Towards Health System Strengthening: Analyzing the adoption of the WHO Health Systems Thinking Framework in the Nigerian and Botswana National Health Policies

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This thesis titled
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ABSTRACT

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Well performing health systems are critical for effectively managing population health. The WHO (2015) acknowledges that policies are a means to an end, the ultimate end being a population’s access to quality health care. This study adopted the WHO (2007) system’s thinking framework, utilizing leadership and governance, service delivery, and health financing in the analysis of the 2004 and 2011 NHPs of Nigeria and Botswana respectively, and the 2009 NSHDP of Nigeria. Document, thematic and content analysis were utilized in analyzing the documents, and the codes were drawn from the WHO’s methodology for monitoring the building blocks of health. Results indicate the need to revise the 2004 NHP for Nigeria, to consider current determinants of health. There are existential gaps between the policy documents and actual situation on ground. More so, there are differences in the way the systems thinking framework was adopted by the NSHDP and the 2011 NHP.
DEDICATION

Dedicated to all past, present, and future scholars that seek to contribute to an existential and unending pool of knowledge.
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Special acknowledgement goes to my committee members for the support and guidance throughout the process. Sincere appreciation to my parents and siblings for their unending prayers and support. My appreciation goes out to friends that encouraged me in my time of weakness both knowingly and unknowingly. Finally, my enormous appreciation to God Almighty from whom all blessings flow.
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ABBREVIATIONS

ADB: African Development Bank
AHPSR: Alliance for Health Policy and Systems Research (AHPSR)
BHOMA: Better Health Outcomes through Mentorship (BHOMA)
BNDP: Botswana National Drug Policy
BOCONGO: Botswana Council of Non-Governmental Organizations
BOCCIM: Botswana Confederation of Commerce, Industry and Manpower
BEOC: Basic Emergency Obstetric Care
CIA: Central Intelligence Agency
CSDH: Commission for Social Determinants of Health
CSO: Central Statistics Office
CBHI: Community-Based Health Insurance
DRSA: Drugs and Related Substance Act
DOTS: Directly Observed Treatment, Short-Course
DPPME: Department of Policy, Planning, Monitoring and Evaluation
EHSP: Essential Health Services Package
FMOH: Federal Ministry of Health
FGM: Female Genital Mutilation
GIS: Geography Information Systems
GoB: Government of Botswana
HHA: Harmonisation for Health in Africa
HSPAF: Health system Performance Assessment Framework
IHSP: Integrated Health Services Plan
ISS: Integrated Supportive Supervision
MOH: Ministry of Health
MDGs: Millennium Development Goals (MDGs)
MDJS: Ministry of Defence, Justice, and Security
MFDP: Ministry of Finance and Development Planning
NGOs: Non-Governmental Organizations
NHP: National Health Policy
NHS: National Health System
NCH: National Council of Health
NSHDP: National Strategic Health Development Plan
NHIS: National Health Insurance Scheme
ODPHC: Ouagadougou Declaration on Primary Health Care
PMI: United States President’s Malaria Initiative (PMI)
PPP: Public and Private Partnerships
PHC: Primary Health Care
RoB: Republic of Botswana
SRG: Stakeholder Reference Group
SHI: Social Health Insurance
UNDP: United Nations Development Programme
WHO: World Health Organization
CHAPTER 1: INTRODUCTION

Background

Well-performing health systems are critical for effectively managing population health. According to the World Health Organization (WHO), health systems include “all the activities whose primary purpose is to promote, restore or maintain health” (WHO, 2000). In order for health systems to effectively manage population health, they must strive to achieve three fundamental objectives: i.) improve the health of the overall population ii.) Respond to the expectation of overall populations and; iii.) Provide financial buffer in terms of ill-health expenses (WHO, 2000). These three fundamental objectives were considered as being of high priority in the WHO ranking of world health systems (WHO, 2000). However, this ranking indicated that sub-Saharan African countries have significantly weak health systems. While there has been a significant increase in the global effort to address health development issues in the recent decades, many sub-Sahara African health systems still struggle to provide basic health care to their populations (Bryan, Conway, Keesmaat, McKeenna, Richardson, 2010). Out of the six factors that Kaseje (2006) highlighted as challenges to health and development in Africa, weak and inappropriate health systems was included as one.

The WHO (2015) acknowledged that policies are a means to an end, the ultimate end being securing a population’s access to quality health care that will in turn cause an increase in the life expectancy of people. Government and Ministries of Health have come under pressure from populations that live within regions characterized by fragmented health systems. As a result of these pressures, there has been an increased focus on increasing the capacity of governments to create National Health Policies
(NHPs) that will enable the provision of universal, quality, affordable and accessible health care services (WHO, 2015). The method of developing NHPs varies across countries depending on characteristically unique contexts within these countries. In like manner, the approach towards health system strengthening varies, with governments either adopting the Millennium Development Goals (MDGs), the WHO (2007) six building blocks of health, or both frameworks as a guiding principle towards the creation of the NHP (WHO, 2015). The six building blocks of health are made up of individual blocks that work together in multiple and complex interactions for the strengthening of the overall health system; use of this framework is often referred to as systems thinking (WHO, 2009).

The Health System Thinking framework has been used across the board by researchers in order to strengthen service delivery within the health system and the overall health system. The Health Systems Thinking framework was adopted by Mutale, Bond, Mwanamwenge, Mlewa, Balabanova, Spicer, Ayles (2013) in studying the status of the six building blocks of health in three Better Health Outcomes through Mentorship (BHOMA) districts in Zambia. The United States President’s Malaria Initiative (PMI) adopted the six building blocks of health in order to build the capacity of malaria control programs in countries with weak health systems (PMI, 2014). The framework was also adopted by Ergo et al. (2011) in order to improve the outcomes of maternal, neonatal and child health. However, there is no literature or studies that have examined the use of the framework in analyzing national health policies and the extent of inclusion of the six building blocks of health in their strategy towards health development.
Objectives and Expectations

NHPs are significant in “defining a country’s vision, priorities, budgetary decisions and course of action for improving and maintaining the health of its people” (WHO, 2015). Thus, it is important to ensure that the NHP is created within a systematic framework that will ensure a progressive path to national health development. The purpose of this study was to analyze the national health policies of Nigeria and Botswana in order to understand how the building blocks of health were incorporated into the health development strategies of these countries. For the purpose of this study, three main building blocks were analyzed within these documents: leadership and governance, service delivery, and health financing. The objectives of this study were to analyze these three blocks of health within the most recent NHP of Nigeria and Botswana and the National Strategic Health Development Plan (NSHDP) framework for Nigeria. After analyzing the inclusion of the three blocks of health within these documents, existing literature was reviewed in order to understand whether the content and claims of these documents correlated with existing evidence from both countries. The NSHDP was analyzed because the 2004 NHP for Nigeria had not adopted the WHO building blocks of health as a framework and was dated in comparison to the more recent 2011 NHP for Botswana.

It is expected that each of the national health document that will be analyzed will thoroughly incorporate leadership and governance for health, provided that they have thoroughly adopted the health systems thinking framework. In their incorporation of leadership and governance, they should address their existence within a strategic policy framework, coalition-building within the health system, regulation of the health system,
attention to the way the health system is designed, and accountability within the health
system. The inclusion of service delivery within these health documents must
significantly address comprehensiveness, accessibility, coverage, continuity, quality,
person-centeredness, coordination, accountability, and efficiency within the health
systems they serve. Health financing with these national health documents must address
the approach towards raising sufficient funds for health, methods of improving financial
risk protection and coverage for vulnerable groups, improving efficiency in the use of
available resources for health development, and the improvement of financial
transparency and management of operational levels within the health system. However,
the level of incorporation of these different variables may differ from one document to
another.

Current indicators show discrepancies between the Nigerian and Botswana health
systems. Nigeria is ranked 212 out of 223 countries rated for life expectancy, Botswana is
ranked 210 (CIA, 2014). In Nigeria, out-of-pocket expenditure as a percentage of private
expenditure on health was 92.7% in 2000 and 95.6% in 2010 (WHO, 2013). These
figures indicate that between 2000 and 2010, the financial burden of health care on the
consumer was increased. In Botswana, out of pocket expenditure as a percentage of
private expenditure on health was 36.7% in 2000 and significantly decreased to 12.7% in
2010 (WHO, 2013). In Botswana, general government expenditure on health as a
percentage of total health expenditure increased from 62.2% in 2000, to 64.5% in 2010;
these figures for Nigeria were 39.2% in 2000 and 54.8% in 2010 (WHO, 2013). With the
differences between indicators from Nigeria and Botswana, it is obvious that Botswana
has better indicators in some areas than Nigeria.
As a result of these differences in health indicators, it may be anticipated that findings from this study will indicate that Botswana has more thoroughly adopted the building blocks of health in the creation of its NHP, as compared to Nigeria. In the areas of leadership and governance, service delivery, and health financing, Botswana’s NHP may have more extensively imputed the variables provided by the WHO (2010) for the monitoring of each of the six building blocks of health. However, it must be acknowledged that there are other factors that may be impacting on the health system such as economic and population growth, and other internal/external factors, amongst others. This study did not take those other factors into account but acknowledges that whether or not the NHPs of these countries adopted a solid framework towards health development, there may be other factors influencing on the health systems of either Botswana or Nigeria.

Significance of Study

Findings from this study may inform the future review of NHPs and health-related documents that are fundamental to health development within Nigeria and Botswana. Health systems research has been defined as the “production of knowledge and applications to improve how societies organize themselves to achieve health goals” (Alliance for Health Policy and Systems Research (AHPSR), 2004, p. 11). More so, health systems research is needed at all levels of the health system, from the micro level of program implementation, down to the macro level of policy and planning (AHPSR, 2004). The creation and revision of NHPs and other related national health documents are included in this referenced macro level of policy and planning. Having established the importance of NHPs to the strategic development of health systems, it is vital that NHPs
are embedded into solid health systems framework. More so, the kind of research undertaken in this study may be applied to other African countries for health systems strengthening. Future research may consider analyzing all the six building blocks of health at once in order to apply the systems thinking for health system strengthening approach. Overall, this study is contributing to existing broader literature on health systems research and even more specifically, African health systems research.
CHAPTER 2: METHODOLOGY

Research Question

This study analyzed the inclusion of the three of the six building block of health suggested by the WHO, into the NHPs of Botswana and Nigeria as well as the NSHDP of Nigeria; the reason for analyzing the NSHDP has been discussed above. After analyses of these documents, there was a review of existing literature to examine whether the claims made within the NHPs and NSHDP was in correlation with evidence from the literature.

Justification for Chosen Countries

The selection of the two countries, Nigeria and Botswana, was based upon specific qualities that each country embodies. Nigeria, a lower middle income country, has just recently been recognized as the largest economy in Africa (African Development Bank, 2014). The 2000 WHO ranking of member states health system performance placed Nigeria at number 187 out of 191 countries that were measured for efficiency within the health system (WHO, 2000). Efficiency here is referring to health systems that meet or are progressively working towards the three fundamental objectives stipulated by WHO (2000). This ranking was based on the levels of health output each country actually produced as compared to what they could be producing if the health system were to be highly efficient. Botswana is an upper middle-income country in Southern Africa that has made remarkable progress in attaining the millennium development goals (MDGs) (UNDP, 2010). Botswana has also attained significant improvements within its health system between the 2000 WHO ranking of member state health systems and the 2013 WHO review of world health systems (The World Health Report, 2000; World Health Statistics, 2013).
These countries have also been chosen based on the structures of their health systems. Although Nigeria has a well-organized and structured health system wherein health care management is decentralized into three-tiers: the federal, state and local level, the health care system still remains greatly challenged (Gilbert, Fleisher, et al., 2009). Problems that have been identified within the three-tiers include a proliferation of departments and agencies that occurs with constant changes in policies; lack of accountability systems where by state governments report financial activities to the federal government; and a mix-up of roles and responsibilities between the three tiers, amongst others (Gilbert, Fleisher, et al., 2009). In Botswana, the health system is decentralized to the district level (9 rural districts and 6 urban districts) and at each district; there is the creation of a hierarchical network of health services ranging from referral hospitals which lay at the top, to the private and medical clinics at the bottom of this hierarchy (WHO, 2014). Problems identified with Botswana’s health system include challenges in organization, management and allocation of responsibilities (WHO, 2009).

Furthermore, these two countries have been chosen based on the economic diversity and demographic diversity that characterize them, although they exist within the same continent. Nigeria is considered a lower middle income country with a population of 168.8 million people, a GDP of $459.6 billion (World Bank, 2014), and a GINI index of 48.83 in 2010 (Index Mundi, 2014). On the other hand, Botswana is considered to be an upper-middle income country with a population of 2.004 million, a GDP of $14.50 billion (World Bank, 2014), and a GINI index of 61.0 in 1994 with no available data on recent trends (World Bank, 2014).
Research Method

The research method that was applied in this study is document analysis. Document analysis is a three process method that involves: the superficial examination of a document, the thorough examination of a document, and the interpretation of the document (Bowen, 2009). In the process of document analysis, both content and thematic analyses are often utilized (Bowen, 2009).

- Content analysis: Hsieh and Shannon (2009) describe this as the process whereby prior research directs the analysis of documents and the discussion of findings from an informed perspective. Findings from document analysis will either contradict or refine existing research. Codes that are used during the analysis of a document are selected before and during the analysis of the document (Hsieh, Shannon, 2009). The use of content analysis makes for the identification of meaningful themes pertinent to the research question (Bowen, 2009).

- Thematic analysis: In the process of a thematic analysis, patterns and new themes are recognized within the document that will inform further analyses (Bowen, 2009).

- Data interpretation: documents should be analyzed critically, handled as incomplete, and meaning should be drawn from the content of the document based on its contribution to the research question (Bowen, 2009).

Justification for Selected Health Documents

In this study, major health documents were analyzed for Nigeria and Botswana. The documents analyzed for Nigeria and the reason for the selection is as follows:
The 2004 Revised National Health Policy

As highlighted by the Federal Ministry of Health (FMOH) (2004), the National Health Policy (NHP) was initially disseminated in 1988, in the bid of the Nigerian government to promote primary health care and provide a comprehensive health care system. The NHP was revised in 2004, when the government identified the need to create updated health policies that correlated with the recent health situations in the country. Following the National Health Summit that was held in 1995, with participation from national health stakeholders, there was an identified need to revise the 1988 NHP. This revision was organized by the FMOH from 1996 to 1997. The NHP addressed the goals and different dynamics surrounding health care delivery in Nigeria. Overall, the ultimate intention for the revised NHP is to ensure that every Nigerian has adequate access to each of the three levels of care within the health system. The revised NHP has not been formally endorsed and it awaits the passing of the National Health Bill in order to obtain legal legitimacy (FMOH, 2004). The 2004 NHP was selected for analysis because it is the most recent NHP for Nigeria.


In accordance with the National Council of Health (NCH) (2009), the National Strategic Health Development Plan (NSHDP) provides a framework for implementing sustainable health development in Nigeria. The FMOH has come up with the NSHDP with the hopes that it will foster the provision of affordable health care to all Nigerians, including poor and vulnerable populations. It is expected that all tiers of government in Nigeria will adopt this framework so that universal access and health coverage will be achieved throughout the country. This framework was developed after the completion of
ten background studies and the involvement of health stakeholders in the health resource 
review process (NCH, 2009). This framework also adopts the eight priority areas that 
were highlighted in the Ouagadougou Declaration on Primary Health Care (ODPHC), six 
of which are the WHO recommended building blocks of health (WHO, 2010; WHO, 
2007). The NSHDP was selected for analysis because the 2004 NHP was dated in 
comparison to the 2011 NHP for Botswana. More so, the 2004 NHP did not adopt the 
WHO building blocks of health as a framework.

The document that was analyzed for Botswana and the reason for its selection is 
descrived below:

_The National Health Policy 2011_

The 2011 NHP is a product of a revision of the 1995 NHP; this revision was 
carried out as a result of the change in the determinant of health over the years. As 
described by the ROB (2011) a result of the irrelevance of the 1995 NHP to present day 
health issues in Botswana, a revision that adopted Vision 2016 as an overall guiding 
document was carried out. The MOH and other health stakeholders developed the process 
of the NHP review. The policy review committee was made up of a Stakeholder 
Reference Group (SRG) and six thematic groups for each of the six building blocks of 
health. This process began with a situation analysis of the health status within the country 
that was followed by an assessment of the gaps that existed within the 1995 NHP. The six 
thematic groups gave recommendations on the kind of policies should be included in the 
revised NHP. The complete revision of the 1995 NHP came through consultations and 
meeting with both national and regional stakeholders.
Justification for Chosen Indicators

The variables that are being studied within these health documents include:

- Leadership and Governance for Health
- Health Service Delivery
- Health Financing

These variables were chosen based on the WHO (2007) six building blocks of health for the strengthening of health systems. While each of the six building blocks: service delivery, health workforce, information, medical products, vaccines and technologies, financing, and leadership and governance are vital to the strengthening of health systems, only three of them will be utilized in studying the Nigerian and Botswana health systems.

