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Exploring the Fundamentals of Health System Governance in Nigeria: an application of the WHO Framework.

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Abstract

Background: There is need for studies geared at assessing the current state of health systems governance in the WHO African Region, with a view generating strategies for strengthening the governance function. There is a dearth of literature on the governance of the health system in the African Region. This study aimed to assess the level of health system governance (HSG) in Nigeria.

Methods: The main study areas were the Federal Capital Territory Abuja, Enugu and Anambra states of Nigeria. However, data was also collected from respondents from other parts of the country. The methods for the assessment of governance in Nigeria were adopted from the WHO/EMRO Analytical Framework for Assessing Health System Governance. Three data collection tools were developed and pre-tested. These tools were an in-depth interview guide, a questionnaire, and a document review guide.

Results: The key findings were as follows: (i) strategic vision for health and policies exist but people are not generally aware of their implementation; (ii) policies and strategies are not explicitly demand-driven and demand-responsive; (iii) there is sizeable number of people that are ignorant about the legal issues in the health sector; (iv) the general population have poor knowledge about their rights in the health sector; (v) there is limited needs-based resource allocation by the government; (vi) the poor may not be optimally accessing health services; (vii) there is inefficient management of information, finances and human resources leading to sub-optimal coverage of health services; (viii) there is moderate to low level of accountability; (ix) there is good information gathering system and moderate capacity for data analysis but poor information dissemination system; (x) ethics in health sector exists although many people may not be well informed.

Conclusion:The governance of the health system in Nigeria can be improved by the passage of the Health Bill into law by the two chambers of the national assembly, the passage of the Right of Information bill into law and the implementation of existing policies amongst others. Strategies to increase consumer awareness of their rights and improve equity in the delivery of health services should be in place.

Keywords: Health System Governance, Nigeria, WHO Framework

Introduction

The fifty-third session of the World Health Organization (WHO) Regional Committee for Africa adopted a resolution urging member states to strengthen their health systems governance (HSG) function [1]. Good governance involves closeness of mission and purpose, trust amongst partners, mutual accountability, leadership/consensus balance, efficient management, acceptable and transparent structure, and transparency of decisions such as financial allocations. Hence, good HSG, in summary, involves a health system that is transparent, involving, participatory, and fair.

The World Health Report 2000 [2] proposed stewardship as one of the four functions of the health system. It recognized stewardship as a function of the government responsible for the welfare of the population and concerned about the trust and legitimacy with which the citizenry views its activities. Stewardship was thus expressed as the very essence of good governance in health. Unfortunately, there is a dearth of literature on the governance of the health system in the African Region. Therefore, there is need for studies geared at assessing the current state of health systems governance in the Region with a view to generating strategies for strengthening the governance function.

Governance is not about governments alone. United Nations Development Program (UNDP) defines governance as the exercise of political, economic, and administrative authority in the management of a country's affairs at all levels. Governance comprises the complex mechanisms, processes, and institutions through which citizens and groups articulate their interests, mediate their differences, and exercise their legal rights and obligations [3].

Governance is thought to be a key determinant of economic growth, social advancement, and overall development, as well as for the attainment of the Millennium Development Goals in low and middle-income countries. The former Secretary General of the United Nations, Kofi Annan's statement that "good governance is perhaps the single most important factor in eradicating poverty and promoting development" is an apt reflection its need [4]. Health is the subject of Transparency International's Global Corruption Report 2006, which acknowledges the vast scale of corruption in rich and poor countries however the poor are disproportionately affected, thus reinforcing the need for good governance for better health outcomes [5].

This study aimed to assess the level of health system governance (HSG) in Nigeria, based on indicators from ten broad principles, which will be explained in the next sub-section. Hence, it is hoped that this paper contributes to knowledge in understanding HSG issues in Nigeria.

Material and Methods

Stuudy Area

The main study areas were the Federal Capital Territory (FCT) Abuja, Enugu and Anambra states of Nigeria. However, data was also collected from respondents from other parts of the country. The main study sites were selected because of their cosmopolitan and the good opportunity that they avail for understanding HSG within the three levels of the Nigerian Health System. These levels are the: primary level which is under the purview of the lowest tier of government (the local government areas); the secondary level which is under the purview of the second tier of government (the states); and the tertiary level which is

mostly controlled by the highest level of government (the federal).

Framework for Assessing Health System Governance

Study Framework

The analytical framework for assessing governance of the health system [6] consists of the following principles: *strategic vision, participation and consensus orientation, the rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information and ethics* (Table 1 of the Appendix). This framework was used to assess health systems governance in Nigeria.

Table 1 Health System Governance Principles

Governance Principle	*Explanation*
Strategic vision	Leaders have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development. There is also an understanding of the historical, cultural, and social complexities in which that perspective is grounded.
Participation and consensus orientation	All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures.
Rule of law	Legal frameworks pertaining to health should be fair and enforced impartially, particularly the laws on human rights related to health.
Transparency	Transparency is built on the free flow of information for all health matters. Processes, institutions, and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters.
Responsiveness	Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users.
Equity and inclusiveness	All men and women should have opportunities to improve or maintain their health and well-being.
Effectiveness and efficiency	Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources.
Accountability	Decision-makers in government, the private sector, and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization.
Intelligence and information	Intelligence and information are essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health.
Ethics	The commonly accepted principles of health care ethics include respect for autonomy, no maleficence, beneficence, and justice. Health care ethics, which includes ethics in health research, is important to safeguard the interest and the rights of the patients.

Assessment levels

Ministry of Health (MOH) being the principal governing body of the health system has the mandate for health policymaking, planning, regulation, monitoring and evaluation and for ensuring access to essential health services. There are thus two levels - health policy formulation and policy implementation. In some countries, the MOH is responsible for both, while in others implementation of health services falls under the jurisdiction of sub-national (state, provincial, district or local) governments. In addition to the MOH, there is a level above that influences HSG. The national government through its broad social and economic policies,

legislative function, civil service reforms, and by its political (in) stability influences health system governance. The analytical framework thus poses the broad and specific questions and items for each principle at three levels - *the national level, the health policy formulation level, and the policy implementation level.*

Each governance *principle* has been disaggregated into domains to capture as best as possible its full meaning and to express it in more operational terms. From the various *domains* are derived broad questions. The broad questions are translated into specific questions and items that form the basic instrument for data collection. The logic of the framework and the sequencing of questions are illustrated in Box 1. The framework asks altogether 63 *broad questions* across the 10 governance principles ranging from contextual, descriptive, process-related and outcomes related [6].

The framework includes analysis of the organizational structure of the MOH and sub-national health departments and their relationship with the stated roles and functions. This is useful to determine the extent to which the organizational structure is aligned with the governance and other functions of the health system.

Box 1 Analytical Framework for Assessing Strategic Vision

The governance **principle** being assessed is *strategic vision* [6]:

the **domain** is long term vision:

the **broad question** at the:

- *National* level - what are the broad outlines of economic policy of the government;
- *Health policy formulation level* – whether there is a long term vision (policy) for health;
- *Policy implementation level* - whether the implementation mechanisms are in line with the stated objectives of health policy.

the **specific question** at the:

- *National level* - Where does health rank in the overall development framework by resource allocation, and as a percentage of total government expenditure and as a percentage increase in expenditure;
- *Health policy formulation level* - Is there a national health policy/strategic plan available stating objectives, strategies with a time frame and resources allocated;
- *Policy implementation level* - What priority programs are being implemented and how do they correspond to the policy objectives.

