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Review Article

Community health practice: the Nigerian model

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ABSTRACT

The Nigerian model of community health practice is a unique approach to healthcare delivery that emphasizes the involvement of community members in the planning and implementation of healthcare services. This model is based on the principle that healthcare should be accessible, affordable, and equitable for all members of the community. This review focused on the Nigerian model of community health practice yesterday, today, and in the future. Findings indicated that the Nigerian model of community health practice was established in 1978 and is characterized by the use of community health practitioners who have acquired National Diplomas, Higher National Diploma, Bachelor, Master and Ph.D. degrees in Community Health. They are licensed by the Community Health Practitioners Registration Board of Nigeria to provide basic healthcare services such as health education, preventive care, treatment of common illnesses, maternal and child health services, and family planning at primary health centers and community levels. While the model of community health practice has faced significant challenges, including inadequate funding, lack of infrastructure, and a shortage of trained personnel, it has demonstrated promising results in improving healthcare access and outcomes in rural communities. The Nigerian Model of community health practice holds important lessons for other countries seeking to strengthen their primary healthcare systems**.**

Keywords: Nigeria, Community health practitioners, Community health practice, Primary health care, CHEW, JCHEW, CHO

INTRODUCTION

The Nigerian model of community health practice focuses on improving the health and well-being of communities through a comprehensive and participatory approach. It recognizes the importance of community involvement in healthcare decision-making and emphasizes the empowerment of individuals and communities to take control of their own health.[1] Community health practice refers to the provision of health care services, aimed at early diagnosis of disease, recognition of environmental and occupational hazards to good health, and prevention of disease in the community.[2] The Community is seen as the hub of Community Health Practice. It is the essential laboratory for the practice of teaching, training, and research in the subject of community health. One key aspect of the Nigerian model is the use of community health practitioners (CHPs) who are trained and licensed to provide basic healthcare services and address the specific health needs of the communities at the primary health centers and community levels.[1] A Community Health Practitioner is a specially trained health professional who provides promotive, preventive, curative, and rehabilitative health services to the people where they live and work.[3] They serve as a bridge between the healthcare system and the community, providing education, preventive services, assisting in birthing, care for the newborn, immunization of the

mother and child, and providing basic treatment for common illnesses. The Nigerian model of community health practice is a clinical and community-centered approach aimed at improving health outcomes and empowering communities to actively participate in their healthcare.[2]

NIGERIAN MODEL OF COMMUNITY HEALTH PRACTICE: YESTERDAY (1978-1989)

Community Health Practice in Nigeria has its origins in the country's efforts to address the healthcare needs of its population, particularly in rural and underserved areas.[4] The concept of community health practice emerged as a response to the challenges faced by the Nigerian healthcare system, such as limited access to healthcare services, shortage of healthcare professionals, and low health literacy rates.[4] One important milestone in the origin of community health practice in Nigeria was the establishment of the Primary Health Care system in 1978. This was a result of the Alma-Ata Declaration, a global commitment to achieving "Health for All" by the year 2000 through the provision of integrated preventive, promotive, curative, and rehabilitative health services and community participation, using technology that will be acceptable to the people, affordable, sustainable, and with an efficient system of supervision and referral.[2,5] The Primary Health Care system was introduced into the Nigerian health system through the Basic Health Services Scheme under the third National Development Plan period (1975-1985). PHC became fully adopted as a Nigerian health system in 1988 under the Babangida administration, with Professor Olikoye Ransome-Kuti as the Minister of Health.[6] The World Health Organisation (WHO) affirms that standard, well-equipped (PHCs) can manage illnesses and prevent them through health promotions, community, and house-to-house outreaches. They also prevent the pressure and substantial burden on secondary and tertiary health facilities.[7] The nation needed a health cadre that would support the community to attain and maintain health and extend modern Health Care (Orthodox) to the people dwelling in rural and hard-to-reach areas through the provision of primary healthcare services. Community Health was signed into Law as a profession by the Nigerian government in 1978 under the then minister of Health (Professor Olikoye Ransome Kuti) of blessed memory.[4]

The training of the community health cadre in Nigeria started during the third development plan tagged the 'Basic Health Services Scheme. It was a ten-year (1975-1985) development plan with the aim of addressing the health problems of the citizens so that they could lead a socially and economically productive life. The Federal Executive Council of Nigeria gave approval for the training of Community Health Practitioners in Nigeria on the 14th of December, 1977.[4] These polyvalent health workers were called 'BHSS' workers. They include: Community health officers (CHOs), Community health supervisors (CHS), Community health assistants (CHA). Community health aides. In 1989, the Community Health Supervisors' cadre was phased out, the Community Health Assistant Cadre was renamed Community Health Extension Worker (CHEW), and the Community Health Aides was renamed Junior Community Health Extension Worker (JCHEW).[3] The CHEWs and JCHEWs were trained in the Schools of Health Technology and the Community Health Officers were trained in the Teaching Hospitals. The graduates were awarded certificates and diplomas at the expiration of their training. Individuals who are interested in joining the profession must conclude the training of the JCHEW and CHEW before being admitted into the CHO training school. The Community Health Officers were trained to Mann the primary healthcare system. [8, 9]