Leadership and governance for health represents an important aspect of the health system. Leadership and governance, recognized as both complex and the most critical aspect of a health system, concerns the supervision of the overall health system including the public and private health system as a whole (WHO, 2007). The other building blocks exist within the overall health system, which are guided by existing leadership and government within the country. Kiriga and Kiriga (2011) noted the importance of leadership and governance in order for African countries to achieve health related MDGs and national health goals. Joyal (2014) highlighted the importance of leadership and governance in helping a fragile health system move from just addressing immediate concerns to developing sustainability within the health system.

The strengthening of health service delivery is important in order to achieve the health related MDGs of reducing child mortality, maternal mortality, and the burden of HIV/AIDS, tuberculosis and malaria (WHO, 2010). Strengthening any of the other five
building blocks of health will result in a positive outcome within service delivery in the health system (WHO, 2010). In order to attain universal health coverage within a health system, there is need for strengthening service delivery with a focus on both people-centered and integrated health services (WHO, 2014).

Health financing has been defined by WHO (2010) as the “function of a health system concerned with the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually, collectively, in the health system” (p. 72). Health financing that is sustainable and protects against the risks of ill health, makes for a strong health system (WHO, 2007). Health system financing is important in providing resources needed within a health system and also in influencing the organization of health delivery within the system (World Bank, 2011). Financing within a health system is vital for the health workforce, the availability of medical products, and health information that can be dispersed to the general public (WHO, 2010).

Thus, leadership and governance can be considered the focal point around which the other five building blocks rotate. While all of the six building blocks impact on one another, service delivery is the outcome of any input into the other five blocks of a health system (WHO, 2007; WHO, 2010). Financing of a health system is also crucial for effective leadership and governance as well as service delivery within a health system (World Bank, 2011).

Codes Utilized in Document Analysis

The codes utilized in this document were retrieved from the WHO (2010) indicators for monitoring each of the six building blocks of health.

- Leadership and Governance:
• Existence of strategic policy framework
• Coalition-building
• Regulation
• Attention to system design
• Accountability

• Health Financing
  • Raising sufficient funds for health
  • Improving financial risk protection and coverage for vulnerable groups
  • Improving efficiency of resource utilization
  • Improving financial transparency and management of operational levels

• Health service and Delivery
  • Comprehensiveness
    • Preventative, curative, palliative, and rehabilitative services and health promotion
  • Accessibility
    • Close proximity to people, primary health care facility as 1st point of entry
  • Coverage
    • All people are covered
  • Continuity
    • The organization of health service delivery so that there is continuity across all levels of health, all network of services, all health issues, and throughout the life time of an individual.
Quality
- Effective, safe, timely, centered on patient’s need

Person-centeredness
- Person and not disease centered
- Users perceive health services to be responsive and acceptable
- Target population participates in service delivery design and assessment

Coordination
- Patient’s primary health care provider facilitates referral systems

Accountability and efficiency
- Well managed, accountable for overall performance and results

(WHO, 2010).

These are themes that were observed within the major health documents that were analyzed for both Nigeria and Botswana. The NHPs of Nigeria and Botswana are parallel in the sense that they are both providing policies for the health systems they serve. However, the NSHDP for Nigeria was analyzed in conjunction with the NHP because the Nigerian NHP was dated and did not adopt the WHO building blocks of health as a framework. While Botswana does not have a NSHDP, it may have been beneficial to analyze an equivalent document in this study. However, evidence from other supporting documents will be used to assess the incorporation of each of the three health indicators within both health systems.
Overcoming Shortcomings of Document Analysis as a Research Method

Using document analysis as a research method comes with some shortcomings. Bowen (2009) has identified some of the limitations of document analysis to include: insufficient detail, increased irretrievability, and biased selectivity. While all of these shortcomings may not perfectly be evaded, this study addressed them in the following ways:

- Insufficient details: this study looked to other peer-reviewed and published documents for evidence supporting or contradicting the meanings put forth by policy documents.
- Increased irretrievability: the documents that were chosen for analysis were easily accessible on the internet.
- Biased selectivity: the documents being analyzed may be biased due to the fact that they are selected because they were published after the year 2000. But these documents are national health policies that were chosen because they provided essential information about the Nigerian and Botswana health systems.
CHAPTER 3: RESULTS- LEADERSHIP AND GOVERNANCE FOR HEALTH

This chapter will discuss findings regarding the incorporation of leadership and governance into the 2004 NHP and NSHDP for Nigeria, and the 2011 NHP for Botswana. The themes that will be analyzed for leadership and governance for health within the a-fore mentioned documents include the existence of a strategic policy framework, coalition-building, regulation, attention to system design, and accountability. These indicators were chosen because they were suggested by the WHO (2010) to be used in the monitoring of leadership and governance within the health system. All of the indicators discussed below have been identified by the WHO (2010) as vital for the building of leadership and governance within a health system.

Leadership and Governance for Health – Nigeria

Existence of Strategic Policy Framework for the 2004 NHP

The FMOH (2004) explained that the 2004 health policy is a revised one from the 1988 NHP, the very first NHP in Nigeria. The 1988 version was revised in 2004 as a result of the changes that occurred within Nigeria’s health system over the years. The 1995 National Health Summit produced some recommendations that addressed factors that negatively affected the national health system; these recommendations were put into consideration during the revision of the NHP, according to the Honourable Minister of Health, Eyitayo Lambo (FMOH, 2004). The time frame between the review of the 1988 NHP (1996-1997), and the actual revision of the NHP that took place in 2004 is significant; the 2004 revision of the NHP was not formally endorsed by the federal government (FMOH, 2004). The delay in decision making from the time of the 1988
policy review to the NHP revision in 2004, challenges the competency of the health system’s leadership and governance.

The 2004 NHP was found within the development context of the following: Health Strategy of the New Partnership for Africa’s Development (NEPAD), an agreement for Africa leaders to eradicate poverty and aim towards sustainable growth and development; National Economic Empowerment and Development Strategy (NEEDS) which aims to respond to Nigeria’s development challenges (NEEDS, 2004); and the Millennium Development Goals (MDGs). NEEDS (2004) includes the plan to reduce poverty by improving health care services in Nigeria through a comprehensive health sector reform that will strengthen the national health system. The 2004 NHP is embedded within a development context that largely seeks to eradicate poverty instead of focusing on health in particular. The creation of the 2004 NHP is a major objective that was included in the health strategy of the NEEDS (NEEDS, 2004).

Existence of Strategic Policy Framework within the NSHDP 2009-2015

The NSHDP 2009-2015 framework was produced from a combination of Federal, State, and Local government health plans, and based on a principle referred to as the “four ones”: one health policy, one national plan, one budget and one monitoring and evaluation plan for all the levels of government in Nigeria (NCH, 2009). The NSHDP was developed with the foundation of health as a basic human right and the need to achieve the following:

i. MDGs

ii. The national seven point agenda: these seven points include wealth creation, land tenure and home ownership, education and human capital development (the
provision of health and strengthening of the health system is included under this),
national security, Niger Delta and energy security, food security, power and energy, and
transportation (Nigerian High Commission, 2009).

iii. Vision 2020: the objective of the Vision 2020 is to ensure that Nigeria
becomes one of the top 20 economies in the world by the year 2020 (National Technical
Working Group, 2009).

iv. Other national health development agenda: no other documents alluding to the
national health development agenda are specifically mentioned in the framework.
The framework also adopts fundamental principles of the Paris Declaration on Aid
Effectiveness which include: national ownership of health initiatives, partners for health
development aligning all health initiatives with NSHDP framework, harmonization
between all health development partners, management towards achieving results, and
mutual accountability (NCH, 2009). Finally, the framework adopts the 8 priority areas in
the Ouagadougou Declaration on PHC for the strengthening of the primary health care
system.

Coalition Building within the 2004 NHP

The 2004 NHP included the need for inter-sectoral collaboration within the health
system; this is referred to as one of the principles that underlie the existence of the NHP
(FMOH, 2004). This collaboration is supposed to occur between the federal, state, and
local governments, private sectors, non-governmental organizations (NGOs) and other
health stakeholders within the health system while these actors continue to maintain their
individual identities (FMOH, 2004). In the 2004 NHP, the word collaboration appears 25
times and each of these instances addresses:
- Collaboration on secondary and tertiary levels regarding the provision and management of human resources for health care (note that the primary level is left out)
- Collaboration in the monitoring and evaluation of health care institutions
- Collaboration in the distribution and management of health care facilities
- Collaboration in tuberculosis and leprosy research and initiatives
- Collaboration of all health stakeholders in planning and implementing health programs
- Collaboration at the federal level in order to promote health information systems
- Collaboration in fostering partnerships for health development
- Collaboration at the federal level for health research
- Collaboration in the implementation of 2004 NHP policy objectives.

Coalition Building within the NSHDP

The word “coalition” is not mentioned in the NSHDP but other words that indicate coalition are mentioned such as collaboration mentioned 27 times, partnership, 38 times, and coordination mentioned 25 times. Coordination often referred to putting measures in place to ensure that collaboration between health stakeholders work.

Collaboration will be fostered in the following ways:

- inter-sectoral, inter-governmental, and intra-governmental collaboration
- public-private partnerships
- Traditional and orthodox health delivery system collaboration
- Collaboration with health development partners in order to coordinate programs
- Collaboration with health advocacy groups to promote transparency and accountability
- Civil society and served communities in ownership of health initiatives
- Collaboration between health professionals and health regulatory bodies
- International collaboration on research for health

The NSHDP extensively discusses collaboration at all levels of the health system, more so than the 2004 NHP. The NSHDP largely admits the lack of collaboration within all health stakeholders and thoughtfully lays out how collaboration is to be achieved with all the health stakeholders within the health system. Specific methods to attaining collaboration between all health stakeholders were not mentioned. Some minor discrepancies exist in regards to the input of collaboration in the 2004 NHP as compared to the NSHDP. For example, the 2004 NHP mentions collaboration for the monitoring and evaluation of health care institutions while the NSHDP omits this. Likewise, the NSHDP mentions the international collaboration for health research while the 2004 NHP mentions collaboration for health research on a national level.

**Regulations and Systems for their Enforcement within the 2004 NHP**

The word “regulation” appears seven times in the 2004 NHP while “enforcement” appears 3 times. The 2004 NHP states that the Federal government shall be responsible for issuing policy planning and development guidelines that shall come in the form of regulations. The making of these health guidelines/regulations shall be with the contributions of other health stakeholders (FMOH, 2004). The major legislation thrusts in the NHP 2004 that addresses health related activities include, the development of a National Health Act, monitoring and supervision of health professionals’ activities,
monitoring and supervision of foods, drugs and vaccines, management of national health parastatals, regulation of media content on health, and addressing stigmatization (FMOH, 2004). In regards to enforcing regulations, the 2004 NHP only mentions the enforcement of regulations that concern food, drugs and vaccines, the tools for enforcement mentioned are effective monitoring and surveillance (FMOH, 2004).

**Regulations and Systems for Their Enforcement within the NSHDP**

The word “regulation” appears 4 times in the NSHDP. The first mention of regulation was included under the stewardship aspect of leadership and governance and the need to make policies that promote transparency and accountability within the health system. The next mention still under leadership and governance, discussed the use of regulations as a tool to exert government influence within the health system. The third mention of regulation was not in relation to leadership and governance. The fourth mention of regulation was asserted the need for legislations to ensure that health professionals are competently executing their assignments. The word “enforce” appears only once and highlighted the need to enforce that private health care providers submit health data.

“Regulation” appears more times within the 2004 NHP than it does within the NSHDP framework and they both majorly addressed regulations for different levels of health parastatals. The NSHDP, however, seemed arguably broad in its inclusion of regulations as a tool to “exert government influence” within the health system; the 2004 NHP appeared to be more specific in its approach.
Reviewing Systems Design within the 2004 NHP

The 2004 NHP identified the need for “an integrated and coordinated National Health Care System” (FMOH, 2004). The 2004 NHP listed some of the roles that the Federal, State and Local governments are to play within the three-tiered health system, and also highlighted how the 1963 constitution listed the roles of state and local governments in providing healthcare, but the 1999 constitution barely assigns responsibilities for any level of government (FMOH, 2004). The 2004 NHP mentioned the need to allocate clear cut responsibilities to each of these tiers of governments and this was to be done in the National Health Act (or National Health Bill). The fragmentation of the health system was not as explicitly addressed as the 2004 NHP said it will. Articles 35 and 43 h were the only articles in the National Health Bill that addressed the allocation of responsibilities between the three tiers of government. Thus, the 2004 NHP is proved wrong in its claim.

Reviewing Systems Design within the NSHDP Framework

The NSHDP framework was more thorough in its approach to system design. The NSHDP discussed the past national and sectoral health policies that have been implemented in Nigeria since independence, 5 and over 24 respectively (NCH, 2009). This framework mentioned the lack of a health development strategy within the Nigerian 1999 constitution and the National Health Bill that identified the roles of the different arms of government within the health care system. Acknowledging the negative impact that a lack of clearly assigned governmental roles has on the health system, the NSHDP proposed to strengthen the government’s regulation of the health system in the following ways:
• By increasing state governments’ capacity to set health care delivery standards and ensure that health care providers meet these standards.

• The federal government will support Public and Private Partnerships (PPP) within the states that are in alignment with PPP provisions in the national policy.

• Technical support will be provided to the state government in the creation of a strategic plan to ensure that the government’s regulation of the health system is strengthened.

• Elements of health delivery will be outsourced by the state government to the private health sector (NCH, 2009).

In addition to the proposed actions above, the NSHDP mentioned the passing of the National Health Bill that will clearly define the roles of the three different arms of government within the health care system (NCH, 2009).

**Accountability within the 2004 NHP**

The 2004 NHP claimed that “a high level of efficiency and accountability shall be maintained in the development and management of the national health system” (FMOH, 2004, p.7). The 2004 NHP did not state what tools will be used to ensure accountability within the health system; the word “accountability” only showed up once in the 2004 NHP. While the 2004 NHP committed to a “high level” of accountability, it did not come across as if this was indeed a priority for the government. Cleary, Molyneux, and Gilson (2013) highlighted the interaction between external accountability (accountability between health system and community) and bureaucratic accountability (within the different levels of the health system). With this systematic neglect for accountability within the 2004 NHP, the NHS seems to be lacking consideration for both levels of
accountability. The need for accountability within the NHS is exacting. The federal government allocates funds to state governments from the federation account but has no influence whatsoever on how state government choose to spend this money, neither does it receive a detailed breakdown on how money was spent. Lack of budgetary accountability and poor coordination between the three tiers of government has hindered integration within the NHS (WHO, 2010). This is an example of a lack of bureaucratic accountability within the NHS.

Accountability within the NSHDP Framework

The NSHDP discussed the intention to strengthen accountability, transparency, and responsiveness within the health system through decentralizing decision making within the health sector (NCH, 2009). This will be achieved by creating a feedback mechanism whereby health stakeholders may give their input that will be instituted into decisions made within the health sector. The use of health sector advocacy group within this process is also highlighted through engaging them on a new platform. Community ownership is another tool that is identified as well the support for independent “watch dogs” within the health sector. The duty of the federal government in promoting transparency, accountability, and responsiveness within the health sector is to create a platform whereby information pertaining to the health sector is available, easily accessible to the public, and may be used for the annual review of the health system by health stakeholders (NCH, 2009).

Accountability is also included as one of the fundamentals upon which the NSHDP was created. This was included in the “Context” section of the framework: “Mutual Accountability: by which the Federal, State, LGAs, Development Partners and
other stakeholders hold each other accountable for health development results” (NCH, 2009, p.4). The emphasis on accountability within the NSHDP framework may be attributed to its adoption of the six building blocks of a health system and the ODPHC.

Leadership and Governance for Health - Botswana

Existence of Strategic Policy Framework within the 2011 NHP

The 2011 revision of the existing NHP was carried out as a result of an identified need for NHP to be relevant to existing determinants of health in Botswana. This review was made with consideration for a number of factors. The Ministry of Health (MOH) was experiencing a major reorganization, taking over the management of the Primary Health Care system that was being managed by the Ministry of Local Government. More so, the determinants of health and dynamics surrounding health care provision and utilization in Botswana had significantly shifted from what it was when the 1995 NHP was created (Republic of Botswana [RoB], 2011). The process of review for the NHP was carried out through the involvement of health stakeholders and utilization of six thematic groups that included leadership and governance. The responsibility of these review group members was to identify gaps in the 1995 NHP and suggest policies that will address these gaps. The 2011 NHP which is the result of a systematic review process was created within both international and national frameworks.

Vision 2016, a document that provides a six-year development plan for Botswana, includes a set of health related goals (RoB, 2011). The goals set for health development in Vision 2016 include the provision of quality and easily accessible health facilities, provision of man power and equipment in the health facilities, focus on health of the mentally challenged, and disabled, as well as infectious diseases like HIV/AIDS
The health related development goals of Vision 2016 were addressed in the NHP, noting that Vision 2016 provides an overall guideline for Botswana’s national development.

The NHP refers to the MDGs as one of the framework for national development whose health related goals are further emphasized in the ODPHC (RoB, 2011). The NHP mentions the Harmonisation for Health in Africa (HHA) which is an initiative that ensures that countries have a single approach to national health development. All health stakeholders may work within this single framework to achieve health development (RoB, 2011). More so, the NHP is largely influenced by the Commission of Social Determinants of Health (CSDH) that has recognized the need to make health development a multi-sectoral approach. The NHP mentioned that its approach to health development is through acknowledging the role of other national sectors in determining and influencing the health status of the population. More so, collaboration between all social and economic sectors of the economy was identified, whose purpose is to ensure that all social determinants of health are considered in the national health development strategy (RoB, 2011).

