
THE ROLE OF CUSTOMARY LAW IN STRENGTHENING THE PRIMARY HEALTH CARE SYSTEM IN NIGERIA*

Abstract

Primary Health Care (PHC) is the foundation of Nigeria's health system, but it faces persistent challenges of weak infrastructure, poor funding, and low community trust. While statutory law provides the formal framework for PHC, customary law continues to shape the daily lives of millions of Nigerians, especially in rural areas. This paper argues that, despite its legal and institutional constraints, customary law can be formally integrated into PHC governance to enhance legitimacy, access, and accountability. Using the lens of legal pluralism, decentralization, and social legitimacy, the paper shows how customary institutions—chiefs, elders, and community courts—can support health education, dispute resolution, land allocation, and cultural adaptation of health services. It proposes a policy framework that recognizes customary law within PHC delivery, while ensuring alignment with statutory law and human rights. The conclusion emphasizes that integration must be carefully regulated, rights-based, and supported by legislation, training, and resources.

Keywords: Customary Law, Primary Healthcare, Health Governance, Community Participation, Legal Pluralism

1. Introduction

Primary Health Care (PHC) is internationally recognized as the foundation of an equitable health system, designed to bring essential health services to communities as close as possible. The Alma-Ata Declaration (1978)¹ enshrined the principle that health systems must begin at the grassroots, anchored in prevention, promotion, and community participation. In Nigeria, PHC centers are formally allocated to Local Government Areas (LGAs) for management, serving as the first point of contact for health care, particularly for the poor and lower middle class who predominantly reside in rural and semi-rural regions. Yet, in practice, state governments often exert direct control over PHC operations, undermining the autonomy and accountability of local authorities. Many PHC facilities are nonfunctional or underutilized, reflecting chronic challenges in infrastructure, staffing, funding, and governance². The government has made laudable reform efforts, such as the 'Primary Healthcare under One Roof' initiative and the establishment of the Basic Healthcare Provision Fund (BHCPF) through the National Health Act. However, these top-down approaches struggle to gain traction in communities where state legitimacy is weaker than that of traditional institutions. A significant gap exists between legislative intent and practice, with state governments often managing a system intended for local control.

The social and normative life of many rural Nigerian communities is deeply shaped by customary laws and traditional institutions: chiefs, elders, customary courts, and local norms that regulate everything from land and family matters to sanitation, hygiene, births, and social sanctions. Yet these customary systems remain peripheral to the formal health regime particularly the primary health care, where the system is profoundly shaped not only by statutory provisions but by the enduring authority of customary law.³ This gap matters because cultural legitimacy, social norms, and trust often determine whether community members accept health interventions, comply with regulations, or view health centers as part of their social world.

This paper argues that integrating customary law and traditional institutions into Nigeria's PHC framework offers a path to strengthen primary health care delivery. Recognizing that Nigeria operates a plural legal system—where statutory, customary, and religious norms coexist. The argument proceeds as follows: customary institutions can contribute to health education, dispute resolution, local governance, and social enforcement of health norms. If harnessed appropriately and carefully regulated, customary law could help bridge the disconnection between formal health systems and the communities they intend to serve.

2. Overview of the Primary Health Care Legal Framework in Nigeria

Primary Health Care (PHC) in Nigeria is shaped not only by health-sector practice and budgets but by statute, national policy, and international cooperation frameworks. A clear account of the legal instruments and policy documents that govern PHC is necessary to (a) identify who holds responsibility for PHC delivery, (b) understand funding and institutional flows, and (c) spot legal openings and constraints for incorporating customary law or traditional institutions into PHC governance.

The Alma-Ata Declaration

This was adopted in 1978, emphasized primary health care as essential for achieving 'Health for All' and highlighted health as a fundamental human right. The Alma-Ata Declaration was adopted during the International Conference on Primary Health Care held in Alma-Ata (now Almaty, Kazakhstan) from September 6 to 12, 1978. This conference marked a pivotal moment in

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¹ <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>. The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All.

