PHC **facilities themselves**, ranging from health posts to primary health centres, are the operational units where services are actually delivered, managed by designated facility officers who are accountable to the LGA health authority. This layered structure creates lines of authority, accountability, and support that, when functioning well, enable coherent national PHC policy to be expressed as locally appropriate services.

Fill in the blank: PHC in Nigeria is organised across federal (NPHCDA), state (PHC Board), LGA (health department), and _____ (facility) levels, creating lines of accountability from national policy to local service delivery.

4.1.2 Supervision and evaluation of PHC programmes

Supervision of PHC programmes involves the regular, structured oversight of PHC workers and facilities by more senior staff, aimed at supporting performance improvement rather than merely finding fault. Effective PHC supervision is **supportive and educational** in character, providing guidance, identifying training needs, and solving problems together with frontline staff, rather than being purely inspectorial. Regular supervisory visits use structured **supervision checklists**

to assess facility readiness, staff performance, record-keeping, drug and supply availability, and the quality of clinical services provided.

Evaluation of PHC programmes involves the periodic, systematic assessment of whether a programme is achieving its intended objectives, examining **process indicators** such as coverage of immunisation and antenatal care, **output indicators** such as the number of consultations conducted, and **outcome indicators** such as changes in disease prevalence or maternal mortality rates. Evaluation findings should feed directly into programme planning decisions, enabling continuous improvement rather than existing as a standalone reporting exercise.

Fill in the blank: PHC supervision is supportive and educational, using supervision checklists; evaluation assesses programme performance using process, output, and _____ indicators to feed findings into planning.

4.1.3 Manpower development and training for PHC

Manpower development refers to the systematic effort to ensure the PHC workforce has the skills, knowledge, and competencies required to deliver high-quality services. In Nigeria, the PHC workforce includes **community health extension workers (CHEWs)**, junior community health extension workers (JCHEWs), community health officers (CHOs), nurses, and midwives, each with defined roles and competency requirements established through the relevant professional regulatory bodies.

Training for PHC manpower occurs at multiple levels: **pre-service training** through schools of health technology and universities prepares new entrants to the PHC workforce, while **in-service training** through workshops, short courses, and supervised practice updates the skills of existing workers as service requirements evolve. Identifying training needs through supervision and evaluation, planning training responses, and assessing the impact of training on service quality together constitute a continuous **human resource development cycle** essential to sustaining PHC quality over time.

Fill in the blank: PHC manpower development includes pre-service training preparing new entrants and in-service training updating existing workers, with training needs identified through _____ and evaluation.

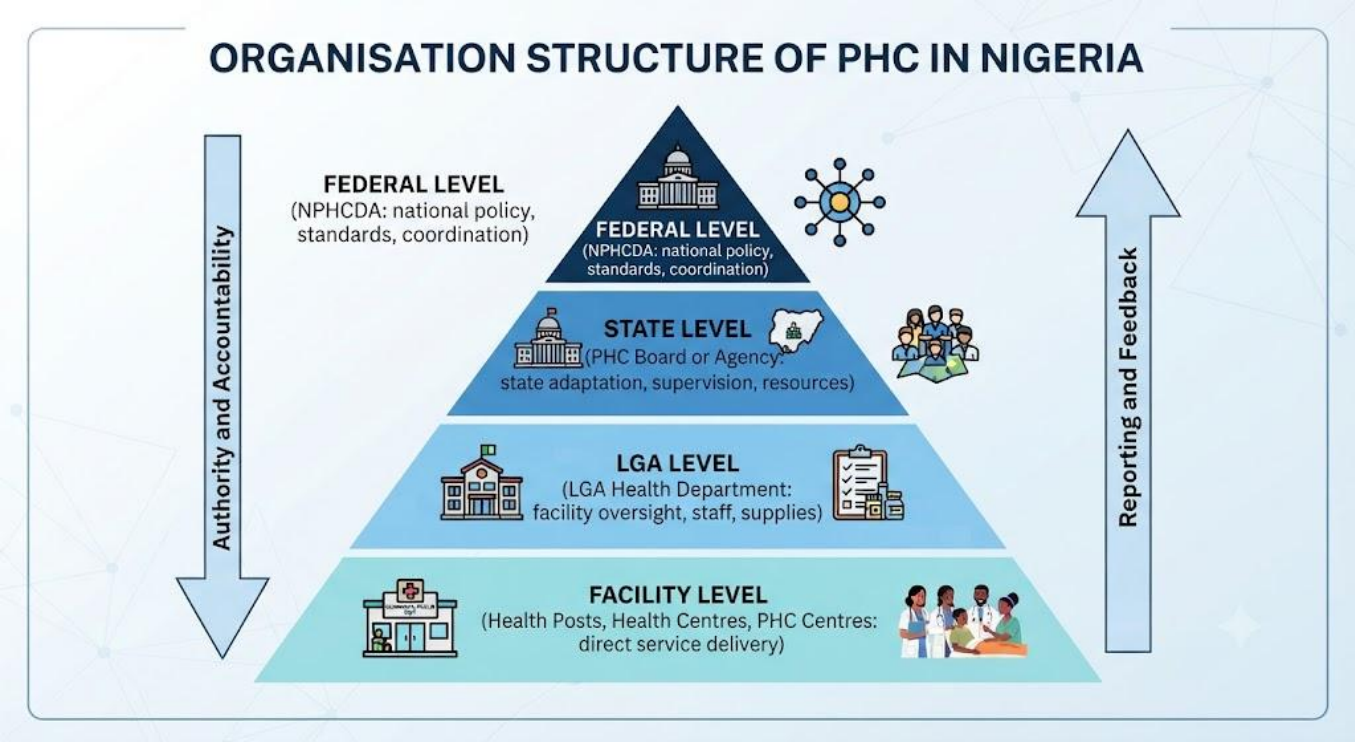

Figure 4.1: The four-tier organisational structure of primary health care in Nigeria, from federal to facility level

Pilot questions 4.1

1. Describe the four levels of PHC organisation in Nigeria and the role of each level. (Linked to SLO 4.1)
2. Distinguish between supportive and inspectorial supervision in PHC. (Linked to SLO 4.1)
3. Explain what is assessed during a PHC supervisory visit. (Linked to SLO 4.1)
4. Distinguish between process, output, and outcome indicators in PHC evaluation. (Linked to SLO 4.1)

5. Describe the two main forms of PHC manpower training and the purpose of each. (Linked to SLO 4.1)

4.2 Management Skills and Techniques

4.2.1 Supervision, delegation, and task shifting

As a management technique, **delegation** involves assigning specific responsibilities or tasks to a subordinate staff member, together with the authority needed to carry out those tasks, while retaining ultimate accountability for the outcome. Effective delegation is essential in PHC management because no single manager or facility officer can perform all necessary functions personally; delegation enables greater coverage of work and develops the skills of junior staff.

Task shifting is a specific form of delegation applied at the system level, involving the rational redistribution of tasks from higher-qualified health workers to workers with fewer qualifications but with the specific training needed to perform the delegated task safely and effectively. In the Nigerian PHC context, task shifting is exemplified by training **community health extension workers** to provide family planning counselling, conduct immunisation, and manage common childhood illnesses that were previously provided only by nurses or clinical officers, extending service coverage without requiring the same number of more highly trained staff.

Fill in the blank: Task shifting rationally redistributes tasks from higher-qualified to appropriately trained lower-qualified staff, exemplified in Nigeria by training CHEWs to provide services previously delivered only by _____ or clinical officers.

4.2.2 Motivation in PHC management

Motivation refers to the internal and external forces that drive individuals to perform their roles with commitment, energy, and sustained effort. In the context of PHC management, understanding motivation matters because PHC workers, particularly in rural settings, often face significant challenges including **difficult working conditions, geographic isolation, inadequate facilities, and limited career advancement opportunities** that can erode the initial commitment that drew them to health service.

