Quarterly Newsletter of the Association of Public Health Physicians of Nigeria

APHPN NEWSLETTER

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From the President

Dear Colleagues,

I bring you warm greetings from the NOC and BOT members. I am delighted writing you at this time especially as we are conscientiously settling down to the business of public health.

We started the advocacy journey following the handover in Abeokuta with visit to the former President of Nigeria at the Olusegun Obasanjo Presidential Library (OOPL) where we were well received by his representative and had a tour of the facility.

Over the past three (3) months, we have done the following:

📍Secured and set up a befitting space for APHPN Secretariat in Abuja

📍Strategic advocacy to key stakeholders in different States across the country

📍 Community health campaigns and engagement in different States

📍 Inauguration of some key committees (APHPN Taskforce on PHC Adoption, APHPN Committee on Climate Change and Health) to advance the frontiers of knowledge and implementation in the dynamic public health space

📍Secured partnership for a studio space for the proposed APHPN Virtual School

To deepen our influence at the national level, we have intentionally ensured the involvement of our members in several national assignments, including the ongoing climate change and health adoption plan workshops.

We are building relationships with corporate organizations to ensure long term mutual beneficial activities that will improve public health in Nigeria.

All these wouldn't have been achieved without your valued support at all levels and I immensely appreciate you all.

We also recorded a lot of appointments and promotions of our members across different States and Institutions. To God be all the glory.

The journey of building on our gains and expanding our reach has just begun. All hands must be on deck to pull it off.

Therefore, I implore us to work together because together we can go far.

🖋For innovation and common good...

Dr. Terfa Kene

President, APHPN.

Newsletter Highlights

Editorial Board

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UPDATE FROM THE SECRETARIAT

Dr. Augustine Ajogwu

ASSUMPTION OF OFFICE IN THE NATIONAL SECRETARIAT.

The Assumption of Office in the donated National Secretariat of the Association of Public Health Physicians of Nigeria, took place on the 30th of April 2025. The event kick started by first recognizing the presence of God, with the blessing of the office. The program was divided into two sessions; The first session was the APHPN presentation, enumerating the profile of the association by the Secretary General, followed by an address, titled APHPN shared Vision by the President. He highlighted the mandate of the current exco to adopt 222 PHCs in the country, furthermore, to build capacity of members and collaboration with partners for public health innovation and common good. Present at the occasion were members of APHPN, BOT represented by Prof Clara Ejembi, Senior Special Assistant to the President on Health, Dr Salma Ibrahim Anas, President of renewable energy, Prof Onuoha, Partners and Press men.

Responding, the SA to the President on Health commended the APHPN for the laudable project it intends to embark on and promised to partner with APHPN to ensure PHCs revitalization and solarization for improvement of PHC functionality in order to reduce maternal and child morbidity and mortality especially at the community level where it occurs the most. On her part, Prof Clara Ejembi tasked the new exco to develop a blue print detailing the roles of a public health physician. This, she believes will facilitate our possession in the public health space in the country. Prof Onuoha commended the APHPN lead by Dr Terfa Kene on the giant stride it has achieved within the short time in office and pledged the collaboration of the renewable energy group with APHPN to ensuring that the mandate is achieved. The second session was Press conference where the shared vision and mandate of the adoption of 222 PHCs in the country was shared with the populace.

Here are some of the clips *https://www.vanguardngr.com/2025/04/poor-investment-aphpn-adopts-222-phcs-across-nigeria-to-improve-functionality/*
https://dailytrust.com/only-40-of-lgas-have-medical-officers-of-health-aphpn/

The President, Dr Terfa Kene, BOT Member, Prof Clara Ejembi, SA to the President on Health, Dr Salma Ibrahim Anas, President of renewable energy, Prof Onuoha.

The President, Dr Terfa Kene with BOT Member, NOC members, SA to the President and Partners at the Assumption of Office.

The President, Dr Terfa Kene, The Secretary General, Dr Augustine Ajogwu, Treasurer, Dr Juliette Ango, and Members of APHPN at the Press Conference Organized by APHPN to mark the assumption of office.

COURTESY VISIT BY THE APHPN NATIONAL PRESIDENT DR. TERFA KENE TO EDO STATE

The APHPN National President Dr. Terfa Kene visited Edo State for the inaugural lecture of the Golden President Prof. Alphonsus Rukevwe Isara.

See pictures of Events/award Presentation by APHPN Edo State branch.

APHPN CAPACITY BUILDING.