Sources of Information

The sources of information for assessing HSG are categorized into published and unpublished reports and information collected through interviews. The information acquired through interviews is essential as it -depicts different points of view for a composite picture to emerge and helps corroborate information retrieved from documents. A wide range of stakeholders should be interviewed such as national and MOH policymakers, mid- and senior managerial staff of the MOH or its component departments, civil society organizations, international development agencies, academic institutions, media personnel, and direct community representatives. A list of possible sources of documents and persons to be interviewed to assess each of the ten principles of health system governance is shared a priori with the country investigators along with the framework. The summary of broad questions is presented in Table 2 of the appendix.

Table 2 Summary of Broad Questions in the Health System Governance Assessment Framework

Assessment level	Types of broad questions				
	Context related	Descriptive	Analytical/ Process related	Outcomes related	Total
National	5	10	6	2	23
MOH policy	0	11	7	2	20
Policy implementation	0	4	14	2	20
Total	5	25	27	6	63

Data Collection Tools

Three data collection tools were developed and pre-tested before they were used to collect data. These tools were an in-depth interview guide, a questionnaire (in form of a checklist) and a document review guide. Interviewers were recruited and trained to assist the principal investigator in collecting the data.

Questionnaire

The questionnaire was pre-tested amongst 5 policy makers/programme managers, 20 health providers and consumers in Enugu. It was thereafter modified for content and the way some of the questions and expected responses were framed. The questionnaire was divided into ten (10) sections in accordance with the framework. The questionnaire is presented in Appendix 1. Trained field workers administered the questionnaires. However, some of the respondents requested that the questionnaires be left with them and the field workers then collected such questionnaires after a day or two. Some of the questionnaires were sent by e-mail to selected respondents who were not resident in Enugu state, Anambra state and the Federal Capital Territory, Abuja.

In-depth Interviews

The in-depth interviews (IDI) were undertaken using a cross-sectional study design. The study was conducted in Anambra and Enugu states, as well as the FCT, Abuja, Nigeria. Purposive sampling method was used to locate the respondents who have useful information on the issue under study. A total of twenty-three (23) in-depth interviews were conducted with health care providers, policy makers at the state and Federal Ministry of Health, International donor agencies, Professional associations and consumers of health care services. An IDI guide that was developed using the WHO guideline was used to guide the interview. The IDIs were conducted by trained interviewers, who were supervised by a medical sociologist. The IDI guide is presented as Appendix 2.

Document Reviews

A document review guide was developed to provide a framework for the review of documents. It is presented as Appendix 3. Using the guide, relevant government legal, policy and programmatic documents were reviewed. These were especially documents at the Federal level, and also focusing on Enugu and Anambra states.

Data Analysis

The IDIs were tape-recorded and transcribed verbatim. Content analysis was used to analyze the data collected. All the responses were put in a matrix table against each of the questions contained in the set of themes in the interview guide. After that, the responses were analyzed thematically. The data from the questionnaire was initially processed using EPI info software and then analyzed in detail using SPSS software package. Content and discourse analysis was used

to analyze the documents that were retrieved.

Results and Discussion

General Information about the Respondents from the Survey and IDIs

Interviews with questionnaires were successfully and completely conducted with one hundred and thirteen (113) respondents that were drawn from both the public and private sectors from around the country. Majority of the respondents were from Enugu and Anambra states. However, 8% of the people were from the Federal Capital Territory (FCT) Abuja and 4.4% from elsewhere. The respondents were from a broad spectrum of policy makers, programme managers, health providers, heads of professional associations and consumers. A total of 71 (62.8%) were from the private sector, and 42 (37.2%) were from the public sector. Also, 67 (59.3%) were females, and 46 (40.7%) were males.

There were twenty-three (23) in-depth interviews (IDIs). The respondents were health care providers, policy makers at the State and Federal Ministry of Health, International donor agencies, Professional associations and consumers of health care services.

The reviewed documents included the country's 1999 constitution [7], National Health Policy [8], National Health Reform Programme (2003 to 2007) [8-10], Enugu State Health Policy [11], Anambra State Health Vision for Health [12], Progress with achieving the Millennium Development Goals (MDGs) in Nigeria [13] and published literature.

Strategic Vision

Health is listed as a fundamental human right in the constitution and in both the national as well as state health policies. Most of the respondents in the survey felt that health was defined as basic human right in the constitution (Table 3). In the IDI, majority of the respondents agreed that the constitution of Nigeria provides that health is a basic human right of every citizen. However, few of the people did not know whether the constitution really states that health was a basic human right.

Table 3: Strategic Vision

VARIABLES	n (%)
NATIONAL/STATE	
Health is defined as a basic human right in the constitution	75 (66.4)
MOH POLICY	
There is a long term vision (policy) for health	84 (74.3)
The health policy is subject to regular review/revision processes	76 (67.3)
The policy remained consistent over the last five/ten years	33 (29.2)
There is a national/state health policy/strategic plan explicitly stating objectives to achieve with a time frame and resources	72 (63.7)
MOH IMPLEMENTATION	
There are policies that have implementation plans that you know of	17 (15.0)

However, the Vision and Mission of the Federal Ministry of Health [7] are:

<u>Vision:</u> To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; to reverse the increasing prevalence of non-communicable diseases; meet the global targets on the elimination and eradication of diseases, and significantly increase the life expectancy and quality of life of Nigerians.

<u>Mission:</u> To develop and implement appropriate policies and programmes, as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective,

quality and affordable health services to all Nigerians.

Also in the survey, most of the respondents stated that there was a long vision for health in Nigeria, which was subject to regular revision. Although a slight majority stated that the policy has not remained consistent over the years, a sizeable proportion (32%) of the people did not know whether or not the policy (policies) had remained constant over the years. There was a consensus opinion that the country has a national health policy/ strategic plan explicitly stating objectives to achieve within a time frame and resources. As one of the respondents said:

"Yes there is a National Health Policy on Health which has been accepted by the state, and if you look at the Millennium Development Goals, they have a time frame'(IDI with a respondent in Anambra State)"

Most of the people in the survey although stating that there were plans and policies did not know how many of them had implementable strategic plans. In the IDI, some of the implementable programmes from the National Health Policies were identified as immunization, National Health Insurance Scheme, HIV/AIDS, Control of River blindness, Roll Back Malaria, etc. Package of services was identified to be in three levels of healthcare, which were the primary, secondary, and tertiary levels. Majority of the respondents had no idea about the number of policy objectives with definite implementation plans.

The 2004 – 2007 Health Reform Program of Nigeria [8] also had improved governance (stewardship) role of the government as one of its major thrusts, and it was presented as:

- *Review of existing health policies and strategies, including existing legislation;*
- *Enactment of a National Health Act that re-defines the National Health System as well as the functions of each level of government;*
- *Deployment of ICTs; and*
- *Development and implementation of 5-year strategic plans and 2-year plans of action by departments of FMOH, State Ministries of Health, Parastatals, Teaching, and other Tertiary Health Institutions*

All in all, although the Nigerian constitution defines health as a basic human right, the extent of its application remains a very critical question in Nigeria. If it is only in principle, then something may be wrong with the health of the people in Nigeria. Another important case in this study is the implementable National Health policy programmes such as immunization, HIV/AIDS, Roll Back Malaria, etc. which according to this study are delivered at the primary health care, secondary and tertiary levels. The distributive levels of these packages are full of inequities with the rural areas being the worst hit. The 2004 – 2007 National Health Reform Program, while having improved governance and delivery of services as one of its major planks, underachieved in those respects.