Effective PHC managers use both **intrinsic motivators**, such as recognising achievement, providing meaningful work, fostering professional identity and mission, and offering learning

and growth opportunities, and **extrinsic motivators**, including fair remuneration, regular salary payment, performance incentives, and access to career development. Identifying which motivational factors are most important for a given workforce, through supervision conversations and staff engagement, and systematically addressing them, is a core skill of effective PHC management.

Fill in the blank: PHC managers use intrinsic motivators such as recognition and meaningful work alongside extrinsic motivators including fair remuneration and career _____ to sustain workforce commitment.

4.2.3 Leadership concepts in PHC

Leadership in PHC management is the ability to influence others, inspire commitment to shared health goals, and guide a team or organisation toward those goals effectively. **Transformational leadership** inspires health workers by connecting their work to a compelling shared vision of community health improvement. **Servant leadership** emphasises the leader's role in removing barriers and supporting staff performance rather than directing from above.

Situational leadership recognises that the most effective style depends on the readiness and capability of the team and the demands of the specific situation; a new, inexperienced staff member may need directive guidance while an experienced, self-motivated team member benefits more from autonomy and delegation. Regardless of style, effective PHC leaders share certain qualities, including **clear communication**, **integrity and trustworthiness**, the ability to make decisions under uncertainty, and commitment to continuous improvement of services for the communities they serve.

Fill in the blank: Transformational leadership inspires through a shared vision; servant leadership removes barriers for staff; and _____ leadership adapts style to the readiness and capability of the team member.

Skill or Technique	Description and Example
Delegation	Assigning tasks and authority to subordinates while retaining accountability

Task Shifting	Redistributing tasks to appropriately trained lower-cadre workers; e.g. CHEWs trained for immunisation in Nigeria
Intrinsic Motivation	Recognition, meaningful work, professional identity
Extrinsic Motivation	Fair remuneration, career advancement, performance incentives
Transformational Leadership	Inspiring through shared vision
Servant Leadership	Removing barriers, supporting staff
Situational Leadership	Adapting style to team readiness

Table 4.1: Key management skills and techniques used in primary health care, with descriptions and examples

Pilot questions 4.2

1. Define delegation and explain why it is essential in PHC management. (Linked to SLO 4.2)
2. Define task shifting and give one example from the Nigerian PHC context. (Linked to SLO 4.2)
3. Distinguish between intrinsic and extrinsic motivators and give two examples of each. (Linked to SLO 4.2)
4. Describe the challenges that can erode PHC worker motivation in rural settings. (Linked to SLO 4.2)
5. Describe three leadership styles relevant in PHC management and state when each is most appropriate. (Linked to SLO 4.2)

4.3 The Health Planning Cycle

4.3.1 Definition and importance of health planning

Health planning is the rational, systematic process of deciding in advance what health services will be provided, by whom, to whom, where, when, and with what resources, in order to achieve defined health objectives within available means. It translates broad health policy goals into specific, actionable programmes with clear timelines, responsibilities, and resource requirements.

Health planning is important because it ensures **rational allocation** of scarce health resources toward the highest-priority needs rather than allowing resources to flow by default to the loudest voices or most visible problems. It creates **accountability** by establishing clear objectives against which performance can later be measured, supports **coordination** among multiple actors whose activities must be aligned to achieve common goals, and provides the **evidence base** for resource mobilisation from government, donors, and communities.

Fill in the blank: Health planning rationally allocates scarce resources, creates accountability through clear objectives, supports coordination among actors, and provides an evidence base for resource _____.

4.3.2 Steps in health planning

The **health planning cycle** is a structured, repeating sequence of steps through which health plans are developed, implemented, and reviewed. The first step is **situation analysis**, assessing the current health status, available resources, and existing services. The second step is **priority setting**, determining which health problems and populations should receive the greatest attention given available resources.

The third step is **objective setting**, defining specific, measurable targets following SMART principles. The fourth step is **activity planning**, specifying the particular activities that will achieve the objectives, with responsible parties, timelines, and resource requirements. The fifth step is **implementation**, carrying out the planned activities, and the sixth is **monitoring and evaluation**, assessing progress and performance against the plan to inform the next planning cycle.

Fill in the blank: The health planning cycle proceeds through situation analysis, priority setting, objective setting, activity planning, implementation, and _____ and evaluation, forming a repeating cycle.

4.3.3 Monitoring, evaluation, and feedback in the planning cycle

Monitoring is the continuous, routine collection and review of data on programme activities and outputs during implementation, providing early warning of implementation problems so they can be corrected while the programme is still running. Monitoring focuses on **what is happening**, using indicators such as the number of antenatal care visits conducted per month, immunisation coverage, or essential drug availability at facilities.

Evaluation is the periodic, in-depth assessment of whether a programme has achieved its objectives and what difference it has made, examining outcomes and, where possible, impact. Evaluation provides the evidence needed to decide whether a programme should be continued, expanded, modified, or discontinued. **Feedback** is the systematic communication of monitoring and evaluation findings back to programme staff, managers, and communities, closing the planning cycle by informing the next round of situation analysis and ensuring continuous quality improvement.

Fill in the blank: Monitoring collects routine data on activities; evaluation assesses objective achievement; and _____ communicates findings back to staff and communities to inform the next planning cycle.

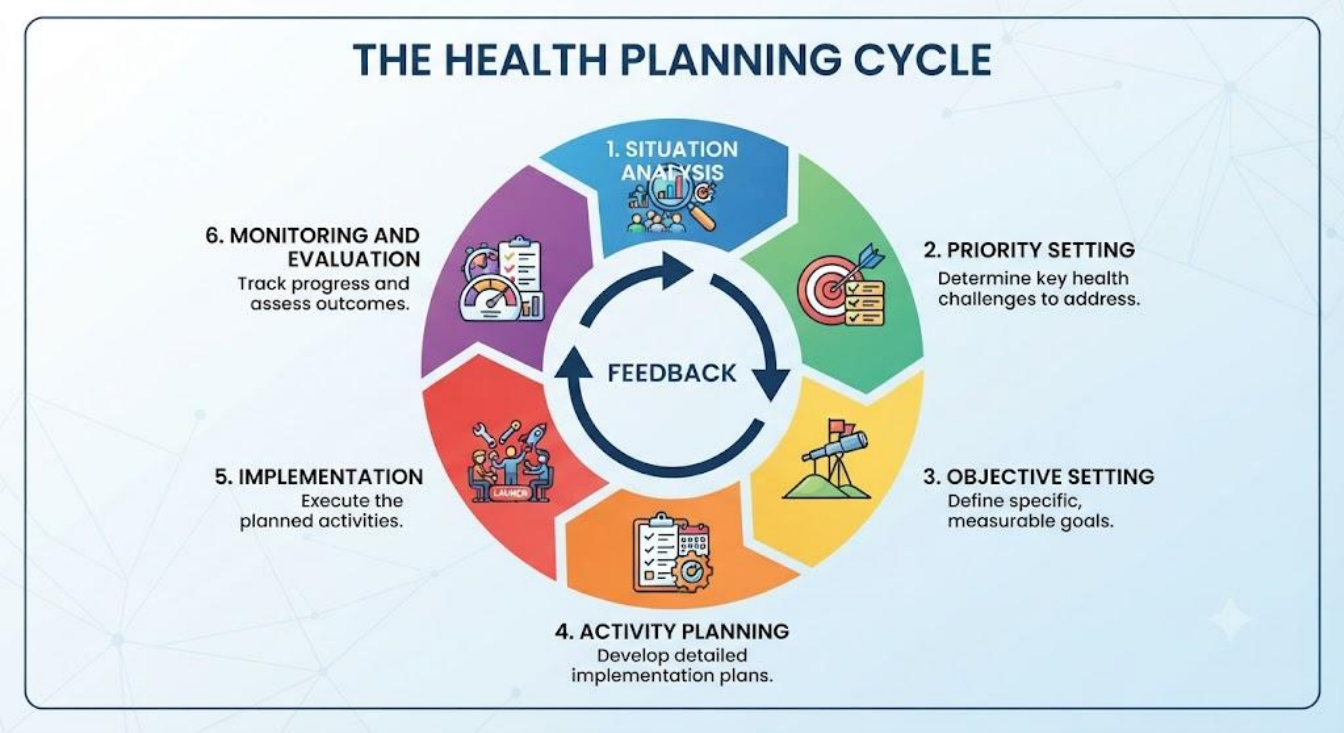

Figure 4.2: The six-step health planning cycle, from situation analysis through to monitoring, evaluation, and feedback