The First edition of the Capacity Building Webinar organized by APHPN in collaboration with World Continuing Education Alliance (WCEA) after the 41st AGM/SC/ Election (current Exco) was held in May 2025. The webinar titled "The One Health Approach in Global Health" was facilitated by Prof. Chima Ohuabunwo. The engaging and interesting session was moderated by Prof. Omosivie Maduka and had about 500 participants from several countries all over the world in attendance. Prof. Ohuabunwo defined One Health as the Collaborative efforts of multiple disciplines working locally, nationally and globally to attain optimal health for people, animal, plants and their shared environment. He emphasized the need for the 3Cs; Coordination, Collaboration and Communication for effective practice of One health.

APHPN Health Management Caucus organized the May 2025 edition of its Lecture Series titled Challenges of Donor Dependency in Nigeria & the Way Forward, Understanding the Past, Navigating the Present, Shaping the Future: An Overview and the Role of Public Health Physicians.

The lecture was delivered by Dr. Obinna Oleribe and Dr Okey Nwanyanwu of the California State University Dominguez Hills Carson, California, USA. He gave an overview of foreign aid and donor funding in Nigeria, analyzed donor history, benefits, challenges, and solutions. They strongly emphasized the importance of reducing donor dependency for sustainable development as the era of big aid is over. The lecture had more than 100 participants across the globe in addition to APHPN members in attendance.

INAUGURATION OF APHPN TASKFORCE FOR PHC ADOTION.

On the 5th of June 2025, the President, Dr Terfa Kene with Exco members, inaugurated the Association of Public Health Physicians of Nigeria (APHPN) Taskforce on the adoption of 222 Primary Health Care in Nigeria committee. They are to ensure that 6 PHCs are adopted and revitalized per a state to improve its functionality. it consists of a seven Man Committee led by Dr Felix Odiah with six other members drawn from the six geo-political zones of the country.

This is one of the core mandates of the current administration to ensure the revitalization of the association's primary constituency the PHCs. The Primary Health Care has been left to degenerate over the years, 20% of the countries local government areas have Medical Officers of Health (MOH) and to show that all hope is not lost, the APHPN want to use the adoption of the PHCs to show-case the necessity of ensuring the workability of the PHCs through collaboration with the states to improve population health.

The terms of reference (ToR) are as follows:

APHPN Taskforce on Adoption of Primary Health Care Facilities to Improve their Functionality

1. Position Title: National Chairman, Taskforce on Adoption of Primary Health Care (PHC) Facilities
2. Reporting To: President, Association of Public Health Physicians of Nigeria (APHPN)
3. Purpose of the Role: To provide strategic leadership and oversight to the APHPN Taskforce charged with coordinating and facilitating the national adoption initiative of Primary Health Care facilities by stakeholders, with the goal of revitalizing and enhancing the functionality, service delivery, and sustainability of PHC systems across Nigeria.
4. Responsibilities and Duties: The National Chairman shall:

a. Leadership and Coordination; Lead the Taskforce in the development and implementation of a national framework for the adoption and revitalization of PHC facilities, Coordinate efforts among state chapters, local partners, and key stakeholders to ensure broad engagement and ownership of the initiative, chair all Taskforce meetings, ensuring effective planning, execution, and follow-up of decisions.

b. Stakeholder Engagement; Identify and engage public and private sector actors (e.g., philanthropists, NGOs, development partners, corporate bodies) for the adoption and upgrading of PHC facilities, work closely with state and local governments to align the adoption initiative with existing health sector plans and community needs, represent APHPN at national forums, policy discussions, and technical meetings related to PHC revitalization.

c. Program Oversight and Monitoring; Develop benchmarks and indicators for tracking the progress of adopted PHC facilities, ensure that adopted facilities receive adequate support in terms of infrastructure, equipment, staffing and quality of care, oversee the collation and dissemination of periodic reports on the status, outcomes, and impact of the adoption program.

d. Advocacy and Communication; Promote public awareness of the adoption initiative through media engagement, stakeholder dialogues and official communications, advocate for increased investment and policy support for PHC revitalization at all levels of government.

e. Reporting and Accountability; Submit quarterly and annual reports to the President detailing the taskforce's activities, achievements, challenges and recommendations. Ensure that all engagements and resource mobilization efforts are conducted transparently and in line with APHPN's ethical standards.

6. Composition of the Taskforce: The National Chairman shall work with an appointed team of zonal and state coordinators, technical advisers and supporting officers as approved by the President.
7. Ethical Conduct: The Chairman must uphold the principles of integrity, accountability, professionalism and transparency in all taskforce-related engagements.
8. Remuneration: This is a voluntary leadership position. Any reimbursements or activity-based allowances shall be subject to APHPN financial policies and prior approval.
9. Termination: The appointment may be terminated by the President at any time in line with APHPN policy or based on performance, misconduct, or restructuring of the initiative.