² Ogah, P., Uguru, N., Okeke, C., Nurudeen M., Oriteseweyimi O., Wende A., Myyiwa A. 'Primary health care in Nigeria: best practices and quality of care in Nigeria.' BMC Health Serv Res 24, 963 (2024). <https://doi.org/10.1186/s12913-024-11406-0>

³ Gyuse, A. N., Ayuk, A. E., & Okeke, M. C. (2018). Facilitators and barriers to effective primary health care in Nigeria. African journal of primary health care & family medicine, 10(1), e1–e3. <https://doi.org/10.4102/phcfm.v10i1.1641>

public health, calling for urgent action to protect and promote the health of all people globally, particularly in developing countries.⁴ Key points of the Declaration include:

Health as a Human Right: The declaration reaffirmed that health is a fundamental human right and that achieving the highest possible level of health is a crucial social goal that requires the involvement of various sectors beyond just health care.

Primary Health Care: It identified primary health care as the key to achieving 'Health for All.' This approach is based on practical, scientifically sound, and socially acceptable methods that are universally accessible to individuals and families in the community.

Inequality in Health: The declaration highlighted the unacceptable health disparities between developed and developing countries, calling for collective action to address these inequalities.

Community Participation: It emphasized the right and duty of people to participate in the planning and implementation of their health care, promoting a community-centered approach.

Global Cooperation: The declaration urged governments, international organizations, and the global community to collaborate in developing and maintaining primary health care systems, particularly in developing nations.⁵

Constitution of the Federal Republic of Nigeria 1999 (As Amended)

The 1999 Constitution of the Federal Republic of Nigeria provides a general foundation for health governance, although it does not explicitly guarantee a justiciable right to healthcare. Section 17(3)(d) of the Constitution mandates the State to ensure the provision of adequate medical and health facilities for all persons, but this section forms part of the Chapter II of the Constitution, which are non-justiciable and unenforceable in a court of law. Nigerians have relied on the fundamental rights provisions—particularly the right to life (Section 33) and the right to dignity of the human person (Section 34) to advocate for healthcare-related entitlements.

National Health Act 2014

The National Health Act, 2014 provides a foundational legal framework for the organization and delivery of healthcare services in Nigeria. It clearly delineates the responsibilities of the Federal, State, and Local governments, thereby promoting intergovernmental coordination in health service delivery. One of its most impactful provisions is the establishment of the Basic Health Care Provision Fund (BHCPF), which is financed by not less than one percent of the Consolidated Revenue Fund. This fund is primarily intended to improve access to primary healthcare services, especially for vulnerable and underserved populations, by supporting the operations of primary health centers across the country. A major policy under the Act is the recognition of patients' rights. Section 20 guarantees the right to emergency medical treatment without preconditions, thus reinforcing the principle of health equity. In addition, the Act mandates the development of a national health information system to improve transparency, data collection, and policy planning. Other key policies include the establishment of the National Tertiary Health Institutions Standards Committee⁶, which is tasked with evaluating the performance and quality standards of federal tertiary hospitals. The Act also provides for the regulation of human health resources and the maintenance of a central register of health practitioners. It further outlines guidelines for public-private partnerships in health service delivery and emphasizes community participation and oversight through health committees at various levels.⁷ Collectively, these provisions are aimed at decentralizing healthcare, improving quality and accountability, and ensuring that health services are accessible, equitable, and efficiently managed. On an institutional level, the National Council on Health, established under the National Health Act of 2014 coordinates health policy and planning across the federal, state, and local levels of government, thereby facilitating collaborative governance in the health sector.

National Primary Health Care Development Agency (NPHCDA)

The National Primary Health Care Development Agency (NPHCDA) is a leading federal agency in Nigeria mandated to develop, implement, and oversee primary healthcare services nationwide. The National Primary Health Care Development Agency was established by statute to provide leadership for PHC development, set standards, and coordinate PHC programming nationwide. The agency focuses on improving health outcomes by ensuring equitable access to essential health services, particularly in rural and underserved communities. Through strategic interventions and partnerships, NPHCDA plays a pivotal role in strengthening Nigeria's primary healthcare infrastructure and promoting health equity.⁸ Established to strengthen the primary healthcare system, the NPHCDA is responsible for supporting states and LGAs in delivering basic health services. The Core functions and Objectives of the NPHCDA include: Revitalization of primary healthcare centers; MNCH programs and skilled birth services; Nationwide immunization campaigns; Deployment of community-based health services; Health worker training and capacity building; Advocacy and support for health insurance schemes; Disease surveillance and emergency health interventions; Health education and awareness campaigns; Nutrition and food security projects; and Coordination with stakeholders at all levels of governance.⁹