**Coalition Building within the 2011 NHP**

Inter-sectoral collaboration and coordination is included under leadership in the 2011 NHP. Collaboration under leadership and governance in the 2011 NHP is mentioned with regards to

- Collaboration between the MOH and other partners in order to create plans for the implementation of the policy.
Partnerships between the MOH and other health stakeholders being encouraged by the government.

The alignment of the different sectors within the overall health system.

Coalition is not mentioned within the 2011 NHP and while inter-sectoral collaboration and coordination is included as contextual to health leadership in Botswana, this is not included among the objectives of leadership and governance in the NHP. More so, there is no further discussion on how inter-sectoral coordination or partnerships will be achieved. There is no mention of fostering international or regional partnerships under leadership and governance within the NHP.

However, collaboration is mentioned in different instances within the NHP which include:

- Collaboration between the MOH and health partners for the implementation of the Integrated Health Services Plan (IHSP).
- Establishment of Port Health Services through collaboration between the MOH and concerned agencies.
- Collaboration between MOH and health partners to oversee health workforce and with the Ministry of Education and Skills Development to ensure the provision of a skilled health workforce.
- International collaboration for exploration of local production of health resources.
- Collaboration in the exploration and promotion of alternate health medicine.
- Collaboration for the development of health infrastructure at all levels of health care and ensuring that provisions are made for people with disability.
• Collaboration in the development and implementation of a national health research agenda.

• Collaboration between MOH and Ministry of Trade and Industry for tobacco, alcohol, and substance control.

• Collaboration between the MOH and Ministry of Environment, Wildlife, and Tourism for ensuring occupational safety.

The 2011 NHP largely emphasized local collaboration within the health system, but not a lot of international cooperation or dependency. When international collaboration was emphasized, it was so that national independence may be achieved with regards to the national production of health resources. The leadership and governance theme within the NHP does not elaborately discuss collaboration and coalition, but embedded within the NHP itself are several references to inter-sectoral and minimally, international collaboration.

*Regulations and Systems for their Enforcement within the 2011 NHP*

The regulations that are addressed in the 2011 NHP include the Botswana National Drug Policy (BNDP) whose quality was reviewed in 2002 (RoB, 2011). More so, the Drugs and Related Substance Act (DRSA) and regulations of 1992 and 1993 respectively were undergoing amendment as at the time the NHP was being written. The DRSA is majorly responsible for the regulation and control of medicines and thus, inform the BNDP (RoB, 2011). The second regulation addressed in the 2011 NHP is the Public Health Bill/Act whose implementation and enforcement will be overseen by the MOH. It should be noted that the Public Health Bill/Act regulates the health sector as a whole (MOH, 2014). The collaboration between the MOH, the Ministry of Environment,
Wildlife and Tourism, and the Department of Buildings and Engineering Services exists so that environmental health standards in form of policies and regulations may be met.

The third reference to regulation within the NHP is the mention of developing and implementing regulations that will ensure the efficient flow of health information. More so, the fourth mention of regulation addresses the need to review policies addressing alcohol and substance abuse. The fifth mention of regulation within the NHP is pertaining to the Ministry of Trade and Industry’s advocacy in order for international regulations on agriculture and industry to benefit Botswana; this is not directly related to the health system. The last mention of regulation identified the national regulation enforcement agency which is the Ministry of Defence, Justice and Security. The duty of this Ministry with regards to health is to enforce health related regulations and ensure that health services are made available to the targeted populace (MOH, 2014). Not very many health regulations are mentioned in the 2011 NHP but it is important to note the presence of an agency that is responsible for enforcing all the health regulations and policies made in Botswana. Thus, it is obvious that the enforcement of health regulations is considered a priority in Botswana. However, there is a need to further understand the effectiveness of these regulations and that of the Ministry responsible for enforcing them.

Two of the objectives under Leadership and Governance in the 2011 NHP referred to health regulations and policies. The first discusses the process towards implementing the 2011 NHP through the creation of National Health Strategic Plans that will guide its implementation. These plans shall be created through collaboration between the MOH and other health partners. The second regulation related objective has to do
with the intention to ensure that the Public Health Act, which is the overall regulatory body within the health system, is functional (MOH, 2014; RoB, 2011).

System Design within the 2011 NHP

With regards to system design, the 2011 NHP created a binary between what is considered as leadership or governance. The 2011 NHP asserted that clarification of roles and relationships between health stakeholders will be considered as leadership for health. Whereas, planning and setting of health agenda and priorities were categorized underneath health governance (RoB, 2011). The clarification of health stakeholders’ roles and relationships as well as the planning and setting of health priorities are considered to be representative of system design, as suggested by the WHO (2010). Some of the objectives listed under leadership and governance within the 2011 NHP are targeted towards system design.

One of these objectives mentions that the clarification of roles and relationships between health partners will be executed by the presidential cabinet with the help of the National Health Council (RoB, 2011). This will ensure that there is limited duplication in the division of labor amongst health partners. More so, objectives that will ensure that fragmentation is avoided within the health system are included in the 2011 NHP. The first one is the intention to “create a platform in the health sector for the provision of strategic guidance and oversight” (RoB, 2011, p.16). This is intended to be achieved with the creation of a National Health Council (NHC); the NHC will be led by a renowned Health Professional in Botswana. The Botswana government will also ensure that health consumers can contribute to the quality of health they are being provided. This will be done by creating associations and groups in which health users are active (RoB, 2011).
Giving health users an avenue to express their opinions about the quality of health they consume will be beneficial in ensuring that the structure and strategy to health care provision fit reasonably.

Another policy initiative introduced in the 2011 NHP in order to ensure that there is a fit between the structure and strategy adopted in the health sector is the separation of inspection and implementation roles. The process towards executing this involves the creation of a self-governing Health Inspectorate (RoB, 2011). The MOH will ensure that there is harmony between all the processes carried out within the health sector from financing to monitoring. This shall be done by borrowing ideas from other sectors within the economy (RoB, 2011). The MOH shall engage in constant evaluation of the health system in order to ensure that the health system is adequately meeting the needs of the population (RoB, 2011). The periodical review of the health system will be helpful in identifying whether the approaches being adopted within the system is effective.

**Accountability**

The 2011 NHP acknowledged that accountability is one of the many components that health governance entails (RoB, 2011). However, there is no mention of the word “accountability” under the goals and objectives of the Leadership and Governance component of the 2011 NHP. Consideration for accountability may be inferred from some of the policy objectives listed underneath the Leadership and Governance component. For instance, one of the policy objectives discussed the intention of the government to foster the creation of associations through which civilians may contribute to their own health (RoB, 2011). A civilian being able to contribute to their health means...
that they can keep the government, health providers, and other health stakeholders accountable.

The Health Inspectorate of Botswana is a body that observes regulatory roles within the health system (MOH, 2014). There is an icon for the Health Inspectorate on the Botswana MOH website, but there is no information under this icon; however, the Health Inspectorate is also listed under “Regulatory Services”. The duty of the Health Inspectorate as asserted on the MOH website is to engage in regular inspections of health care facilities and their personnel so that quality health care may be provided throughout Botswana (MOH, 2014). This kind of regulatory agency has the capacity to keep health stakeholders accountable.

Conclusion

Existence of a Strategic Policy Framework

The 2004 NHP has its framework embedded in the NEPAD health strategy, NEEDS, and the MDGs. The framework within which the NHP is grounded is one that seeks to eradicate poverty. The ideology is that through the eradication of poverty, health issues will be addressed. The NSHDP was more focused on health with its reference to the Ouagadougou Declaration on PHC and the Paris Declaration on Aid Effectiveness. Overall, the Nigerian government seemed to have adopted an economic development approach to health development. The Botswana 2011 NHP has its framework embedded in the six thematic building blocks of health and the additional two highlighted in the ODPHC. The Botswana NHP approaches health development from a standpoint that acknowledges the role of other health stakeholders in influencing population health.
Coalition Building

Collaboration is emphasized in the Nigerian 2004 NHP and was referenced as one of the underlying principles of the NHP (FMOH, 2004). Collaboration is supposed to occur with a varied number of sectors, while these sectors continue to maintain their individual identities (FMOH, 2004). The NSHDP for Nigeria extensively acknowledged the lack of collaboration between health stakeholders and discusses methods through which this may be addressed (NCH, 2009). Collaboration in the Botswana 2011 NHP is not as emphasized as it was in the Nigerian NHP. However, an analysis of the 2011 NHP indicated that the MOH in Botswana is very strategic in initiating and overseeing collaboration and partnerships occurring within the health system.

Regulations and Systems for their Enforcement

The 2004 NHP asserted that the Nigerian Federal Government will be responsible for creating health guidelines/regulations but with contributions from other health stakeholders. The enforcement of health regulations is only mentioned in regards to one specific issue i.e food, drugs and vaccines (FMOH, 2004). The tool for this enforcement includes effective monitoring and surveillance. The uses of regulation in the NSHDP are for promoting transparency and accountability in the health system, and exerting government influence within the health system. More so, the federal government will create regulations to ensure that private health care workers execute their duties professionally (NCH, 2009). Enforcement is only mentioned in the NSHDP in reference to private health care providers’ responsibility to submit acquired health data. From an analysis of these documents, it was found that the 2004 NHP is more specific than the NSHDP in its inclusion of regulations into the health system.
In the 2011 NHP for Botswana, health regulations are satisfactorily discussed with reference to national bills and acts that contribute to the running of the health system (Rob, 2011). The Ministry of Defence, Justice, and Security (MDJS) is responsible for the enforcement of regulations within the health system. However, there are no clear cut specifications on which department within the MDJS is responsible for ensuring the efficient implementation and adherence to health regulations. In Botswana, health regulatory services are shared amongst six different agencies. Thus, these six agencies share the responsibility of regulating the provision of health services within the health system.

System Design

The 2004 NHP addressed the roles that the Federal, State, and Local government in Nigeria are to play within the three-tiered health system. The 2004 NHP asserted that the National Health Bill will address the fragmentation that exists with the health system in regards to roles verification (FMOH, 2004). The NSHDP also stated the need to pass the National Health Bill which will clearly state the roles of each of the levels of government within the health system (NCH, 2009). The 2011 NHP largely discussed the clarification of roles within the health system which is to be done by the presidential cabinet with the help from the National Health Council (NHC) (RoB, 2011). The 2011 NHP has some objectives that assert the need to ensure that fragmentation and duplication within the health system are prevented. More so, in order to ensure a fit between the structure of and the strategy adopted within the health system, a health inspectorate will see to the separation of inspection and implementation roles within the health system. The MOH shall also take responsibility for the periodical review of the
health system in order to ensure that the adopted strategies within the system are effective.

Accountability

The 2004 NHP only mentioned accountability once; however, it did not mention the specific tool and method that will be used to ensure accountability. The NSHDP on the other hand, extensively discusses mutual accountability within the health system and between all health stakeholders. Other tools for ensuring accountability as mentioned in the 2004 NHP include the decentralization of decision making through the use of a feedback mechanism; the support of “independent watchdogs” within the health system, and the fostering of community ownership (FMOH, 2004). The 2011 NHP infers accountability within the health system through the use of civilian groups who may contribute to their own health, and the health inspectorate that will be responsible for periodically reviewing health delivery (RoB, 2011). Both civilians and the health inspectorate may play the role of keeping health stakeholders accountable.
Results at a Glance

Table 1

Leadership and Governance for Health

<table>
<thead>
<tr>
<th>2004 NHP (Nigeria)</th>
<th>NSHDP (Nigeria)</th>
<th>2011 NHP (Botswana)</th>
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<tbody>
<tr>
<td><strong>Existence of strategic policy framework.</strong></td>
<td><strong>Framework embedded in the NEPADS, NEEDS, and MDGs.</strong></td>
<td><strong>The MDGs, Vision 2020, national seven point agenda.</strong></td>
</tr>
<tr>
<td>Framework seeks to achieve health development through the eradication of poverty.</td>
<td><strong>Adopted fundamental principles of the ODPHC and the Paris Declaration on Aid Effectiveness.</strong></td>
<td><strong>Adoption of the Harmonisation for Health in Africa (HHA). Largely influenced by the Commission of Social Determinants of Health (CSDH).</strong></td>
</tr>
<tr>
<td><strong>Coalition Building</strong></td>
<td><strong>Collaboration= 27 times, partnership=38 times, coordination= 25 times. Collaboration in traditional and orthodox health care, ownership, transparency, health regulation.</strong></td>
<td><strong>No mention of international and regional partnerships as in the NSHDP.</strong></td>
</tr>
<tr>
<td>Inter-sectoral collaboration within the health system as an underlying principle. Collaboration between federal, state, and local governments, NGOs, private sectors, and other health stakeholders.</td>
<td></td>
<td><strong>Collaboration in Botswana’s NHP not as emphasized as in the Nigerian NHP.</strong></td>
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<tr>
<td>Regulations and systems for their enforcement.</td>
<td>Attention to systems design</td>
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<tr>
<td>Regulation appears seven times, enforcement appears 3 times. Federal government responsible for issuing policy planning. Contribution from other stakeholders. No emphasis on enforcement of regulation. Only one mention of enforcement with regards to food, drug, and vaccines regulations.</td>
<td>Highlighted some roles for each level of government. Emphasized need to assign clear-cut roles to each tier. Claimed that allocation will be carried out in the National Health Act. Upon review, the Act does not allocate roles and responsibilities.</td>
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<tr>
<td>Appears 4 times in the NSHDP. Mentioned in relation to (promoting transparency and accountability). Enforcement appears once (private health care providers submit health data).</td>
<td>More thorough in discussion of systems design. Identifies the lack of a health development strategy in the Nigerian 1999 constitution and the National Health Bill. Acknowledges the negative impact of the lack of assigned governmental roles.</td>
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<tr>
<td>Six mentions of regulations (drug policy, Public Health Bill, meeting environmental health standards, health information, addressing alcohol and substance abuse, international regulations on agriculture and industry). Existence of an enforcement agency: Ministry of Defense, Justice and Security (MDJS). No specific mention of the department within the MDJS responsible for health regulations.</td>
<td>Importance of role clarifications and relationship between stakeholders. Avoiding fragmentation within the health system. Health consumers may contribute to their health (health users association). Separation of inspection and implementation of roles (health inspectorate). Harmony between all processes within the health</td>
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### Table 1 Continued

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<tr>
<th>Accountability</th>
<th>Decentralization of decision making will strengthen accountability and transparency.</th>
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<td>Importance of role clarifications and relationship between stakeholders.</td>
<td>Encouraging community “watch dogs” within the health sector.</td>
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<tr>
<td>Avoiding fragmentation within the health system.</td>
<td>Mutual accountability amongst health stakeholders as a fundamental principle.</td>
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<tr>
<td>Health consumers may contribute to their health (health users association).</td>
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<td>Separation of inspection and implementation of roles (health inspectorate).</td>
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<td>Harmony between all processes within the health sector.</td>
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<td>Sector.</td>
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<td>One mention.</td>
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<td>One of the main components comprising of health governance.</td>
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<td>Health users’ association.</td>
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<td>Health Inspectorate.</td>
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CHAPTER 4: RESULTS-HEALTH SERVICE DELIVERY

This chapter will discuss findings regarding the incorporation of health service delivery into the 2004 NHP and NSHDP for Nigeria, and the 2011 NHP for Botswana. The themes that will be analyzed for health service delivery within the a-fore mentioned documents include comprehensiveness, accessibility, coverage, continuity, quality, person-centeredness, coordination and, accountability and efficiency.

Health Service Delivery in Nigeria: Reviewing the 2004 NHP

Comprehensiveness (Preventative, Curative, Palliative, and Rehabilitative Services and Health Promotion)

The 2004 NHP mentions that one of its goals is to make primary health care comprehensive within the confines of existing resources in Nigeria (FMOH, 2004). This comprehensive health care will be made available to every citizen of Nigeria by providing them with a minimum health care package (FMOH, 2004). The services that will be provided within the “minimum package” are not mentioned, neither is there a detailed breakdown of what the comprehensive service will entail. Although the provision of comprehensive health care is mentioned in the 2004 NHP, there is no thorough breakdown regarding how this process will come about.

Accessibility (Close Proximity to People, Primary Health Care Facility as 1st Point of Entry)

The word accessibility appears only twice in the 2004 NHP. The first mention of accessibility in the 2004 NHP pertains to the National Health Care Financing. In this section, accessibility to resource is identified as one of the guiding principles for the development of the national health care financing strategy (FMOH, 2004). The second
mention of the word accessibility comes under the section discussing the provision and utilization of health care indicators whereby the provision of essential drugs indicators and list of essential drugs must be made available and accessible (FMOH, 2004).

However, the 2004 NHP does mention the PHC as the first entry point to the health care system. This is mentioned in the description of the different levels of care (FMOH, 2004). It should be noted that the 2004 NHP does not discuss methods of ensuring that the PHC remains the first point of entry to the health system, neither does it acknowledge whether or not the PHC is actually serving as the first point of entry.