Participation/ Consensus Orientation

Some of the major points about participation/consensus orientation that were elicited in the survey are presented in Table 4. At the national/state level, a slight majority of the respondents either stated that there was no forum for dialogue between stakeholders for health decisions or they did not know whether such for an existed. Just 52 (46%) of the respondents stated that such forums existed. Nonetheless, majority of the respondents felt that there was no practice of having submissions from the public and civil society organizations before decisions are made and that stakeholders with divergent views to the MOH do not have a

reasonable opportunity to express their opinion on vital issues. Only 32 (28.3%) of the respondents stated that stakeholders with divergent views to the MOH had opportunities of expressing such opinion.

Regarding MOH policy, majority of the respondents in the survey (54.9%) stated that there was no regular consultation with civil society when health policy issues are being debated/discussed (Table 4). It was only 19 (16.8%) that stated that such consultation takes place. Also, since 65 (57.5%) of the respondents stated that decentralization was part of overall government structure, 49.6% of respondents responded that states and LGAs have authority to reallocate resources. However, most people were either non-affirmative or did not know whether district health committees are convened to debate and decide policy implementation. Also, most people stated that there was no public forum for reviewing the progress of health services provision.

The IDI showed that at the National level, it is the Federal Executive Council that has the authority to approve a policy. Others also hold the view that the legislature is involved too. However, at the state level, the governor was identified as the one having sole authority to approve a policy. On financial allocation, quite a few said the federal and state executive councils approve financial allocation at federal and state levels, whereas the majority did not know who has the final authority to give financial allocation.

Table 4: Participation/ Consensus Orientation

VARIABLES	n (%)
NATIONAL/STATE	
Specific forums exist to facilitate dialogue between all stakeholders for health decisions	52 (46.0)
There is a practice of hearing submissions from members of the public and civil society organizations before major decisions	32 (28.3)
Stakeholders with divergent views to the MoH have a reasonable opportunity to express their opinion on important issues	32 (28.3)
Decentralization is part of the overall government structure or reform process	65 (57.5)
MOH POLICY	
There is regular consultation with civil society when health policy issues are being debated/discussed?	19 (16.8)
MOH IMPLEMENTATION	
The state/LGA level have authority to reallocate resources; financial, human, physical	56 (49.6)
District health committees are convened to debate/decide policy implementation etc	37 (32.7)
There is a public forum for reviewing the progress of health services provision	34 (30.1)

On regular consultation with the Civil Society when policy issues are being debated, consensus opinion was that there used to be consultations. Though quite a few of the respondents had no clue whether the Civil Society is consulted or not. Affirming the issue of consultation with the civil society, one of the respondents has this to say,

"Yes, I have said that we use the State Council of Health meeting which is the widest stakeholders meeting we have, where people are drawn from the public and private sectors to the meeting' (IDI with a respondent in MOH, Enugu).

The low level of consultation with civil society in the discussion/debate on health matters leaves much to be desired. A situation where the professionals are excluded, and some important groups of civil society are not consulted to make inputs during health debates is a problem. If therefore, decisions on health are taken at the national level without inputs from the

civil society and all concerned, there is bound to be problems with implementation.

Rule of Law

Most respondents knew that laws governing the health sector existed and that most laws were either made by the legislature or through executive decrees as obtained during the military era (Table 5). However, most of the respondents either felt that the existing laws were not reviewed regularly or they did not know whether such laws were regularly revised. Table 5 also shows that majority of the respondents stated that the MOH is consulted for laws/regulations pertaining to health. Some of the laws actually originate from the MOH. A current example is the National Health Bill presently in the National Assembly, which originated from the Federal Ministry of Health (FMOH).

In the IDIs, there were diverse opinions about who initiates laws concerning health. Some of the respondents were of the opinion that it is the National Council of Health, whereas others were of the view that it is the Ministry of Health. A few of the respondents singled out the legislature as the entity that can initiate law on health matters. On how most laws are promulgated, it was noted that the State House of Assemble gets inputs from stakeholders before the final draft of documents is sent to the Governor or the president for assent. The Ministry of Health was also identified as the agency that packages the draft bills sent to the legislature for enactment into law. The process of translating health legislation into implementable strategies was opined by the majority of the respondents to be undertaken at the federal level and adopted by the states. However, few respondents said that it emanates from the Federal Ministry of Health. Majority of the respondents did not know the process usually adopted to translate health laws into implementable rules.

With regards to contracting, 53 (46.9%) of the respondents stated that there was available expertise in MOH for contracting and regulating. However, it was clear that most of the respondents did not know who performs the contracting and regulating functions in the MOH as 25.7%, 17.7%, 20.4% and 36.3% of the people respectively opined that they were performed by sections in the ministry, independent bodies, both and do not know (Table 5). A minority of the people (33.6%) stated that there were clear legal recourses for consumers, although the majority affirmed that consumer rights organizations and patients' safety mechanisms exist. However, only 28.3% of the respondents stated that the patients' charter exists.

It was found in the IDI that withdrawal of certificate of practice is one of the tools for enforcing health-related legislature. Others, however, mentioned the use of task force. It was also gathered that the Medical Service Department in the MOH has a regulation that guides private practitioners. Many people stated that the various professional bodies with their various disciplinary committees constitute the bodies that enforce this health-related legislation.

Transparency

Table 6 shows that apart from the indicator of MOH implementation that deals with the performance of staff audit, all other answers were either in the "negative" or "do not know" category. This shows limited transparency and/or lack of knowledge on issues of access to information and transparency in the system. A significant proportion of the respondents (48.7%) opined that there were no procedures and effective guarantees for citizens and journalists to official information required (Table 6).

Table 5: Rule of Law

VARIABLES	n (%)
NATIONAL/STATE	
How are most of the laws concerning health promulgated/formulated	
• Parliamentary committees	44 (38.9)
• Ordinances	6 (5.3)
• Executive decrees or all	40 (35.4)
• Do not know	23 (20.4)
Are laws/regulations related to health service provision, infrastructure, technology, human resources, pharmaceuticals in place, revised regularly	
• Yes	40 (35.4)
• No	47 (41.6)
• Do not know	26 (23.0)
MOH POLICY	
Is the MoH consulted for laws/ regulations which relate to health? (Environment, Water and Sanitation, Occupational Health, etc)	
• Yes	67 (59.3)
• No	14 (12.4)
• Do not know	32 (28.3)
Does the MoH consult other Line departments for Laws/ regulations pertaining to health? (Food Safety, Regulation	
• Yes	52 (46.0)
• No	17 (15.0)
• Do not know	44 (38.9)
Is expertise available at the MoH for: contracting, regulating	
• Yes	53 (46.9)
• No	43 (38.1)
• Do not know	17 (15.0)
Are the contracting, regulating functions performed by specific sections in the Ministry or independent bodies	
• Sections in the Ministry	29 (25.7)
• Independent bodies	20 (17.7)
• Both	23 (20.4)
• Do not know	41 (36.3)
MOH IMPLEMENTATION	
Is there a clear legal recourse for consumers	
• Yes	38 (33.6)
• No	46 (40.7)
• Do not know	29 (25.7)
Do consumer rights organizations, patient safety mechanisms exist	
• Yes	59 (52.2)
• No	37 (32.7)
• Do not know	17 (15.0)
Is there a patients' charter (rights document)	
• Yes	32 (28.3)
• No	37 (32.7)
• Do not know	44 (38.9)
Is there a clear recourse for contractors in the event of disputes	
• Yes	20 (17.7)
• No	32 (28.3)
• Do not know	61 (54.0)

The predominant response in almost all the cases/indicators was 'do not know' in the survey. However, in the IDIs, there was a general consensus among the respondents that there is a policy on the provision of access to information. The right of access to information extends to information held by the local governments and state-owned enterprises. However, a few of the respondents had no idea of the issue. The lack of access to information may soon be a thing of the past in Nigeria if the "Right to information" bill currently in the National assembly is passed and signed into law.