⁴ <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>

⁵ Ibid

⁶ S. 11 National Health Act 2014

⁷ Section 18 of the National Health Act, 2014. This section outlines the regulation of human health resources, the maintenance of a central register of health practitioners, guidelines for public-private partnerships in health service delivery, and emphasizes community participation and oversight through health committees at various level

⁸ <https://phc.nphcda.gov.ng/infographic>

⁹ Ibid

National Health Policy 2016

The National Health Policy identifies Primary Health Care (PHC) as the foundation of Nigeria's health delivery system and the first point of contact for most citizens, especially those in rural and semi-urban communities. It recognizes that about 88% of all health facilities in the country are PHC centers, yet many are poorly equipped, understaffed, and inadequately funded. Fragmented governance and overlapping roles between the federal, state, and local governments have further weakened the PHC system. As a result, the quality of service delivery remains low, and utilization by communities is limited.¹⁰ To correct these weaknesses, the policy calls for a stronger, better coordinated, and more accountable PHC framework. It emphasizes the need to integrate all PHC facilities under a unified structure, promote equitable access, and ensure sustainable financing. Strengthening PHC is presented not only as a technical goal but also as a social justice issue—ensuring that essential care reaches the poorest and most vulnerable Nigerians who rely on the public health system for survival.¹¹ The policy stresses that the success of PHC depends heavily on the active involvement of communities. It argues that communities must not only be beneficiaries of health programs but also co-owners and decision-makers. Through Ward and Village Development Committees, communities are to play roles in identifying priorities, monitoring progress, and evaluating outcomes. This participatory model aligns with Nigeria's long-standing philosophy of health for all by the people, emphasizing that sustainable health development must be built from the grassroots.¹² Furthermore, the policy integrates cultural and gender considerations into community participation. It acknowledges that local norms and traditional institutions strongly influence health behavior and service utilization. Therefore, engaging community and traditional leaders is essential for mobilization, education, and enforcement of public health initiatives. The policy envisions communities that are empowered, informed, and organized to sustain PHC interventions over the long term.¹³

3. Customary Law and Public Health Care

Defining Customary Law and Legal Pluralism in Nigeria

Customary Law refers to indigenous norms and practices accepted by a community as binding, often unwritten, enforced through traditional or customary institutions (chiefs, elders, customary courts), and regulating social relationships, land, family matters, rites, and local behavior.¹⁴ Customary law is dynamic (changes with custom), embedded in local culture, and carries social legitimacy in many Nigerian rural/local settings.¹⁵ Legal Pluralism is the coexistence of two or more legal systems within the same social field. In Nigeria, the formal legal system (statutory / common law) coexists with customary law (native law and custom) and, in many states, religious law (Islamic / Sharia) for certain matters. These systems overlap or sometimes conflict, and parties often navigate between them depending on social, cultural, religious, or procedural preferences.¹⁶ The constitutional framework in Nigeria recognizes customary law in certain respects: courts (especially customary courts) may apply 'native law and custom' so long as it is not repugnant to natural justice, equity and good conscience, nor incompatible with any written law or (in some jurisdictions) Sharia / statutory law. But in practice, customary law's role, particularly in health or public policy matters, is seldom directly invoked or integrated.¹⁷

Theoretical Perspectives on how Customary Law Might Strengthen PHCs

To understand how customary law might strengthen PHC, several theoretical perspectives are relevant:

Legal Pluralism Theory: This theory highlights that legal systems are not monolithic and that formal law does not hold exclusive authority over all social regulation. When people live by customary norms, formal law that ignores those norms may lack legitimacy or compliance. Utilizing customary law can bridge the implementation gap in addressing challenges at the Primary Health Care level.

Decentralization and Local Governance Theory: According to this theory, bringing decision-making, administration, and regulatory power closer to local levels enhances accountability, responsiveness, and effectiveness. Local authorities and traditional institutions are often better placed to understand local conditions, and infrastructural constraints in line with accepted cultural and customary norms.

Theory of Social Legitimacy and Trust: Health interventions and health systems are more effective when the community trusts institutions. Where formal health systems are seen as 'alien,' 'government,' or disconnected from local norms, uptake and cooperation suffer. Traditional leaders and customary legal mechanisms often enjoy higher trust in many rural communities.