In response, the Chairman of the PHC adoption Dr Odiah thanked the president for finding them worthy to serve the association and promised to ensure that the mandate is achieved. Other, dignitaries were Members of the Committee, Chief Executive Officer Healthnomics HMO ltd and Africa Disease Prevention and Research Development Initiative. They all expressed their readiness to serve the association to achieve its mandate.

The President Dr Terfa Kene with Dr Felix Odiah, Chairman of PHC Adoption.

The President, Dr Terfa Kene, Secretary General, Dr Augustine Ajogwu, Chairman of PHC Adoption, Dr Felix Odia, and CEO Healthnomics HMO LTD, Dr Obioma Obikeze.

PUBLIC HEALTH SPOTLIGHT

Optimizing the health workforce for Universal Health Coverage: a framework for analysis and action

Dr. Gafar Alawode
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Chief Executive Officer, DGI Consult


Dr. Gafar Alawode

INTRODUCTION

An efficient health care system relies on a well-equipped and optimized human resource for health (HRH) [1]. Adequate, equitably distributed, and motivated HRH is central to achieving Universal Health Coverage (UHC) [2, 3]. The Millennium Development Goals (MDGs) set a health workforce density target of a minimum of 2.3 health workers (doctors, nurses, and midwives) per 1000 population to deliver essential health services, while the Sustainable Development Goals (SDGs) raised it to 4.45 per 1000 population [4]. However, many low- and middle-income countries (LMICs) have not met the MDGs target and are even farther from the SDGs [5]. Despite a well-established correlation between health worker numbers and service coverage [6, 7], regions with the highest disease prevalence often have the lowest health worker density. In Africa, the average density of medical doctors is 2.6 per 10,000, compared with Europe's 37.6 per 10,000 population in 2022 [8], despite Africa's four times higher disease burden [9].

In 2023, 55 countries were on the WHO Health Workforce Support and Safeguard List, all from low-income or lower-middle-income groups, indicating that income level significantly impacts HRH recruitment and retention [10]. However, HRH performance varies in countries within the same income groups, suggesting there are other drivers of HRH optimization [8]. Existing frameworks, such as the International HRH Action Framework, WHO HRH Assessment Guidelines, and WHO Health System Governance Action Plan for UHC, provide valuable guidance [11,12,13]. The Action Framework outlines HRH planning and management strategies, the Assessment Guidelines offer metrics for workforce evaluation, and the Governance Action Plan emphasizes policy coherence for UHC. However, these frameworks are not explicit about how their different components will drive optimization in a resource-constrained setting like Nigeria.

Nigeria's decentralized, three-tiered health care system (primary, secondary, and tertiary) mirrors its three levels of government (federal, state, and local government) [14]. While there are considerable overlaps in health management of the three tiers of government, the federal government is the primary player responsible for tertiary health care; states manage the secondary level of care, while the local government handles primary health care (PHC) [15]. Despite its potential, Nigeria faces weak governance and policy formulation, underfunding, poor infrastructure, inequitable distribution of human and material resources, and low health workers' motivation [16]. These contribute to an HRH crisis marked by a shortage of skilled health workforce, inefficient distribution, poor remuneration, and poor working conditions, leading to perpetual brain drain to developed countries [17, 18].

Governance is critical for strong policies and effective health system performance [19], yet understanding how governance interacts with HRH management is limited [20]. Weak governance often leads to inadequate HRH policy design and implementation [21]. At the same time, strong institutional arrangements, including multisectoral coordination mechanisms and HRH units in Ministries of Health, are crucial for ensuring HRH issues are prioritized [22, 23]. Health financing, particularly health workforce wages, also shapes HRH outcomes [24]. Salaries typically consume around 50 to 70% of recurrent health expenditure in Africa [25]. Efficient allocation and utilization of funding enhance workforce density, distribution, and performance [26]. The persistent HRH challenges in Nigeria and similar LMICs highlight the need for a comprehensive framework to optimize HRH performance. Existing frameworks, while valuable, do not fully integrate several interconnected drivers, necessitating a new approach to guide HRH analysis and strategic planning.

The Objectives of the Highlights

This highlight aims to illustrate a practical framework for optimizing the health workforce in LMICs, using Nigeria as a case study.

The objectives are to;

1. Present a practical framework for health workforce optimization that integrates key drivers of HRH performance.
2. Explore the application of the framework in identifying HRH challenges and designing optimization strategies, using Nigeria as a case study.
3. Discuss the policy implications of the framework and provide evidence-based recommendations for relevant stakeholders to support optimization efforts.