Table 6: Transparency

VARIABLES	n (%)
NATIONAL/STATE	
There is a policy on the provision of information which favors access	38 (33.6)
Rights of access to information extend to information held by LGA and state-owned enterprises	35 (31.0)
Rights of access to information include records of private companies that relate to government contracts	32 (28.3)
If access to information is refused by a government department, there a right of appeal or review	42 (37.2)
The right of appeal or review independent of government	29 (25.7)
Do courts award punitive sums in libel cases involving politicians and government officials	38 (33.6)
If courts award punitive sums, these serve as a deterrent to the media	36 (31.9)
The courts give appropriate protection to journalists' sources	30 (26.5)
Justifications are usually given for increasing/slashing budgets	42 (37.2)
There is a specific commitment to increase public health spending over a given time period	48 (42.5)
This commitment has led to increase public health spending over a given time period been met	11 (9.7)
MOH POLICY	
The overall public expenditure on health has increased in adjusted monetary figures in the past five years	51 (45.1)
Some previous programs been slashed /cut	26 (23.0)
There are clear procedures and effective guarantees for citizens and journalists to access the official information they require	22 (19.5)
Training is given to officials in the proper handling of records and the making of information available to the public	44 (38.9)
There are monitoring mechanisms in place to ensure transparency of decisions	30 (26.5)
MOH IMPLEMENTATION	
The recruitment and promotion of health managers are performance based	48 (42.5)
Managerial positions are tenure-based	51 (45.1)
Detailed information about budgetary and non budgetary sources of funds are available	32 (28.3)
Performance audits of staff, programs are conducted	59 (52.2)
When was the last performance audits of staff, programs conducted	
• Less than 1 year	15 (13.3)
• 1 – 3 years	24 (21.2)
• more than 3 years	6 (5.3)
• Do not know	68 (60.2)
Documentation on performance audits of staff, programs are available	34 (30.1)

However, it is worthy to note that 57.5% of the respondents stated that the specific commitment to increase public spending on health had not been met. However, it was gathered in the IDI that there was a commitment on the part of the government to increase public spending, particularly to achieve the Millennium Development

Goals. A minority of the respondents did not agree that there is a commitment in this regard.

Resource allocation to health was said to be based on the budget which is prepared and sent to the legislature in the IDI. It was also said to be done through the budget Department and State Economic Planning Commission. Other respondents hold that each Ministry submits what it needs to do for the year. A number of respondents believed that the budget office prepares the budget based on the proposal from the different ministries whereas some equally hold that allocation is based on need. With particular emphasis on the budget for the health system, one of the respondents she said,

Health has never been given enough. It has not received its rightful allocation. Health is under-funded ……...so health has always been under-funded (IDI with a respondent in a teaching Hospital).

Also, in the issue of how resources are allocated within health, it was found that this is achieved through prioritization, needs assessment, and proposals submitted by the different ministries, department, and agencies (MDAs). It was gathered in the IDI that the overall public expenditure in health in the past five years has slightly increased in monetary terms given the emergence of some public health diseases like HIV/AIDS.

On monitoring of health services outside the Ministry of Health, there was no consensus. Majority of our respondents did not know who is involved in the monitoring. The IDI also found that all the respondents stated audit of staff is often carried out the various health institutions.

Restriction of access to information by the government may be an attempt by officials to hide corrupt practices. Also, restricting information on budget allocation and spending may be to avoid the public knowing how much is spent on a given project. Hence, for governance to be improved, proper public finance management systems, with expenditure tracking systems should be instituted and the information on public expenditures made available to the public.

Responsiveness of Institutions

The majority (65.5%) of the respondents in the survey stated that there were national policies/strategies to identify specific disadvantaged/vulnerable groups of the population (Table 7). However, while 49% of the respondents felt that the provision of social services was targeted to specific groups, 49% equally stated that they were provided for the general population.

Table 7: Responsiveness of Institutions

VARIABLES	n (%)
NATIONAL/STATE	
The national policy/strategy identifies specific disadvantaged/vulnerable groups of population	74 (65.5)
The provision of social (health, education) services is targeted to specific groups of people or is it government provision for all (no targeting)	
• Targeted	49 (43.4)
• Provision to all	49 (43.4)
• Don't know	15 (13.3)
There is evidence that reforms/ changes have been made in policy/strategy /implementation in response to identified population needs	59 (52.2)
MOH POLICY	
The health policy addresses the health needs/ burden	81 (71.7)
Current, future projections of resource requirements, disease patterns are available at the MoH	44 (38.9)
MOH IMPLEMENTATION	
Decisions are taken for implementation based on evidence from needs assessment?	57 (50.4)
Regular needs assessment is a mandatory exercise	45 (39.8)
Resource allocation follows identified priorities	45 (39.8)
Activities in target areas have been undertaken. e.g. strengthening human resources	43 (38.1)
User satisfaction surveys are conducted	18 (15.9)
User satisfaction surveys form part of evidence for decision making	24 (21.2)
Interventions are targeted to areas/ regions with demonstrated need	47 (41.6)

Table 7 also shows that most of the respondents felt that reforms have been made in response to identified needs and that health policies address health needs/burden. However, only 39.8% stated that regular needs assessment was a mandatory exercise and that resource allocation follow identified priorities. This appears contradictory to the earlier point where majority of the respondents stated that policies were in response to identified needs and add address health needs. However, it may not necessarily be a contradiction if in the first case, addressed needs are seen to flow from provider perspectives, while in the latter case, resource allocation follows needs assessment following identified priorities from the consumer perspectives. Also, it is seen that 50.4% of the respondents stated that user satisfaction surveys were not conducted and such surveys do not form part of the evidence for decision making, hence reinforcing the notion that the health sector is not demand driven.

From the IDIs, it was found that reforms/changes have been made in response to identified population needs, there was no consensus on this. Some people did not know if there was evidence, while a few others hold the view that there is evidence. One of the respondents affirmed that there was evidence in the following excerpt,

"Yes, there are, the issue of anti-Retroviral Drugs given free is based on the rising cases of HIV/AIDS and need to control it as well as preventing maternal to child transmission of HIV/AIDS" (IDI with a respondent in Enugu).

Another respondent claimed ignorant of any evidence of reform made in response to an identified need. Her claim is captured in the following statement,

"I am not aware of what the reform is all about. We are still functioning as a private institution. I do not know whether there is

health reform by the government" (IDI with a respondent in the private sector)

On intervention being targeted to areas with demonstrated needs, the IDI showed that while the federal government may target the whole country as its areas of need, the development partners, on the other hand, may focus on 2 or 3 local government areas that may have more health need. One of the respondents holds the view that,

"……, if you look at UNICEF programme, although UNICEF is for all the children and women particularly children, but if you look at the most vulnerable group in the state in terms of what is happening, UNICEF based on their findings are targeting Uzo-Uwani, Aninri, and Isi-Uzo LGAs. These are the remotest local health authorities or LGAs in the state with specific health issues or health programmes. So it is based on that, they are targeted. Look at the issue of HIV/AIDS; there are also areas where it is more endemic than others; they also focus in these areas". (IDI with a respondent at the Ministry of Health, Enugu).