NIGERIAN MODEL OF COMMUNITY HEALTH PRACTICE: TODAY (1992-2023)

In 1992, The law establishing the Community Health Practitioners Registration Board of Nigeria (CHPRBN) was promulgated and signed into law on the 24th of November 1992 as Decree 61 of 1992 by Gen. Ibrahim Badamosi Babangida (Rtd), the then Head of State of Nigeria. Now it is in CAP C19, Laws of the Federation of Nigeria 2004.[10] The mission statement of the Community Health Practitioners Registration Board (CHPRBN) was to improve the standard of community health care in Nigeria by regulating the teaching, learning, and practice of community health in Nigeria. This means that the training of any of the community health practitioners cadre must be approved by the Board and the graduands must be licensed by the CHPRBN before they can practice in Nigeria.[10] In 1992, a Direct Entry into the CHO programme (DECHO) was approved in three zones of the Federation: North Central, South West, and South East by the CHPRBN, but this cadre was also phased out in the year 2000. In 2004, the CHPRBN started issuing professional certificates of JCHEW (Certificate), CHEW (National Diploma), and CHO (Higher Diploma) to graduates respectively.[3] In 2014, Nigeria approved the Task-Shifting and Task-Sharing (TSTS) for Essential Health Care Services policy in Nigeria. Based on the realization of severe healthcare worker shortage globally especially in sub-Sahara Africa, the World Health Organization proposed task shifting to improve access to healthcare services and increase the numbers of skilled health workers.[12,16] Task shifting involves shifting some tasks from one cadre to another, for example from doctors to nurses, midwives, or community health practitioners.[11] The TSTS policy focuses on key priority areas such as Reproductive Health, Maternal and Child Health (RMNCH), family planning, HIV, tuberculosis, malaria, and other communicable and non-communicable diseases in the essential health services package.[13]

Although the curricula for the training of the Community Health Practitioners captured maternal, newborn, child health, and family planning, the TSTS policy officially empowered those who have gone through the Modified

Life-Saving Scheme programme to conduct birthing and also to administer family planning products to clients in the community and primary health care facilities.[11] Community Health Extension Workers, Junior Community Health Extension Workers, and Community Health Officers can safely and effectively provide specific services such as Ante-natal care, delivery, and newborn care; post-natal care; Family planning; Child health – integrated Management of Childhood Illnesses (IMCI); growth monitoring and essential nutrition; immunization; Adolescent reproductive health; manage Tuberculosis (TB) and leprosy; HIV/AIDS and sexually transmitted infections; Epidemic diseases (including malaria surveillance); rabies; Treatment of major chronic conditions, Hygiene, Water-borne diseases; Health education and communication (as outlined in Annex/table 4 of the TSTS document), both in a health facility and in the community in the context of service delivery according to the task shifting approach.[11;16] This has greatly improved the birthing conducted by skilled birth attendants and improved facility delivery in Nigeria. In 2018, some universities in Nigeria commenced postgraduate programmes (PGD, M.Sc., and Ph.D.) in community health to give opportunities for community health practitioners to acquire postgraduate degrees after obtaining the CHO Higher Diploma. In 2020, the National University Commission in collaboration with the CHPBN approved a 5-year Bachelor of Community Health Science programme in some universities in Nigeria. The graduates are expected to graduate with two professional certificates and a Bachelor's degree in Community Health.[10] In 2023, the CHPBN and The National Board for Technical Education (NTBE) approved and signed an MOU for the upgrading of the certificates of the JCHEW from Certificate to Ordinary National Diploma (OND) and CHEW from National Diploma to Higher National Diploma (HND). These extension workers in the community health profession are trained in accredited Colleges of Health Technology.[3] They are licensed by the Community Health Practitioners Registration Board of Nigeria (CHPRBN) to provide services such as maternal and child health, family planning, nutrition, disease prevention and control, and HIV/AIDS counseling and treatment at the primary health facilities and communities. They are the mitochondria of primary health care in Nigeria.[18]

