Nigeria National Quality Policy and Strategy

An analysis of the state of quality in the Nigerian health system:

SITAN

2023

Foreword

The goal of Universal Health Coverage is that all persons and communities can enjoy the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality, while also ensuring that the use of these services does not expose users to financial hardship.

World Health Organization and other global health institutions has identified the need for countries to develop a National Quality Policy and Strategy that will provide guidance and direction on quality of health care at all levels of the health system as a critical step in propelling the country towards achieving UHC.

This situation analysis employed a rigorous process of in-depth desk review of existing documents, Key Informant Interviews, and stakeholder engagements to provide insight on the situation of quality in the Nigeria Health System and provides a shared understanding of the strengths and identified gaps in quality of the system. It is therefore intended to provide a foundation for the development of National Quality Policy and Strategy for Nigeria and serve as a valuable body of knowledge and information for reference.

Therefore, I encourage all stakeholders to use the evidence generated in this document to guide their actions as necessary, as we continue our common pursuit of achieving UHC as a Nation.

Dr. E. Osagie Ehanire, *MD, FWACS, CON*
Honourable Minister of Health

ACKNOWLEDGEMENT

Over the last decade or so, several components of quality have been described, as the world sought consensus on what quality of care really encapsulates. To harmonise this body of knowledge in a way that strengthens the National Health System and ensures integration and harmonization towards better health outcomes, the WHO, World Bank and OECD publication, "Delivering Quality Health Services: A Global Imperative for Universal Health Coverage", recommended the development of a National Quality Policy and Strategy (NQPS) by all governments as one of the high-level actions by key constituencies for quality in health care.

This Assessment of the State of Quality of Care in Nigeria is a critical step towards the implementation of this recommendation towards the development of an NQPS for Nigeria. It is the product of an extensive, all-inclusive consultative process that included collaboration and engagements with multiple stakeholders.

The Department of Health Planning Research and Statistics, Federal Ministry of Health (FMOH) through the Policy and Planning Division, and with the support of the World Health Organization (WHO), coordinated the process of development of this document as a baseline to inform a National Quality Policy and Strategy.

My sincere appreciation goes to the Honourable Minister of Health, Dr. Osagie Ehanire, MD, FWACS and the Honourable Minister of State for Health, Barr. Joseph Nkama Ekumankama for not only ensuring the required political support but also providing exceptional leadership and guidance for the exercise. I am also grateful to the Permanent Secretary, Mallam Mahmuda Mamman for the instrumental administrative support provided for the process. We highly appreciate the World Health Organization (WHO), whose support was vital to the success of the exercise. and to all other stakeholders too numerous to mention, I say a very big thank you for your invaluable contributions to the preparation of these very important documents.

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Also, I thank my family, especially my husband for all his support and sacrifice that allowed me to provide technical leadership to this and so many other initiatives and processes at the same time. Finally, I must always thank God, my guide and my guard through all seasons and challenges. To Him alone be all the glory, as nothing would have been possible without Him.

On behalf of the Federal Ministry of Health, I sincerely thank you all.

Alaigbe Dr. Ngozi Rosemary C. Obike Azodoh,
Director, Department of Health Planning Research and Statistics
Federal Ministry of Health, Abuja
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List of Acronyms

AE	Adverse Effects
AFB	Acid-Fast Bacillus
AMR	Antimicrobial Resistance
ART	Antiretroviral Therapy
ASSIST	Applying Science to Strengthen and Improve Systems Project
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Healthcare Provision Fund
BMGF	Bill and Melinda Gates Foundation
CACOVID	Coalition against COVID-19
CBO	Community Based Organization
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHAI	Clinton Health Access Initiative
CHPRBN	Community Health Practitioner Registration Board of Nigeria
COVID-19	Coronavirus
CPD	Continuing Professional Development
CPC	Consumer Protection Council
CRF	Consolidated Revenue Fund
DFID	Department for International Development
DHIS	Demographic Health Information System
DHIS2	District Health Information System 2
DHS	Department of Hospital Services
DPRS	Department of Health Planning, Research and Statistics
DTRBN	Dental Therapist Registration Board of Nigeria
EMS	Emergency Medical Services
EOC	Emergency Operations Centre
EPHS	Essential Package of Health Care Services
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunizations
HEFAMAA	Health Facility Monitoring and Accreditation Agency
HCHC	Hygeia Community Healthcare
HIS	Health Information System
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HMIS	Health Management Information System
HMO	Health Maintenance Organizations
HPRG	Health Policy Research Group
HRH	Human Resources for Health
HRRBN	Health Record Registration Board of Nigeria
HSDF	Health Strategy and Delivery Foundation