Equity

As shown in Table 8, only 31.9% of the respondents stated that there exist social protection schemes to address financial barriers for the poor. Unsurprisingly, only 13.3% knew how the schemes functioned. Just 30.1% of the respondents stated that equity was reflected in policy documents, while 15.9% responded that equity was understood and considered in its various dimensions in developing MOH policy. Regarding MOH implementation on equity, just 27.4% of the respondents reported that there was evidence of access to services by the poor. Significantly, 59.3% of the respondents stated that there were disparities in access to services among the poor and non-poor.

Table 8: Equity

VARIABLES	n (%)
NATIONAL/STATE	
There are social protection schemes in place to address financial barriers for the poor	36 (31.9)
They are evaluated/ reviewed	15 (13.3)
MOH POLICY	
The issue of equity is reflected in policy documents	34 (30.1)
Equity is understood and considered in its various dimensions – e.g. financing and provision; vertical and horizontal	18 (15.9)
MOH IMPLEMENTATION	
There is evidence on access of services among the poor/non poor	31 (27.4)
There are disparities in access of services among the poor/non poor	67 (59.3)

The IDI revealed different types of social protection scheme for the poor. There is the Rapid Response Approach for pregnant women in Anambra state, and the free maternal and child health in Enugu state. Other respondents did not think there is any programme in existence that addresses the financial barriers of the poor. On the current distribution of health care infrastructure, the study shows that there is a disparity with the rural area being affected both in human resources and the support services.

One of the respondents views the situation this way,

*"There is a problem of shortfall with the urban area being overstaffed while the rural areas are understaffed. The same is applied to infrastructure which is dilapidated. Our former president refurbished facilities at the teaching hospitals. Why stop with the tertiary? "(*IDI with a respondent in Enugu).

The current utilization of health care services in terms of rural /urban is tilted against rural areas. The same thing applies to level of services as better services and more qualified, and greater number of health care professionals is in the urban areas, leaving the rural areas with unqualified and sometimes semiskilled health care workers which in most cases are inadequate to the need of the rural areas. Such inequity in health care services utilization negates the inclusion of health as a basic human right in the Nigerian constitution. Adequate attention needs to be given to this in order to strategize ways of improving access to health care services in the rural areas.

Effectiveness and Efficiency

At the national and state levels, 52.2% of the respondents stated that there were minimum criteria for appointing leadership at the MOH in the survey (Table 9). It was also found that 54% and 46.9% of the people stated that there was a career path within the MOH and that there was tenure of appointment. However, while 49.6% did not know the turnover rate/tenure at the MOH, 31% stated that it was moderate. It was found that 45.1% of the respondents stated that there was no respectable remuneration and incentive system for staff and 29.2% did not know whether or not such existed. In addition, the IDI showed that on leadership and political appointment at the MOH, the post of commissioner is by appointment, while the permanent secretary though a career civil servant is decided by the president or governor at the federal and state levels respectively. Some others hold the opinion that there are no criteria for such appointments but depend only on politics. Appointment of chairmanship of teaching hospitals was said to be by appointment while administrative heads were by the application of public service rule.

At the MOH Policy level, only 20.4% of the respondents stated that the quality of bureaucracy/technocracy at the MOH was high. Nonetheless, the results show that there is high attrition rate of qualified staff and in addition, staffs are being frequently recruited by international agencies. Also at the MOH policy level, most respondents rated the efficiency of communication process as well as the extent of use of communication technology at the MOH to be between moderate to low.

The IDIs also found that bureaucracy varies with institutions. In some institutions, it was found to be moderate, whereas in others it is high. Some of the respondents maintained that their institutional bureaucracy is unclear and that it makes things difficult. One person expressed his view on bureaucracy:

“It is poor because you have to spend weeks and months to treat file (IDI with a respondent).

The survey found that the normal time for approval/release of budget was long and the rate of financial implementation of projects/budget was low. The IDIs also found that approval of budget was equally found to be a problem. In some institutions, there is a delay. Some of the respondents said that approval has no fixed time but depends on one's rapport with the person that approves the budget.

There was also minimal level of computerization. In the IDIs, the extent of use of computer technology was found to be inadequate in some institutions whereas it is working well in others. In some departments, they are using a personal computer belonging to a staff member since his department could not provide one.

Also, on the current utilization of health care services, the IDIs showed that majority of the respondents were of the view that the rural areas do not have access to health services the way urban

dwellers do. Women were said to access health care services more than the men, whereas there is mal-distribution of the health services against the poor and rural dwellers. On the issue outcomes verses objectives, a few of our respondents opined that they are achieving their objectives while majority did not agree achieving any objectives.

As one of the respondents told us,

"Nothing is happening. The machinery are not there. The wrong thing is being done. We are just going round and round" (IDI with a respondent).

On MOH implementation, 44.2% of the people stated that private consulting among MOH staff was a common phenomenon and 37.2% did not know whether the phenomenon was common. However, there was evidence of staff development as 55.8% of the respondents stated that there were specific induction training or in-service training programmes for health personnel. There was stated evidence of the existence of exposure to financing and other aspects of management in the MOH.

In the survey, Table 9 also shows that the current levels of utilization of services by the different groups in the population were rated as: high (8.0%); moderate (38.1%); low (28.3%) and do not know (25.7%). Finally, peoples' scoring of their perception of outcomes achieved in the health sector versus the objectives were: high (3.5%); moderate (22.1%); low (38.1%) and do not know (36.3%) (Table 9). In real sense, there are public commitments to increase government spending over a given period, but it is not enough to state a commitment without actually implementing such commitment. For instance, the commitment to increase the proportion of government spending devoted to health to 15% of government expenditure has not yet been met in Nigeria. However, sometimes, there could be an increase in government spending yet the overall health care delivery systems remain in a shambles. Infrastructural decays and inadequate human resources are common characteristics of the health care system. A bit of more commitment to delivering health goals is needed. But it is also noted that resource allocation of apportioned resources within the health sector is not without its bottlenecks. Delays and disparity based on ability to negotiate and play local politics are factors that necessitate allocation within the health sector. On the issue of how leadership, administrative and political positions are appointed, it leaves much to be desired. Qualification most times is thrown overboard. In some cases, these positions are negotiated. The tenure of appointment even when it has elapsed, one may go politicking just to find himself or herself back in the same position whether doing well or not. This ugly trend has no good intention to good health care system. In as much as bureaucracy helps to get government business done, when it assumes a greater dimension, could constitute a cog in the wheel. The delays in getting business of the day done in the MOH could sometimes be frustrating. Sometimes files are not treated for a long time. Some staff now adds more delays by seeking gratification thereby compounding the process of getting the business of the day done. For any sector that wants to get in tune with reality in delivery of services, this is obviously a bad trait that has the potential to deliver negative outcomes.

Accountability

At the National/State level, 39.8% of the respondents stated that the press/media had a moderate role to play in the accountability process, while only 15.9% opined that the press had a high level of role to play in the process (Table 10). In the IDI, the majority of our respondents

maintained that the press plays important roles as watchdogs in accountability process and awareness creation.