CORE COMPETENCY OF THE NIGERIAN MODEL OF COMMUNITY HEALTH PRACTITIONERS

The Nigerian model of community health practice outlined the following core competencies for community health practitioners as follows:[3] Analytic/Assessment Competency: A community health practitioner must have the ability to collect, collate, and evaluate monitoring and evaluation data, and to teach other staff, simple methods of data analysis. Program Planning Competency: The community health practitioner should be able to develop plans to ensure the effective functioning of the PHC system based on national standards. Communication: A community health practitioner must possess excellent communication skills to interact with patients, fellow healthcare professionals, and community members. Health education: Community health practitioners must have knowledge and demonstrate skills in health education, including developing, implementing, and evaluating health education programs. Health promotion: They should have strong knowledge of preventive health measures, designing and implementing programs and initiatives to promote healthy behaviors in the community. Disease prevention: Community health practitioners must have knowledge of common illnesses in the community and the measures required to prevent and manage them, including vaccinations, screenings, and preventive care. Epidemiology: Knowledge of epidemiology helps community health practitioners identify disease trends and patterns in the population and develop interventions to prevent the spread of diseases. Cultural Competency: The community health practitioner should have cultural competency and sensitivity to work effectively with diverse populations. She/he should successfully consider the cultural background of the intended audience for primary health care services and education. Community Diagnosis Competency: Competency related to ensuring the initiation and participation of the community and other health workers in identifying major health problems of the community and developing their capacity and access to resources including health insurance, food, quality care, and health information. Primary Health Care Delivery Competency: The community health practitioner must have the skills to provide integrated primary health care services e.g., Nutrition, immunization, focused antenatal and obstetric care, essential and community-based newborn care, basic clinical management of minor ailments, care of the aged, adolescent care, school health service, etc. Financial Planning and Management Competency: The community health practitioner should be able to develop and manage a PHC facility, develop an annual work plan with the approval of the PHC coordinator, etc. Leadership and Systems Thinking Competency: Should exhibit leadership characteristics, serving as a PHC role model, and establishing mentoring, peer advising, and other professional development opportunities for other health workers in the community. Information and technology Competency: Application of technology to improve PHC delivery system. Understand various populations and how to communicate with them in ways that make the most sense for them. Community health practitioners must be technology-savvy, and conversant with electronic health records and various health-related software, devices, and platforms to deliver up-to-date health solutions to their patients and the larger community. Emergency preparedness: Community health practitioners must have knowledge of emergency preparedness and response, including mitigating the effects of environmental disasters. Advocacy: They must have the skills, knowledge, and commitment required, to advocate for

improved health policies and healthy living conditions in their communities to improve the general quality of life. Outreach Competency: Should willingly and skillfully conduct outreach services to hard-to-reach areas within the catchment she/he serves. Build and strengthen communities by educating community members about programmes and services that will benefit them through community outreach programmes. Capacity Building Competency: Help individuals explore and build their capacities. Build connections, support, and ally-ship within communities. Help individuals advocate for themselves through empowerment and education. Lead community initiatives confidently, as well as identify local leaders and provide them with support Professional and Conduct Competency: Learn to manage time, resources, and priorities on an individual basis while balancing stressors. Assess situations and determine risk factors and potential solutions. Set goals and follow a work plan. Use critical thinking and problem-solving techniques and available resources to their best potential, including technology, assessment tools, and more. Follow ethical standards including the use of approved professional uniforms, practice with a valid license, codes of ethics, laws, bills, and other institutional guidelines. Assume professional education and self-improvement as a pillar for personal development. Set boundaries and practice self-care strategies. Evaluation and Research Skills: Help larger teams with evaluation and research projects to find root causes of diseases and health-related problems. Use evidence-based practices for research.

NIGERIA MODEL OF COMMUNITY HEALTH PRACTICE: IN THE FUTURE

Nigeria is a country facing a shortage of healthcare workers, with a doctor-to-patient ratio lower than the World Health Organization recommendation of 1:600. In this context, community health practitioners (CHPs) have emerged as an essential part of the healthcare system, providing basic health services at the primary health care centers and community-based health services.[1] In the future, the Nigeria model of Community Health Practice is likely to play an even more significant role in the healthcare system.[2] There is an ongoing effort to strengthen their training and professional certification and expand their scope of practice to include more specialized services. The CHPRBN has also developed the curricula of some specialty programmes at the Postgraduate level: Community Epidemiology and Disease Control, Community ENT Care, Community Nutrition and Dietetics, Community Child Health and IMCI, Community Disaster and Humanitarian Emergencies, Community Eye Care, Community Immunology, Community Mental Health, Community Reproductive, Maternal and Newborn Health. These programmes are to be floated at the Community Health Institute (CHI), Teaching Hospitals, and Universities in Nigeria.[3,19]

Also, the use of digital health technologies, such as telemedicine and mobile health, could further enhance the reach and effectiveness of CHPs' services. The Nigerian government should also explore ways to increase the number of CHPs by incentivizing their recruitment and retention. For instance, CHPs could be given opportunities for advanced training and career development, or financial incentives for working in remote or hard-to-reach areas. Community health practitioners in Nigeria are also looking forward to the establishment of the West African College of Community Health which will bring all community health practitioners in West Africa under an umbrella institution to foster unity and collaboration in implementing community health practice in West Africa. Overall, the future of the Nigerian model of CHPs looks promising as a means of improving healthcare access, particularly in rural areas. However, it will require sustained investment and political commitment to ensure its success.