Thus, it is clear that the proximity of health care facilities to Nigerian citizens and PHCs representing the 1st point of entry in the health care system is not thoroughly addressed within the 2004 NHP.

*Coverage (All People are Covered)*

The 2004 NHP discussed the need for an increased geographic and therapeutic coverage in Onchocerciasis control programs, increased DOTS coverage in the Tuberculosis control programs, and coverage of children and women with respect to health services targeted towards them such as ante/post natal care and immunization programs (FMOH, 2004). Equally as important is the stipulation for referral service provision whereby referral services should be within a 5km or 1hr travel time from the location of users (FMOH, 2004). The 2004 NHP identified specific health services and the need for an increase in their coverage. While its mention of health services is not comprehensive, it is obvious that health service coverage of every member of the population is an important factor that is highlighted in this document. Moreover, despite
the mention of increased health coverage for these health services, there is no detailed breakdown of how this increase will be ensured.

Continuity

The long term goal of the 2004 NHP is to ensure that every Nigerian has access to all three levels of health care “through a well-functioning referral system” (FMOH, 2004, p.iii). The 2004 NHP highlighted the weak and ineffective referral systems that exist within the health system. In order to ensure strong and functioning referral systems, the MOH shall allocate health resources across the different levels of health care according to their needs. Priority will be given to the PHC especially in areas that are severely underserved (FMOH, 2004). In more effort to foster continuity within the health system, traditional health practitioners will be trained on how to effectively make use of referral systems. The NHP mentioned that efforts will be made to provide the necessary services in the bid to ensure that tertiary health care facilities have effective referral systems. The MOH with other relevant stakeholders will take the responsibility of creating minimum requirements and standards for first level referral health facilities. More so, health care indicators shall also pay attention to referral systems by measuring coverage of referral systems. This measurement shall be carried out by observing the proportion of the population that lives within a 5km radius or 1 hr travel time from a referral facility, the proportion of referred patients that receive care at the referral hospitals, and the number of referral services that are actually available at the referral facilities (FMOH, 2004). The indicators will also measure the proportion of two-way referrals that occur within the health system. Particularly, the government shall focus on the needs of underserved areas when strengthening referral systems (FMOH, 2004).
Quality (Effective, Safe, Timely, Centered on Patient’s Need)

The 2004 NHP extensively discusses the poor quality of health care delivered within the Nigerian health system. One of the objectives embedded within the NHP is as follows: “[To] strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable health services” (FMOH, 2004, p.6). Also included in the underlying principles guiding the NHP is the notion that access to quality health care is a human right that will be assured all Nigerians (FMOH, 2004). One of the methods through which the NHP aims to ensure quality health care is through the implementation of health programs that are cost-effective. The NHP also aims to attain quality health care for Nigerians through achieving the health related MDGs, elimination of Female Genital Mutilation, and the provision of quality reproductive health services (FMOH, 2009). Equally as important is the plan to increase the quality of human resource for health, food, drugs and vaccines, health facilities, health information, and health research (FMOH, 2009).

The idea of time within the NHP is mostly discussed in relation to the release of health information and only once does it refer to service delivery. The only instance whereby timely service delivery is mentioned is in reference to the implementation of interventions for children with hearing impairments. Safety with regards to health service delivery is discussed in the application of health technologies, injection safety during immunization, safe blood transfusions, safe drugs, water, and food (FMOH, 2004). All of these will contribute to the overall delivery of quality health care in Nigeria. There is no specific mention of providing health care that is particularly centered on the needs of the patient within the NHP.
Person-Centeredness (Person and Not Disease Centered, User’s Perceive Health Services to be Responsive and Acceptable, Target Population Participates in Service Delivery Design and Assessment)

Under health policy declarations and commitment within the NHP, it is asserted that the participation of individuals and the collective community within health delivery is not only a right but in fact a “solemn duty” of Nigerians (FMOH, 2004). The measures that are put in place to enable people/communities to participate in health delivery include the government’s creation of mechanisms to foster participation. There is no significant mention of the health care being person and not disease centered, neither is there any mention of the users’ perception of the health services being delivered.

Coordination (Patient's Primary Health Care Provider Facilitates Referral Systems)

In the foreword of the NHP, there is mention of the long term goal of the NHP which is to provide the whole population with adequate access to all levels of health care within a referral system that is of good performance (FMOH, 2004). The 2004 NHP acknowledged the presence of weak referral systems within the health care system. In order to improve the performance of referral systems, the NHP claimed that the primary health care will be given high priority with regards to available resources, while the facilities and resource available at both the secondary and tertiary levels will also be strengthened (FMOH, 2004). More priority will be given to remote communities with which geographical location of referral facilities is a challenge. Traditional health workers will also be trained so that they can effectively make use of the referral systems (FMOH, 2004).
Accountability and Efficiency (Well Managed, Accountable for Overall Performance and Results)

One of the underlying principles of the NHP is the maintenance of a high degree of efficiency and accountability within the health system (FMOH, 2009). This is in fact, the only instance whereby accountability is mentioned. Thus, there is no breakdown of methods by which accountability will be ensured. The 2004 NHP mentioned the need for evaluations of the health development strategy in order to ensure its efficiency. There was mention of efficiency in the use of health technologies and resources for health development (FMOH, 2004). However, there was no thorough breakdown of how efficiency and accountability will be ensured within the different levels of health care and in the overall health system.

Service Delivery within the NSHDP Framework

Comprehensiveness (Preventative, Curative, Palliative, and Rehabilitative Services and Health Promotion)

One of the NSHDP’s goals under service delivery is to strengthen access to an essential care package that is universal (NCH, 2009). This is to be done through the strengthening of certain communicable and non-communicable diseases program and also through the creation of Standard Operating Procedures (SOPs) to which all health care service delivery will adhere (NCH, 2009). The communicable and non-communicable control programs that will be strengthened were not mentioned. More so, there is no mention of providing a comprehensive health care package to the population. In the place of comprehensive, the word essential is used.
Reviewing the NSHDP 2010-2015 document whose content is highly similar to the framework itself, there is further breakdown of what an essential package consists of.

Taking a look at the essential health services package delivered in Nigeria, one can see that the services provided may be categorized into preventative, curative, palliative and rehabilitative services and health promotion. For example:

- Preventative: provision of insecticide treated nets (Family/community oriented services)
- Curative: provision of Artemisinin-based Combination therapy
- Palliative: management of complicated AIDS
- Health promotion: hand washing with soap

There are no services in this essential health service package that may be considered rehabilitative. More so, while the services provided in the essential health service package have been categorized above, there was no intentional inclusion of comprehensive health service delivery within the NSHDP framework.

*Accessibility (Close Proximity to People, Primary Health Care Facility as 1st Point of Entry)*

The NSHDP framework mentioned the need to create equal access to quality health care based on geographical location (NCH, 2009). This will be done through the application of Geographic Information Systems (GIS) in mapping all health facilities in the country and using this information to create guidelines for the location of new health facilities in the country (NCH, 2009). Pre-existing health facilities will be upgraded and health facilities will be made to follow guidelines surrounding access to health care. Referral systems will be strengthened and there will be an improvement in the application
of telemedicine. The maintenance of health facilities and health equipment will also be emphasized (NCH, 2009). While there is a mention of plans to strengthen referral systems within the health care system, there is no mention of methods of ensuring that PHC facilities remain the 1st point of entry for consumers.

Coverage (All People Are Covered)

In order to ensure that all people have access to health care services, the NSHDP, in addition to providing a universal essential health service package and geographic equity in the location of health facilities, proposed a few other elements. These elements include,

- Ensuring that drugs and equipment are available at all levels of care: this will be carried out through the periodical review of essential drug/equipment list and distribution of these drugs/equipment to all levels of care.

- Provision of financial access to health care for vulnerable groups: vulnerable groups refer to children under the age of five, orphans, old people, and pregnant women. In order to make health care financially accessible to them, the NSHDP seeks to create other methods for them such as vouchers, health cards, etc. as well as review existing programs targeted at this populations (NCH, 2009).

The above are the measures that the NSHDP framework aimed to put in place in order to ensure health care coverage for all. Conspicuously missing from this list of interventions are programs that are directly targeted towards the poor or people living below the poverty line.
Continuity

Included in the undertakings of the NSHDP is the intention to ensure that health strategies are inclusive of referral system strengthening. The NSHDP acknowledged the presence of weak referral services within the country, as tertiary facilities may be found delivering PHC services (NCH, 2009). The result of this is what the NSHDP referred to as “diminishing the continuum of care and making the health system inefficient” (NCH, 2009, p.24). Thus, one of the interventions that are suggested in order to increase access to health care services is the strengthening of referral systems. Referral systems will be strengthened by ensuring an efficient two-way referral system and ensuring the availability of logistical infrastructure to enable effective referrals. In addition to this, mechanisms will be put in place to ensure that referral services may be monitored (NCH, 2009). The NSHDP also created provisions for traditional health workers who will be trained on how to utilize referral systems.

Quality (Effective, Safe, Timely, Centered on Patient’s Need)

The NSHDP framework has a number of objectives that, if implemented, can improve the quality of health care delivery. These include:

- Strengthening of professional regulatory bodies and institutions
- The development and institutionalization of a quality assurance model
- Health Management and Integrated Supportive Supervision (ISS)
- Maintenance of health equipment and facilities
- Strengthening of referral systems (NCH, 2009).

All of these are objectives that if implemented, will increase the quality of health service provided. Moreover, the framework did not specifically identify the aim of these
objectives as increasing the quality of service provided. There is no specific mention of timely delivery of health service that is safe and centered on patients’ needs.

*Person-Centeredness (Person and Not Disease Centered, Users Perceive Health Services to be Responsive and Acceptable, Target Population Participates in Service Delivery Design and Assessment)*

The idea of community participation and ownership is strongly featured in the NSHDP framework. In order to foster community participation and ownership within health development, the NSHDP framework highlights specific objectives that will be put in place. These include,

- The creation of a policy framework that will foster community participation by providing the direction towards this process.
- Creating a framework within which community involvement in the planning, management, and evaluation of health interventions may be enhanced.
- Empowering communities with health knowledge and resources to participate in community level health activities.
- Review and strengthen links between the existing health structures and the community within which they exist.
- The creation of policies that create linkages between the health sector and other sectors so as to foster community participation in health delivery.
- Creating a framework for measuring the level of community involvement in the health sector.

While the NSHDP framework thoroughly discusses community participation within the health sector, there is no specific mention of shifting the focus of health
service delivery from the disease to the individual. Even without the mention of this, it is obvious that the involvement of community in health delivery is of priority within the NSHDP framework. Community Participation and ownership is featured as the 6th priority area within the NSHDP framework (NCH, 2009).

**Coordination (Patient’s Primary Health Care Provider Facilitates Referral Systems)**

In the NSHDP framework, it is acknowledged that referral systems are weak and the “continuum of care” is diminished with other levels of health care delivering first-entry level care (NCH, 2009). Thus, one of the objectives featured under increasing access to health services is the strengthening of referral systems. In order to improve referral systems, the NSHDP framework proposes to map out network linkages for a two-way referral systems that will be done according to national standards. There is need for resources like transportation and communication systems to be available so that referral systems may be efficient. More so, outcomes of referral systems will be monitored by an appropriate body (NCH, 2009).

The NSHDP briefly discusses the strengthening of referral systems and mentioned nothing particularly pertaining to the idea that referral systems should be facilitated by patients’ primary health care provider. More so, the document does not further discuss the national standards for referral systems nor refer readers to a document containing information on these standards. Further research regarding national standards for referral systems in Nigeria brought up no significant results. This might mean that there are, in fact, no national standards for referral systems in Nigeria and there may be a need for creating one.
Accountability and Efficiency (Well Managed, Accountable for Overall Performance and Results)

While accountability is well highlighted in the NSHDP framework (and has been discussed above), the word “efficiency” only comes up four times. Out of these four mentions, the most relevant is the mention of efficiency in the overall allocation of resources at all levels of health delivery (NCH, 2009). However, there is no significant mention of efficiency in relation to the overall performance of the health system. With regards to accountability for overall health outcomes, the “mutual accountability” clause within the NSHDP asserts that all health stakeholders will be held accountable for health development results (NCH, 2009).

Reviewing Health Service Delivery in the 2011 NHP

Comprehensiveness (Preventative, Curative, Palliative, and Rehabilitative Services and Health Promotion)

Objective 1 under the service delivery component of the 2011 NHP is most related with increasing the comprehensiveness of health service packages in Botswana. The objective is “to scale up the utilization of a well defined and comprehensive package of essential health interventions” (RoB, 2011, p. 23). The policy initiative for the accomplishment of this objective includes the implementation of an Essential Health Services Package (EHSP) by the MOH. The creation of this package shall take into account the economic, social, health, geographical, and political factors interacting within Botswana (MOH, 2010). The EHSP consists of rehabilitative, preventive, curative, and promotive health care services (MOH, 2010).
The MOH (2010) asserted that the EHSP does not meet all the health needs within the country but rather identifies health interventions that are cost-effective and provide for the essential health needs of the population. The EHSP ensures that limited health resources are efficiently used towards health development. More so, the EHSP looks to the government and health stakeholders to “obtain the best possible value for money by allocating their scarce resources using cost effectiveness as the main criteria” (MOH, 2010, p.9). The MOH (2010) asserted that this method of resource allocation is more efficient as compared to the more often practiced 10% annual increment on national health budgets.

*Accessibility (Close Proximity to People, Primary Health Care Facility as 1st Point of Entry)*

In the initial executive summary of the service delivery component, there is mention of the need to enhance health infrastructure so that people with disability may be considered and included in health service delivery (RoB, 2011). However, the objective section of the policy makes no mention of plans to create health infrastructure that are inclusive of people with disabilities. There is no mention whatsoever of ensuring that health facilities are in close proximity to people and primary health care facilities are considered as the first point of entry for the population. The exclusion of this aspect of accessibility from the 2011 NHP may be as a result of positive indicators within the context of accessibility in Botswana. WHO (2014) reported that the percentage of both rural and urban populations in Botswana that live within eight kilometers of a health facility is 95%.


Coverage (All People Are Covered)

The overall goal of the service delivery component within the 2011 NHP is to provide quality and essential health services with universal coverage for the whole population (RoB, 2011). More so, an objective of the service delivery component of the 2011 NHP is to ensure that the private sector and NGOs increasingly collaborate in order to provide essential health services to the whole population (RoB, 2011). The provision of free, comprehensive, essential health services to the population at all health facilities in Botswana is a policy initiative mentioned in the NHP 2011. These essential health services will be provided at no cost to patients patronizing public health services, but at a set price in private facilities. More so, the 2011 NHP mentions that treatment for diseases that are considered threats to public health will be provided at no cost to the whole population (ROB, 2011). However, it is not mentioned whether this treatment will be provided at no cost at private facilities, and if so, how the government will manage the financial cost of this.

Population wide coverage is also put into consideration in the policy initiative that addresses the availability and access to comprehensive health services in Botswana. This initiative proposes that comprehensive health packages will be made available “in all health facilities, including those owned by the mission, the mines, the private sector and other government organs” (RoB, 2011, p. 23-24). The implementation of this policy will ensure that people from all walks of life have access to a comprehensive health service package. Another policy initiative under the service delivery component in the NHP 2011 discusses the Integrated Health Services Plan (IHSP) as the venue through
which the MOH, in collaboration with other partners, shall provide comprehensive health service packages to the population (ROB, 2011).

As listed under the objectives of the IHSP, “the goal of service delivery is the attainment of universal coverage of high-quality package of essential health services” (MOH, 2010, p.11). All of these will be achieved through the following ways:

- Scale up of utilization of a well defined and comprehensive essential health service package;
- Redefining existing service delivery levels and delineating types of health services for each of these levels of the health care to ensure continuity and harmonized referral and supervisory functions;
- Increasing and strengthening partnerships with the private sector and NGO’s;
- Community involvement to ensure effective demand for health services;
- Promoting community participation in the planning and delivery of health services (MOH, 2010, p.11-12).

All of the objectives listed above are in coherence with some of the policy initiatives that were included in the NHP 2011. For instance, objective 2 is a direct translation of the policy initiative from the NHP 2011 that discusses the availability of comprehensive health packages in mines, missions, public and private health facilities. More so, all the objectives listed above are the same as the objectives listed underneath service delivery within the Integrated Health Sector Plan (IHSP). This may speak to the consistency that exists within the MOH beyond the 2011 NHP to other health related national documents.
Continuity

Under the service delivery component of the 2011 NHP, continuity is mentioned in reference to the different levels of health care services that are provided in Botswana (RoB, 2011). Thus, referral systems will be put into consideration when addressing each level of health care delivery in Botswana; this is one of the objectives of the service delivery component. In order to achieve this continuity, one of the policy initiatives included in the 2011 NHP is the reconfiguration of the health system into five-tiers of health care delivery. The hierarchy of this health care system is as follows: “individual/family, primary health clinics/centers, primary hospitals, district/secondary hospitals, and referral hospitals” (RoB, 2011, p.23). More so, the MOH is ensuring that continuity of health care and consolidation of referral systems are included in the provision of comprehensive health packages at all health facilities in Botswana (RoB, 2011).