Human Rights and Equity Norms: Laws, whether statutory or customary, must be consistent with human rights obligations (domestic constitution, international treaties). Integration of customary law in PHC must ensure protections for vulnerable groups (women, children, marginalized persons).

¹⁰ Chapter 2. National Health Policy 2016. <https://www.naca.gov.ng/wp-content/uploads/2019/10/National-Health-Policy-Final-copy.pdf>

¹¹ Ibid

¹² Chapter 4. National Health Policy 2016. <https://www.naca.gov.ng/wp-content/uploads/2019/10/National-Health-Policy-Final-copy.pdf>

¹³ Ibid

¹⁴ Derek Asiedu-Akrofi, Judicial Recognition and Adoption of Customary Law in Nigeria, *The American Journal of Comparative Law*, Volume 37, Issue 3, Summer 1989, Pages 571–593, <https://doi.org/10.2307/840092>

¹⁵ Ibid

¹⁶ Abdulmumini A. Oba, 'Religious and Customary Laws in Nigeria', *Emory International Law Reviews*, Vol. 25 No. 2, September 2011

¹⁷ Derek Asiedu-Akrofi, Judicial Recognition and Adoption of Customary Law in Nigeria, *The American Journal of Comparative Law*, Volume 37, Issue 3, Summer 1989, Pages 571–593, <https://doi.org/10.2307/840092>

Customary Law in Nigeria and Its Relationship with Health and Health Care

As stated above, Customary Law refers to indigenous norms and practices accepted by a community as binding, often unwritten, enforced through traditional or customary institutions (chiefs, elders, customary courts), and regulating social relationships, land, family matters, rites, and local behavior.¹⁸ Customary law is the body of unwritten rules developed from the traditions and practices of Nigeria's over 250 ethnic groups. It predates colonial law and still governs personal matters such as marriage, inheritance, and land tenure. Courts recognize it as valid if it is not 'repugnant to natural justice, equity, and good conscience' and not inconsistent with statutory law.¹⁹ Because it is rooted in culture and enforced by respected leaders, customary law commands strong legitimacy in rural communities where formal legal systems may feel distant. Customary law fills this gap by shaping how communities organize health practices, allocate resources, and resolve disputes about care.²⁰

How Customary Law Relates to Health and Health Care

Community Trust and Legitimacy: Traditional leaders and elders are often the first point of advice when people fall ill. Their endorsement of clinics, immunization, or maternal care can increase acceptance of PHC services.²¹ An illustration is created as follows: In a rural Igbo community, elders declare that vaccination is consistent with ancestral protection rituals. Uptake of polio vaccines rises sharply.

Dispute Resolution: Customary courts can mediate conflicts between patients and health workers. This avoids costly litigation and maintains community harmony. An illustration is created as follows: A family accuses a nurse of negligence. Instead of going to a statutory court, the matter is settled by the village council, which orders compensation and reconciliation.

Land and Infrastructure: Customary law governs land tenure. Communities often donate land for health centers through customary agreements. An illustration is created as follows: In a Yoruba town, the Oba allocates communal land for a PHC clinic, resolving disputes through customary arbitration.

Health Financing and Mutual Aid: Traditional savings groups (e.g., esusu, ajo) are rooted in customary practice. These can be adapted to fund community health insurance. An illustration is created as follows: A women's cooperative in Ogun State uses their ajo contributions to cover maternity fees at the local PHC.

Cultural Sensitivity in Care: Customary norms influence attitudes toward childbirth, mental health, and end-of-life care. Health workers who respect these norms gain more trust. An illustration is created as follows: A PHC center in Northern Nigeria allows traditional birth attendants to work alongside midwives, blending custom with modern care.

Legal Constraints on Using Customary Law to Strengthen Primary Health Care in Nigeria

Customary law can help build trust and access to care, but there are hard legal limits on how far it can shape public health. A number of these constraints include:

Constitutional non-justiciability of the right to health: Nigeria's Constitution places health under Chapter II (Directive Principles), which courts generally do not enforce directly. This weakens legal pressure to integrate customary institutions into health delivery because communities cannot rely on constitutional health rights to compel government action. It makes any customary-led health initiative depend on policy goodwill rather than enforceable rights.²² An illustration is created as follows: A council of chiefs signs a community pact to support antenatal care. When the local government fails to supply vaccines, the chiefs cannot sue to enforce a constitutional 'right to health' because the courts treat it as non-justiciable. They must lobby instead.