STRATEGIES FOR ACHIEVING EFFECTIVE COMMUNITY HEALTH PRACTICE

Community health means ensuring that people are able to act in ways that improve their own health.[20] The following are the key strategies for achieving effective community health practice in Nigeria:[21] Fostering Community Participation: In the national quest for health, people constitute a major resource, both individually and in groups. Experience confirms that people understand and are interested in the circumstances and events that influence their health. People are seeking opportunities to take responsibility.[21] Encouraging community participation means helping people to assert control over the factors which affect their health. We must equip and enable them to act in ways that preserve or improve their health. By creating a climate in favour of community participation, we can channel the energy skills, and creativity of community members into the national effort to achieve health.[21] Strengthening Community Health Services: Community health services are playing an indispensable role in preserving health. It is expected that there should be an expansion of this role and that it should be expressly oriented toward promoting health and preventing disease.[21] Community health services will have to focus more on dealing with the major health challenges identified. For example, it assumes that there will be a greater emphasis on providing services to groups that are disadvantaged. It further takes for granted that communities will become more involved in planning their own services and that the links between communities and their services and institutions will be strengthened. In these ways, community health services will become an agent of health promotion, assuming a key role in fostering self-care, mutual aid, and the creation of healthy environments.[21] This will involve coordinating programs much more closely with those of social services in order to maintain momentum in the health promotion effort. Community health services provide a natural focal point for coordinating services such as assessment, home care, respite care, counseling, and the valuable work of volunteers. For all those seeking to take responsibility for

their own health, whether in groups or as individuals, community health services are well situated to assume a far more prominent role in the health promotion effort.[21] Coordinating Healthy Public Policy: The potential of public policy to influence people's everyday choices is considerable. It is not an overstatement to say that public policy has the power to provide people with opportunities for community health, as well as to deny them such opportunities. All policies, and hence all sectors, have a bearing on health. What to sought after is healthy public policy. Self-care, mutual aid, and healthy environmental change are integral to community health, and they are more likely to occur when healthy public policies are in place.[21] Policies that are healthy help to set the stage for community health, because they make it easier for people to make healthy choices. All policies which have a direct bearing on health need to be coordinated. They include income, security, employment, education, housing, business, agriculture, transportation, justice, and technology, among others. It will not be an easy undertaking to coordinate policies among various sectors, all of which obviously have their own priorities. We must bear in mind that health is not necessarily a priority for other sectors. This means that we have to make community health matters attractive to other sectors in much the same way that we try to make healthy choices attractive to people.[21]

CHALLENGES OF THE COMMUNITY HEALTH PRACTICE IN NIGERIA

Despite its strengths, the Nigerian model of community health practice faces challenges such as the lack of capacity of some health facilities to provide essential healthcare and community-based services due to a shortage of skilled healthcare professionals, quackery, inadequate equipment, poor distribution of community health practitioners, poor quality of healthcare services, poor condition of infrastructure or no infrastructure, lack of essential drug supply, none implementation of the two-way referral system, tribal and religious wars.[17] Other challenges include ignorance of how to manage the primary healthcare system among policymakers, no political will, fraud, and inadequate funding. The handover of primary health care to local government administration was a huge mistake because in Nigeria the local government is the weakest level of government.[5]

CONCLUSION

Overall, the Nigerian model of community health practice is a holistic, facility and community-centered approach aimed at improving health outcomes and empowering communities to actively participate in their healthcare. The Nigerian model of community health practice is implemented by trained and licensed Community Health Practitioners. The Community Health Practitioners Registration Board of Nigeria is the only agency mandated to regulate the training and practice of community health in Nigeria.

Recommendations

The government of Nigeria should make efforts to address these challenges through increased government investment in community health practice, partnerships with non-governmental organizations to improve community health practice, and the recruitment and training of licensed CHPs to prevent quackery. PHC centers should be built according to the recommended standard with residential apartments for health workers. Essential drugs should be available and affordable according to the principle of primary health care.[5] Training of health workers at the primary, secondary, and tertiary facilities on the importance and implementation of the referral system. Means of reaching out to the hard-to-reach areas for outreaches should be available and accessible. Communities should embrace peace and provide security for health workers. Community health practitioners should be willing to make health services available in the primary health centers and in the community.

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