Another mention of continuity within the 2011 NHP comes under the Human Resources for Health component. One of the policy initiatives discusses the partnering of the MOH and other stakeholders to ensure that turnover of health workers are limited, thus, fostering continuity in the provision of health care (RoB, 2011). The next reference to continuity comes under the infrastructure aspect of the Medicines, Vaccine and Health Technologies component of the 2011 NHP (RoB, 2011). Here, continuity is not mentioned as a goal, objective, or policy initiative, rather, attention is drawn to the need to improve referral systems so that continuity of health care may be maintained.
Quality (Effective, Safe, Timely, Centered on Patient’s Need)

The goal of the service delivery component is to ensure “attainment of universal coverage of a high-quality package of essential health services” (RoB, 2011, p.23). Thus, the objectives and policy initiatives that come under this goal are assumed to be tailored towards meeting it. Some of these policies include re-arranging the levels of health service delivery in Botswana into a five-tier system, strengthening of referral systems, developing strong partnerships between the public and private sector to ensure the universal coverage of essential health services; and ensuring that comprehensive health services are provided at all health facilities in Botswana to ensure continuity in health care delivery. One of the policy initiatives under the service delivery component discusses the maximization of efficiency in the health system through the creation of Centres of Excellence by the government. These Centres of Excellence will contribute to reducing the number of referrals that are exported outside of the country, maximize the overall efficiency of the health system, and promote health tourism in Botswana (RoB, 2011).

The inclusion of patients in the delivery of health care in Botswana is discussed in the policy initiatives under the service delivery component. The Clients’ Charter is introduced in a policy initiative; a Clients’ Charter will outline the rights and responsibilities of a client in the delivery and utilization of health services. In like manner, a Providers’ Charter will entail the rights and responsibilities of health providers in service delivery and their responsibilities to the clients (RoB, 2011).
One of the objectives of the service delivery component discusses the fostering of an “effective” demand for health services within the community by involving community groups in health service delivery (RoB, 2011). More so, another objective discussed the need for community involvement throughout the process of designing to the delivery of health services. By involving the community in the design and delivery of health services, the services being delivered may be more focused on the needs of the patients. The MOH is looking to create a framework that will “effectively” include traditional/alternative medicinal methods into the health system. This policy initiative may also address the needs of patients who may be more comfortable with the traditional/alternative methods.

The establishment of Clients’ Charter helps patients and consumers of health services to better understand how to participate in their own health (RoB, 2011). The policy initiative that introduced the Clients’ Charter goes as follows, “the NHC shall establish a Clients’ Charter outlining the rights of clients to health services and in the process of health service utilisation, as well as their roles in taking responsibility for their own health” (RoB, 2011, p.18). This indicates that the provision of health care is largely centered on the individual, to the extent that they will have their own rights and responsibilities as consumers. One thing that is not discussed under the policy initiatives but is just as important is ensuring that these individuals are made aware of their rights and responsibilities.
More so, the provision of free essential health services at public health facilities takes the attention away from the disease and places it on the individual. This ensures that the majority of the population, who may not be able to afford private health care, can get access to comprehensive, essential health care that is free. One of the tiers of the health system as proposed in the 2011 NHP is the individual/family level. While there is no detail whatsoever of what these different levels of health care delivery entail, it is important to note that the individual/family was considered as a significant entity in health care delivery. This may also point to the effort of the MOH to be person/individual-centered. There however is no mention of methods through which one may analyze if users’ perceive health service delivery to be responsive and acceptable. This may be achieved through a feedback process whereby consumers are able to assert their feelings about the efficiency of health care delivery. However, helping consumers to understand their rights according to the proposed Client Charter will make it possible for them to fully contribute to health care delivery.

Coordination (Patient’s Primary Health Care Provider Facilitates Referral Systems)

In order to ensure that the primary health care provider facilitates referral systems, the MOH proposed that all primary health facility providing comprehensive health packages, foster continuity in form of a referral system (RoB, 2011). More so, the division of the health system into five tiers is systematic so that referral systems are put into consideration. The five different tiers of health care delivery that has been proposed include: “individual/family, primary health clinics/centers, primary hospitals, district/secondary hospitals and referral hospitals” (RoB, 2011, p. 18).
The plan to redefine the health system shows that there is a need to coordinate health care delivery in the health system. The 2011 NHP mentioned the strengthening of referral services with regards to the delivery of ambulatory health care services. In addition, one of the reasons for the establishment of the Centres of Excellence is to reduce the occurrence of external referrals in Botswana (RoB, 2011). In addition to the aforementioned methods that will contribute to the strengthening of referral systems, the 2011 NHP mentioned the need to enhance health infrastructure at each level of care and according to the need of the community. This will in turn ensure that there is continuity in the delivery of health services and referral systems are strengthened.

Accountability and Efficiency (Well Managed, Accountable for Overall Performance and Results)

From the language used in the 2011 NHP, it is assumed that the MOH will be responsible and held accountable for the overall performance of the health system. For example, one of the policy initiatives says that the MOH shall be responsible for defining the comprehensive list of what is considered to be essential health services and shall also be responsible for redefining the five tiers of health care delivery (RoB, 2011). The 2011 NHP makes it clear that the MOH is in charge of the management of the overall health system. Thus, it is assumed that they will be held accountable for the overall performance and results of the health system.

Conclusion

Comprehensiveness

The 2004 NHP mentioned its goal to make PHC comprehensive by providing every Nigerian with a minimum health care page (FMOH, 2004). However, the 2004
NHP failed to explicitly state what the minimum package will entail. More so, the 2004 NHP gave no breakdown regarding how comprehensive health services will be delivered. The minimum health package will be provided within the confines of available resources in the nation (FMOH, 2004). The NSHDP’s approach to providing comprehensive health care services includes strengthening of access to a universal, essential care package (NCH, 2009). More so, the NSHDP mentioned the creation of SOPs that will guide health care service delivery throughout the country (NCH, 2009). It was observed that the NSHDP omitted rehabilitative health services from its list of essential health services. The 2011 NHP discussed the scale up of the use of an essential health package that is comprehensive. The EHSP which was initiated by the MOH was introduced in the 2011 NHP. The EHSP consists of rehabilitative, preventive, curative, and promotive health care services that will be made cost effective (MOH, 2010).

**Accessibility**

The 2004 NHP addressed accessibility to health care services with regards to the national health care financing and to essential drugs. The 2004 NHP mentioned the PHC as the first point of entry but does not discuss the methods through which this will be ensured. Overall, the 2004 NHP did not thoroughly discuss proximity and accessibility to health services for Nigerian citizens. The NSHDP mentioned how GIS will be used to map out all the health facilities in Nigeria in an effort to create equal access to health care based on geographical location (NCH, 2009). Referral systems will be strengthened while health facilities will be upgraded and made to follow guidelines so that access to health care will be increased (NCH, 2009). The NSHDP did not necessarily mention how PHC facilities will continue to remain the 1st point of entry for consumers. The 2011 NHP’s
The executive summary mentioned the need to make health infrastructure accessible to people with disabilities (RoB, 2011). However, increased accessibility to health infrastructure for people with disabilities is not mentioned in the objective section. The 2011 NHP did not discuss the proximity of health facilities to the population or making the PHC the 1st point of entry. However, 95% of the rural and urban populations in Botswana live within an 8km radius of a health facility (WHO, 2014).

Coverage

The 2004 NHP discussed increased service coverage for some specific health issues and for some vulnerable populations. The NHP also stipulated that referral services should be within a 5km or 1hour travel time from users (FMOH, 2004). However, the 2004 NHP did not give a breakdown on how coverage of these specific services will be increased. The NSHDP proposed that coverage of health care should be ensured through the provision of a universal health service package and geographic equity in the distribution of health facilities (NCH, 2009). In addition, the NSHDP proposed that drugs and medical equipment are available at all levels of care and those vulnerable groups are financially protected (NCH, 2009). However, there are no provisions made for the poor or people living below the poverty line.

In the 2011 NHP, the overall goal of the service delivery component is to provide quality and essential health services with universal coverage for the whole population (RoB, 2011). Comprehensive and essential health services will be provided for free at public health facilities to all Batswana. The 2011 NHP asserted that a comprehensive health package will be available at all health facilities (RoB, 2011).
Continuity within the health system is noted in the 2011 NHP. The NHP discussed the reconfiguration of the health system into five-tiers of health care delivery. In addition to this is the consolidation of referral systems that will come with comprehensive health packages at all health facilities. Other methods that will be adopted in order to foster continuity include reducing the turnover of health workers. Overall, the strengthening of referral systems is emphasized within the 2011 NHP for the fostering of continuity within health service delivery (NCH, 2009).

Quality

One of the objectives of the service delivery component of the health system is to provide quality health services to the population (FMOH, 2004). The 2004 NHP asserted that access to quality health service is a human right that will be assured all Nigerians (FMOH, 2004). While the 2004 NHP alluded to timeliness and safety in service delivery, it does not make mention of the provision of health care that is focused on the needs of patients. The NSHDP has a list of objectives that if implemented, will contribute to improving the quality of health services. However, the NSHDP did not mention time or safety nor focus on the patient’s needs while delivering services to them. The 2011 NHP discussed some plans to increase the quality of health services being delivered through a reconstruction of the health system, strengthening of referral systems, ensuring universal health coverage, as well as a nationwide delivery of comprehensive health services.

Person-Centeredness

The 2004 NHP asserted that all Nigerians have a duty to participate in the delivery of health services in Nigeria. As a result, the government will invest in mechanisms to make this possible (FMOH, 2004). However, there was no significant
mention of health services being person-centered or mechanisms that will be used for collecting users’ feedback and putting them into consideration. In the NSHDP, community participation and ownership of the health system is emphasized. The NSHDP highlighted six objectives that will further community participation in health development (NCH, 2009). Moreover, just like the 2004 NHP, there is no specific mention of making service delivery more person-centered. The 2011 NHP discussed the involvement of the community in the process of designing and delivery of health services. This way, the services may be more focused on the needs of the individual. The Client’s Charter that is introduced in the 2011 NHP discussed the rights of clients in taking responsibility for their health (RoB, 2011).

Coordination

The 2004 NHP acknowledged the presence of weak referral systems within the health system and asserted that available resources will be targeted at the PHC so that referral systems may be improved (FMOH, 2004). In addition, priority will be given to remote locations that are especially lacking strong referral systems. Traditional health workers will be trained on making effective use of the referral systems (FMOH, 2004). In comparison to the 2004 NHP, the NSHDP acknowledged the weakness of the referral system in Nigeria. In order for them to be improved, all referral systems must follow national standards and will be subject to monitoring. Also, infrastructure that will boost the quality of referral systems will be provided (NCH, 2009). However, the NSHDP did not identify the role of the PHC in fostering the use of referral systems; neither did it further discuss the national standards for referral systems and what it would entail.
In the 2011 NHP, the RoB (2011) proposed that all PHC providing a comprehensive health package should promote continuity in the health system by making use of the referral system. The redefinition of the health system will take into consideration the need for effective referral systems. Referral systems will be strengthened with the delivery of ambulatory health services. The Centres of Excellence will also play a significant role in reducing external referrals and strengthening the referral systems. The 2011 NHP asserted the need to improve health infrastructure at each level of health care to promote continuity in health delivery (RoB, 2011).

Accountability and Efficiency

The maintenance of a high degree of efficiency and accountability within the health system is a fundamental principle of the 2004 NHP (FMOH, 2004). This is the only instance where accountability is mentioned in the 2004 NHP. In order to ensure efficiency within the health system, there will be a periodical evaluation of health development within the health system (FMOH, 2004). The NHP did not describe the process through which the evaluation will be carried out or the body that will be carrying out the evaluation. Efficiency is however mentioned in the utilization of health resources and technologies. In the NSHDP, efficiency is mentioned with regards to the overall allocation of resources at all levels of health care delivery (NCH, 2009). The “mutual accountability” clause within the NSHDP ensures that health stakeholders will be responsible for health development outcomes (NCH, 2009). In contrast, the 2011 NHP makes it clear that the MOH is in charge of the health system (RoB, 2011). Thus, it is assumed that the MOH will be held accountable for the overall performance of the health
system The 2011 NHP did not breakdown the methods by which accountability will be enforced in the health system.
Results at a Glance

Table 2

*Service Delivery*

<table>
<thead>
<tr>
<th>2004 NHP (Nigeria)</th>
<th>NSHDP (Nigeria)</th>
<th>2011 NHP (Botswana)</th>
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<tbody>
<tr>
<td><strong>Comprehensiveness</strong>&lt;br&gt;One of its goals is to make primary health care comprehensive.&lt;br&gt;This will be done through a minimum health care package. No mention of services that comprise this package.&lt;br&gt;There is no breakdown of how comprehensive health care will be made available to all Nigerians.&lt;br&gt;FGM, and the provision of quality reproductive health services.&lt;br&gt;Improving quality of human resource for health, food, drugs, vaccines, health facilities, health information and health research.&lt;br&gt;Timely release of health information and interventions for children with hearing impairments.&lt;br&gt;Safety in application of health technologies, injection safety during immunization, safe blood transfusions and safe drugs.</td>
<td>Provision of a universal essential care package.&lt;br&gt;Achieved through the strengthening of certain communicable and non-communicable package (these programs were not mentioned).&lt;br&gt;Also through adherence to the Standard Operating Procedures (SOPs).&lt;br&gt;“Essential” is used in place of comprehensive.&lt;br&gt;No rehabilitative services included in essential health package.</td>
<td>Objective 1 under service delivery component related with increasing comprehensiveness of health service package.&lt;br&gt;This will be achieved through the implementation of the EHSP.&lt;br&gt;EHSP consists of rehabilitative, preventive, curative, and promotive health care services.&lt;br&gt;EHSP does not meet all the health needs but identifies cost-effective health interventions.&lt;br&gt;EHSP ensures that health stakeholders assign their scarce resources with cost-effectiveness as an objective.&lt;br&gt;This method is better than 10% annual increment on national health budgets.</td>
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### Table 2 Continued

<table>
<thead>
<tr>
<th><strong>Accessibility</strong></th>
<th><strong>Coverage</strong></th>
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<tbody>
<tr>
<td>Appears 2 times (guiding principle for national health care financing strategy and in the provision and utilization of health care indicators).</td>
<td>Need for an increased geographic and therapeutic coverage of specific health services.</td>
</tr>
<tr>
<td>Does not mention PHC as the 1st point of entry.</td>
<td>Stipulation for referral services: (within 5km or 1hr travel time).</td>
</tr>
<tr>
<td>Does not discuss methods through which this will be made possible.</td>
<td>No detailed breakdown on how increased coverage will be achieved.</td>
</tr>
<tr>
<td>Mentions the need to create equal access to health care based on geographical location.</td>
<td>Availability of drugs and equipment of all levels of care.</td>
</tr>
<tr>
<td>Achieved through the use of GIS.</td>
<td>Provision of financial access.</td>
</tr>
<tr>
<td>Upgrade of pre-existing health facilities.</td>
<td></td>
</tr>
<tr>
<td>Health facilities will be made to follow guidelines surrounding access to health care.</td>
<td></td>
</tr>
<tr>
<td>No mention of PHC remaining 1st point of entry.</td>
<td></td>
</tr>
<tr>
<td>Strengthening of referral systems.</td>
<td></td>
</tr>
<tr>
<td>Make health infrastructure accessible to people with disabilities.</td>
<td></td>
</tr>
<tr>
<td>No breakdown of methods through which this will be done.</td>
<td>Providing universal coverage for essential health services.</td>
</tr>
<tr>
<td>No mention of ensuring that health facilities remain the first point of entry.</td>
<td>Collaboration with private sector and NGOs for the provision of essential health services to the whole population.</td>
</tr>
<tr>
<td>However, 95% of both rural and urban populations live within 8km of a health facility.</td>
<td>Provision of free, comprehensive essential health services at all public health facilities in Botswana.</td>
</tr>
<tr>
<td>Treatment for diseases considered as threat to public health will be provided at no cost.</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity.</strong></td>
<td>Referral system strengthening.</td>
</tr>
<tr>
<td>Well-functioning referral system through the allocation of health resources according to their needs.</td>
<td>Acknowledges the presence of weak referral systems in the country which diminishes the continuum of care.</td>
</tr>
<tr>
<td>Priority will be given to severely-underserved areas.</td>
<td>Referral system strengthening by: ensuring an efficient 2 way referral system; ensuring the availability of logistical infrastructure to enable effective referrals.</td>
</tr>
<tr>
<td>Traditionalists trained in using referral systems.</td>
<td>Mechanisms to monitor referral services.</td>
</tr>
<tr>
<td>Measuring coverage of referral systems according to proportion of population that lives within a 5km or 1hr travel time to referral facility; proportion of referred patients that receive care at referral facilities; number of referral services that are actually available at referral facilities.</td>
<td>Provisions for traditional health workers to be trained on how to utilize referral systems.</td>
</tr>
<tr>
<td>Indicators shall measure the proportion of 2 way referrals that occur.</td>
<td>Comprehensiveness health package made available at all health facility.</td>
</tr>
</tbody>
</table>

| **Quality** | Strengthening of professional regulatory bodies and institutions. |
| Access to quality health care as a human right for all Nigerians. | Development and institutionalization of a quality assurance model. |
| Attain quality health care through achieving health related MDGs, elimination | Re-arranging the levels of health service delivery. |

| | Reconfiguration of health care system into 5 tiers; one of which will be referral systems. |
| | Continuity of health care and consolidation of referral systems are included in the provision of comprehensive health package at all health facilities. |
| | Reduction in turnover of health workers to foster continuity in care. |
| | Improving health infrastructure to ensure continuity. |
| | Partnership between public... |
Table 2 Continued