HRH optimization framework

The research team developed an HRH optimization framework to examine the HRH landscape, considering all drivers of optimal HRH performance. This framework (Fig. 1) serves as an analytical tool for assessing HRH optimization and a strategic planning guide.

HRH optimization refers to achieving the best possible HRH management outcomes within a given fiscal context, such as workforce density, equitable distribution, skill mix, and performance.

Complementary HRH Frameworks

A targeted literature review identified three complementary frameworks for integration:

1. The International HRH Action Framework [11],
2. WHO HRH Assessment Guidelines [12], and the
3. WHO health system governance action plan for UHC [13].

The International HRH Action Framework emphasizes workforce drivers but omits political economy, while the WHO guidelines focus on assessment metrics, and the governance action plan prioritizes UHC-aligned governance. Combining these three frameworks addresses gaps in political economy and resource optimization.

The framework links HRH governance, financing, management, regulation, optimization indicators, and service delivery. It can be viewed through an issue-root cause-effect lens, where HRH optimization issues (e.g., low density, inequitable distribution, and poor performance) stem from gaps in policy, governance, financing, political economy, and management, affecting access to quality care and service coverage.

1. HRH governance and financing

The findings for the first component of the HRH optimization framework, HRH governance and financing, are described under the five headings outlined below.

1.1 HRH policy and strategy

Several HRH optimization-enabling policies formulated and implemented in the states were identified through KIIs, desk review, and stakeholder workshops. The Task Shifting and Task Sharing (TSTS) Policy promotes task redistribution among health workforce cadres and expanded training programs (Table 1). For example, Nasarawa State domesticated the TSTS policy in 2018, training 500 Community Health Extension Workers (CHEWs) in Modified Life-Saving Skills, which increased the percentage of deliveries by skilled providers from 48.5% in 2016 to 55.5% in 2021, surpassing the national average of 50.7% [27]. Other key policies include the National HRH Policy, which aims to ensure sufficient competent, motivated, and skilled health workers, and the BMGF-supported 10-year PHC HRH Strategy, which addresses HRH gaps in the focus states [28]. Lagos State's standing order for prompt replacement of exiting health workers has mitigated the impact of attrition [29]. Additional state-level policies include the migration of health workers from Local Government Areas to the State PHC Development Agency, Sokoto State's cadre conversion program, and rural accommodation for health workers in Borno, Kaduna, and Yobe States to reduce absenteeism.

1.2 . Institutional arrangements for HRH

Dedicated HRH agencies and units exist at national and sub-national levels, undertaking HRH policy development, HRH information system management, research, and monitoring and evaluation. Multisectoral HRH technical working groups (TWGs) also exist but are often moribund, such as the National HRH TWG, which last met in 2017 [29]. Despite these challenges, TWGs in states such as Gombe and Kaduna have been critical in improving HRH coordination, advocacy, and planning, including efforts to establish HRH units in state ministries of health and support workforce capacity building,

1.3 Use of data for HRH decision-making

The National Health Workforce Registry (NHWR), supported by Global Affairs Canada and WHO, is the primary source of healthcare workforce data in Nigeria. However, state-level challenges hinder the full integration of sub-national data into the NHWR. Many states rely on manual information systems due to budget constraints, a lack of integration with payroll systems, which impedes HRH optimization [29]. Nevertheless, data-driven initiatives like Sokoto state's cadre conversion program in 2021 have addressed critical HRH gaps

1.4 Political economy

Political economy analysis highlights stakeholder interests and influences on HRH optimization. The TSTS policy faced resistance from doctors and nurses due to concerns about task delegation. In the words of a respondent from Kano State on the TSTS policy, "There has been a lot of resistance from doctors and nurses to train CHEW and other low cadre health care workers to handle delivery and provide family planning services, especially invasive family planning services". Political interference in recruitment and distribution processes contributes to disparities in healthcare access and quality between urban and rural areas. For instance, political interference in Kano State recruitment processes has led to disparities in healthcare access. According to a Kano State respondent, "When you call for recruitment, (due to) political interference, the front line that you are looking for (you won't get them), people are trying to bring others and insist that they should also be considered". These underscore the intricate interplay between political agendas and HRH optimization [29].