ICCON	Institute of Chartered Chemist of Nigeria
IHI	Institute for Healthcare Improvement
IHP	Integrated Health Partners
IOM	Institute of Medicine
IPAN	Institute of Public Analyst of Nigeria
IPC	Infection Prevention and Control
IRMNCAH+N	Integrated Reproductive, Maternal, Newborn, Child and Adolescent Health Plus Nutrition Services
ISQua	International Society for Quality in Healthcare
JCI	Joint Commission International
KIIs	Key Informant Interviews
Lagos SMoH	Lagos State Ministry of Health
LGA	Local Government Area
LIMH	Lagos Island Maternity Hospital
LSHTM	London School of Hygiene and Tropical Medicine
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria
MDG	Millennium Development Goals
MLSCN	Medical Laboratory Science Council of Nigeria
MLSCN	Medical Laboratory Scientist of Nigeria
MoH	Ministry of Health
MNCAH+N	Maternal Newborn Child Adolescent Health Plus Nutrition
MNCH	Maternal, Newborn and Child Health
MPCDSR	Maternal, Perinatal and Child Death Surveillance and Response
MRTB	Medical Rehabilitation Therapist Board
MSS	Midwife Service Scheme
MTBC	Mycobacterium Tuberculosis Complex
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drugs Administration and Control
NAM	National Academy of Medicine
NCDC	Nigerian Centre for Disease Control
NAHSS	Nigerian Alliance for Health Systems Strengthening
NCH	National Council of Health
NDPR	Nigerian Data Protection Regulation
NEMTC	National Emergency Treatment Committee
NEWPHAN	Network of People Living with HIV/AIDS in Nigeria
NFELTP	Nigeria Field Epidemiology and Laboratory Training Program
NHA	National Health Act
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHP	National Health Policy
NHQI	Nigeria Healthcare Quality Initiative

NHRHP	National Human Resources for Health Policy
NHRHSP	National Human Resources for Health Strategic Plan
NHWR	National Health Workforce Registry
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute of Pharmaceutical Research and Development
NITDA	National Information Technology Development Agency
NMA	Nigerian Medical Association
NMCN	Nursing and Midwifery Council of Nigeria
NMEP	National Malaria Elimination Programme
NPC	National Pharmacovigilance Centre
NPHCDA	National Primary Health Care Development Agency
NQPS	National Quality Policy and Strategy
NQS	National Quality Strategy
NSHDP	National Strategic Health Development Plan
NTBLCP	National Tuberculosis and Leprosy Control Programme
ODORBN	Optometry and Dispensing, Optician Registration Board of Nigeria
OOP	Out of Pocket
PATHS2	Partnership for Transforming Health Systems Phase II
PCN	Pharmacists Council of Nigeria
PEPFAR	President's Emergency Plan for AIDS Relief
PforR	Program for Results
PHC	Primary Health Care
PHIMA	Private Health Institutions Management Agency
PMTCT	Prevention of Mother-to-Child Transmission
PPMVs	Patent and Proprietary Medicine Vendors
QED	Quality, Equity and Dignity
QoC	Quality of Care
RICOM3	Reducing the Indirect Causes of Maternal Morbidity and Mortality
RIF	Resistance to Rifampin
RMNCAEH+N	Reproductive Maternal, Newborn, Child, Adolescent and Elderly Health Plus Nutrition
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition Services
RRBN	Radiographers Registration Board of Nigeria
SERVICOM	Service Compact
SMoH	State Ministry of Health
SITAN	Situational Analysis
SOMLi	Saving One Million Lives initiative
SOP	Standard Operational Procedures
SPFMUs	State Project Financial Management Units
SPHCBs	State Primary Healthcare Boards
SPHCDA	State Primary Health Care Development Agency
SQHN	Society for Quality in Healthcare in Nigeria
SSHIS	State Social Health Insurance Scheme
SURE-P	Subsidy Reinvestment and Empowerment Programme

