

Primary Health Care Services in Secondary and Tertiary Institutions: The Impacts and Challenges of Community Health Practitioners in the Nigerian Health System

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Abstract- Background: Primary health care (PHC) is the foundation of universal health coverage, but continuity of care depends on effective linkages between community, primary, secondary and tertiary services. In Nigeria, Community Health Practitioners (CHPs) Junior Community Health Extension Workers (JCHEWs), Community Health Extension Workers (CHEWs) and Community Health Officers (CHOs) are primarily deployed within PHC. Their work nevertheless interfaces with secondary and tertiary services through referral, surveillance, health promotion, patient navigation, follow-up and selected task-sharing arrangements.

Objective: This review analyzes CHP contributions to the continuum of care involving secondary and tertiary institutions, identifies barriers to effective integration, and proposes policy and practice measures for safer and more coordinated utilization.

Methods: Evidence was synthesized from Nigerian regulatory and policy documents and peer-reviewed literature concerning community health workers, task-sharing, referral, PHCUOR, workforce development and PHC integration. Evidence involving the wider community health worker category was distinguished from evidence specifically involving Nigeria's regulated CHP cadres.

Results: CHPs can contribute to referral initiation, community-to-facility linkage, preventive services, chronic disease support, surveillance, health education and post-discharge follow-up. Nigerian evidence also indicates that community health workers sometimes perform duties beyond formal guidance because of service needs, while referral feedback between PHC and higher-level facilities may be weak. International evidence indicates that task-sharing can improve selected outcomes when supported by training, clear roles, coordination, supervision and financing.

Conclusion: CHPs should not be regarded as substitutes for specialist hospital professionals. Their principal system value lies at the interface between communities, PHC facilities and higher levels of care. Harmonized scope-of-practice arrangements, competency-based continuing

professional development, two-way referral systems, multidisciplinary governance, supportive supervision and measurable accountability mechanisms are required to integrate CHPs safely into Nigeria's continuum of care.

Keywords: Community Health Practitioners; primary health care; Nigeria; task-sharing; referral systems; continuity of care; universal health coverage; health-system strengthening

I. INTRODUCTION

Primary health care is a comprehensive approach uniting primary care and essential public health functions, multisectoral action and empowered communities. The Declaration of Astana reaffirmed PHC as a foundation for universal health coverage and the Sustainable Development Goals (World Health Organization [WHO], 2018a). WHO and UNICEF subsequently emphasized integrated, accessible and people-centred services across the life course (WHO & UNICEF, 2020).

Nigeria's health system is organized across primary, secondary and tertiary levels, but effective care requires functional connections among them. Patients move between levels through referral, counter-referral, diagnostic services, specialist consultation, discharge planning and community follow-up. Workforce roles at one level can therefore influence efficiency and quality at another.

CHPs occupy a distinctive position in this continuum. Their statutory functions are primarily community- and PHC-oriented. The National Standing Orders provide standardized guidance for management of health conditions at PHC facilities (Community Health Practitioners Registration Board of Nigeria [CHPRBN] & National Primary Health Care Development Agency [NPHCDA], 2024). Their

contribution to higher-level care should therefore be understood principally as an interface function identification, referral, linkage, follow-up, selected delegated/shared tasks and community participation rather than unrestricted hospital practice.

This distinction is important because Ajisegiri et al. (2023) found that Nigerian community health workers sometimes performed tasks outside formal guidance in response to service needs. Such role expansion may support access but can also create security and responsibility risks when not formalized.

1.1 Aim and objectives

This paper studies the contribution of CHPs to the continuum of care involving secondary and tertiary institutions and the system conditions required for effective integration.

- Examine contributions to referral, continuity, prevention, surveillance, navigation and selected task-sharing.
- Identify regulatory, workforce, organizational and interprofessional barriers.
- Examine the relationship between task-sharing, referral coordination and health-system performance.
- Propose an implementation framework and recommendations for regulation, service delivery and professional development.

II. METHODS

This descriptive review and policy synthesis used the author's supplied literature and targeted searches of PubMed, WHO, Nigerian government and professional-regulatory sources. Priority was given to literature from 2016–2026, while seminal policy/framework documents were retained where necessary. Search concepts included community health workers/community health practitioners, Nigeria, task-shifting, task-sharing, referral, PHCUOR, continuity of care, secondary care, tertiary care and universal health coverage.

The synthesis was organized around service contribution, referral/continuity, workforce/role governance and institutional enabling conditions. Because the literature frequently uses the wider term

community health worker (CHW), evidence involving CHWs is explicitly distinguished from evidence specifically involving Nigeria's JCHEW, CHEW and CHO cadres. This review does not claim exhaustive database coverage, pooled effects or causal inference.