1.5 Financing

Personnel expenditure constituted over 50% of total health expenditure in all focus states in 2021, except Sokoto, where the state's health expenditure increased drastically in 2021 due to increased capital expenditure without increasing personnel expenditure. This limits funding for HRH planning and management activities crucial for HRH optimization. Further, it was observed that non-personnel HRH expenditure often does not reflect the prioritized needs of the states [29]

2. HRH management and regulation

The second component of the HRH optimization framework focuses on HRH management and regulation, including workforce planning, recruitment, administration, remuneration, and motivation

2.1 Workforce planning

HRH planning responsibility lies with the administrative and Human Resources Departments in Ministries, Departments, and Agencies (MDAs), often collaborating with the Ministry of Establishment. In Kano State, for example, the overall workforce planning is conducted by the Office of the Head of Civil Service, which is the custodian of the state's Human Resource Management Policy [29]. Despite annual workforce planning, HRH supply and recruitment frequently deviate from the plan due to funding constraints and government embargoes, hindering HRH optimization.

2.2 Workforce production

Health workforce production faces challenges, including unaligned student admissions with workforce plans, exceeding enrollment quotas, infrastructure deficiencies, and tutor shortages, notably in Bauchi and Borno States. A respondent from Bauchi stated that "The challenges are many, ranging from outdated curriculum, inadequately trained staff, overcrowded classrooms and inadequate lecture theaters and laboratories." These issues impact the quality of healthcare training.

2.3 Workforce recruitment

Political interference and funding constraints impede HRH recruitment, creating a disconnect between workforce planning and implementation. Strategies such as exit replacement and automatic recruitment policies exist in some states but vary in effectiveness. For example, Lagos State has a robust exit replacement plan, while other states experience challenges in formalizing such policies. Automatic recruitment policies in states such as Sokoto and Nasarawa streamline the entry of health workers but face challenges like employment backlogs and financial constraints [29].

2.4 Workforce administration

Administrative strategies include integrated supportive supervision guidelines and performance appraisal systems such as the Staff Performance Appraisal and Development (SPADEV) in Lagos State and the Annual Performance Evaluation Report (APER) in Kano, Bauchi, Sokoto, Niger, and Yobe States. However, these systems face challenges related to subjectivity and external pressures. Emerging tools like Biometric Attendance and Tracking Technologies (BATT) used in Gombe can objectively address issues of absenteeism and improve accountability, but are limited by high costs, restricting their availability

States such as Kano, Bauchi, and Yobe have established reward and sanction systems, while others lack such mechanisms. The use of financial incentives, awards, and disciplinary measures contributes to motivation and accountability in some states, highlighting the need for consistent enforcement of policies and adaptation to contemporary workforce management practices.

2.5 Remuneration and motivation

States such as Kano, Bauchi, and Yobe have established reward and sanction systems, while others lack such mechanisms. The use of financial incentives, awards, and disciplinary measures contributes to motivation and accountability in some states, highlighting the need for consistent enforcement of policies and adaptation to contemporary workforce management practices.

3. HRH optimization

3.1 HRH density

There are significant shortages in Nigeria's health workforce, particularly in the northern region and rural areas. The WHO's National Health Workforce Accounts Data Portal 2021 data show only 3.95 doctors, 9.45 nurses, 6.18 midwives, 0.20 dentists, and 0.81 pharmacists per 10,000 population in Nigeria [30]. These are considerably below WHO's minimum threshold of 23 per 10,000, and the 44.5 workforce density threshold for achieving UHC [5]. Factors responsible for this low density include Bauchi State's recruitment embargo since 2016, high attrition rates, and the refusal of staff to work in rural areas, such as in Sokoto State. A respondent noted, "Out of maybe 50 graduates, you see more than 40 will be within the urban areas." Kaduna State faces a shortage of doctors and nurses, with a high (41%) attrition rate among the public sector health workforce due to retirement, death, abscondment, transfers, and resignation. These factors also decrease HRH density in Gombe, Niger, Yobe, and Lagos States despite recent recruitment as attrition rates exceed recruitment rates [31].

3.2 HRH distribution

HRH distribution in Nigeria significantly impedes equitable access to quality healthcare. Generally, healthcare workers are concentrated in urban areas, while rural areas face severe shortages. For instance, in Bauchi State, the distribution of healthcare workers skews toward urban zones due to poor pay for rural workers, lack of rural posting allowances or accommodation, high workload, unfavourable working conditions, and political interference, leading to shortages in rural areas [32]. A gender imbalance in rural areas also adds to the complexity, with more male than female health workers. This uneven distribution hinders healthcare access, especially for maternal health services, which have a culture-driven preference for female health workers.

Strategies deployed to mitigate HRH distribution challenges include the implementation of the Community Health Influencers, Promoters and Services (CHIPS) program and the TSTS policy. However, lower cadre healthcare workers upskilled to deliver services in rural areas often migrate to urban areas to compete for better opportunities with their new skills.