<table>
<thead>
<tr>
<th>Human resource for health, food, drugs, vaccines, health facilities, health information and health research.</th>
<th>Improving quality of human resource for health, food, drugs, vaccines, health facilities, health information and health research.</th>
<th>Improving quality of human resource for health, food, drugs, vaccines, health facilities, health information and health research.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance of health equipment and facilities.</td>
<td>Strengthening of referral systems.</td>
<td>No specific mention of timely delivery of health service that is safe and centered on patients’ needs.</td>
</tr>
<tr>
<td>Health Management and Integrated Supportive Supervision (ISS).</td>
<td>Safety in application of health technologies, injection safety during immunization, safe blood transfusions, safe drugs, water and food.</td>
<td>Safety in application of health technologies, injection safety during immunization, safe blood transfusions, safe drugs, water and food.</td>
</tr>
<tr>
<td>No specific mention of providing care that is centered on the needs of patients.</td>
<td>No specific mention of providing care that is centered on the needs of patients.</td>
<td>No specific mention of providing care that is centered on the needs of patients.</td>
</tr>
<tr>
<td>Health Management and Integrated Supportive Supervision (ISS).</td>
<td>Policy framework that provides direction towards community participation.</td>
<td>Policy framework that provides direction towards community participation.</td>
</tr>
<tr>
<td>Maintenance of health equipment and facilities.</td>
<td>Framework for enhancement of community involvement in planning, management, and evaluation of health interventions.</td>
<td>Framework for enhancement of community involvement in planning, management, and evaluation of health interventions.</td>
</tr>
<tr>
<td>Strengthening of referral systems.</td>
<td>Empowering community with health knowledge and resources to participate in community level health care.</td>
<td>Empowering community with health knowledge and resources to participate in community level health care.</td>
</tr>
<tr>
<td>No specific mention of timely delivery of health service that is safe and centered on patients’ needs.</td>
<td>and private sectors to ensure universal coverage of essential health services.</td>
<td>and private sectors to ensure universal coverage of essential health services.</td>
</tr>
<tr>
<td>Involving community groups in design and delivery of health services.</td>
<td>Designing a method of effectively include traditional medicinal methods into the health system.</td>
<td>Designing a method of effectively include traditional medicinal methods into the health system.</td>
</tr>
<tr>
<td>Clients’ Charter.</td>
<td>Provision of free essential health services at public</td>
<td>Provision of free essential health services at public</td>
</tr>
</tbody>
</table>
Table 2 Continued

<table>
<thead>
<tr>
<th>No mention of users’ perception of health services being delivered.</th>
<th>activities.</th>
<th>facilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and strengthen links between health structures and the community within which they exist.</td>
<td>Creating a framework for measuring the level of community involvement in the health sector.</td>
<td>No method through which users’ perception of health service may be analyzed.</td>
</tr>
<tr>
<td>Map out network linkages for a two-way referral system done according to national standards.</td>
<td>Availability of resources like transportation and communication for successful referral systems. Monitoring outcomes of referral systems.</td>
<td>All primary health facility providing a comprehensive package must facilitate referral system.</td>
</tr>
<tr>
<td>No mention of primary health care provider facilitating referrals.</td>
<td>No details on the “national standards” and there might be a need for creating one.</td>
<td>Strengthening referral systems with regards to the delivery of ambulatory services.</td>
</tr>
<tr>
<td>Accountability and Efficiency. Maintenance of a high degree of efficiency and accountability within the health system. Accountability mentioned once.</td>
<td>Efficiency mentioned four times.</td>
<td>MOH accountable and responsible for overall performance of health system.</td>
</tr>
<tr>
<td>Most relevant mention is the allocation of resources at all levels of health delivery.</td>
<td>No further discussion of how accountability and efficiency will be ensured.</td>
<td></td>
</tr>
<tr>
<td>Table 2 Continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No breakdown of methods by which accountability will be ensured.</td>
<td>Evaluation of health development strategy to ensure its efficiency.</td>
<td>No significant mention of efficiency in relation to the overall performance of the health system.</td>
</tr>
</tbody>
</table>
CHAPTER 5: RESULTS-HEALTH FINANCING

This chapter will discuss findings regarding the incorporation of health financing into the 2004 NHP and NSHDP for Nigeria, and the 2011 NHP for Botswana. The themes that will be analyzed for health service delivery within the a-forementioned documents include raising sufficient funds for health, improving financial risk protection and coverage for vulnerable groups, improving efficiency of resource utilization, and improving financial transparency and management of operational levels.

Health Financing in Nigeria: Reviewing the 2004 NHP

*Raising Sufficient Funds for Health*

In Nigeria, public funds for health is less than $8 per capita, making private expenditure on health to be more than 70%. The internationally recommended public fund on health is $34 per capita (FMOH, 2004). The NHP acknowledges that health financing strategy in Nigeria is weak and this is propagated by the lack of partnerships with the private health care, corruption within the health care system, and the inefficient management of existing health resources (FMOH, 2004). The strategies listed in the 2004 NHP in other to gather sufficient health funds include:

- Giving high priority to primary healthcare especially in underserved areas.
- Mobilization of community and financial sector resources so that the resources allocated to health care will be in line with international standards.
- Using extra resources within the economy to cater for primary health care that are of high priority.
- Ensuring that promotive and preventive health services have equal financial inputs as curative services.
• Applying health insurance schemes and levies to ensure finances for health
development. Employers shall be encouraged to provide health insurance for their
employees.

• Ensuring that consumers pay for curative services but get preventive services at a
subsidized rate while economic and socially challenged populations get assisted. The
type of assistance that will be given too these populations and how the assistance will
be organized is not specified.

• Private health practitioners serving under-served areas will be given incentives in the
form of tax breaks.

• Communities will be encouraged to participate in health development either through
contribution of financial aid, labor, or materials.

• Continued studies to observe the effectiveness of health programs in relation to their
costs and revenues.

• Periodical review of the national health financing strategy will be promoted through
the creation of a national health account (FMOH, 2004).

The 2004 NHP comprehensively discussed the sources of financial funds for the
sustenance of the health system. It should be noted that all the financial sources named
are all from within the country and no external sources were mentioned.

Improving Financial Risk Protection and Coverage for Vulnerable Groups

The 2004 NHP referred to the provision of public assistance to socially and
economically disadvantaged groups that may not be able to afford health services
(FMOH, 2004). The exact nature of this assistance is not specified. More so, the NHP
proposes that the federal government grants tax incentives to private practitioners that
will choose to establish health care services in under-served parts of the country (FMOH, 2004).

**Improving Efficiency of Resource Utilization**

Efficiency in the use of resources is promoted in some of the strategies that are named for financing the health care system. The 2004 NHP discussed the idea of allocating resources to the health sector according to standards that are internationally recommended (FMOH, 2004). Efficiency in the use of resources is one of the guiding principles for the development of the national health care financing strategy (FMOH, 2004). More so, consideration will be given to programs within the primary health care that are considered of high priority. High priority health care programs will be determined through a continuous study of these programs within the context of their costs and the revenue they accrue (FMOH, 2004). The focus on promotive and preventive health without taking away from curative health is also another way that the health system is ensuring efficiency in resource utilization. However, the 2004 NHP does not elaborately discuss efficiency in the allocation and use of health finances and resources.

**Improving Financial Transparency and Management of Operational Levels**

The 2004 NHP acknowledged the culture of corruption that is in existence within the health system and the ineffective management of limited health resources. However, there are no highlighted steps on how to deal with corruption and ineffective management within the health sector.
Reviewing Health Financing in the NSHDP Framework

_Raising Sufficient Funds for Health_

The current health care system in Nigeria is financially sustained from a variety of sources that include public, private, external, and out-of-pocket (NCH, 2009). Despite these various sources of funding, the NSHDP noted the need for increased sources of funds for the health sector. In order to secure funding for the health sector, the NSHDP framework proposes a number of objectives. These objectives are as follows:

- Ensure that all levels of government increase their allocation of public resources to the health sector. This allocation will be 15% of their total budget as was proposed by African leaders at the Abuja Declaration.

- The federal government will assist both local and state government in drawing financial resources from other sources within the economy. These sources include taxes on alcohols and cigarettes as well as donations from charities.

- Promote the coordination of donor funding in the context of health development in Nigeria. This will be carried out through the implementation of the Paris declaration on aid effectiveness and the Accra agenda (NCH, 2009).

The NSHDP did not specify how the federal government will ensure that the local and state governments are contributing 15% of their budget to the health sector. More so, consideration is not made for the impact this will have on other sectors of the economy that have been utilizing these funds. The NSHDP also lacks any clause discussing how external or donor funding will be regulated by the federal government with regard to the interests of the donors versus the existing need.
Improving Financial Risk Protection and Coverage for Vulnerable Groups

In order to improve financial protection for vulnerable groups, the NSHDP framework proposed the creation of financial risk protection methods within the health system. This will be achieved through the promotion of social health protection schemes like insurance. The federal government will technically assist the other levels of government in implementing successful health protection approaches on a larger scale. In the exploration of alternative public sources for funding the health sector such as taxes, consideration will be made for the impact of this on poor and vulnerable groups (NCH, 2009).

Improving Efficiency of Resource Utilization

One of the objectives of the NSHDP is to ensure that health resources are allocated and utilized with equity and efficiency. Thus, the NSHDP suggested that the federal government provides assistance to the state and local government in the creation of cost effective annual budgets. The development of capacities will ensure that financial expenses are recorded and financial reports are produced periodically. Primary and secondary health care services will be trained in efficient ways of managing their financial systems (NCH, 2009). All of the measures above address the need for efficiency within the primary and local health care levels. The tertiary health care level controlled by the federal government is conspicuously omitted from all of the above measures. Also, the NSHDP framework did not thoroughly discuss details about the process of developing capacities for bookkeeping within the health system.
Improving Financial Transparency and Management of Operational Levels

The NSHDP does not thoroughly discuss measures of ensuring financial transparency within the health system. In order to ensure transparency in the health sector, the NSHDP framework proposes that Health Accounts should be developed at both the National and State levels (NCH, 2009). Other measures of ensuring overall transparency and accountability within the health system are discussed under the leadership and governance component. The creation of Health Accounts should not be limited to the National and State levels but should also be established on the Local level as well. This will ensure the implementation of maximal levels of transparency within the health system. More so, consequences for inconsistencies within the health accounts need to be enforced.

Health Financing in Botswana: Reviewing the 2011 NHP

Raising Sufficient Funds for Health

The overall goal of the health financing component in the 2011 NHP is the raising of sufficient funds in the health system so that people of all economic status will have access to health care (RoB, 2011). The very first objective also discussed the need to raise sufficient funds so that sustainability may be achieved in the way health services are provided to the general population. One of the policy initiatives that will assist in achieving this objective is the proposed creation of a financing strategy by the MOH. This financing strategy will help in directing the finances of the health system. Although the policy mentions the creation of a health financing strategy, there is no mention of sources where finances will be recurred. More so, there is no mention of how national revenue, and if any, what percentage, will contribute to the overall health system.
There are a number of policy initiatives that work towards improving the financial risk protection and possible coverage for vulnerable groups/individuals. The first includes the objective to ensure that there is the availability of funds for the essential health service package (EHSP). This is also included in the policy initiative so that the EHSP will be available at no cost to the population of Botswana. As pointed out under the service delivery component, this service will be made free at public health facilities in Botswana, but will be offered at a charge within the private facilities (RoB, 2011). Ensuring that these essential health services are free at the public health facilities will remove their financial burden on the Botswana population, especially those of low income and socio-economic status. In addition to the provision of free EHSP at public health facilities, one of the policy initiatives asserted that the MOH will take up partial responsibility for the cost of other services that are not stated within the EHSP. This however, will be dependent on the availability of financial resources (RoB, 2011). One of the policy initiative notes the intention of the MOH to increase government’s funding of the health system to 15% of the national budget as per the Abuja Declaration (RoB, 2011). With the government bearing more of the financial responsibility within the health system, the financial burden on citizens should significantly reduce.

Improving Efficiency of Resource Utilization

Improved efficiency in the management of funds within the health system was mentioned as an objective. This efficiency is considered in both the acquisition and utilization of funds for health development. Another objective under the Health Financing component that suggests the efficient use of health resources is the fourth objective. This
objective proposes a consistent review of the different levels of health care in order to
adequately determine their financial needs (RoB, 2011). This objective is accompanied
by a policy initiative that suggests that the MOH will ensure that the financial needs of all
health care level will be met through a consistent review of financial revenue sources.
Another policy initiative suggests efficiency in the utilization of financial resources by
suggesting the alignment of donor support with the actual needs of the health sector.
Overall, the MOH will be responsible for consistently reviewing the distribution of
resources amongst all health parastatals so that they may all have access to adequate
resources for optimum functioning (RoB, 2011).

Improving Financial Transparency and Management of Operational Levels

With regards to the improvement of financial transparency in the health system,
there is no explicit mention of this under the health financing component in the 2011
NHP. Although the periodical review of revenue sources and their equitable allocation to
the different health care levels may be considered a form of transparency, it is not
followed up by means of ensuring accountability in the way these financial resources are
utilized. The improvement in the management of operational levels is indirectly
suggested through the creation of a financial strategy by the MOH and ensuring that there
are periodical reviews of the financial resources available to all sectors within the health
system. In the 2011 NHP, transparency is only mentioned once in the whole document.
The one time mention of transparency appears underneath the leadership and governance
component and is mentioned in reference to what health governance refers to.
Conclusion

*Raising Sufficient Funds for Health*

Public fund for health in Nigeria is $8 per capita, significantly lower than the internationally recommended $34 per capita, annually (FMOH, 2004). The 2004 NHP acknowledged that the national health financing strategy is weak as a result of corruption, lack of partnerships within the private health sector, and inefficient management of health resources (FMOH, 2004). The NHP listed 10 strategies that will be adopted towards gathering sufficient funds within the health system. All the financial sources named within the 2004 NHP were domestic with no mention of external sources. The NSHDP proposed a number of objectives in order to increase sources of funding for the health sector. The first includes that all levels of government allocate 15% of total budget to health; local and state government drawing financial resources from other sectors within the nation; and coordinating donor funding in Nigeria (NCH, 2009). Although the NSHDP lists all these strategies, there are no specifications as to the measures that will be utilized by the federal government to ensure state and local governments invest 15% of their budget into the health sector. Consideration is not made for other sectors within the nation that will receive lesser funding as a result of this. More so, the NSHDP did not discuss how the federal government will deal with conflict of interest with donors.

*Improving Financial Risk Protection and Coverage for Vulnerable Groups*

The 2004 NHP addressed the provision of public assistance to socially and economically disenfranchised people (FMOH, 2004). However, the nature of this assistance is not specified. Another method of protecting vulnerable groups is through granting private practitioners tax incentives so that they may establish health care
services in under-served parts of the country (FMOH, 2004). The NSHDP proposed the creation of financial risk protection schemes by promoting financial protection schemes like insurance, others levels of government receiving technical assistance, and state and local government exploring other public sources of funds for the health sector (NCH, 2009). In the 2011 NHP, financial risk protection and coverage for vulnerable groups will be fostered by ensuring the availability of funds for the EHSP so that they can be free. The 2011 NHP highlighted that the MOH will be taking up partial financial responsibility for other health services not included in the EHSP (RoB, 2011).

**Improving Efficiency of Resource Utilization**

In the 2004 NHP, efficiency in the use of resources will be executed through adherence to internationally recommended standards on the allocation of resources within the health sector. Efficiency in the use of resources was one of the guiding principles of the national health care financing strategy. Programs considered to be of high priority will be considered first in the allocation of resources (FMOH, 2004). More so, will be put on promotive and preventive health care without taking attention away from curative care. One of the objectives of the NSHDP is ensuring equity and efficiency in the allocation and utilization of health resources (NCH, 2009). In order to achieve this, the NSHDP suggested methods by which the federal government may provide technical assistance to other levels of government. However, there are no measures on how efficiency will be fostered on the tertiary health care level which is controlled by the federal government. The 2011 NHP has an objective to improve efficiency in the management of funds within the health system. A consistent review of the different levels of health care in relation to revenue sources in order to properly allocate resources was...
also suggested. Just as stated in the NSHDP, the 2011 NHP suggested that efficiency may be fostered in the health system through the alignment of donor support with national health needs (NCH, 2009; RoB, 2011).