Repugnancy and incompatibility tests limiting custom: Customary rules only stand if they are not 'repugnant to natural justice, equity, and good conscience' and not inconsistent with any legislation. Any custom that restricts women's access to care, discourages vaccination, or undermines patient dignity can be invalidated. This means health planners cannot rely on problematic customs, even if locally accepted.²³ An illustration is created as follows: A custom requiring husband's consent before clinic visits are rejected during a dispute at a customary court because it conflicts with statutory and rights-based standards. The clinic adopts a rights-based consent policy, limiting the custom's effect.

Proof, variability, and fragmentation of customs: Customary law is mostly unwritten and varies across communities, even within the same ethnic group. In court, a custom must be proved as widely accepted. This makes standardizing health

¹⁸ Derek Asiedu-Akrofi, *Judicial Recognition and Adoption of Customary Law in Nigeria*, *The American Journal of Comparative Law*, Volume 37, Issue 3, Summer 1989, Pages 571–593, <https://doi.org/10.2307/840092>

¹⁹ See *Oyewunmi v. Ogunesan* [1985] 1 NWLR 621

²⁰ I.T. Imoban, *Right to Health Under the Nigerian Law: The Justiciability and Otherwise* (2025) BarristerNG [<https://barristerng.com/right-to-health-under-the-nigerian-law-the-justiciability-and-otherwise-by-i-t-imoban-esq/>]

²¹ Omaplex Law Firm, *The Role of Customary Law in Contemporary Nigerian Legal System* (2025) [<https://omaplex.com.ng/the-role-of-customary-law-in-contemporary-nigerian-legal-system/>]

²² Lugard, S. B. (2023). The Right to Health in Nigeria and Its Impact on Citizens' Access to Medical Care. *Journal of African Law*, 67(1), 59–77. doi:10.1017/S0021855322000304

²³ Igbozurike & Anor. V. Onuador (2015) LPELR-25530 (CA)

interventions through customary rules difficult and slows enforcement because each locality may need to demonstrate its specific custom before it can be applied in disputes or governance. This is a constraint of concern because it means that Health agencies cannot draft one 'customary health protocol' for all communities. They must map and validate local practices, increasing time and cost.

Jurisdictional limits and civil focus: Customary courts and processes mostly address civil matters and community relations, not public regulatory functions. Criminal law must be written, and many health regulations (licensing, professional discipline, drug control) are statutory and technical. Customary institutions cannot replace regulatory enforcement for clinical standards, pharmaceuticals, or infectious disease control. An illustration is given as follows: A traditional healer disputes a closure notice. The issue turns on statutory licensing requirements, which customary forums cannot override. The state health agency's written rules prevail.

Weak legislative frameworks and judicial reluctance: Beyond the Constitution's limits, courts have historically been cautious in enforcing socio-economic rights. Without strong legislation that clearly assigns roles to customary institutions in PHC, judges may hesitate to recognize customary mechanisms for health governance. This judicial stance narrows the legal pathway for formal integration of custom into PHC structures. A constraint of concern is that even well-designed community agreements may be treated as soft commitments unless backed by clear statutes and enforceable instruments.²⁴

Federalism and coordination challenges: Health is a concurrent responsibility involving federal, state, and local governments. Customary systems are deeply local and diverse. Aligning local customs with federal standards on immunization, surveillance, and professional practice is hard. Fragmentation leads to uneven adoption and legal uncertainty when state policies do not expressly recognize customary roles. An illustration is given as follows: A state adopts a PHC plan that ignores traditional councils. Neighboring local governments embrace them. People experience different rules across borders, complicating referrals and data reporting.

Statutory dominance in health regulation: The National Health Act and other public health laws establish statutory institutions, standards, and rights of patients and professionals. Because these are written and binding, any customary rule that contradicts them must give way. This places an upper limit on how far custom can influence clinical protocols, medicines access, or facility operations. A constraint of concern is that customary endorsement can bolster uptake but cannot alter clinical guidelines or drug safety protocols defined by statute.

Human rights alignment and gender equality: Customs that restrict women's autonomy, stigmatize illness, or permit disclosure of confidential health information conflict with rights frameworks and ethical duties. Integrating such customs into PHC would expose health agencies to legal risk and complaints. Rights protections take priority over local practices when they clash. An illustration is given as follows: A customary rule allows elders to access a woman's antenatal record without her consent. The clinic denies the request, citing privacy and dignity protections supported by rights discourse and policy norms.