3.3 HRH skill mix

There are challenges of inadequate frontline healthcare workers with an excess of supporting staff across various states, negatively impacting service delivery. For instance, Kano State has an over 800% surplus of environmental health officers and 72% excess laboratory personnel in its health system, while there is a shortage of doctors, nurses, and midwives at the primary healthcare level [33]. Efforts to bridge these gaps include HRH recruitment plans in Kano State to increase the percentage of frontline HRH, cadre conversion to convert non-clinical staff to clinical roles in Sokoto State, absorption of volunteer health workers in Nasarawa State, increased admission quotas in Yobe State health training institutions, and the implementation of the task-shifting and task-sharing policy to upskill non-frontline workers

3.4 Workforce performance

Health workforce performance is crucial for service delivery, patient outcomes, and overall health system performance. Absenteeism is rampant in several states, particularly in rural areas, due to a lack of social amenities, accommodation, tools and incentives, difficulty in reaching facilities, insecurity, inadequate monitoring and evaluation, weak disciplinary measures, lack of capacity building, and political interference in recruitment and posting. The problem is more prevalent among lower cadre officers, but even senior officers may be absent if there are issues with salary, security, or monitoring. Non-clinical and supporting cadres are more likely to be absent due to a lack of specific job descriptions and roles.

Other factors hampering performance include high workloads on existing health workers and the recruitment of unqualified personnel due to political interference, which hampers quality service delivery. Investments in continuous HRH training, such as in Lagos State, are perceived to increase healthcare workers' competence. However, there is a lack of strong data, calling for more research to provide objective insights on health workforce competence and performance.

4. Service coverage

4.1 Health service coverage

Health service coverage reflects the availability, accessibility, and affordability of healthcare services for the population and hinges on the optimization of the existing health workforce. Maternal health indicators from the Multiple Indicator Cluster Survey (MICS) 2021 indicate that Nigeria faces challenges in providing adequate coverage, particularly in maternal health care. Lagos outperforms others due to its metropolitan status, attracting skilled health professionals and enhancing access. In contrast, states such as Sokoto, Gombe, Borno, and Bauchi exhibit notably lower maternal healthcare access (Fig 1)

4.2 Quality of care

Despite national initiatives for quality improvement, data inconsistencies in the District Health Information System (DHIS2) challenge reliable quality assessment. Several states have initiated quality-of-care (QoC) strategies focusing on HRH interventions, evaluations, and facility assessments. Initiatives to update the national Health Management Information System (HMIS) aim to include essential indicators on quality of care, addressing discrepancies between health facility registers and DHIS2.

4.2. Quality of care (continuation)

Individual states have undertaken quality improvement measures through the implementation of the state QoC Strategy, conducting routine supervisory visits, and implementing protocols to maintain service quality. In Yobe State, the Committee on Standard Quality and Regulation within the Ministry of Health, responsible for ensuring standard QoC, recently evolved into a State Health Care and Health-related Facilities Regulatory Agency, overseeing registration, inspection, accreditation, and monitoring of facilities regarding standards and quality.

4.3 Equity of access

Achieving healthcare equity faces notable obstacles in Nigeria, including limited health insurance penetration, HRH shortages, and cultural preferences for healthcare providers. Disparities in healthcare coverage across states, along with gender preferences for healthcare workers, hamper service accessibility, particularly for women in rural areas. Educational and socioeconomic factors further exacerbate healthcare disparities, influencing service utilization and accessibility across all examined states [29]

CONCLUSION

As a resource-constrained country, Nigeria struggles to attract and retain the necessary health workforce due to limited fiscal space. While government expenditure on personnel is crucial, other factors also impact workforce management outcomes such as density, skill mix, distribution, and performance in productivity, competence, availability, and responsiveness. This study's workforce optimization framework highlights how HRH policy, financing, institutional arrangements, and political economy influence workforce production, recruitment, distribution, and performance.

The Nigerian case study demonstrates that in a situation of severe HRH shortages, HRH policy actors can use the HRH optimization framework to identify challenges and opportunities for optimization within their health systems. By leveraging these opportunities, significant improvements in health service delivery and outcomes can be achieved despite resource constraints.

Prioritizing workforce optimization as part of the human resource for health strategy is essential for accelerating UHC progress in Nigeria. The country needs to appraise its health workforce landscape with an optimization lens to identify system improvements through pro-optimization governance and financing approaches.