Table 9: Effectiveness and Efficiency

VARIABLES	n (%)
NATIONAL/STATE	
Are there any minimum criteria for appointing the leadership at the MOH	
• Yes	59 (52.2)
• No	18 (15.9)
• Do not know	36 (31.9)
Is there a set career path inside the MoH	
• Yes	61 (54.0)
• No	13 (11.5)
• Do not know	39 (34.5)
Is there tenure of appointment	
• Yes	53 (46.9)
• No	23 (20.4)
• Do not know	37 (32.7)
What is the turnover/ tenure of the leadership at the MoH?	
• High	12 (10.6)
• Moderate	35 (31.0)
• Low	10 (8.8)
• Do not know	56 (49.6)
Is there a career structure for the technocrats/ bureaucrats within or outside the MoH	
• Yes	35 (31.0)
• No	14 (12.4)
• Do not know	64 (56.7)
Is there a respectable remuneration and incentive system for staff	
• Yes	29 (25.7)
• No	51 (45.1)
• Do not know	33 (29.2)
MOH POLICY	
What is the quality of bureaucracy/technocracy at the MoH	
• High	23 (20.4)
• Moderate	35 (31.0)
• Low	17 (15.0)
• Do not know	38 (33.6)
Is attrition of qualified staff high	
• Yes	32 (28.3)
• No	35 (31.0)
• Do not know	46 (40.7)
Is staff being frequently recruited by international agencies	
• Yes	24 (21.2)
• No	45 (39.8)
• Do not know	44 (38.9)
How efficient are the communication processes at the MoH	
• High	7 (6.2)
• Moderate	34 (30.1)
• Low	36 (31.9)
• Don't know	36 (31.9)
What is the extent of use of communication technology	
• High	8 (7.1)
• Moderate	38 (33.6)
• Low	33 (29.2)
• Don't know	24 (30.0)
Computerization	
• High	12 (10.6)
• Moderate	31 (27.4)
• Low	40 (35.4)
• Don't know	30 (26.6)

Table 9 Cont'd

VARIABLES	n (%)
MOH POLICY	
Is the system paper based	
• Yes	60 (53.1)
• No	21 (18.6)
• Do not know	32 (28.3)
What is the normal time for approval/ release of a budget request	
• Short	3 (2.7)
• Moderate	17 (15.0)
• Long	38 (33.6)
• Don't know	55 (48.7)
Is information about procedural delays or pending cases available	
• Yes	20 (17.7)
• No	41 (36.3)
• Do not know	52 (46.0)
MOH IMPLEMENTATION	
Is private consulting (clinical or non-clinical) among MoH staff a common phenomenon?	
• Yes	50 (44.2)
• No	21 (18.6)
• Don't know	42 (37.2)
Are there specific induction training or in service training programs for health personnel	
• Yes	63 (55.8)
• No	25 (22.1)
• Do not know	25 (22.1)
Specific expertise in financing, human resource management etc, in terms of experience and qualifications	
• Yes	50 (44.2)
• No	26 (23.0)
• Do not know	37 (32.7)
Current utilization of services in terms of urban, rural, level of service, gender, socioeconomic groups	
• High	9 (8.0)
• Moderate	43 (38.1)
• Low	32 (28.3)
• Do not know	29 (25.7)
The rate of financial implementation of projects, budget	
• High	
• Moderate	2 (1.8)
• Low	31 (27.4)
• Don't know	44 (38.9)
	36 (31.8)
Outcomes achieved vs. objectives	
• High	
• Moderate	4 (3.5)
• Low	25 (22.1)
• Don't know	43 (38.1)
	41 (36.3)

Table 10: Accountablility

VARIABLES	n (%)
NATIONAL/STATE	
What is the role of the press/media in the accountability process?	
• High	18 (15.9)
• Moderate	45 (39.8)
• Low	25 (22.1)
• Do not know	25 (22.2)
Is the accountability process limited by political, other considerations	
• Yes	64 (56.6)
• No	24 (21.2)
• Do not know	25 (22.1)
What is the role of elected bodies (legislature	
• High	12 (10.6)
• Moderate	31 (27.4)
• Low	42 (37.2)
• Do not know	28 (24.8)
Is there a Public Accounts/ Health oversight committee	
• Yes	39 (34.5)
• No	17 (15.0)
• Do not know	57 (50.5)
Is there an independent body to look into consumer complaints	
• Yes	41 (36.3)
• No	41 (36.3)
• Do not know	31 (27.4)
Has the Oversight/ Health Committee met in the past year	
• Yes	16 (14.2)
• No	18 (15.9)
• Do not know	79 (69.9)
Does the Oversight/ Health Committee have power to call officials (including Ministers) for questioning	35 (31.0)
• Yes	24 (21.2)
• No	54 (47.8)
• Do not know	
Were any recommendations issued in the last year	
• Yes	9 (8.0)
• No	21 (18.6)
• Do not know	83 (73.5)
Have these been accepted and acted upon	
• Yes	4 (3.5)
• No	21 (18.6)
• Do not know	88 (77.9)
What is the role of judicial system in relation to health issues	
• High	8 (7.1)
• Moderate	34 (30.1)
• Low	2 (28.3)
• Do not know	39 (34.5)

Table 10 Cont'd

VARIABLES	n (%)
Does the judicial system have specific legislations and rules to address issues related to health such as; medical malpractice, insurance, adulteration, environmental issues	
• Yes	55 (48.7)
• No	26 (23.0)
• Do not know	32 (28.3)
Or are these addressed through the general criminal or civil codes	
• Yes	34 (30.1)
• No	41 (36.3)
• Do not know	38 (33.6)
Are the public able to complain effectively about judicial misconduct (other than appeal through the formal court system	24 (21.2)
• Yes	64 (56.6)
• No	25 (22.1)
• Do not know	
Are there rules requiring annual auditing of financial accounts of state and parastatal health institutions by independent auditors, and requiring public disclosure of the results	
• Yes	41 (36.3)
• No	30 (26.5)
• Do not know	42 (37.2)
MOH POLICY	
Are there procedures for the monitoring of assets and life-styles of civil servants (e.g. disclosure pro-visions)?	
• Yes	58 (51.3)
• No	36 (31.9)
• Do not know	19 (16.8)
If disclosure provisions exist, are the disclosures checked or subject to random checking	
• Yes	25 (22.1)
• No	36 (31.9)
• Do not know	52 (46.0)
Are the disclosures either made to an independent body or made available to the public/media	
• Yes	28 (24.8)
• No	31 (27.4)
• Do not know	54 (47.8)
Are there clear rules against political interference in day-to-day administration i.e. formal rules requiring political independence of civil servants	
• Yes	24 (21.2)
• No	46 (40.7)
• Do not know	43 (38.1)
Are transparent methods used to award government contracts? Are mechanisms for overseeing adherence to financial, administrative rules in place	
• Yes	25 (22.1)
• No	58 (51.3)
• Do not know	30 (26.5)
MOH IMPLEMENTATION	
Are there examples of cases where law was enforced such as Revocation of licenses of professionals, institutions for medical practice, sale and use of pharmaceuticals/biologicals	
• Yes	62 (54.9)
• No	22 (19.5)
• Do not know	29 (25.7)

However, majority of the respondents felt that accountability process is limited by political and other considerations and the role of elected bodies in the process is low. This low level of involvement of elected bodies could be due to their obvious low level of performance of their oversight functions over relevant ministries, departments, and agencies (MDAs). Issues about health committee and consumer complaints were not well known to most of the respondents. The roles of the

elected bodies were law making and oversight functions. On the issue of Public Account /health committee, only a few of our respondents agreed that such committee exists. The rest of our respondents were not aware of the existence of such committee.