SWOT	Strengths, Weaknesses, Opportunities and Threats
SWV	Service-Wide Votes
TSS	Task Shifting and Sharing
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WDCs	Ward Development Committees
WHO	World Health Organization
ZIP	Zonal Intervention Projects

0.0 Executive Summary

0.1 Introduction

The Federal Ministry of Health of Nigeria (FMoH) with the support of the World Health Organization (WHO), and in alignment with the National Strategic Health Development Plan II, has embarked on a journey to develop a National Quality Policy and Strategy (NQPS) to improve the quality of health care and foster a culture of quality across the Nigerian health system. The development of the Nigerian NQPS, which will be in phases, commenced with a situational analysis (SITAN) to assess the current state of quality and to identify and prioritize gaps in quality in the healthcare system.

The specific objectives of the SITAN are to (i) develop a shared understanding of the historical and current organization of quality in the Nigerian health system and the multi-dimensional context in which care is governed, delivered, and monitored from the national to the subnational level; (ii) localize the definition for quality and understand the vision for the culture of quality in Nigeria; (iii) present an overview of current healthcare quality-related indicators and key quality challenges from available data and identify relevant data sources that can be leveraged in ongoing strategic efforts; (iv) determine the challenges and bottlenecks in the implementation of current policies on quality, understand current initiatives in quality across the public and private sector, identify opportunities and gaps in quality as well as barriers and facilitators including entry points at the national and state level (including fragile, conflict-affected states) to enable acceleration of progress towards national health priorities; (v) develop a key list of priority areas that the FMoH can use to build an integrated NQPS for health and healthcare in Nigeria; and (vi) secure high-level commitment to the NQPS development, implementation and monitoring process through comprehensive stakeholder engagement and consensus-building.

0.2 Methodology

The SITAN takes a pragmatic approach to identifying and prioritizing major gaps in quality in the Nigerian healthcare system on which to build a foundation for a Nigerian NQPS and is guided by the World Health Organization (WHO) Handbook for NQPS. The methodology is based on a participatory and collaborative effort, fully owned and led by the FMoH, Department of Health Planning, Research and Statistics (DPRS) with support from the WHO Nigeria Office, Regional Office and Headquarters as well as national and international consultants. The SITAN involves a three-pronged approach for data collection and synthesis comprising a desk review, key informant interviews and a stakeholder consultation workshop to collate information and validate evolving themes that will inform priority areas for the NQPS.

0.3 Country Background

Nigeria is located in West Africa and is divided into 36 states and the FCT, which are subdivided into 774 local government areas (LGAs). Nigeria has a population of over 206 million multi-ethnic and culturally

diverse people. The provision of public health services in Nigeria is the responsibility of three tiers of government namely: the primary, secondary and tertiary levels of care, which are the responsibilities of the local government areas, state government and federal government respectively. Based on a Lancet ranking of health systems performance, Nigeria ranks 142 out of 195 countries regarding healthcare access and quality. The country also ranks poorly on the World Bank's Universal Health Service Coverage Index (service coverage index of 42). Though Nigeria has shown some improvement in its health indicators, the country is still plagued with the burden of communicable and non-communicable diseases and maternal and child morbidity and mortality. According to the WHO, Nigeria accounts for about 20 percent of all global maternal deaths with a maternal mortality ratio of 512 per 100 000 live births, under-5 mortality rate of 132 per 1000 live births, infant mortality rate of 67 per 1000 live births and neonatal death rate of 39 per 1000 live births.