Pilot questions 4.3

1. Define health planning and explain its importance for PHC programmes. (Linked to SLO 4.3)
2. List the six steps of the health planning cycle in order. (Linked to SLO 4.3)
3. Explain what is assessed during the situation analysis step. (Linked to SLO 4.3)
4. Distinguish between monitoring and evaluation in the health planning cycle. (Linked to SLO 4.3)
5. Explain the role of feedback in the health planning cycle. (Linked to SLO 4.3)

Series Summary

This Series examined the management and planning foundations of primary health care. PHC programmes in Nigeria are organised across four levels: the NPHCDA at federal level sets national policy and standards; state PHC Boards adapt policy and supervise LGA activities; LGA health departments manage PHC facilities and staff; and facilities are the operational service delivery units. Supervision of PHC is most effective when supportive and educational, using structured checklists to assess facility readiness, staff performance, and service quality, with findings informing training and improvement. Evaluation uses process, output, and outcome indicators to assess whether programme objectives are being achieved, and manpower development combines pre-service and in-service training to maintain a competent PHC workforce.

The management skills required of PHC managers include delegation, assigning tasks and authority while retaining accountability; task shifting, redistributing tasks to appropriately trained lower-cadre workers to extend service coverage; motivation through intrinsic factors such as recognition and meaningful work and extrinsic factors such as fair remuneration and career development; and situational leadership adapting style from transformational to servant to directive depending on team capability. The health planning cycle provides the systematic framework for translating policy into action, proceeding through situation analysis, priority setting, objective setting, activity planning, implementation, and monitoring and evaluation, with feedback closing the cycle by communicating findings back to planners and communities to inform the next round of planning and ensure continuous quality improvement.

Glossary of Terms

1. **Organisational structure:** the defined arrangement of roles, responsibilities, and lines of authority and accountability within a PHC programme.
2. **Supportive supervision:** PHC supervision that is educational and improvement-oriented, providing guidance and solving problems with frontline staff.

3. **Process indicator:** a measure of programme activity, such as immunisation coverage, used to monitor whether planned activities are being carried out.
4. **Outcome indicator:** a measure of the health change produced by a programme, such as reduction in under-five mortality, used to evaluate programme impact.
5. **Community health extension worker (CHEW):** a category of PHC worker in Nigeria trained to provide preventive, promotive, and basic curative services at the community level.
6. **Delegation:** the assignment of specific tasks and authority to a subordinate while the delegating manager retains ultimate accountability.
7. **Task shifting:** the rational redistribution of tasks from higher-qualified to appropriately trained lower-qualified health workers to extend service coverage.
8. **Transformational leadership:** a leadership style that inspires workers by connecting their work to a compelling shared vision of community health improvement.
9. **Situational leadership:** a leadership approach that adapts style to the readiness and capability of the team member and demands of the situation.
10. **Health planning cycle:** the structured repeating sequence of situation analysis, priority setting, objective setting, activity planning, implementation, and monitoring and evaluation.
11. **Feedback:** the systematic communication of monitoring and evaluation findings back to staff, managers, and communities to inform the next planning cycle.

Concept Check Questions [Series 4]

Objective Questions

- The apex federal body responsible for PHC development, coordination, and monitoring in Nigeria is the _____. (Linked to SLO 4.1)
- Effective PHC supervision is _____ and educational, supporting performance improvement rather than merely finding fault. (Linked to SLO 4.1)
- Task _____ rationally redistributes specific tasks from higher-qualified to appropriately trained lower-qualified health workers. (Linked to SLO 4.2)
- Intrinsic motivators include recognition and meaningful work, while extrinsic motivators include fair remuneration and career _____. (Linked to SLO 4.2)
- The first step of the health planning cycle is _____ analysis, assessing current health status, resources, and services. (Linked to SLO 4.3)
- _____ communicates monitoring and evaluation findings back to staff and communities to inform the next planning cycle. (Linked to SLO 4.3)

Short-Answer Questions

- Describe the four levels of PHC organisation in Nigeria. (Linked to SLO 4.1)
- Define task shifting and give one example from the Nigerian PHC context. (Linked to SLO 4.2)
- List the six steps of the health planning cycle in correct order. (Linked to SLO 4.3)

Long-Answer Questions

- Discuss the management skills required for effective PHC management, including delegation, task shifting, motivation, and leadership. (Linked to SLO 4.2)
- Describe the health planning cycle, explaining the purpose of each step and the role of monitoring, evaluation, and feedback. (Linked to SLO 4.3)

Answers to Concept Check Questions [Series 4]

Objective Questions

1. National Primary Health Care Development Agency (NPHCDA).
2. Supportive.
3. Shifting.
4. Development.
5. Situation.
6. Feedback.

Short-Answer Questions

7. Federal level: NPHCDA sets national policy, standards, and guidelines. State level: PHC Board adapts policy, manages resources, and supervises LGA activities. LGA level: LGA health department manages facilities, staff, and supply chains. Facility level: health posts, health centres, and PHC centres deliver services directly to communities.
8. Task shifting is the rational redistribution of specific tasks from higher-qualified to appropriately trained lower-qualified workers. In Nigeria, CHEWs are trained to provide family planning counselling, immunisation, and management of common childhood illnesses previously delivered only by nurses or clinical officers.
9. The six steps in order are situation analysis, priority setting, objective setting, activity planning, implementation, and monitoring and evaluation.

Long-Answer Questions

10. **Basic response:** Delegation: assigns tasks and authority to subordinates while retaining accountability; enables wider coverage; develops junior staff. Task shifting: system-level redistribution of tasks to appropriately trained lower-cadre workers; Nigerian example: CHEWs trained for immunisation, family planning, and childhood illness management. Motivation: intrinsic (recognition, meaningful work, professional identity, learning); extrinsic (fair pay, regular salary, incentives, career

development). Leadership: transformational (shared vision); servant (removes barriers, supports staff); situational (adapts to team readiness; directive for new staff, autonomy for experienced staff); qualities include communication, integrity, decision-making under uncertainty.

Value-added response: These management skills form a mutually reinforcing system: supportive supervision identifies training needs addressed through manpower development and the motivational issues that leadership must address; delegation and task shifting free senior staff for planning and supervisory functions rather than routine tasks; and motivated, well-led staff respond more effectively to supervision and sustain quality through the resource constraints that characterise Nigerian PHC delivery.

11. **Basic response:** Six steps: (1) situation analysis: assesses current health status, resources, existing services. (2) priority setting: determines which problems and populations receive greatest attention. (3) objective setting: defines SMART targets. (4) activity planning: specifies activities, responsibilities, timelines, resource requirements. (5) implementation: carries out planned activities. (6) monitoring and evaluation: monitoring is continuous routine data collection on activities and outputs (process and output indicators); evaluation is periodic in-depth assessment of objective achievement (outcomes and impact). Feedback: systematically communicates findings to staff, managers, and communities; closes the cycle by informing the next situation analysis; ensures continuous quality improvement.

    Value-added response: The planning cycle's greatest value lies in its iterative nature: each evaluation informs a better situation analysis, each situation analysis generates more refined priorities, and continuous monitoring catches problems early enough to correct them; in practice, Nigerian PHC planning is often disrupted by resource shortfalls and staff changes, making institutional planning capacity building, including training staff in data use and feedback communication, as important as the technical content of any particular plan.