The role of the judicial system in relation to health issues was rated to be moderate by the respondents in the survey. A total of 34.5% did not know about the role of the judiciary. It was found that 48.7% of the respondents stated that the judicial system had specific laws to address health issues. Also, 30.1% of the respondents affirmed that available general criminal or civil codes could also be used to address health issues. However, majority of the respondents stated that the public is no able to complain effectively about judicial misconduct. Factors militating against transparency and accountability are the findings that there are no clear rules against political interference in day-to-day administration and transparent methods are mostly not used to award government contracts.

With respect to MOH policy on issues of accountability, majority of the respondents were aware of the existence of procedures for monitoring of assets and life-style of civil servants. On the roles of the judicial system, the IDIs, however, found out that the patients can seek legal action if maltreated in the course of treatment. The judiciary according to some of our respondents consults the arms of government packaging health bills. It was also found that the Federal Ministry of Health has a judicial unit that settles dispute.

However, the disclosures are apparently not checked, either systematically or randomly. The procedure for monitoring the assets and life styles of civil servants were found to be mainly through the Code of Conduct Bureau. Examples of cases of revocation were found to be minimal. Nonetheless, in a related issue, revocation of licenses of professionals, institutions for medical practice, sale and use of pharmaceuticals/biologicals exist.

The role of the media in the accountability process cannot be overstressed. But the extent to which it's able to measure up in a system whose access to information is wooly remains an issue. Information could be easily released when there is nothing at stake. However, when the wrong thing is done which is against the public conscience, the press may not have access to such information. The overall accountability process in the Nigeria health sector is still at the elementary stage, and certainly, the press has an onerous task in this regard.

Intelligence and Information

Majority of the respondents in the survey affirmed that the country has a vital statistics health information system, that the health system has information processes to identify the health needs of the population and that there is a regular reporting system for health conditions/diseases (Table 11). However, a majority of the respondents stated that the information is not disseminated through publications and that is not online. Also, from the responses, information from the private sector is not usually included in national statistics. In addition, health databases are not generally subjected to reliability checks, and nationally representative surveys may generally not be in agreement with the official reported data.

In the IDI, majority of the respondents agreed that the health system has information processes to identify the health needs of the population. This was said to be in the form of needs assessment, interaction with the community, carrying out of survey, and by the use of disease

pattern. However, some of the respondents stated that the information obtained was not usually used for policy making or developing programs but a mere academic exercise.

According to one of the respondents,

"I do not think the information they get is meaningful to them. Some studies are conducted and the result not being used. Most studies are just mere academic" (IDI with a respondent).

Then whether the information is incorporated into policies, minority of the respondents were of the opinion that they use the data in order to know the areas to focus attention, whereas others hold the view that such information is not used for policy making.

A majority of the respondents in the IDI stated that there is annual reporting system for health conditions/disease. But on whether this report is disseminated through publication attracted a contrary view. A majority of them were of the view that the information end in the Ministry of Health. Similarly, it was also agreed among the majority that the report is not online as none of the Federal/ State Ministries of Health has a website. On the other hand, it was gathered that the general public who need the information has no access to it.

The Ministry of Health was identified as the institution responsible for collecting data about health while the analysis and coordination come through the Health Information Management System which has desk officers in all the health institutions. Also, it was shown that analysis and coordination pass from the health facility to the Local headquarters and finally the state.

Regarding MOH policy, 42.5% of the respondents stated that capacities exist in MOH to synthesize data into information (Table 11). Similarly, 44.2% stated that regular reports are issued for notifiable diseases. Also on the existence of capacity in the MOH to synthesize data into information, majority of the IDI respondents agreed that the ministry has the capacity to do that. One of our respondents affirms that when he said,

"Yes, capacity exists. In fact, right now as I am talking to you, a group of stakeholders are conducting and having their training at Dannic Hotels on the use of 1.4 version of health information system programme on the software. We are using 1.3, but the FMOH want to key or adopt that software but for the purposes of having a holistic way of doing national data. They now upgraded into 1.4. The software we are using in Enugu State and in other parts of Northern States is being adopted nationwide. This is for capturing and analyzing data. In fact, Enugu State has cause to be lucky to have the best in the country in the use of that software. Some are being trained in South Africa on the use of the software" (IDI with a respondent from the MOH). With regards to involvement of the private sector, 43.4% did not know whether protocols for involvement of private providers in disease notification exist, while 28.3% stated that such protocol exists (Table 11). However, while 45.1% stated that private providers contribute information to disease notification systems, 24.8% did not know whether or not private providers contribute information. Nonetheless, most of the respondents stated that the reports on health programmes are not disseminated on a regular basis. At MOH implementation level, there are apparently different information systems, but these include to some extent, information from private sector health institutions. The results show that 30.1% of the respondents affirmed that the health information system contains information on human resources, but 41.6% did not know whether it did. There are indicators to monitor priority health

problems. However, the level of computerization of the health information system appears to be low. On whether reports on health programmes are generated /disseminated on a regular basis, the IDIs show that some of our respondents were of the view that they generate the information but do not disseminate. Others hold that they report frequently but not regularly. Some also are of the view that the dissemination is very poor.

Concerning whether regular report is issued for notifiable disease, there was an agreement amongst the IDI respondents that there is report but that such report is not published. On the other hand, the World Health Organization, state epidemiology, disease surveillance and notification officer (DNSO), Ministry of Health and people in the disease control unit are those charged with monitoring of these report. The diseases notifiable by law were mentioned as follows: Malaria; Cholera; HIV/AIDS; Smallpox; chicken pox; Meningitis; and TB.

Finally, with regards to the level of monitoring and implementation of health policies, the scores were: high (1.8%); moderate (23.9%); low (36.3%) and do not know (38.0%) (Table 11). In the IDIs, the implementation of health policies was said to be monitored through regular checks, through MOH with its monitoring committees and if the project is being sponsored by the WHO or UNICEF, the implementation will be monitored by its monitoring units. On the contrary, majority of the respondents did not know how the implementations of health policies are monitored.

The procedure for the monitoring of assets and lifestyle of civil servants is in existence but not functional. Most times the procedure is a mere academic exercise without any concrete function. Those involved in embezzlement and fraud in some health institutions still go unpunished either because of the link they have with the higher boss or on the ground of procedural technicalities of the law. The idea of monitoring of assets and lifestyle seems to be a check which is yet to yield expected outcomes in the life of civil servants. This is a systemic problem that needs a systemic approach.

The health system has information processes to identify the health needs of the population, but the extent of its incorporation into policymaking is abysmally low. The relationship between the policy makers and researchers appear thin. A cordial relationship is needed between the policy makers and researchers so that health policymaking will be evidence-based.

Ministries of Health, both at the state and federal level, primary health care centers, secondary and tertiary health institutions are all involved in collecting data on health. Private health care is also involved including independent researchers. But synthesizing of these data to have a pool of data across disease type is yet to be realized. There appears to be a problem of coordination among the different health care institutions. Most at times, these data are wasted or even before they are compiled, new cases might have emerged which may require immediate attention. Therefore, there is need for functional coordination mechanisms to pool data collected about health for more accurate and reliable health report.