0.4 Key Findings

The Nigerian Health System despite being multi-layered and complex has many gaps that impede quality of care. While there is no dearth of health policies and strategies enacted to create a quality healthcare system, the country's health system is still been barraged by myriads of challenges. The findings accentuated challenges to implementation and revealed possible opportunities and implications for the development of the NQPS using five themes namely: (i) Transforming the systems environment; (ii) Reducing harmful practices on patients and staff; (iii) Improving the effectiveness of clinical care; (iv) Engaging patients, families and communities; and (v) Improving monitoring, evaluation and learning systems.

0.4.1 *Transforming the systems environment*

There are no discrete frameworks or mechanisms that provide detailed guidance on how to achieve a unified, integrated quality healthcare system; there is a lack of available resources to enact change, deliver high-quality care and implement quality assurance and quality improvement initiatives; the Federal quality assurance structure is large, diffuse, and complex and the different actors in the quality management infrastructure all use different tools and methodologies to drive quality; there is also poor allocation of the national budget for health. While the budgetary allocation for health is pegged at 15 percent of the country's national budget, Nigeria still falls short of meeting this allocation.

The work of regulatory bodies presents an opportunity to embed quality improvement into the different healthcare professions. Through an NQPS that is built on a truly participatory process, embedding quality as an operating principle within the regulatory agencies, can dramatically improve communication, accountability, transparency and inter-agency collaboration; there is also a need to improve the registration and accreditation of facilities across Nigeria. It is, therefore, important for states to utilize their facility management boards and push for an increase in this accreditation and requisite support to build the capability of facilities to achieve accreditation status; there needs to be a change in the current regulatory operational model so that healthcare providers are more likely to see regulatory bodies as trusted partners in providing quality care.

0.4.2 *Reducing harmful practices on patients and staff*

Health workforce supply shortages and the inequitable distribution of staff and facilities across Nigeria increase patient harm, reduce staff job satisfaction and motivation to work, and worsen patient outcomes; there is no established programme dedicated to tackling occupational health and safety and while there is a policy in place, implementation is limited meaning that healthcare organizations may not be providing adequate workplace health and safety measures.

There is an opportunity to build on discrete systems (adverse effect reporting systems) and establish a recognized and available system that is reliable for patients and facilities across the different levels of care. The NQPS could build on current investments in addressing these workforce challenges to ensure an integrated approach.

0.4.3 *Improving the effectiveness of clinical care*

The degree to which staff, especially at the primary healthcare (PHC) level, can receive capability building support is dependent on the location of the facility, whether there is implementing support from non-governmental organization partnership, and their relationships with the local government area (LGA) headquarters. The laboratories that Nigeria needs to make evidence-based diagnostic decisions are plagued by poor quality assurance and control of laboratory services as well as an ineffective regulation of these services across Nigeria. There is also an inadequate number and distribution of necessary healthcare workers within the PHC system and health care professionals may not understand what is fully expected of them in terms of quality of health care delivery as they are unaware of the policy documents that detail these expectations.

Healthcare facilities may invest in continuous learning programs for their staff especially on quality improvement; existing laboratory and facility quality improvement teams could be supported to make investments in process improvement and supply chain management to augment current efforts in this arena; the NQPS could provide guidance on how feedback from patients (which is already obtained in many facilities) is incorporated into the health system as currently this process depends heavily on the facility that receives the feedback. An opportunity exists with the use of finance for improved quality in line with the World Bank's use of performance-based financing (PBF); an important policy implication from the PBF initiatives is that PBF should be carefully harnessed for specific service delivery indicators. Non-financial incentives such as non-financial rewards and recognition also exist that can be leveraged upon.