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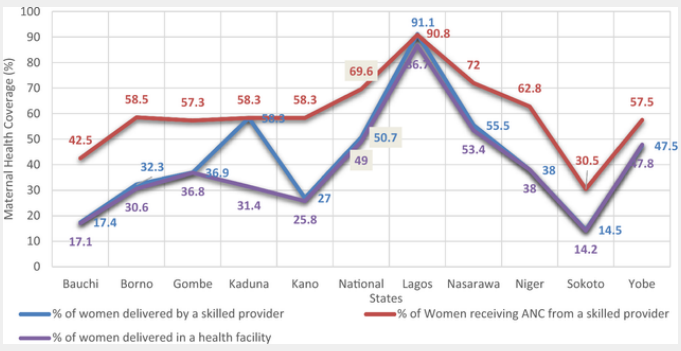
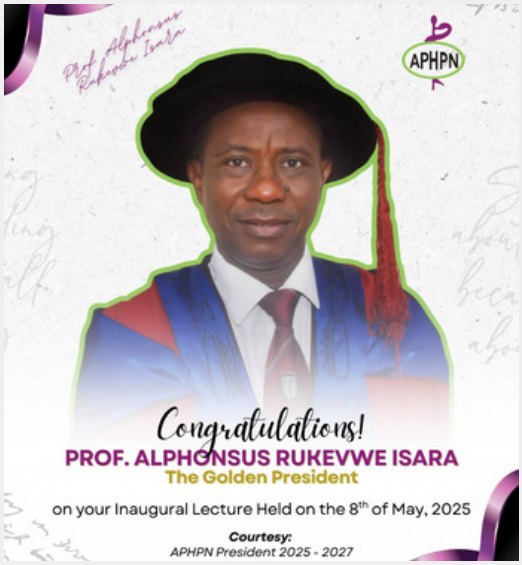
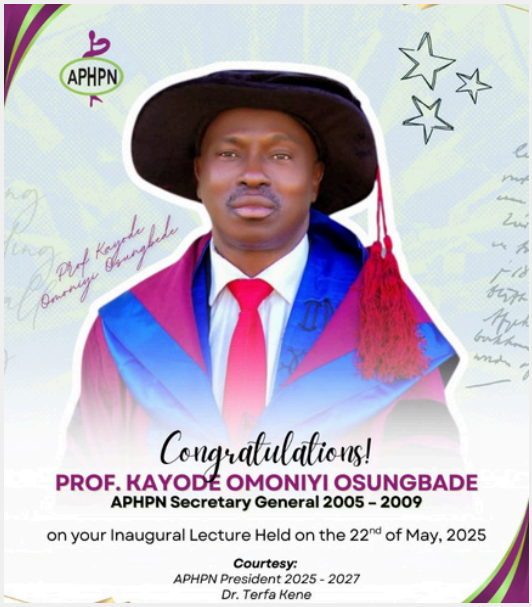


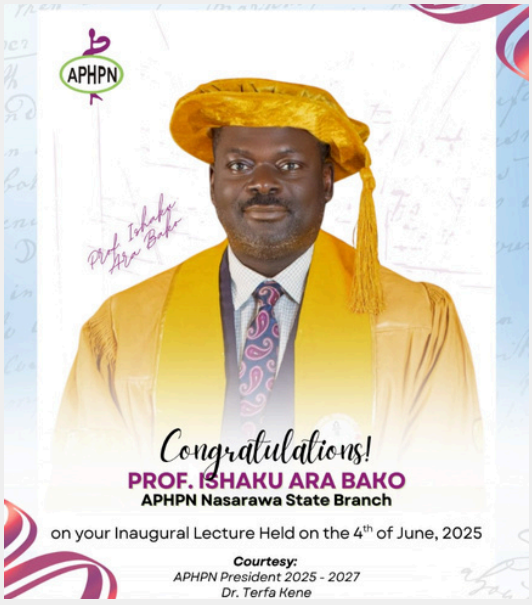
Fig 1 : Maternal health coverage across all (10) focal states against the national average.

CONGRATULATIONS!!!

On behalf of the Association of Public Health Physicians of Nigeria (APHPN), The Board of Trustees (BOT) The National Executive Council, The National President, Dr Terfa Kene wish to Congratulate it's members on their Inaugural lectures.







NEWS IN BRIEF

APHPN PRESIDENT VISIT RIVERS STATE

The National President of APHPN, Dr Kene Terfa, paid a working visit to APHPN Rivers State, on Monday 7th April, 2025 during the celebration of WORLD HEALTH DAY 2025. During this visit, the President was well received by APHPN Rivers State branch. The highlight of the visit was the presentation of a Title to the APHPN National President as the AMAYANABO of APHPN, and in return, the Chairman presented the Rivers Attire as a gift to the National President Dr. Terfa Kene as seen in the pictures below.