Answers to Pilot Questions [Series 4]

Part 4.1

6. Federal level: NPHCDA sets national policy, standards, and coordination. State level: PHC Board adapts policy, manages resources, and supervises LGAs. LGA level: LGA health department oversees facilities, staff, and supplies. Facility level: health posts, health centres, and PHC centres deliver direct services to communities.
7. Supportive supervision aims to improve performance through guidance, education, and joint problem-solving, while inspectorial supervision focuses on finding fault and enforcing compliance without building staff capacity.
8. A supervisory visit assesses facility readiness including equipment and supplies, staff performance, record-keeping quality, drug and supply availability, and the quality of clinical services delivered.
9. Process indicators measure programme activities such as immunisation coverage. Output indicators measure the volume of services produced such as number of consultations. Outcome indicators measure health changes such as reduction in disease prevalence or maternal mortality.
10. Pre-service training through schools of health technology prepares new entrants with foundational PHC competencies. In-service training through workshops and short courses updates existing workers' skills as service requirements and evidence evolve.

Part 4.2

11. Delegation assigns specific tasks and the authority to carry them out to a subordinate while retaining ultimate accountability; it is essential because no single manager can perform all functions personally, enabling wider coverage and developing junior staff.
12. Task shifting is the rational redistribution of specific tasks from higher-qualified to appropriately trained lower-qualified workers. In Nigeria, CHEWs are trained to

provide immunisation, family planning counselling, and management of common childhood illnesses previously reserved for nurses.

13. Intrinsic motivators are internal, such as recognition of achievement and meaningful work. Extrinsic motivators are external rewards, such as fair remuneration and career advancement opportunities.
14. Challenges include difficult working conditions, geographic isolation from family and peers, inadequate facilities and supplies preventing effective care, and limited career advancement compared to urban health workers.
15. Transformational leadership inspires through a shared vision, most appropriate for motivating teams toward ambitious goals. Servant leadership removes barriers for staff, most appropriate when teams need enabling conditions. Situational leadership adapts style to team readiness, using directive guidance for new staff and delegating autonomy to experienced self-motivated staff.

Part 4.3

1. Health planning is the rational, systematic process of deciding in advance what services will be provided, by whom, where, and with what resources. It is important because it rationally allocates scarce resources, creates accountability, supports coordination, and provides an evidence base for resource mobilisation.
2. The six steps in order are situation analysis, priority setting, objective setting, activity planning, implementation, and monitoring and evaluation.
3. Situation analysis assesses the current health status, available resources, and existing services to establish a clear and accurate picture of where the health system currently stands as the foundation for all subsequent planning.
4. Monitoring is continuous routine data collection during implementation, focusing on what is happening using process and output indicators. Evaluation is periodic in-depth assessment of whether objectives have been achieved, examining outcomes and impact.

5. Feedback systematically communicates monitoring and evaluation findings to staff, managers, and communities, closing the planning cycle by informing the next situation analysis and ensuring each planning cycle benefits from the evidence of the previous one.

References and Attributions [Series 4]

Textual References

6. National Primary Health Care Development Agency. (2010). Ward Minimum Health Care Package. Abuja: NPHCDA.
7. Federal Ministry of Health Nigeria. (2016). Basic Health Care Provision Fund Implementation Framework. Abuja: FMOH.
8. Park, K. (2017). Park's Textbook of Preventive and Social Medicine (24th ed.). Jabalpur: Banarsidas Bhanot.
9. World Health Organization. (2010). Monitoring the Building Blocks of Health Systems. Geneva: WHO.

Figures, Plates, Tables, and Boxes

10. Figure 4.1: The four-tier organisational structure of PHC in Nigeria. AI generation prompt: "Create a clean four-tier pyramid diagram titled Organisation Structure of PHC in Nigeria, showing from top to bottom: Federal Level (NPHCDA: national policy, standards, coordination); State Level (PHC Board or Agency: state adaptation, supervision, resources); LGA Level (LGA Health Department: facility oversight, staff, supplies); Facility Level (Health Posts, Health Centres, PHC Centres: direct service delivery); add downward arrows labelled Authority and Accountability on the left side and upward arrows labelled Reporting and Feedback on the right side; use a clean professional infographic pyramid style." Suggested OER search string: "PHC organisation structure Nigeria NPHCDA LGA pyramid diagram".
11. Table 4.1: Key management skills and techniques in PHC. AI generation prompt: "Create a clean two-column table titled Management Skills and Techniques in PHC;

columns Skill or Technique and Description and Example; seven rows: Delegation, Task Shifting (CHEWs for immunisation), Intrinsic Motivation, Extrinsic Motivation, Transformational Leadership, Servant Leadership, Situational Leadership; use a clean professional table design with alternating row shading." Suggested OER search string: "PHC management skills techniques delegation task shifting motivation leadership table".

12. Figure 4.2: The six-step health planning cycle. AI generation prompt: "Create a clean circular cycle diagram titled The Health Planning Cycle, with six stages clockwise: Situation Analysis; Priority Setting; Objective Setting; Activity Planning; Implementation; Monitoring and Evaluation; add a Feedback arrow from Stage 6 back to Stage 1; clean professional infographic style with distinct colours." Suggested OER search string: "health planning cycle six steps circular diagram monitoring evaluation feedback".

Course code: COM 401
Course title: Introduction to Primary Health Care
Course credit load: 1 Unit

Series 5: Financing, Information Systems, Laws, and Laboratories in PHC

- **Part 5.1: Financing of Primary Health Care**
    - Sub Part 5.1.1: Sources of PHC financing in Nigeria
    - Sub Part 5.1.2: The Basic Health Care Provision Fund
    - Sub Part 5.1.3: Challenges and strategies for sustainable PHC financing
- **Part 5.2: Health Management Information Systems**
    - Sub Part 5.2.1: Definition and purpose of health management information systems
    - Sub Part 5.2.2: Data collection and reporting in PHC
    - Sub Part 5.2.3: Using information for decision-making in PHC
- **Part 5.3: Laws, Regulations, and Laboratory Services in PHC**
    - Sub Part 5.3.1: Legal and regulatory framework for PHC in Nigeria
    - Sub Part 5.3.2: Health and safety regulations relevant to PHC
    - Sub Part 5.3.3: Laboratory services at the PHC level

Introduction

Primary health care cannot function sustainably without adequate, reliable financing, a functioning information system to guide decisions, a supportive legal framework, and accessible diagnostic support through laboratory services. These infrastructure elements are less visible than direct service delivery but are among the most important determinants of whether PHC systems actually work in practice or exist only on paper.

This final Series examines the financing of PHC, including the sources of funding available in Nigeria, the landmark Basic Health Care Provision Fund established under the National Health Act, and the persistent challenges of resource mobilisation and allocation. It then examines health management information systems, how data are collected, reported, and used for decision-making at the PHC level. The Series concludes by reviewing the legal and regulatory framework governing PHC in Nigeria and the laboratory services that support PHC diagnosis and disease surveillance.

Together, these topics complete the foundation knowledge required for effective and informed participation in Nigeria's primary health care system, connecting the principles, components, services, and management approaches examined in earlier Series to the enabling systems and structures that support them.

Series Learning Outcomes

Upon completing this Series, you should be able to:

- **SLO 5.1** describe the sources of PHC financing in Nigeria, the Basic Health Care Provision Fund, and the challenges of sustainable PHC financing (Linked to Part 5.1),
- **SLO 5.2** define health management information systems and describe data collection, reporting, and use for decision-making in PHC (Linked to Part 5.2), and

- **SLO 5.3** describe the legal and regulatory framework for PHC in Nigeria and the laboratory services available at the PHC level (Linked to Part 5.3).

5.1 Financing of Primary Health Care

5.1.1 Sources of PHC financing in Nigeria

PHC financing in Nigeria draws on multiple sources, reflecting the country's federal structure and the involvement of multiple stakeholders in health. **Government funding** at the federal, state, and local government area levels constitutes the primary intended source of PHC financing, with each tier theoretically responsible for funding the PHC services within its jurisdiction. In practice, however, the LGA level, which bears primary constitutional responsibility for PHC delivery, is chronically underfunded, receiving the smallest share of the federation account allocations despite its frontline service delivery role.