0.4.4 *Engaging patients, families and communities*

Ward Development Committees (WDCs) in some local government areas are not fully functional even though they are important for community health ownership of the health projects in the community Apart from investment in the supply side such as policies and health infrastructure, there is a lack of investment in the demand side, which includes patient empowerment, health seeking behavior support and so on.

Revitalization of WDCs to drive a community-led engagement and participation in health is an opportunity to explore in the NQPS; more regulatory agencies can create patient and community demand for quality and patient centered care. In addition, local engagement through state and local government politicians as well as service providers at the PHC level can communicate the benefits of the new PHC system to members of the community including traditional and religious leaders as well as professional unions. Ensuring that patient voices are heard through the adoption of digital technologies with a quality-focused patient review system could promote a more inclusive approach, which galvanizes providers' responsiveness and improvement.

0.4.5 *Improving monitoring, evaluation and learning systems*

While the District Health Information System 2 (DHIS2) exists as a single data management tool for the National Health Management Information System (NHMIS), there is little reporting on the DHIS2 from the private sector despite the fact that the private sector provides over 60 percent of healthcare services in the country. Significant problems with the NHMIS also include the multiplicity of Health Information System (HIS) that exist within the country and the poor data reporting and fragmentation that results from these; overall, poor data quality still persists at all levels. Furthermore, there is no systematic analysis of HMIS data and feedback to health institutions thereby limiting the use of HMIS data for health planning and decision-making; health research in Nigeria has been uncoordinated, lacking synergy, harmonized efforts, and a prioritization of activities.

The Federal Ministry of Health has strengthened its data reporting system recently and reporting into the NHMIS is now compulsory across the country. There is an opportunity to integrate structure, process and outcome indicators for a whole quality lens approach. The NQPS should include in its implementation plan guidelines on the process for developing these core quality indicators across multiple key stakeholders. The stakeholders should include clinical, patient, policy, regulatory, academic and political stakeholders in the decision-making process. The core quality indicators should be linked to the specific goals laid out in the NQPS; to improve quality at a national level, data for these core quality indicators must be easy to report and to feed back into the system at all levels, particularly at the facility level. This way, data could be harnessed in quality improvement approaches such as appreciative inquiry and root cause analysis to promote continual improvement.

0.5 Recommended Priority Areas and Quality Ambitions

Based on the challenges and opportunities highlighted, the SITAN lists potential priority areas for the NQPS, and a quality ambition for at least one of the areas on the prioritized list. The priority areas are, however, not final but will inform the development of the forthcoming NQPS alongside further prioritization processes.

Quality Dimension	Priority Areas	Quality Ambition
Transforming the Systems Environment	1. Address healthcare financing challenges that lead to large out-of-pocket payments, inefficient and ineffective care. 2. Reduce the proliferation of counterfeit drugs, vaccines and medical technology by 10 percent by 2030. 3. Address challenges in coordination between regulatory, local governments, programmatic departments working to ensure quality of care. 4. Build health strategies that improve the shortages of human resources for health.	• Institutionalised community health care system with a functional community structure in the country. • Increased proportion of people seeking health care services in the community • Sustained ownership of the healthcare systemby the community in the 36 states and FCT.
Improving the effectiveness of clinical care	1. Improve delivery of person-centered and effective care. 2. Address inadequate staffing due to brain drain and inadequate remuneration. 3. Reduce the irrational use of medicines at the facility level.	• Provision of adequate medical equipment with efficient drug and health commodity supply chains across all levels of care to support timely and effective care.
Reducing harmful practices on patients and staff	1. Ensure skilled human resources for health facilities to provide infection prevention and control (IPC) and ensure patient safety. 2. Provide adequate basic amenities such as water, sanitation and hygiene and electricity for IPC/sterilization equipment and lighting of the health facilities. 3. Ensure adherence to the use of protocols and guidelines	• Institutionalised IPC in health facilities in all states of the country. • Reduced harmful practices on health care workers and patients. • Implemented task shifting and sharing for health workers to reduce burnout and workload. • Implemented performance evaluation and rewards systems. • Provision of basic amenities to facilitate and reduced harm for patients and health workers.