III. POLICY AND REGULATORY CONTEXT

Nigeria's task-shifting and task-sharing policy was developed to rationally redistribute selected tasks among available cadres in response to workforce shortages and access constraints (Federal Ministry of Health [FMoH], 2014). The policy was subsequently reviewed; current Nigerian health sector documentation continues to describe task-shifting/task-sharing as a mechanism for redistribution of selected tasks according to training and competence (FMoH, 2022).

The CHPRBN/NPHCDA National Standing Orders provide a professional and clinical framework for CHP practice at PHC level. The published orders describe standardized history-taking, examination, decision-making and management guidance for PHC services (CHPRBN & NPHCDA, 2024). Thus, employment in a higher-level institution should not, by itself, be interpreted as automatic expansion of professional scope.

PHCUOR sought to integrate PHC planning, budgeting, provision and monitoring under state-level PHC structures. Implementation studies show both progress and variation in implementation fidelity and institutional capacity (Eboreime et al., 2017, 2019). WHO similarly recommends that CHW programmes be integrated into health systems through appropriate selection, education, certification, supervision, working conditions and career development (WHO, 2018b).

IV. IMPACTS AND CONTRIBUTIONS OF CHPS

4.1 Referral initiation and transition of care

CHPs may identify danger signs, provide appropriate pre-referral measures inside scope, document findings, communicate with receiving facilities and support transition. However, the value of referral depends on

the whole chain. Ajisegiri et al. (2023) found that two-way referral mechanisms existed but feedback from secondary facilities was often weak. The key analytical issue is therefore not simply whether CHPs can refer, but whether the system closes the referral loop.

4.2 Prevention and health promotion

CHPs can support health education, screening, immunization linkage, family-planning counselling, adherence support and community follow-up. Their proximity to households provides a comparative advantage for continuity and local community involvement (WHO, 2018b).

4.3 NCD care and task-sharing

Ajisegiri et al. (2023) documented informal task-sharing in hypertension and diabetes care among community health workers in four Nigerian states. International evidence supports carefully structured task-sharing: Leong et al. (2021) found possible improvements in selected outcomes when task-shifting was accompanied by collaboration, coordinated care, training, supportive organizational systems and financing. A systematic review and meta-analysis found reductions in blood pressure with task-sharing interventions involving community health workers (Anand et al., 2019).

4.4 Surveillance and outreach

Community-based workers can support surveillance, health promotion and linkage to preventive programmes. Nigeria's experience using the polio programme as a platform for wider PHC delivery demonstrates how community-level structures can support wider health-system functions once integrated with formal systems (Bawa et al., 2019).

4.5 Patient navigation and post-discharge continuity

Patient navigation is a logical extension of the CHP-community interface. Appropriately trained CHPs can reconnect discharged patients with PHC, reinforce education, support adherence and identify warning signs requiring re-referral. This is consistent with integrated, people-centred PHC (WHO & UNICEF, 2020). Community-based maternal-health interventions in Nigeria also demonstrate the potential of household-level linkage to formal services (Cockcroft et al., 2019).

V. CHALLENGES

5.1 Role ambiguity and scope-of-practice tensions

Informal task expansion may arise from unmet need, but it creates uncertainty over responsibility, competence and accountability when not formally governed (Ajisegiri et al., 2023).

5.2 Cross-professional collaboration

Higher-level care needs coordinated teams. The appropriate response to role overlap is structured team design: define shared tasks, supervision, escalation criteria and performance measures instead than treating cadres as interchangeable.

5.3 Training and competency

Secondary/tertiary interface roles may require additional competencies. Balogun et al. (2023) demonstrated where blended learning significantly improved knowledge and OSCE performance among student CHOs, supporting competency-based CPD and simulation.

5.4 Referral communication

Incomplete feedback from higher-level facilities can fragment care and force informal workarounds by community health workers (Ajisegiri et al., 2023).

5.5 Career development and working conditions

WHO identifies supportive supervision, appropriate management, working conditions and professional development as core elements of sustainable CHW programmes (WHO, 2018b).

5.6 System and governance barriers

Task-sharing cannot compensate for weak medicines, diagnostics, transport, information systems or referral capacity. Nigerian PHC implementation research shows that governance, financing and accountability interact with service performance (Eboreime et al., 2017, 2019).

VI. ANALYTICAL DISCUSSION

The evidence indicates that CHP impact is a function of both worker capability and system design. Figure 1 positions CHPs primarily at the community/PHC end

of the system while showing their defined interfaces with secondary and tertiary care.

Figure 1. Proposed CHP role across the continuum of care.

Three conclusions follow. First, CHP value is relational: a trained worker cannot deliver continuity if referral communication, transport and feedback are absent. Second, task-sharing is a governance intervention as well as a workforce intervention because it redistributes responsibility and requires accountability. Third, integration should be measured by system outcomes rather than deployment alone.