Beyond government funding, PHC financing sources include **donor and international partner contributions**, which have historically funded significant portions of immunisation, malaria control, and reproductive health programmes in Nigeria, **community financing mechanisms** such as community health funds and cooperative health schemes that pool resources at the community level, and **out-of-pocket payments** by individual households, which remain the dominant form of health financing for most Nigerians despite their well-documented tendency to deter service utilisation among the poor and to cause financial catastrophe for households facing major illness.

Fill in the blank: PHC financing in Nigeria draws on government funding at federal, state, and LGA levels, donor contributions, community financing, and out-of-pocket _____ by households.

5.1.2 The Basic Health Care Provision Fund

The **Basic Health Care Provision Fund (BHCPF)** was established under Section 11 of the National Health Act of 2014 as a transformative mechanism for improving and stabilising PHC financing in Nigeria. The Fund is constituted from a **one percent annual allocation from the**

Consolidated Revenue Fund of the federal government, supplemented by contributions from donor partners, providing a dedicated and predictable funding stream for PHC specifically protected from the annual discretionary budget process.

The BHCPF is disbursed through three channels: **fifty percent** is directed through the National Health Insurance Authority to reimburse PHC facilities for services provided to enrolled and indigent beneficiaries; **forty-five percent** is directed through the NPHCDA to fund the Ward Minimum Health Care Package, supporting facility infrastructure, essential medicines, and basic equipment at the ward level; and **five percent** is directed to the Federal Ministry of Health for emergency medical treatment. The BHCPF represents the most significant financing reform in Nigerian PHC history and, when fully and consistently implemented, has the potential to transform resource availability at the community level.

Fill in the blank: The BHCPF is constituted from one percent of the Consolidated Revenue Fund and disbursed 50% through the National Health Insurance Authority, 45% through the NPHCDA, and 5% to the Federal Ministry of Health for _____ treatment.

5.1.3 Challenges and strategies for sustainable PHC financing

Several persistent challenges undermine the sustainability of PHC financing in Nigeria. **Underfunding** remains the most fundamental, with the country falling well short of the 15 percent of government budgets committed to health by African heads of state in the 2001 Abuja Declaration, leaving PHC facilities chronically short of essential medicines, equipment, and qualified staff. **Irregular and delayed fund releases** even where funds are budgeted prevent facilities from planning and maintaining consistent services throughout the year.

Strategies to address financing challenges include **full and timely implementation of the BHCPF**, advocacy for increased government health budget allocations at all levels, strengthening **community-based health insurance schemes** to pool risk and reduce dependence on out-of-pocket payments, improving **public financial management** and accountability systems to ensure that allocated funds actually reach facility level, and engaging **private sector partners** through public-private partnerships in PHC delivery where appropriate. Building

sustainable financing for PHC requires simultaneous action on resource mobilisation, efficient allocation, and accountability.

Fill in the blank: Strategies for sustainable PHC financing include full BHCPF implementation, increased budget allocations, community health insurance, improved public financial management, and _____ sector partnerships in service delivery.

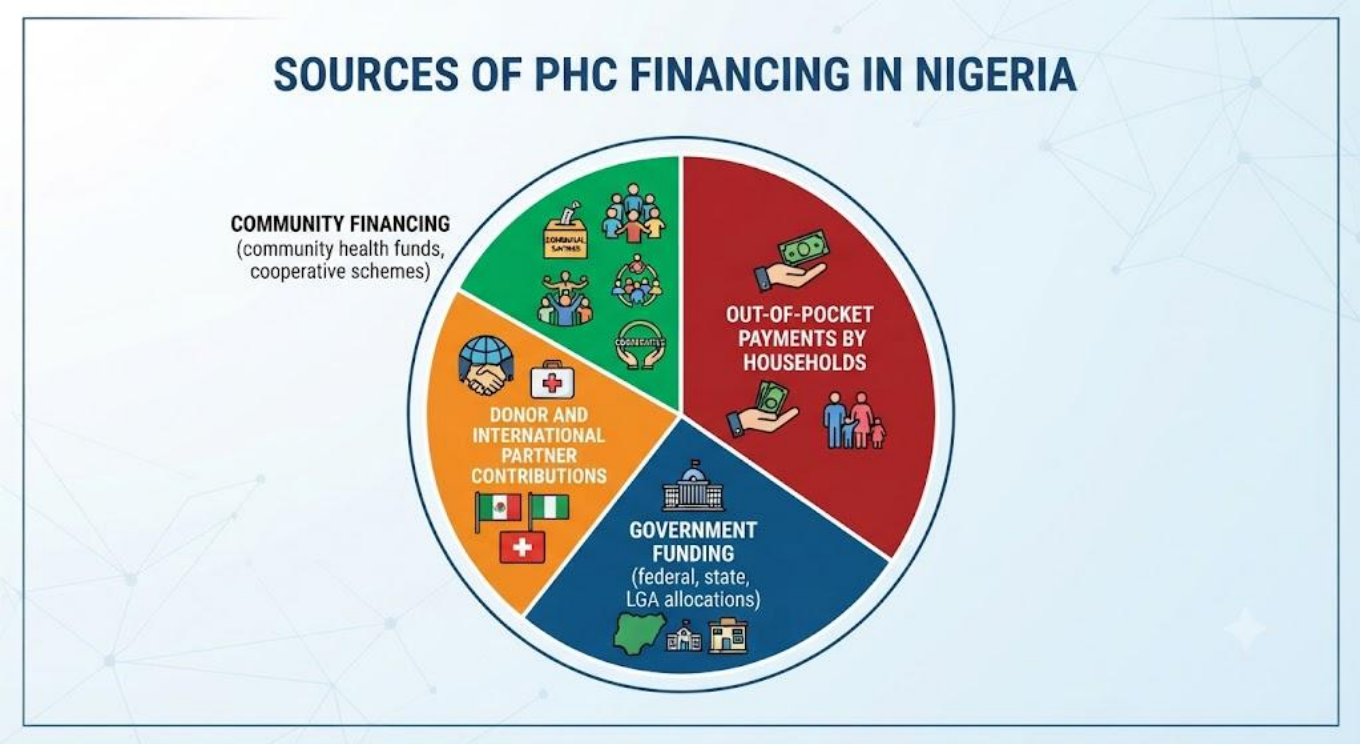

Figure 5.1: Sources of primary health care financing in Nigeria, showing the mix of government, donor, community, and household sources

Pilot questions 5.1

1. List four sources of PHC financing in Nigeria. (Linked to SLO 5.1)
2. Explain why out-of-pocket payments are a problematic form of PHC financing. (Linked to SLO 5.1)
3. Describe the legal basis and constitution of the Basic Health Care Provision Fund. (Linked to SLO 5.1)

4. Describe how the BHCPF is disbursed across its three channels. (Linked to SLO 5.1)
5. Identify three challenges to sustainable PHC financing in Nigeria. (Linked to SLO 5.1)

5.2 Health Management Information Systems

5.2.1 Definition and purpose of health management information systems

A **Health Management Information System (HMIS)** is an organised system for the collection, processing, analysis, storage, and communication of health data, designed to provide decision-makers at all levels of the health system with the information they need to plan, manage, and evaluate health programmes effectively. Without a functioning HMIS, PHC managers lack the evidence needed to identify priority health problems, allocate resources rationally, or monitor whether programmes are reaching their intended beneficiaries.

The purpose of an HMIS extends beyond mere data collection; it exists to support **informed decision-making** at every level from the individual facility to the national ministry of health. A well-functioning HMIS generates **timely** data, available when decisions need to be made; **accurate** data, reflecting the actual situation rather than recording errors or fabricated returns; **complete** data, covering all facilities and all service dimensions; and **actionable** data, presented in formats and at levels of aggregation useful for the specific decisions being made.

Fill in the blank: An HMIS collects, processes, analyses, and communicates health data to support informed decision-making; effective HMIS data must be timely, accurate, complete, and _____.