Engaging patients, families and communities	1. Address poor demand for health care services due to unavailability and unaffordability of services. 2. Address poor community participation in healthcare planning and implementation of health care delivery.	• Increased proportion of people seeking health care services in the community.
Improving monitoring, evaluation and learning systems	1. Create a system for adequate recruitment and allocation of monitoring, evaluation and learning system staff based on needs. 2. Build capacity and track performance indicators of staff for collection and analysis of high-quality data and improved monitoring, evaluation and learning processes.	• Adequate numbers of monitoring, evaluation and learning staff, properly allocated across the country who have access to job aids and regular capacity building on data management and are properly evaluated for the collection and analysis of high-quality data.

0.6 Next Steps for the National Quality Policy and Strategy

The next steps for the NQPS include constituting and inaugurating a multi-sectoral technical working group informed by SITAN to lead the development of the NQPS; convening a national and sub-national policy dialogue on quality in Nigeria's Health Sector through a series of workshops to co-develop strategic focus areas and prioritized interventions; developing national and sub-national health sector quality policy and strategy and operational plans; and launching and disseminating national quality of care policy and strategy documents.

0.7 Conclusion

The findings show the need to bolster the implementation of policies and regulatory systems and leverage on the strengths of existing quality improvement and quality assurance initiatives. There is also a need to identify siloed programs and consolidate the efforts of these programs to reduce the complexity of the health system and increase its efficiency. The recommendations discussed in the SITAN provide a selection of priority areas recommended for inclusion in the NQPS. The SITAN of the state of quality of the Nigerian health system will be leveraged on to inform the development of the National Quality Policy and Strategy and transform the quality of care in Nigeria.

1.0 Introduction

To improve the quality of healthcare and promote a culture of quality across the Nigerian health system, the Federal Ministry of Health (FMoH) in collaboration with the World Health Organization (WHO), and in alignment with the National Strategic Health Development Plan II, has embarked on a journey to develop a National Quality Policy and Strategy (NQPS). Building on over a decade of discrete efforts, this strategy will harmonize existing quality initiatives towards a shared national aim while institutionalizing quality at all levels of the system. The development of the Nigerian NQPS, which will be in phases, commenced with a situational analysis (SITAN) to assess the current state of quality and to identify and prioritize gaps in quality in the healthcare system. The SITAN aims to establish a solid foundation upon which the NQPS will be developed and implemented.

1.1 Objectives

The overarching objective of the SITAN is to examine the Nigerian landscape of quality and facilitate a shared understanding of the current state of quality, which will inform the development of a National Quality Policy and Strategy. The specific objectives of the SITAN are to:

i. Develop a shared understanding of the historical and current organization of quality in the Nigerian health system and the multi-dimensional context in which care is governed, delivered, and monitored from the national to the subnational level.

ii. Localize the definition for quality and understand the vision for the culture of quality in Nigeria.

iii. Present an overview of current healthcare quality-related indicators and key quality challenges from available data and identify relevant data sources that can be leveraged in ongoing strategic efforts.

iv. Determine the challenges and bottlenecks in the implementation of current policies on quality, understand current initiatives in quality across the public and private sector, identify opportunities and gaps in quality as well as barriers and facilitators including entry points at the national and state level (including fragile, conflict-affected states) to enable acceleration of progress towards national health priorities.

v. Develop a key list of priority areas that the FMoH can use to build an integrated NQPS for health and healthcare in Nigeria.

vi. Secure high-level commitment to the NQPS development, implementation and monitoring process through comprehensive stakeholder engagement and consensus-building.

1.2 Rationale

The government of Nigeria has spearheaded significant gains in healthcare access and coverage; however, population health outcomes have declined or stagnated, mainly due to low-quality care. Increasingly over the last decade, the FMoH has focused on improving the quality of care across the healthcare system, more recently evidenced by the second National Strategic Health Development Plan (NSHDP II) 2018-2022, which expresses "improved quality health services" as a key output for tracking the success of the NSHDP II interventions and highlights key elements of quality across the strategy including enhancing patient safety and improving effectiveness.