*Improving Financial Transparency and Management of Operational Levels*

While the 2004 NHP acknowledged the culture of corruption within the Nigerian health system, there is no discussion of measures to address this. To ensure transparency in the health sectors, the NSHDP proposed the creation of a national health account on the national and state levels of health care (NCH, 2009). The 2011 NHP did not explicitly mention financial transparency within the health system.
## Results at a Glance

### Table 3

**Health Financing**

<table>
<thead>
<tr>
<th>2004 NHP (Nigeria)</th>
<th>NSHDP (Nigeria)</th>
<th>2011 NHP (Botswana)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Raising sufficient funds for health.</strong>&lt;br&gt;Acknowledge that health financing is weak, propagated by lack of partnerships with the private health care, corruption within the health care system, and the inefficient management of existing health resources.</td>
<td>Ensuring that all levels of government increase their allocation of public resources to the health sector.</td>
<td>• Creation of a financing strategy by the MOH that will help to direct finances of the health system.</td>
</tr>
<tr>
<td></td>
<td>Drawing financial resources from other sources within the economy.</td>
<td>• No mention of potential sources of funds.</td>
</tr>
<tr>
<td></td>
<td>Coordinate donor funding.</td>
<td>• No mention of how national revenue, and what percentage will contribute to the overall health system.</td>
</tr>
<tr>
<td></td>
<td>No mention of how the Federal government will ensure local and state governments are contributing 15% of their budget to the health sector.</td>
<td>Availability of funds for the EHSP.</td>
</tr>
<tr>
<td><strong>Improving financial risk protection and coverage for vulnerable groups.</strong>&lt;br&gt;Provision of public assistance to socially and economically disadvantaged groups.</td>
<td>Promotion of social health protection schemes like insurance.</td>
<td>MOH will bear partial financial responsibility for other health services not included in EHSP depending on availability of financial resources.</td>
</tr>
<tr>
<td></td>
<td>Federal government will technically assist the other levels of government in implementing health protection approaches on large scales.</td>
<td>Government funding of the health system to be increased to 15% of the national budget as per the Abuja Declaration.</td>
</tr>
<tr>
<td></td>
<td>The exact nature of this is not specified.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tax incentives for private practitioners that choose to establish health care services in under-served parts of the country.</td>
<td></td>
</tr>
</tbody>
</table>
Table 3 Continued

<table>
<thead>
<tr>
<th>Improving efficiency of resource utilization.</th>
<th>Health services allocated and utilized with equity and efficiency.</th>
<th>Efficiency in the acquisition and utilization of funds.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency in health financing strategy and use of resources.</td>
<td>Federal government provide assistance to state and local government to create cost effective annual budgets.</td>
<td>Consistent review of different levels of health care to determine financial needs.</td>
</tr>
<tr>
<td>Allocating resources to the health sector according to standards that are internationally recommended.</td>
<td>Financial book keeping; primary and secondary health care levels trained on managing their financial systems efficiently.</td>
<td>Aligning donor support with the actual needs of the health sector.</td>
</tr>
<tr>
<td>More consideration for programs considered to be of high priority.</td>
<td>No mention on how efficiency will be maintained on the tertiary level.</td>
<td>MOH consistently reviewing distribution of resources to all health parastatals so that they may all have access to adequate resources.</td>
</tr>
<tr>
<td>More focus on promotive and preventive health without taking away from curative health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No thorough breakdown of how efficiency will be ensured in allocation of health finances and resources.</td>
<td></td>
<td>No explicit mention of improving financial transparency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving financial transparency and management of operational levels.</th>
<th>Development of health accounts at both national and state levels.</th>
<th>No mention of ensuring accountability with resource allocation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement of corruption and ineffective management of limited resources.</td>
<td>No mention of creation of health accounts on the local level.</td>
<td>Periodical review of revenue sources.</td>
</tr>
<tr>
<td>No steps on how to deal with corruption and the ineffective management of resources.</td>
<td>No mention of consequences for inconsistencies within the</td>
<td></td>
</tr>
<tr>
<td>health accounts.</td>
<td>Equitable allocation of resources to different health care levels.</td>
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<td>-----------------</td>
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</tr>
</tbody>
</table>

Table 3 Continued
Reviewing Leadership and Governance for Health in Nigeria

While the 2004 NHP extensively mentioned collaboration between health stakeholders in Nigeria, there is evidence that collaboration is weak within some areas. Adeleye and Ofili (2010) discussed the lack of inter-sectoral collaboration with regards to health issues in many developing countries, most specifically, Nigeria. They noted that there has been no intersectoral effort in Nigeria, to provide potable water to the masses, despite the reoccurrence of cholera epidemics in the country. Obionu (2007) also identified the lack of intersectoral collaboration between the health and industrial sectors in Nigeria. Abimbola (2012) has identified a lack of coordination and collaboration between the three tiers of government in efforts to strengthen PHC in Nigeria. There is need for the Federal and State government to help the local government in the strengthening of PHC that is considered the foundation of a health care system (WHO, 2008).

It could be difficult to measure the performance of a government using its ability to create and enforce regulations. This is because creating regulations does not necessarily translate into their enforcement, more so, in the case where they are enforced, they may rather be detrimental to the health system. Health regulations may also become so complex that they serve as constraints to getting things done within the health system as acknowledged by Field (2008). Considering that the 2004 NHP has not been officially approved, this may be considered as a weakness on the part of the Nigerian government when it comes to implementing policies and regulations. The Nigerian National Health Bill, although mentioned in the 2004 NHP (referred to as the National Health Act), was

The delay in passing the health bill has been attributed to a lack of consensus between involved health stakeholders, the Health Minister’s increased bureaucratic power, the discrepancy in the treatment of doctors versus health workers, and the source of funds for implementing the content of the bill (Akinloye, 2013). But also important to note was a cause of delay that was brought about by clause 51 of the health bill. This clause supposedly utilized vague language in describing the donation of embryos and genetic materials, thereby leaving room for a breach of human rights (Akinloye, 2013). The President of the Nigerian Medical Association, Osahon Enabulele, asserted the dire need for quickening the process of passing the bill (Akinloye, 2013). Umeokafor, Isaac, David, and Umeadi (2014) found that barriers to enforcing Occupational Safety and Health Regulations in Nigeria included bribery and corruption, a lack of commitment from government, insecurity, a lack of adequate legislation, and political influence.

Muhondwa, Nyamhanga and Frumence (2010) attributed the high vulnerability of the Nigerian health system to corruption, to the large number of stakeholders involved and difficulty in dispersing health information. Some of these reasons were further reiterated by Hussmann (2006) who attributed the occurrence of corruption within the health system to the presence of high levels of uncertainties, unequal distribution of information among health stakeholders (e.g, pharmaceutical companies, health care providers etc), and large numbers of health stakeholders. This corruption comes as a result of a high demand for health care services and low levels of information accessibility for health care consumers (Kamorudeen and Bidemi, 2012). This level of
corruption whereby the public is manipulated due to their lack of information on national health expenditure is an example of a lack of external accountability discussed by Cleary et al., (2013).

There are various instances within the NHS where corruption has been recorded. A news outlet, Premium Times, identified some of the corrupt practices within the NHS that are hindering the achievement of the Millennium Development Goals (MDGs) (Premium Times, 2014). The NHS was granted N21.3bn, N16.7bn, and N16.9bn, in 2006, 2007 and 2008 respectively for the purpose of achieving the health MDGs 4, 5, and 6. Most of these funds were allegedly stolen by health officials while the remainder was mismanaged (Premium Times, 2014). Fagbadebo (2007) has also noted the deleterious effects of corruption, which leads to the gradual collapse of a system. The type of corruption noted in the Premium Times (2014) article is one that has come about as a result of the lack of both bureaucratic and external accountability.

Reviewing Leadership and Governance for Health in Botswana

The 2011 NHP largely emphasized local collaboration within the health system, but not a lot of international cooperation or dependency. When international collaboration was emphasized, it was so that national independence may be achieved with regards to the national production of health resources. The leadership and governance theme within the NHP does not elaborately discuss collaboration and coalition, but embedded within the NHP itself are several references to inter-sectoral and, minimally, international collaboration.

The mission of the Ministry of Defence, Justice and Security’s (MDJS) is to: “provide safety, protection and promote human rights and rule of law through effective
implementation of relevant national policies and programmes to achieve national peace and tranquility” (RoB (b), 2011). This definition insinuates that the MDJS is responsible for enforcing and implementing national policies, including health policies, in Botswana. The departments that are in the MDJS include the following: Botswana Prison Service, Administration of Justice, Attorney General’s Chambers, Botswana Police Service, and Botswana Defence Force (RoB (b), 2011). There are no clear cut specifications of which department is responsible for ensuring the efficient implementation and adherence to health regulations. As a matter of fact, the MDJS is the national court system in Botswana, whose duty is to ensure security and justice for all (RoB, 2011). Thus, although the 2011 NHP refers to the MDJS as the agency that ensures the enforcement of health regulations, there is no explicit mention of this duty on the MDJS’s website.

The website of Botswana’s MOH breaks down the regulatory services provided within the health system into six categories which include:

- Drug Regulatory Services
- Health Inspectorate
- Health and Allied Professionals Council
- Licensing of Private Practice: this is carried out by the MOH
- Food Control: this is also carried out by the MOH.
- Nursing and Midwifery: regulation of this service is carried out by the Botswana Nursing Council (MOH, 2014).

From the above, it may be deduced that the regulation of health services in Botswana is not carried out by just one agency. It is rather a responsibility that has been divided amongst a number of concerned agencies whose responsibilities are to regulate
the provision of the named service. The overall health sector in Botswana is operating under the Public Health Act but there are other Acts regulating the provision of health services. For instance, the Medical, Dental and Pharmacy Act enforces that health professionals be accredited by health councils. More so, the Drug Regulation Services follow the provisions provided by the Drugs and Related Substance Act for the control of medicine and other related substances (MOH, 2014).

The clarification of health stakeholder roles is a topic that is extensively discussed in the “Integrated Health Service Plan (IHSP): A Strategy for Changing the Health Sector for Healthy Botswana 2010-2020”. One of the goals of the IHSP is in relation to Health Information and Research and one of the objectives underneath this is to clarify the roles of health partners that handle health data so as to avoid duplication and promote the use of these data (MOH, 2010). The document further discussed the different strategic actions that will be taken to ensure role clarification. Some of these strategic actions include the description of duties, and the development of human resources as required, amongst others. The Leadership and Management goal of the IHSP includes the clarification of stakeholder roles as one of its objectives (MOH, 2010). However, there are no specifications on what roles need to be clarified, and the particular sector within which this will be carried out. With regards to the creation of a NHC, Botswana has begun plans to establish the council that will manage all the activities occurring within the health sector (WHO, 2014).

The Botswana government’s effort to provide people-centered health care is asserted in the 2011 NHP. This was seen in the improvement of six health facilities that were made just to meet the needs of both the consumers and health workers themselves.
(WHO, 2014). More so, systems for community ownership are promoted within the health sector. Community ownership and participation in the health sector are fostered through the presence of traditional chiefs, village development/health committees, and the community home-based care committees (WHO, 2014). The functions of some of these bodies are as follows:

- Traditional Chiefs: they are responsible for relaying development decisions made by community members, to the available local authority. Decisions are made during an open community session and governments also engage with community members through these sessions. These sessions are locally referred to as “dikgotia” and they play a significant role in ensuring that consumer feedback gets to decision makers. More so, government policies may be disseminated to civilians through this process (WHO, 2014).

- Village development committees: acts as a liaison between villagers and the local authority. This committee communicates the needs of the villagers to local authorities (WHO, 2014).

- Village health committees: these are similar to the development committee with the only difference being that they are focused on health development (WHO, 2014).

- Community Home-Based Care (CHBC): this type of care has been in existence in Botswana since the early 1990s and is assumed to be a system whereby the burden of health care is on the health facilities, and communities (Mathebula, 2000; WHO, 2000).
On the civil level, there is the existence of the Botswana Council of Non-Governmental Organizations (BOCONGO) while the private sector has the Confederation of Commerce, Industry and Manpower (BOCCIM). These organizations frequently communicate their concerns about the health sector to the government (WHO, 2014). The BOCONGO, a national body for all non-governmental organizations in Botswana, was established in 1995 (Trickle Out Project, 2014). BOCCIM is an association that protects the interests of employers within all sectors in Botswana. This organization, formed in 1971, majorly represents the voice of employers within the private sector in Botswana. The method of communication with the government is through constructive policy dialogues (BOCCIM, 2011). One of the major achievements of BOCCIM includes the initiation of dialogues for the creation of the “A Long Term Vision for Botswana” document, otherwise known as vision 2016 (BOCCIM, 2011). This document makes significant contributions to plans for health development in Botswana.

Health Partners- Southern Africa is an organization that is assisting in the creation of the Botswana Health Inspectorate strategic plan (Health Partners, 2011). The strategic plan that will be created will include:

- Overarching goals, objectives, and mission of the Health Inspectorate.
- The plan for implementing the Health Inspectorate which is supposed to last 5 years.
- The method through which the plan will be undertaken
- A monitoring and evaluation component to observe the implementation process.
- A workforce to undertake the many components of the implementation process (RoB, 2011).
One of the identified challenges with the delivery of primary health care services in Nigeria is the neglect of the needs of people in the rural areas (Abdulraheem, Olapipo, and Amodu, 2012). This neglect comes as a result of limited health workers in the rural as compared to the urban areas, the challenge of transportation, and gaps in the knowledge of rural health workers, amongst others (Abdulraheem et al., 2012). A World Bank (2010) assessment of health care delivery in Nigeria indicated that health outcomes and the use of health care in the country are low and significantly vary throughout the country. Low health outcomes in the Northern part of the country are attributed to the incidence of higher levels of poverty and income inequality in these parts as compared to other parts of the country (World Bank, 2010). The organization of PHC with regards to the number of health posts, basic health centers, comprehensive health centers and hospitals, vary across states (World Bank, 2010). More so, the state of health facilities and equipment within these facilities vary across states as a result of location within the urban area or private ownership. Ademiluyi and Aluko-Arowolo (2009) have attributed the skewed distribution of health care facilities to an inheritance from the colonial era.

The colonial era saw the urban areas having more health facilities because of the caliber of people who lived there as compared to the rural areas. Ademiluyi and Aluko-Arowolo (2009) noted that a larger proportion of the Nigerian population actually lives in the rural areas, hence the need to create equality in the distribution of health facilities. Referral systems have remained considerable weak as a result of constraints with transportation. To address this issue, the federal government aimed to provide all wards with a Ward Minimum Health Care package by 2012. Included in this package is a
vehicle for health facilities that provide Basic Emergency Obstetric Care (BEOC). Meanwhile, only 36% and 12% of health centers and health posts/dispensaries respectively, have access to a vehicle for referral purposes (World Bank, 2012). Nigeria remains greatly challenged with the availability of health workers, availability of pharmaceuticals, and limited availability of a variety of services, amongst others, within the PHC (World Bank, 2010). Anyika (2014) has shown how specific types of uncertainties present in Nigeria interact with the health system and thus, negatively influence health delivery. Some of the identified uncertainties include: i. consecutive strikes by health workers both at the state and national levels, ii. Inefficiency and lack of transparency in the appointment of chief executive officers for public hospitals iii. Limited experience of private general practitioners iv. High operational costs of hospitals leading to high cost of health care v. infrastructural challenges vi. Lack of essential pharmaceuticals and vii. Corruption within the health system that also fosters the availability of inferior drugs, amongst other negative impacts (Anyika, 2014). All of the listed uncertainties have been identified as significant challenges to establishing a sustainable health care delivery system in Nigeria.

Reviewing Health Service Delivery in Botswana

Using the WHO Health System Performance Assessment Framework (HSPA F), Seitio-Kgokgwe, Gauld, Hill, and Barnett (2014) evaluated the performance of the Botswana public hospital system. This framework was provided in accordance with what the WHO (2007) refers to as the six building blocks of a health system. The researchers used the service delivery component of the WHO HSPA F to evaluate health delivery services in Botswana. The four areas that were particularly evaluated included:
organization and governance in health delivery, the quality of the service being delivered, the availability of health services, and the capacity of health service delivery. At the organization and governance level, heavy centralization of the health system was found to be a challenge, raising questions regarding the effectiveness of supervision of health service delivery. Centralization within the system was also responsible for the little control that hospital managers have in prioritizing health issues for funding and sometimes in the deployment of staff. Concerns were raised about the management of hospitals, drawing attention to the fact that management of hospitals in Botswana is often the responsibility of doctors. At other times, management of hospitals is carried out by people who have not been professionally trained for the position. Concerns were shown for the unspecified job description of both hospital managers and superintendents alike.

With regards to the availability of health services, there has been a remarkable increase in the proportion of the population, living within a 5km radius to a health facility, now 84% (Central Statistics Office, 2007). This figure used to be at 15km radius for 88% of the population (Ministry of Finance and Development Planning (MFDP), 1997). In 2006, 89% of the rural population of Botswana, and 95% of the total population lived within 8km of a health facility (WHO, 2014). However, there is disparity in these figures with regards to rural versus urban areas. While 72% of the rural population in Botswana lives within a 5km radius of a health facility, this figure is significantly higher at 96% for the urban population (CSO, 2007).