5.2.2 Data collection and reporting in PHC

Data collection in PHC facilities occurs primarily through standardised **patient registers and tally sheets** maintained by PHC staff for each service area, such as the antenatal care register, the immunisation tally sheet, and the outpatient attendance register. These primary data sources are aggregated into **monthly summary forms** that are submitted from facilities to LGA health departments, and from LGAs to state health authorities, following a defined reporting schedule.

The quality of HMIS data depends critically on the **completeness and timeliness of facility reporting**, since missing or late returns create gaps and distortions in the aggregate data upon which planning and evaluation depend. In Nigeria, the **District Health Information System 2 (DHIS2)** platform is the primary electronic tool through which facility-level data is entered, aggregated, visualised, and transmitted up the reporting hierarchy, replacing earlier paper-based systems and enabling more timely and flexible data use at all levels.

Fill in the blank: PHC data is collected through patient registers and tally sheets, aggregated into monthly summary forms, and entered into the _____ 2 (DHIS2) electronic platform for transmission and analysis.

5.2.3 Using information for decision-making in PHC

The value of an HMIS is fully realised only when the data it generates are actively used to guide decisions at the facility, LGA, state, and national levels. At the **facility level**, monthly data review meetings allow PHC staff and facility managers to identify service gaps, declining coverage trends, or emerging disease patterns that require immediate action. At the **LGA level**, aggregated facility data supports supervision planning, resource allocation, and identification of underperforming facilities requiring targeted support.

Building a culture of **data use** within PHC facilities and health departments requires deliberate investment in staff capacity to interpret data and act on findings, as well as management systems that reward data-driven decision-making rather than treating data collection as a reporting obligation with no practical consequence. Presenting data visually through **graphs, charts, and dashboards** increases its accessibility and comprehension, while regular **data quality reviews** at facility and LGA level catch recording errors and incomplete returns before they propagate into flawed aggregate data that misleads decision-makers.

Fill in the blank: Data use in PHC requires monthly review meetings at facility level, aggregated analysis at LGA level, staff capacity to interpret data, and regular data _____ reviews to catch errors before they distort aggregate findings.

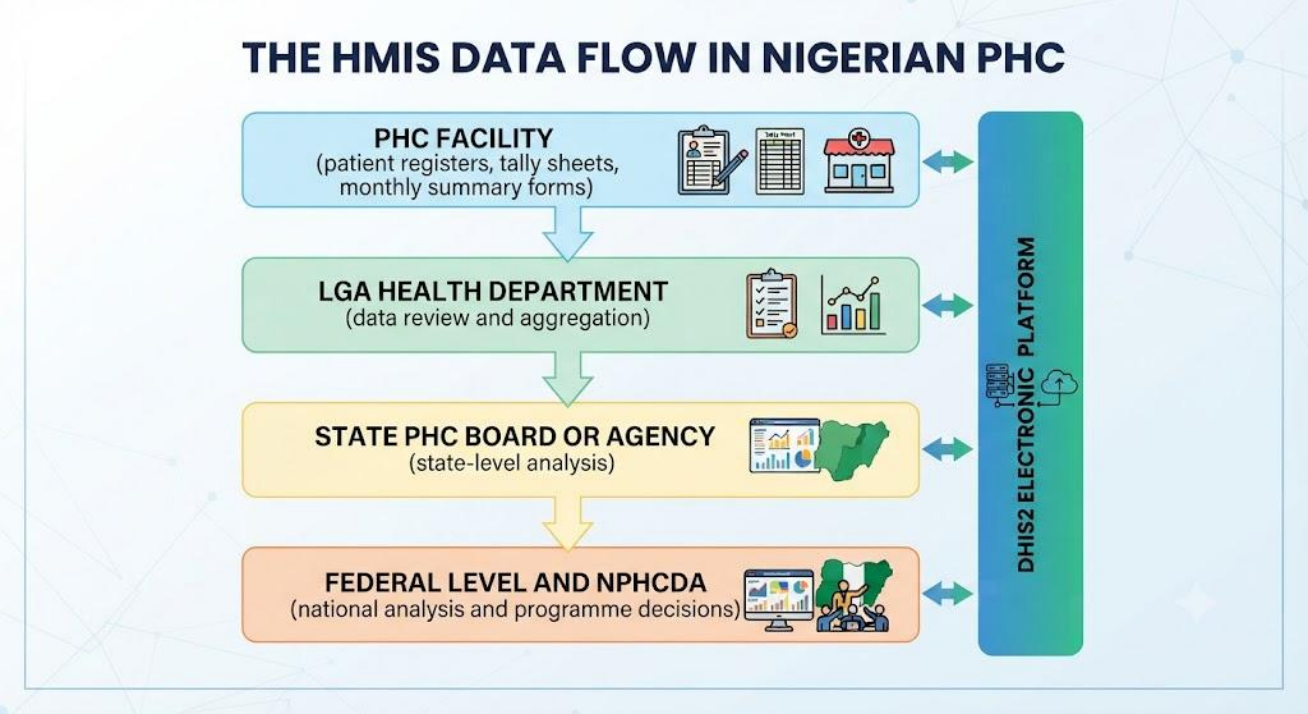

Figure 5.2: The flow of health management information from PHC facility level to the national level through the DHIS2 platform

Pilot questions 5.2

1. Define a health management information system and explain its purpose. (Linked to SLO 5.2)
2. List four qualities that effective HMIS data must possess. (Linked to SLO 5.2)
3. Describe the data collection and reporting process in a PHC facility. (Linked to SLO 5.2)
4. Explain the role of DHIS2 in the Nigerian PHC information system. (Linked to SLO 5.2)
5. Explain why data use at the facility level is as important as data collection. (Linked to SLO 5.2)

5.3 Laws, Regulations, and Laboratory Services in PHC

5.3.1 Legal and regulatory framework for PHC in Nigeria

The legal framework for PHC in Nigeria is anchored by the **National Health Act of 2014**, which provides the most comprehensive legislative basis for health care organisation and financing in Nigerian history. The Act formally establishes the right of every Nigerian to a basic minimum package of health services, defines the structure of the health system, establishes the BHCPF, provides for the establishment of a National Health Insurance Authority, and sets out the responsibilities of the three tiers of government in health care financing and delivery.

Other relevant legislation includes the **Local Government Act**, which establishes local government councils as the primary authority responsible for PHC delivery, the **Public Health Laws** of each state, governing environmental health, sanitation, disease notification, and other public health functions performed at the primary care level, and the various professional regulatory acts governing the registration and practice of PHC cadres including the **Community Health Practitioners Registration Board Act**, which establishes the regulatory framework for CHEWs, JCHEWs, and CHOs.

Fill in the blank: The legal framework for PHC in Nigeria is anchored by the National Health Act of 2014, supplemented by Local Government Acts, state Public Health Laws, and the Community Health Practitioners _____ Board Act.

5.3.2 Health and safety regulations relevant to PHC

PHC facilities are subject to a range of **health and safety regulations** designed to protect patients, staff, and the community from harm. **Infection prevention and control (IPC) standards** require PHC facilities to follow defined protocols for hand hygiene, personal protective equipment use, safe injection practices, and the management of potentially infectious waste, protecting both health workers and patients from healthcare-associated infections.

Medical waste management regulations govern the safe segregation, storage, treatment, and disposal of waste generated in PHC facilities, including sharps, contaminated materials, and

pharmaceutical waste, recognising that improper disposal poses serious risks to community health and the environment. **Occupational health and safety** regulations protect PHC workers from workplace hazards including needlestick injuries, exposure to infectious diseases, and musculoskeletal strain from patient handling. Compliance with these regulations is monitored through facility inspection by state environmental health and health regulatory authorities.

Fill in the blank: PHC facilities must comply with infection prevention and control standards, medical waste _____ regulations, and occupational health and safety regulations protecting staff and patients.