APHPN National President, Dr Terfa Kene with Prof. Oluseye Babatunde (WHO) during OGM in rivers State

L-R Prof. Nnesochi Ofor, APHPN President Dr. Terfa Kene (Amayanabo of APHPN), Dr. Maria Krukrubo (The oldest Public Health Physician in the State at the moment and Dr. Ishmael Jaja

The APHPN National President (The Amanayabo of APHPN) in a group photograph with APHPN Rivers State Branch.

APHPN National President, Dr. Terfa Kene with the Chairman of Rivers State

MEET THE NEW EXCOS OF APHPN FCT BRANCH

L-R Dr. Sabastibe Esomonu, Chairman, Dr Ramsey Yelma, Vice Chairman, Dr. Esther Cegbeyi, Sectretary, Dr Ronke Akande Treasurer, Dr. Oko PRO.

COURTESY VISIT BY THE PRESIDENT APHPN DR. TERFA KENE

On the 20th of April 2025 the APHPN National President paid a courtesy visit to one of the Elder and member of APHPN Dr. (Gen) Benard Ewa Abang

APHPN President (Dr. Terfa Kene), the National Treasurer (Dr. Juliette Ango), FCT Branch Chairman (Dr Sabastine Esomonu) and the Admin Staff of our National Office (Caroline Momoh) visited one of our elders and a memeber of our BOT (Retierd General Benard Ewa Abang) during the Easter holidays.

APPOINTMENTS & PROMOTIONS

APHPN celebrates its members who have risen to enviable heights of service to mankind.

Prof .Adeyinka Adeniran
Professor of Community Medicine
Lagos State University (LASU)

Prof. Modupe Rebekah Akinyinka
Professor of Community Medicine
Lagos State University (LASU)

Dr Omowumi Qubrat Bakare
Associate Professor of Community Medicine
Lagos State University (LASU)

Dr. Kayode Rasaq Adewoye
Associate Professor of Community Medicine
Afe Babalola University

Prof. Tyavyar J Akosu
Professor of Community Medicine
University of Jos

Dr.Elizabeth Oko
Reader, Department of Community Medicine
University of Jos

Dr Uchenna Ewelike
Executive Secretary/CEO Imo State Health Insurance Agency

Dr Innocent Alenoghena
Associate Professor of Community Medicine
Ambrose Alli University (AAU)

Prof.Taiwo Gboluwaga Amole
Professor of Community Medicine
Bayero University Kano (BUK)

Dr. Kenneth Onome Adagba
Principal, National Tuberculosis and Leprosy Training Centre (NTBLTC), Saye-Zaria

Prof. Musa Abubakar Kana
Deputy CMAC (Research, Ethics & Partnership)
Barau Dikko Teaching Hospital (BDTH), Kaduna.

Prof. Ishaku Ara Bako
Deputy Provost , College of Medicine .
Federal University, Lafia, Nasarawa State.

Prof Mobolanle Rasheedat Balogun
Professor of Community Medicine.
University of Lagos

Dr. Adeola Afolake Adejimi
Associate Professor of Community Medicine.
University of Lagos

Dr. Doyin Ogunyemi
Associate Professor of Community Medicine.
University of Lagos

Dr. Esther Oluwole
Associate Professor of Community Medicine.
University of Lagos

APPOINTMENTS & PROMOTIONS

APHPN celebrates its members who have risen to enviable heights of service to mankind.

Prof. Oluwakemi Odukoya
Professor of Community Medicine.
University of Lagos

Prof Alero Roberts
Professor of Community Medicine.
University of Lagos

Prof. Olatunji Abiola
Professor of Community Medicine.
University of Lagos

Prof. Ade Kemi Sekoni
Professor of Community Medicine.
University of Lagos

Dr. Tolulope Olufunlayo
Associate Professor of Community Medicine.
University of Lagos

Prof Folu Olatona
Professor of Community Medicine.
University of Lagos

Prof. Ifeoma Okafor
Professor of Community Medicine.
University of Lagos

Global Public Health Dates of Significance: July - September 2025

CULLED FROM THE WORLD HEALTH ORGANIZATION AND UNITED NATIONS WEBSITES

JULY 25TH 2025
WORLD DROWNING PREVENTION DAY

SEPTEMBER 29TH 2025
WORLD HEART DAY

JULY 28TH 2025
WORLD HEPATITIS DAY

AUGUST 1ST 2025 - AUGUST 07TH 2025
WORLD BRESTFEEDING WEEK

SEPTEMBER 10TH 2025
WORLD SUICIDE PREVENTION DAY

SEPTEMBER 17TH 2025
WORLD PATIENT SAFETY DAY

SEPTEMBER 28TH 2025
WORLD RABIES DAY