The international task-sharing literature reinforces this systems interpretation. An umbrella review found that task-shifting can improve selected outcomes and may generate savings, but successful implementation

depends upon collaboration, coordinated care, training, supportive organization, clear processes and financing (Leong et al., 2021). Nigerian evidence adds an important qualification: informal task expansion may be a response to unmet needs but should not be normalized as a substitute for formal policy and competency assurance (Ajisegiri et al., 2023).

PHCUOR offers a governance platform, but policy adoption alone does not guarantee implementation fidelity. Future CHP integration should therefore specify responsibilities across federal, state, facility and professional-regulatory levels.

VII. EVIDENCE-TO-ACTION FRAMEWORK

Figure 2. Evidence-to-action framework for CHP integration beyond the PHC facility.

Domain	Challenge	System response	Indicator
Scope	Informal role expansion	Approved role descriptions/SOPs	Facilities with approved CHP roles
Referral	Weak feedback	Two-way digital/standard referral	Referrals with feedback
Competency	Additional skills	CPD, OSCE, simulation	Staff meeting competency threshold
Teamwork	Role tension	Multidisciplinary protocols	Team-training completion
Continuity	Poor post-discharge linkage	CHP-enabled discharge-to-PHC pathway	Eligible discharges linked
Governance	Variable PHCUOR implementation	Joint accountability	Quarterly interface review

VIII. SUMMARY OF FINDINGS

- CHPs are primarily PHC/community practitioners, but their work can affect secondary and tertiary care through referral, linkage, prevention, surveillance and follow-up.
- The strongest system contribution is at the interface between levels of care, not unrestricted substitution for specialist professionals.
- Task-sharing can expand access, but it requires defined competencies, supervision, coordination and financing.
- Weak referral feedback is a major barrier to continuity and may encourage informal workarounds.
- Blended learning and OSCE-based education can improve CHP competencies.
- PHCUOR can provide a governance platform, but implementation fidelity varies.

- Professional recognition, career development and supportive supervision are indispensable for sustainable integration.

IX. RECOMMENDATIONS

Regulatory coordination: Develop a national interface framework specifying CHP functions in secondary/tertiary settings, supervision requirements and escalation limits.

Credentialing: Align hospital appointment and credentialing with CHPRBN scope and approved SOPs.

Referral reform: Implement standardized two-way referral and counter-referral protocols, preferably with interoperable electronic communication.

Competency-based CPD: Provide targeted training in triage, documentation, IPC, patient navigation, NCD follow-up, communication and referral.

Simulation and assessment: Use OSCEs, case-based learning and simulation before assigning CHPs to defined interface functions.

Multidisciplinary governance: Include CHP representatives in facility teams reviewing interface performance and referral outcomes.

Career pathways: Create transparent professional-development and advancement opportunities recognizing additional competencies.

Quality improvement: Include CHP referral, follow-up and continuity indicators in facility quality dashboards.

PHCUOR linkage: Use PHCUOR structures to strengthen coordination without blurring statutory responsibilities.

Research: Conduct multicentre studies measuring clinical outcomes, referral completion, cost, safety, patient experience and workforce effects.

X. CONSEQUENCES FOR POLICY AND PRACTICE

For regulators, the priority is to define safe, measurable interface roles. For managers, the objective is to integrate CHPs into referral and continuity pathways without treating them as substitutes for other cadres. For training institutions, the evidence supports competency-based and simulation-supported education. For decision-makers, investment in referral systems, information exchange, supervision and governance is essential because these connective functions determine whether workforce capacity translates into overall system performance.

For other low- and middle-income settings, the Nigerian case illustrates a wider lesson: community-based cadres can contribute beyond the physical boundaries of PHC, but such contribution should be governed by competency, supervision, referral safeguards and accountability.

XI. LIMITATIONS

This is a narrative review rather than a systematic review or meta-analysis. The evidence base is heterogeneous and frequently uses the wider CHW category; therefore, not every finding is specific to Nigeria's JCHEW, CHEW or CHO cadres. Immediate empirical research on CHP deployment inside secondary and tertiary institutions remains limited. State-level variation also limits national generalization. Future studies should directly evaluate defined interface roles using patient, workforce, safety and health-system outcomes.

XII. CONCLUSION

CHPs are able to contribute meaningfully to continuity of care across Nigeria's health-system levels, particularly through referral, prevention, surveillance, patient navigation, discharge linkage and appropriately regulated task-sharing. The evidence does not support unrestricted role expansion. The main challenge is to convert potentially useful interface activities into clearly defined, competency-based and supervised components of the health system.

A strengthened model should combine CHPRBN regulatory clarity, PHCUOR-aligned governance, competency-based CPD, multidisciplinary teamwork, two-way referral communication, supportive supervision and measurable quality indicators. This approach may help Nigeria use its community-based workforce more efficiently while protecting professional accountability and patient safety.

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