Evidence, data, and accountability gaps: Public health requires reliable data, transparent budgets, and formal accountability. Customary institutions may lack written procedures for record-keeping, complaint handling, and audit trails. Without statutory recognition and capacity-building, customary enforcement can be seen as informal and inadequate for program monitoring and rights oversight. A constraint of concern is that A vaccination drive led by chiefs succeeds locally but fails to meet reporting standards for national surveillance, limiting its integration into official metrics.

Policy implementation bottlenecks: Even where policy recognizes community participation, poor infrastructure, underfunding, and governance, bottlenecks hinder effective collaboration with customary leaders. Legal recognition without operational resources leaves initiatives symbolic. Implementation deficits make customary partnerships fragile and inconsistent across regions. A constraint of concern is that local health attendants are trained as health advocates, but clinics lack staff and supplies. The partnership stalls because the legal/policy framework is not matched by resources.

Customary law and traditional institutions are neither monolithic nor uniformly beneficial, but they are unavoidable facts of social life in much of Nigeria. Their influence on health-seeking behaviour, community norms, and local enforcement is empirically strong and has already been harnessed successfully (e.g., polio campaigns).

4. Conclusion and Recommendations

Customary law remains a powerful force in shaping health behavior in Nigeria. While statutory law provides the formal framework for PHC, it often lacks legitimacy in rural communities. Customary institutions, if properly integrated, can bridge this gap by mobilizing trust, resolving disputes, and adapting health services to cultural realities. However, integration must be carefully regulated. Harmful customs must be reformed, and all practices must align with statutory law and human rights. With legislative reform, institutional collaboration, and capacity building, Nigeria can create a pluralist health governance system where statutory and customary law work together. This approach will not only strengthen Primary Health Care but also advance equity, legitimacy, and sustainability in Nigeria's health system. There is need for the following:

²⁴ Chime I. 'Access to healthcare as a fundamental right in Nigeria: Legal Challenges and Policy Implementation' [Http://instituteofeducation.unn.edu.ng/journal/review of education](http://instituteofeducation.unn.edu.ng/journal/review%20of%20education). Vol 34. 2. 2022

Legal Recognition and Framework

a) *An amendment of Chapter 2 of the Constitution* to explicitly make the right to health justiciable; b) *An amendment of the National Health Act (2014)* to explicitly recognize the role of customary institutions in PHC governance; c) *Establishing a Customary Health Integration Clause* that allows chiefs, elders, and customary courts to participate in PHC oversight, provided their actions are consistent with statutory law and human rights; d) *Creating state-level bye-laws* that define the scope of customary participation in PHC, ensuring uniformity across local governments.

Institutional Integration

a) *Forming Community Health Councils (CHCs) at ward level*, combining PHC staff, local government officials, and customary leaders; b) *Assigning Community Health Councils roles in mobilization for immunization*, maternal health campaigns, and sanitation drives; c) Empower customary courts to mediate non-criminal health disputes (e.g., negligence claims, land for clinics).

Training and Capacity Building

a) Developing health literacy programs for chiefs, elders, and traditional birth attendants (TBAs); b) Training customary leaders on patients' rights, gender equality, and confidentiality to prevent harmful practices; c) Providing certification schemes for traditional healers who collaborate with PHC centers.

Financing and Resource Mobilization

a) Adapting traditional savings groups (*esusu, ajo*) into community-based health insurance schemes; b) Allowing Community Health Councils to manage micro health funds for emergency care, overseen by both statutory and customary representatives; c) Encouraging public-private partnerships where customary institutions co-manage PHC infrastructure.

Safeguards and Human Rights

a) Applying the repugnancy test to exclude customs that restrict women's autonomy or stigmatize illness; b) Requiring gender representation in Community Health Councils to ensure women's voices in decision-making; c) Screening customs for compliance with gender equality and patient rights; d) Establishing monitoring mechanisms to ensure customary practices align with statutory health standards.

Data and Accountability

a) Mandating CHCs to keep written records of health campaigns, disputes, and community contributions; b) Integrating customary health data into the National Health Information System for planning and evaluation; c) Providing annual audits of customary contributions to PHC; d) Transforming traditional savings groups into community health insurance schemes.