Despite this increased access to health facilities, participants in Seitio-Kgokgwe et al’s (2014) study noted the need for patients to travel long distances to hospitals that have the medicine they need. Thus, the availability of health facilities does not mean access is
completely guaranteed. In their study, Seitio-Kgokgwe et al. (2014) found that although there has been no increase in the number of hospitals in Botswana since 2000, some rural areas in Botswana still suffer from a lack of available health care centers. While Botswana continues to upgrade existing health facilities, only 22%, 5% and 14% of the populations of Boteti, Kweneng West, and South East respectively, live within a 5km radius of a health facility (Seitio-Kgokgwe et al., 2014).

According to the MOH (2008), bed occupancy rate in Botswana increased from 3,572 beds in 1998 to 5,013 in 2010; thus, the bed/population ratio in Botswana is 27.9 beds/population. While this figure represents the national average, there are parts of Botswana that record an average of 6.6 beds/10,000 population. More so, some hospitals still struggle with bed 61 occupancy rates as high as 222% (Princess Marina) (Statistics Botswana, 2012). Another major concern within the realm of service delivery in Botswana is the lack of lower level facilities situated around referral hospitals, thus referral hospitals are found providing these services (MOH, 2009).

With regards to service delivery capacity, overcapacity was one of the issues identified by a participant in Seitio-Kgokgwe et al’s (2014) study. The lack of maintenance of health facilities was also strongly identified as a concern, by study participants. The issue of maintenance of medical equipment was deemed a problem by majority of the health personnel that participated in the study. The management of the supply chain of medication was faulted for the inconsistent supply of medicines in Botswana by study participants. The Botswana MOH has made efforts to improve the use of Information and Communication Technology (ICT), such as creating the Integrated Patient Management System, and the Patient Information Management System for people
with more specialized illnesses e.g. ICT for patients with HIV, tuberculosis, and cancer (MOH, 2009). However, more than 50% of health workers in Seitio-Kgokgwe et al’s (2014) study indicated the lack of sufficient ICT for the enhancement of quality care provision. This may indicate a problem with the introduction of ICT into the health facilities, or health workers not getting the adequate amount of training on how to utilize the implemented ICT. A shortage of health workers and especially specialized professionals, and the wrongful placement of health workers in a field that is not their specialization, was identified as issues of concern by the participants in the study.

Seitio-Kgokgwe et al’s (2014) study highlighted some faults with the quality of health care being provided. The lack of efficient and updated quality management systems in most hospitals was a problem that was identified by more than half of the health workers. A lack of a national performance standard, accreditation processes for hospitals, and inadequate policies to regulate the provision of health care services, were other problems associated with the quality of health care. While most managers of health care facilities in the study had the perception that the quality of services being provided at health facilities has improved, patients were of a different opinion. The concerns of patients in this study ranged from a shortage of health workers to rude attitudes of health personnel, limited access to health services, and long waiting periods.

Reviewing Health Financing in Nigeria

The existing methods of paying for health care that are used by Nigerians include out-of-pocket, Social Health Insurance (SHI), Community-Based Health Insurance (CBHI), and through donor funding (Olakunde, 2012). Out-of-pocket payment for health represents the highest proportion of health expenditure in Nigeria, whose origination can
be traced back to the adoption of the Bamako Initiative in 1998 (FMOH, 1994; Olakunde, 2012). A high incidence of catastrophic health expenditure has been recorded in Nigeria, where user fees put a burden on the income of individuals below the poverty line (Onoka et al., 2010). While exemptions from waiver fees have been considered for the poor, weak administrative systems and poor efforts by health workers in implementing these exemptions have hindered their success (Kivumbi et al., 2002). Although government’s spending on health has increased significantly between 1991 and 2007, 1.7% to 7.2%, it hasn’t reached the 15% benchmark (Olakunde, 2012). The National Health Insurance Scheme (NHIS) is a form of SHI that is meant for every sector in the Nigerian economy but only functions within the formal sector where it is mandatory for federal employees (Olakunde, 2012). Yet again, vulnerable populations that may not be able to function within the formal sector are systematically neglected. As NHIS is optional, only 0.8% of the population is actually covered by this insurance (World Bank, 2008). Meanwhile, the goal is to ensure that every Nigerian will be mandated to have NHIS by the end of 2015 (Ogbonnaya, 2010). CBHI is a private health insurance that is voluntary for the populations unlike the NHIS. In Nigeria, CBHI is a form of health insurance for employed workers within the informal sectors or in rural areas (Uzochukwu, Onwujekwe, Soludo, Nkoli, and Uguru, 2010). CBHI was initially introduced in 2003 in Anambra state but has since then been adopted in a few other state (Jimoh, 2009). The success of CBHI in Nigeria can be potentially hindered by its low utilization, weak institutional systems that exist in Nigeria, and limited funding of the initiative (Olakunde, 2012). There have been suggestions to improve utilization of the CBHIs by ensuring that the payment scales are done according to each consumer’s ability to pay (Onwujekwe,
Okereke, Onoka, and Uzochukwu, Kirigia, Petu, 2010; Ataguba, Ichoku, Fonta, 2007). More so, the need for making the population aware of the availability of CBHIs in their communities, have been identified (Adinma, Adinma, 2010). Olakunde (2012) explained the complexity of tax revenue as a form of funding for the health system. As a result of limited monitoring and accountability within the government, the Federal government is unable to manage the inflow of funds into the primary and secondary health services. On the Federal level, major tax revenues are gotten from oil and gas and this revenue is shared amongst other tiers of government. The amount allocated to each government is not specified and the other levels of government are not mandated to report their financial spending to the federal government (Olakunde, 2012).

Reviewing Health Financing in Botswana

The African Health Observatory for the World Health Organization (WHO) (2014) did an analytical review of the Botswana health system, of which health financing was a component. This review indicated some progress that has been made in the funding of the health system as well as areas that are in need of strengthening. Overall, the budgetary system in Botswana is monitored by the parliament, with health funds invested into the three agencies: the Ministry of Health, the Ministry of Skills Development, and the National AIDS Coordinating Agency. The distribution of the health funds into these three bodies are 64%, 3% and 9% respectively. In line with the policy objective listed under the NHP as well as the Abuja Declaration, the Botswana government invests more than 15% of its total expenditure on health.

From 1975 to 2009, the Botswana government increased its health expenditure by about 96%, a total sum of $1,660,700. More so, the government is largely responsible for
health financing while external donors are responsible for merely investing in high
burden diseases. What is left of the budget set aside for health, which is more than 20%,
is invested into other private health stakeholders such as health insurances. In terms of
health financing, one of the areas that need strengthening, as suggested by the WHO
(2014) is associated with the consistent payment of the salaries of those involved with
health service delivery. In Botswana, tax revenues play a significant role in the funding of
the health care system (Akinkugbe et al., 2011).

The World Bank (1996) produced a report on the financing of the health system in
Botswana with regards to sustainable health system financing. This report highlighted
some successful strategies adopted by Botswana within their health system financing as
well as some of the weaknesses. Some of these strengths include the fact that the
distribution of resources across all levels of health service delivery are done according to
the needs of those levels. This is something that was highlighted in the 2011 NHP (RoB,
2011); the intention to prioritize the allocation of resources across all levels of health
care, according to the needs. The allocation of these funds is prioritized by the central
government which is then reflected on all district levels. This makes for the maintenance
of consistency in financing throughout the health care system. The World Bank (1996)
further highlighted some weaknesses of this central and so called rigid form of resource
allocation. There is a concern that this will inhibit the prioritization of health care needs
that are actually significant to communities. Thus, communities may not be able to
participate actively in the allocation of funds to their health needs.

However, the 2011 NHP places emphasis on the inclusion of communities in the
delivery of health services especially in the creation of an Integrated Health Sector Plan
IHSP) that will further the implementation of the 2011 NHP. The creation of this IHSP will be inclusive of different health stakeholders other than the public sector such as NGOs, community based organizations, and private sectors (RoB, 2011). Included in the IHSP 2010-2020 is a detailed health financing strategy that highlights the strategy that will be adopted, indicators, activities, time period and the party(ies) that will be responsible for implementation (MOH, Government of Botswana (GoB), 2010). Some of the strategic objectives listed in the IHSP align with those in the 2011 NHP while others may be found under the sub-objectives within the IHSP. This shows consistency with funding strategies within the health system.

Some issues were mentioned in the strategic plan for health financing in the IHSP but were not mentioned in the 2011 NHP. The improvement of transparency and accountability within the health system was barely mentioned in the 2011 NHP, and was included as strategic objective 3 in the IHSP. The method by which transparency will be fostered is through making data on health financing readily available, and on time. More so, there will be efforts to ensure that these data on health financing are utilized so that decisions may be made accordingly (MoH, GoB, 2010). The responsibility of fostering accountability and transparency within the health system was contracted out to the Department of Policy, Planning, Monitoring and Evaluation (DPPME) in Botswana (MoH, GoB, 2010). This could be an advantage because an external body is responsible for ensuring that there is accountability within the health system. In like manner, this could be a disadvantage because of bureaucracy and a lack of complete understanding by the DPPME of how the health system works.
CHAPTER 7: CONCLUSION

This study has highlighted the extent to which the NHPs for Nigeria and Botswana and the NSHDP for Nigeria incorporated three of the six building blocks of health for health system strengthening. The three building blocks that were utilized in this study include leadership and governance for health, health service delivery, and health financing. For leadership and governance for health, the study analyzed how the documents were able to incorporate the following themes: the existence of strategic policy framework, coalition-building, regulation, attention to system design, and accountability. Health service and delivery were analyzed using the incorporation of the following themes in the documents: comprehensiveness of the health services delivered, accessibility, coverage, continuity, quality of the services delivered, person-centeredness, coordination of health services delivered, and the level of accountability and efficiency in the delivery of health services. The themes that were used for analyzing the incorporation of health financing into these documents include: methods of raising sufficient funds for health, improving financial risk protection and coverage for vulnerable groups, improving the efficiency of resource utilization, and the improvement of financial transparency as well as the management of operational levels.

Following the analysis of these documents, more literature was reviewed in order to understand the performance of each of the three building block of health within these countries. This analysis helped to understand the current state of the health system in Nigeria and Botswana, with regards to the indicators that were utilized in this study. More so, findings from the NHPs were compared to findings from the other literature; this comparison helped to highlight the similarities or differences that existed between the
findings from the NHPs and those from other literature. Results from this analysis differed for different indicators for both Botswana and Nigeria. This study helped to shed light on the extent to which NHPs and related documents have imbibed the WHO building blocks of a health system for health development. The two countries have their unique approach to health development; while Nigeria takes an economic approach, Botswana approaches health from a health development standpoint.

Limitations of Study

Systems thinking as an approach to health development, involves examining the six building blocks of health together as a whole, but this study examined just three of the six block of health. Analyzing the six building block of health together, will help in showing the relationships and interactions between these blocks and how they impact on one another (WHO, 2009). More so, the documents that were utilized in this study were restricted to the NHPs of these countries, while there may have been other relevant health related documents that will significantly contribute to the study. Finally, all the documents that were utilized consisted of secondary sources; the use of primary sources may have positively benefitted the overall findings of the study.

Despite these limitations, this study has successfully analyzed the 2004 NHP, NSHDP, and the 2011 NHP, assessing their incorporation of leadership and governance, service delivery, and health financing. This study has indicated the need for a review of the 2004 NHP that will show consideration for the current determinants of health in Nigeria, the gaps that exist with the incorporation of these three building blocks of health in the health documents, as well as the gaps that exist within policy and practice in Nigeria and Botswana.
Implications of Study

WHO (2015) identified the importance of national policies to ultimately securing the health of the population. Government and Ministries of Health have come under pressure from populations that live within regions characterized by fragmented health systems. As a result of these pressures, there has been an increased focus on increasing the capacity of governments to create National Health Policies (NHPs) that will enable the provision of universal, quality, affordable, and accessible health care services (WHO, 2015). The method of developing NHPs varied across countries depending on characteristically unique contexts within these countries. It is important for governments to create NHPs that are embedded within a framework that seeks the overall development and strengthening of the health system.

The research methodology adopted in this study may be utilized by policy makers and other researchers in order to review existing national health policies and analyze their adaptation of a valid health systems strengthening framework. An analysis of existing NHPs will help governments better understand what elements to consider in future review of the NHPs. For instance, findings from this study indicate the lack of a framework that works towards health system strengthening in the 2004 NHP. Thus, the Nigerian government may set up a NHP review committee that will consider adopting a health systems’ strengthening framework in the future review of the 2004 NHP. More so, findings from this study may be used to understand the gaps that exist between policy and practice in Nigeria and Botswana; it is important to identify where these gaps exist in order to bridge them. Overall, this style of research may be adopted by policy makers so
that they can identify the need to adopt a health systems strengthening framework for health development within the national health system.

Implications for Policy

This study identified gaps in specific areas of the different themes analyzed. The gaps will be discussed below. Policy makers may work towards filling these gaps in future review of policy documents towards health development.

Leadership and Governance

Analysis of the 2004 NHP and the NSHDP indicate that the Nigerian government adopts an economic development perspective towards health development. In the revision of future health policies, it may be impactful for the policy review committee to adopt health development perspectives, separate from economic development. In the 2011 NHP, inter-sectoral collaboration is mentioned but there was no mention of specific objectives that may be adopted towards accomplishing this. More so, there is no mention of international and regional partnerships as in the NSHDP. Collaboration was not as emphasized in the Botswana 2011 NHP as it was in the Nigerian 2004 NHP. In the 2004 NHP, there was no emphasis on the enforcement of regulations likewise in the NSHDP. In the 2011 NHP, there was mention of the MDJS as the enforcement agency in Botswana; however, there was no mention of the specific department within the MDJS that was responsible for regulations pertaining to health. While the 2004 NHP claimed that the allocation of clear-cut roles within the three tiers of government will be done in the National Health Act, a review of this document indicated that there was no allocation of roles and responsibilities within. The NSHD has identified a lack of a health development strategy in the Nigeria 1999 constitution and the National Health Act. This
indicates a need to review the constitution and ensure that it is inclusive of health issues.

The NSHDP also acknowledged the negative impact of the lack of assigned governmental roles across the three tiers of government within the health system. While the 2004 NHP mentions the need to maintain a high level of accountability within the health system, there is no mention of the tools that may be used to ensure this. More so, accountability was not thoroughly discussed in this document. All of the above are gaps that were identified within the 2004 and 2011 NHP, and the NSHDP. These gaps may be addressed in future revision of the policy documents and other documents concerning health development.

*Health Service Delivery*

Within the 2004 NHP, there was no mention of the services that compose the minimum health care package. More so, this document does not mention how the comprehensive health care will be made available to all Nigerians. In the NSHDP, there is no mention of rehabilitative services that is supposed to be included in the essential health package. The 2004 NHP did not mention the PHC as the 1st point of entry nor discuss methods through which the PHC will become the 1st point of entry for the health care system. The NSHDP also did not mention the PHC as the 1st point of entry. The 2011 NHP mentioned making health infrastructure available to people with disabilities, however, there is no breakdown of methods through which this will be accomplished. More so, there is no mention of ensuring that health facilities are in close proximity to people and that primary health care remains the 1st point of entry. The 2004 NHP does not give a detailed breakdown on how increased coverage of health services will be achieved. The NSHDP discussed the provision of financial aid for vulnerable groups so
they may get covered. However, reference to vulnerable groups was not inclusive of poor or low income people. Both the 2004 NHP and the NSHDP did not make mention of making health services person-centered. However, this may be something that may be reviewed in the future by policy makers. Questions regarding whether this is appropriate to the cultural environment in Nigeria may be discussed. It is also important to note that the NSHDP did not specifically mention the timely delivery of safe health services.

The 2004 NHP made no mention of getting users’ perception of the type of health services being delivered. This was the case for the 2011 NHP where there was no mention of methods through which users’ perceptions of health services may be analyzed. The NSHDP did not mention methods of the PHC facilitating referrals but it mentions the creation of national standards for referrals. However, upon research, no national standards for referrals were found. The 2004 NHP did not breakdown methods through which accountability will be achieved within the health system and there is no thorough breakdown of how efficiency will be ensured within the different levels of health care in the health system. This is the same for the NSHDP where there was no relevant mention of efficiency in relation to the overall performance of the health system. In the 2011 NHP, while it was mentioned that the MOH is responsible for the overall performance of the health system, there is no further discussion on how accountability and efficiency will be ensured.

*Health Financing*

The 2004 NHP mentioned mechanisms for raising sufficient funds within the health system, all of which are internal and no external sources were mentioned. This may promote sufficiency within the health system if completely achieved. The NSHDP
mentions that the Federal government will ensure that local and state governments are contributing 15% of their budget to the health sector they control. In the 2011 NHP, there is no mention of potential sources of funds, and no mention of how national revenue, and what percentage, if any, will contribute to the overall health system. The 2004 mentioned the provision of public assistance to socially and economically disadvantaged groups. The exact nature of this was not specified. The 2004 NHP did not thoroughly breakdown how efficiency will be ensured in the allocation of health finances and resources. The NSHDP also omitted methods through which efficiency will be maintained on the tertiary level. The 2004 NHP did not include steps on how to deal with corruption and the ineffective management of resources. In the NSHDP, there is no mention of the creation of health accounts on the local level and there is no mention of inconsistencies within the health accounts. In the 2011 NHP, there is no explicit mention of improving financial transparency or ensuring accountability with resource allocation.
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