Test	Clinical Purpose at PHC Level
Malaria Rapid Diagnostic Test	Confirm malaria infection to guide treatment
Urinalysis	Detect urinary tract infection, diabetes, proteinuria
Pregnancy Test	Confirm pregnancy for antenatal care registration
Haemoglobin Estimation	Detect anaemia in pregnant women and children
Sputum Smear Microscopy	Detect acid-fast bacilli for tuberculosis diagnosis

Table 5.1: Laboratory tests appropriate at the PHC level in Nigeria and their clinical purpose

5.3.3 Laboratory services at the PHC level

Laboratory services at the PHC level provide diagnostic support for the clinical and preventive services delivered by PHC facilities, enabling health workers to confirm diagnoses, guide treatment decisions, and contribute to disease surveillance. The range of laboratory tests appropriate at the PHC level is defined by the **Ward Minimum Health Care Package** and includes **malaria rapid diagnostic tests**, **urinalysis**, **pregnancy tests**, **haemoglobin estimation**, and basic **sputum smear microscopy** for tuberculosis case detection.

In many Nigerian PHC facilities, laboratory services remain limited by inadequate equipment, unreliable supply of reagents and consumables, and a shortage of trained laboratory technicians, leading to excessive reliance on clinical diagnosis alone without laboratory confirmation. Strengthening PHC laboratory capacity through the provision of appropriate point-of-care

diagnostic tools, regular supply of consumables, and training of PHC staff in basic **specimen collection and test interpretation** is an important but often overlooked component of improving the quality of PHC services in Nigeria.

Fill in the blank: PHC laboratory services include malaria rapid diagnostic tests, urinalysis, pregnancy tests, haemoglobin estimation, and sputum smear microscopy; many facilities are limited by inadequate equipment and unreliable supply of _____.

Pilot questions 5.3

1. State the legal basis of the National Health Act and describe two of its provisions. (Linked to SLO 5.3)
2. Name three pieces of legislation relevant to PHC practice in Nigeria. (Linked to SLO 5.3)
3. Explain what infection prevention and control standards require of PHC facilities. (Linked to SLO 5.3)
4. Describe three laboratory tests appropriate at the PHC level in Nigeria. (Linked to SLO 5.3)
5. Identify three constraints on laboratory services in Nigerian PHC facilities and suggest how each might be addressed. (Linked to SLO 5.3)

Series Summary

This final Series examined the enabling systems and structures that support primary health care in Nigeria. PHC financing draws on multiple sources including government allocations at federal, state, and LGA levels, donor contributions, community financing mechanisms, and out-of-pocket household payments, the last of which remains dominant despite deterring service use among the poor. The Basic Health Care Provision Fund, established under Section 11 of the National Health Act 2014, represents the most significant PHC financing reform in Nigerian history, drawing one percent of the Consolidated Revenue Fund and disbursing it through the National Health Insurance Authority, NPHCDA, and Federal Ministry of Health. Persistent financing challenges include underfunding, irregular releases, and the gap between budget commitments and actual expenditure, addressed through strategies including full BHCPF implementation, expanded health insurance, and improved financial management.

Health management information systems collect, process, and communicate health data from PHC facilities through patient registers, tally sheets, monthly summary forms, and the DHIS2 electronic platform, with data quality dependent on completeness, timeliness, accuracy, and active use at facility and LGA levels for planning, supervision, and resource allocation. The legal framework governing PHC is anchored by the National Health Act 2014, supplemented by Local Government Acts, state public health laws, and the Community Health Practitioners Registration Board Act; PHC facilities must comply with infection prevention and control standards, medical waste management regulations, and occupational health and safety requirements. Laboratory services at the PHC level, including malaria rapid diagnostic tests, urinalysis, pregnancy testing, haemoglobin estimation, and sputum smear microscopy, provide essential diagnostic support, though many facilities remain constrained by inadequate equipment and unreliable supplies, representing an important quality improvement priority for the Nigerian PHC system.

Glossary of Terms

1. **Basic Health Care Provision Fund (BHCPF):** the fund established under Section 11 of the National Health Act 2014, constituted from one percent of the Consolidated Revenue Fund and dedicated to PHC financing in Nigeria.
2. **Out-of-pocket payment:** direct household expenditure on health care at the point of service, the dominant health financing mechanism in Nigeria, known to deter utilisation among the poor and cause financial catastrophe for households facing major illness.
3. **Abuja Declaration:** the 2001 commitment by African Union heads of state to allocate at least 15 percent of government budgets to the health sector, a target Nigeria has consistently fallen short of achieving.
4. **Health Management Information System (HMIS):** an organised system for collecting, processing, analysing, storing, and communicating health data to support informed decision-making at all levels of the health system.
5. **DHIS2:** the District Health Information System 2, the primary electronic platform used in Nigeria for entering, aggregating, visualising, and transmitting facility-level PHC data up the reporting hierarchy.
6. **National Health Act 2014:** the primary Nigerian legislation establishing the legal basis for PHC, the BHCPF, the National Health Insurance Authority, and the responsibilities of each tier of government in health care.
7. **Infection prevention and control (IPC):** the standards and protocols required in PHC facilities covering hand hygiene, personal protective equipment, safe injection practices, and waste management to prevent healthcare-associated infections.
8. **Medical waste management:** the regulated segregation, storage, treatment, and disposal of waste from PHC facilities including sharps and pharmaceutical waste.
9. **Community Health Practitioners Registration Board:** the regulatory body established under Nigerian law to register and regulate the practice of community health extension workers, junior CHEWs, and community health officers.

10. **Ward Minimum Health Care Package:** the defined package of essential PHC services, including basic laboratory tests, equipment, and essential medicines, that each ward-level PHC facility in Nigeria should provide.
11. **Point-of-care diagnostic test:** a rapid diagnostic test such as a malaria rapid diagnostic test or pregnancy test that can be performed at the facility where the patient presents without requiring a central laboratory.

Concept Check Questions [Series 5]

Objective Questions

- PHC financing in Nigeria draws on government funding, donor contributions, community financing, and out-of-pocket _____ by households. (Linked to SLO 5.1)
- The BHCPF is constituted from one percent of the Consolidated _____ Fund, as established under Section 11 of the National Health Act 2014. (Linked to SLO 5.1)
- An HMIS collects, processes, and communicates health data; effective data must be timely, accurate, complete, and _____. (Linked to SLO 5.2)
- The primary electronic platform for PHC data entry and transmission in Nigeria is _____ 2. (Linked to SLO 5.2)
- The primary legislation establishing the legal basis for PHC, the BHCPF, and health system responsibilities in Nigeria is the National Health Act of _____. (Linked to SLO 5.3)
- PHC laboratory services include malaria rapid diagnostic tests, urinalysis, pregnancy tests, haemoglobin estimation, and sputum smear microscopy for _____ case detection. (Linked to SLO 5.3)

Short-Answer Questions

- Explain why out-of-pocket payments are a problematic form of PHC financing. (Linked to SLO 5.1)
- Describe the data collection and reporting process in a Nigerian PHC facility. (Linked to SLO 5.2)
- Explain what infection prevention and control standards require of PHC facilities. (Linked to SLO 5.3)

Long-Answer Questions

- Discuss PHC financing in Nigeria, including the sources of funding, the BHCPF, and the challenges and strategies for sustainable financing. (Linked to SLO 5.1)

- Describe health management information systems in PHC, including their purpose, data collection and reporting processes, and the importance of data use for decision-making. (Linked to SLO 5.2)

Answers to Concept Check Questions [Series 5]

Objective Questions

1. Payments.
2. Revenue.
3. Actionable.
4. DHIS.
5. 2014.
6. Tuberculosis.

Short-Answer Questions

7. Out-of-pocket payments are problematic because they deter utilisation of health services among poorer households who cannot afford to pay at the point of care, and because a single major illness episode requiring large out-of-pocket expenditure can cause catastrophic financial consequences that push households into poverty.
8. Data is collected through patient registers and tally sheets for each service area; these are aggregated into monthly summary forms submitted from facilities to LGA health departments following a defined reporting schedule; data is entered into the DHIS2 electronic platform for transmission to state and national levels.
9. IPC standards require PHC facilities to maintain hand hygiene protocols, use appropriate personal protective equipment, follow safe injection practices, and manage potentially infectious waste through defined segregation, treatment, and disposal procedures, protecting both health workers and patients from healthcare-associated infections.