The private sector health institutions contribute to health information systems. However, its contribution needs to be maximized. Some information from the private health institution is being wasted. The Federal Ministry of health should have a way of coordinating their information so that they can be useful to the overall health sector development.

Table 11: Intelligence and Information

VARIABLES	n (%)
NATIONAL/STATE	
Does the country have an information system that reports: vital statistics, morbidity and disability information	64 (56.6)
• Yes	32 (28.3)
• No	17 (15.0)
• Do not know	
Does the health system have information processes to identify the health needs of the population	
• Yes	62 (54.9)
• No	33 (29.2)
• Do not know	18 (15.9)
Is there a regular (annual?) reporting system for health conditions/diseases	
• Yes	63 (55.8)
• No	28 (24.8)
• Do not know	22 (19.5)
Is the report disseminated through publication	
• Yes	44 (38.9)
• No	38 (33.6)
• Do not know	31 (27.4)
Is it available online	
• Yes	17 (15.0)
• No	44 (38.9)
• Do not know	52 (46.0)
Is private sector health provision information included in the national statistics	
• Yes	29 (25.7)
• No	40 35.4)
• Do not know	44 (38.9)
Are the health databases subject to reliability checks	
• Yes	18 (15.9)
• No	42 (37.2)
• Do not know	53 (46.9)
Are nationally representative surveys generally in agreement with the official reported data	
• Yes	10 (8.8)
• No	44 (38.9)
• Do not know	59 (52.2)
MOH POLICY	
Do capacities exist in the MoH to synthesize data into information	
• Yes	48 (42.5)
• No	26 (23.0)
• Do not know	39 (34.5)
Are regular reports issued for notifiable diseases	
• Yes	50 (44.2)
• No	38 (33.6)
• Do not know	25 (22.1)
Who monitors these reports? Please list _____	
Is there a protocol for involvement of private providers	
• Yes	32 (28.3)
• No	32 (28.3)
• Do not know	49 (43.4)
Do private sector providers contribute information to disease notification systems	
• Yes	51 (45.1)
• No	34 (30.1)
• Do not know	28 (24.8)

Table 11 Cont'd

VARIABLES	n (%)
Are reports on the health programs generated /disseminated on a regular basis	
• Yes	32 (28.3)
• No	58 (51.3)
• Do not know	23 (20.4)
Are these reports accessible to the general public	
• Yes	35 (31.0)
• No	46 (40.7)
• Do not know	32 (28.3)
MOH IMPLEMENTATION	
Are there different information systems for collecting information about health activities/programs?	
• Yes	49 (43.4)
• No	24 (21.2)
• Do not know	40 (35.4)
Does the health information system include information from private sector health institutions (hospitals, nursing homes, clinics)?	
• Yes	53 (46.9)
• No	36 (31.9)
• Do not know	24 (21.2)
Does the HIS contain information on Human resources	
• Yes	34 (30.1)
• No	32 (28.3)
• Do not know	47 (41.6)
Is the procedure computerized	
• Yes	22 (19.5)
• No	37 (32.7)
• Do not know	54 (47.8)
What is the completeness, timeliness, reliability of reporting?	
• High	4 (3.5)
• Moderate	27 (23.9)
• Low	36 (31.9)
• Do not know	46 (40.7)
Are their specific indicators to monitor priority health problems as identified in the health policy/strategy	
• Yes	49 (43.4)
• No	26 (23.0)
• Do not know	38 (33.6)
What is the level of monitoring of the implementation of health policies	
• High	2 (1.8)
• Moderate	27 (23.9)
• Low	41 (36.3)
• Do not know	43 (380)

Table 12: Ethics

VARIABLES	n (%)
NATIONAL/STATE	
Is there a national body to oversee ethical aspects of research and service delivery	
• Yes	50 (44.2)
• No	25 (22.1)
• Do not know	38 (33.6)
MOH POLICY	
Is there a policy on promoting ethics in health research and health care?	
• Yes	56 (49.6)
• No	20 (17.7)
• Do not know	37 (32.7)
MOH IMPLEMENTATION	
Does a code of ethics exist for various cadre of practitioners and is it recognized and observed	
• Yes	65 (57.5)
• No	25 (22.1)
• Do not know	23 (20.4)

Ethics

As shown in Table 12, 33.6% of the respondents did not know whether there is a national body to oversee health sector ethics, although 44.2% of the respondents stated that such a body exists. However, there is a policy of promoting ethics in health research, and care and code of ethics exist for various cadres of health practitioners. Such ethics are recognized and observed.

On the institutional mechanisms to promote and enforce high ethical standard in health research and health standard care, the IDI found that there are monitoring units in the various health and training institutions that ensure ethical standards. Other respondents hold that they ensure ethical standards using their professional associations, and having ethical committees.

Limitations and Recommendations for Improving Methods for HSG assessment.

Study design and the Instruments

Many respondents complained that the IDI guide and questionnaire were too lengthy. The guideline may become more efficient if it is reduced to five principles especially as there are overlaps between some of the principles, especially between 2,4 and 9 and 5,6 and 7. Also, it would be good if a scoring system could be introduced for ranking HSG across different countries or states in Nigeria.

In addition, in order to engender cross-country comparisons, WHO/AFRO could develop uniform data collection tools which would be used in different countries and settings. The design of the instruments will take into consideration the way that the health system and political structure of the countries are organized. For instance, in Nigeria, the redesign of the questionnaire should take into cognizance the existence of both national and state policies. Consequently, specific questions should be targeted at state and national policies/programmes.

The design should also better delineate which of the three levels of the health system that the assessment should be undertaken – (a) Technical or the field or hands-on level, (b) Managerial or the policy implementation management level, or (c) the Policy level – mega or meta policy-making level – depending on decision making jurisdiction. A design that would accommodate the three levels is possible and more likely to yield good comparative results.

Data analysis

The non-dis-aggregation of data by characteristics of respondents such as public-private; state-federal; MOH and non-MOH so as to understand specific governance issues from different perspectives, is a potential weakness of the study. Nonetheless, in future, it will be necessary to ask whether or not the respondent works in the health sector when collecting socio-demographic information. This will be useful if it turns out that those who know about policies etc are health workers, while other members of the public are in the dark. However, since the intention is on aggregate HSG within Nigeria, it may not really matter.

Conclusion

Health system governance (HSG) in Nigeria is weak with the overall quality of HSG in the country from the assessment been low to moderate. Hence, much needs to be done to strengthen it. This is because, good HSG involves closeness of mission and purpose, trust amongst partners, mutual accountability, leadership/consensus balance, efficient management, acceptable and transparent structure and transparency of decisions such as financial allocations. All these attributes are not quite present in the Nigerian health system from the assessment.

Finally, the intention to achieve high levels of governance are enshrined in National and State health policies, but the implementation is lacking. Health System Governance (HSG) is weakened by the near absence of mention of health in the operational 1999 constitution. Most people are ignorant about governance issues in the health sector. Most policies and programmes are results of top-bottom planning and policy-making and not explicitly demand-responsive and demand-driven. The Nigerian health system is not adequately transparent which reduces its effectiveness and efficiency. However, there are presently two bills in the national assembly which will improve HSG when passed into law and these are: the Health Bill and the Right of Information Bill. Many things should be done to improve the governance of the health system in Nigeria – this includes the enactment of the aforementioned bill into law when passed by the two chambers of the national assembly, the implementation of existing policies amongst others. Most pertinent interventions will also include strategies to increase consumer awareness of their rights and improve equity in delivery of health services.

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