Long-Answer Questions

10. **Basic response:** Sources: government allocations (federal, state, LGA); donor and international partner contributions; community financing (community health funds, cooperative schemes); out-of-pocket household payments. BHCPF: established Section 11 National Health Act 2014; one percent of Consolidated Revenue Fund; disbursed 50% through National Health Insurance Authority (service reimbursement), 45% through NPHCDA (Ward Minimum Health Care Package), 5% to Federal Ministry of Health (emergency treatment). Challenges: underfunding; irregular fund releases; gap between Abuja Declaration commitment and actual allocation. Strategies: full BHCPF implementation; increased budget allocations; community health insurance; improved public financial management; private sector partnerships.

    Value-added response: The BHCPF is potentially transformative precisely because it creates a protected, dedicated funding stream for PHC outside the annual discretionary budget process, addressing the root cause of chronic underfunding, namely the vulnerability of health allocations to reallocation toward politically visible expenditures; however, its potential can only be realised through consistent political will to release funds fully and on schedule, robust accountability mechanisms to ensure funds reach facility level, and complementary action on the demand side through expanding health insurance to reduce households' dependence on catastrophic out-of-pocket payments.

11. **Basic response:** Definition: organised system for collecting, processing, analysing, storing, and communicating health data. Purpose: support informed decision-making at facility, LGA, state, and national levels. Data qualities: timely, accurate, complete, actionable. Collection: patient registers and tally sheets by service area; aggregated into monthly summary forms; submitted to LGA. Reporting: DHIS2 electronic platform for entry, aggregation, visualisation, and transmission. Data use: monthly review meetings at facility level; aggregated analysis at LGA for supervision

and resource allocation; data quality reviews; staff capacity building for data interpretation; visual presentation through charts and dashboards.

Value-added response: The most common failure mode of HMIS in Nigerian PHC is not the absence of data collection but the absence of data use: facilities dutifully complete registers and submit monthly returns but never review the data they collect to identify trends or guide decisions, reducing the HMIS to a compliance exercise rather than a management tool; addressing this requires not only staff training in data interpretation but a management culture that asks at every supervision visit what the data shows and what has been done in response, making data use an expectation rather than an afterthought.

Answers to Pilot Questions [Series 5]

Part 5.1

6. Four sources are government funding at federal, state, and LGA levels; donor and international partner contributions; community financing mechanisms such as community health funds; and out-of-pocket payments by individual households.
7. Out-of-pocket payments deter utilisation among the poor who cannot afford to pay at the point of care, and can cause financial catastrophe for households facing major illness, undermining both access to care and household economic security.
8. The BHCPF is established under Section 11 of the National Health Act of 2014; it is constituted from one percent of the federal Consolidated Revenue Fund annually, supplemented by donor partner contributions.
9. The BHCPF is disbursed through three channels: 50% through the National Health Insurance Authority to reimburse PHC facilities for services to enrolled and indigent beneficiaries; 45% through the NPHCDA for the Ward Minimum Health Care Package; and 5% to the Federal Ministry of Health for emergency medical treatment.

10. Three challenges are chronic underfunding well below the Abuja Declaration's 15 percent commitment, irregular and delayed release of budgeted funds preventing facilities from maintaining consistent services, and the gap between budgeted allocations and actual expenditure reaching facility level.

Part 5.2

11. An HMIS is an organised system for collecting, processing, analysing, storing, and communicating health data. Its purpose is to provide decision-makers at all levels with the information needed to plan, manage, and evaluate health programmes effectively.
12. Four qualities are timely (available when decisions must be made), accurate (reflecting actual situations without recording errors), complete (covering all facilities and service dimensions), and actionable (presented in formats useful for specific decisions).
13. Data is collected through patient registers and tally sheets for each service area such as antenatal care and immunisation; these primary sources are aggregated into monthly summary forms submitted from facilities to LGA health departments on a defined schedule.
14. DHIS2 is the primary electronic platform through which facility-level PHC data is entered, aggregated, visualised, and transmitted up the reporting hierarchy from facility to LGA to state and national levels, replacing earlier paper-based systems and enabling more timely and flexible data use.
15. Data use at the facility level is as important as collection because data that is collected but never reviewed cannot inform decisions or improvements; monthly facility review meetings allow PHC staff to identify coverage gaps, declining trends, or emerging disease patterns requiring action before they become serious.

Part 5.3

1. The National Health Act of 2014 provides the comprehensive legislative basis for health system organisation and financing in Nigeria. Two provisions are the

establishment of the BHCPF to ensure dedicated PHC financing and the formal establishment of every Nigerian's right to a basic minimum package of health services.

2. Three pieces of legislation are the National Health Act 2014, the Local Government Act (establishing LGAs as primary PHC authority), and the Community Health Practitioners Registration Board Act (governing the regulation of CHEWs, JCHEWs, and CHOs).
3. IPC standards require PHC facilities to maintain defined hand hygiene protocols, use appropriate personal protective equipment, follow safe injection practices, and manage infectious waste through defined segregation, treatment, and disposal procedures, protecting both patients and staff.
4. Three appropriate tests are malaria rapid diagnostic tests to confirm malaria infection, urinalysis to detect urinary tract infections and conditions such as diabetes, and sputum smear microscopy for tuberculosis case detection.
5. Three constraints and strategies: inadequate equipment (addressed by provision of appropriate point-of-care diagnostic tools through BHCPF and NPHCDA supply systems); unreliable reagent supply (addressed by strengthening supply chain management at LGA level); shortage of trained staff (addressed by including basic laboratory skills in PHC in-service training programmes for CHEWs and CHOs).

References and Attributions [Series 5]

Textual References

6. Federal Republic of Nigeria. (2014). National Health Act. Abuja: National Assembly.
7. National Primary Health Care Development Agency. (2010). Ward Minimum Health Care Package. Abuja: NPHCDA.
8. Federal Ministry of Health Nigeria. (2016). Basic Health Care Provision Fund Implementation Framework. Abuja: FMOH.
9. Park, K. (2017). Park's Textbook of Preventive and Social Medicine (24th ed.). Jabalpur: Banarsidas Bhanot.

Figures, Plates, Tables, and Boxes

10. Figure 5.1: Sources of PHC financing in Nigeria. AI generation prompt: "Create a clean pie chart titled Sources of PHC Financing in Nigeria with four labelled segments: Government Funding (federal, state, LGA allocations, largest segment); Out-of-Pocket Payments by Households (second largest); Donor and International Partner Contributions (medium segment); Community Financing (community health funds, cooperative schemes, smallest segment); use a clean professional infographic pie chart style with distinct colours and labels." Suggested OER search string: "PHC financing Nigeria sources pie chart government donor out-of-pocket".
11. Figure 5.2: The HMIS data flow from PHC facility to national level. AI generation prompt: "Create a clean vertical flow diagram titled The HMIS Data Flow in Nigerian PHC, with five boxes connected by downward arrows: PHC Facility (patient registers, tally sheets, monthly summary forms); LGA Health Department (data review and aggregation); State PHC Board or Agency (state-level analysis); Federal Level and NPHCDA (national analysis and programme decisions); add a vertical bar on the right side labelled DHIS2 Electronic Platform connecting all levels; clean professional infographic style." Suggested OER search string: "HMIS data flow Nigeria PHC facility LGA DHIS2 reporting diagram".

12. Table 5.1: Laboratory tests appropriate at the PHC level in Nigeria. AI generation prompt: "Create a clean two-column table titled PHC Laboratory Tests: Appropriate Level and Clinical Purpose; columns Test and Clinical Purpose; five rows: Malaria Rapid Diagnostic Test (confirm malaria infection), Urinalysis (detect UTI, diabetes, proteinuria), Pregnancy Test (confirm pregnancy for ANC), Haemoglobin Estimation (detect anaemia), Sputum Smear Microscopy (detect TB); alternating row shading." Suggested OER search string: "PHC laboratory tests Nigeria table malaria urinalysis tuberculosis haemoglobin".