In specific areas at the national and sub-national levels and in the public and private health sectors there have been marked efforts at improving quality of care.[1] While these efforts have all been aimed at improving the quality of health care delivery and services, these initiatives have often been discrete, not always well coordinated, and many have lost momentum due to the coronavirus (COVID-19) pandemic. The pandemic has uncovered existing gaps in quality systems across a host of areas including infection prevention and control (IPC), data and information systems and resource mobilization.

Given that one of the NSHDP II goals is to ensure quality of care as a key tenet for achievement of Universal Health Coverage (UHC), the FMoH has committed to developing a National Policy and Strategy for Quality, and In alignment with the WHO Handbook for National Quality Policy and Strategy and the WHO Quality of care in fragile, conflict-affected and vulnerable settings: taking action resources, this situational analysis explored existing system-level opportunities to leverage quality and accelerate the achievement of health priorities. The report was developed through a highly participatory process led by the FMoH and establishes a foundational understanding of the quality of healthcare services, including identification of context-specific needs for enhanced quality service delivery and challenges to delivering quality care in Nigeria. The SITAN is a key initial step in the development and implementation of the Nigerian NQPS.

1.3 Scope

The SITAN provides a comprehensive national level overview of the current system for assuring and improving quality with an integration of sub-national and community level initiatives, governance, coordination and feedback mechanisms. However, it does not provide a detailed breakdown of quality of care by facility, region and state, and is by no means exhaustive in its findings. It takes a pragmatic approach to identifying and prioritizing major gaps in quality in the Nigerian healthcare system on which to build a foundation for a Nigerian NQPS.

The SITAN adapts and is guided by the WHO Handbook for NQPS. The handbook proposes eight essential elements for developing strategic direction for quality (Figure 1), which represents common steps to be considered by countries as they embark on developing an NQPS.

[1] https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2902488-0

The WHO elements for developing an NQPS include:

1. National health priorities - process of ensuring an alignment of the NQPS with pre-existing health goals and priorities and existing processes for national health planning and priority setting.

2. Local definition of quality - process of informing meaningful dialogue about quality with a variety of stakeholders to ensure that there is a shared understanding and common language around quality, which is applicable and acceptable for the local context.

3. Stakeholder mapping and engagement - process of identifying key stakeholders to involve in the process of developing and implementing an NQPS.

4. Situational analysis - understanding the current state of quality and health system in the country. It involves assessing the current quality of services across the health system, political context, threats and opportunities for the successful implementation of an NQPS.

5. Governance and organizational structure - outlining existing governance and leadership structures of national quality interventions, technical capacity and allocation of roles and responsibilities to ensure proper accountability and implementation of the NQPS.

6. Improvement methods and intervention - managing available resources and selecting context-specific interventions to improve quality across a health system.

7. Health management information systems and data systems - assessing and improving the current data and measurement systems to support the NQPS development, implementation and monitoring of progress.

8. Quality indicators and core measures - developing standardized indicators frameworks to assess quality improvement progress at all levels of healthcare and stages of implementing the NQPS.

The eight elements are organized as a non-linear and inter-connected process where some elements may be addressed simultaneously.

Figure 1: WHO Eight Elements for Developing a National Quality Policy and Strategy

Source: National Quality Policy and Strategy: Tools and Resources Compendium

1.4 Country Background

1.4.1 Geography and Administrative Structure

Nigeria is located in West Africa and shares land boundaries with Benin, Niger, Cameroon and Chad. The country is divided into 36 states and the FCT, which are subdivided into 774 local government areas

(LGAs). The LGAs are further divided into 9,565 political wards. Nigeria is also divided into six geopolitical zones namely the North-East, North-West, North-Central, South-East, South-West and South-South zones. These geopolitical zones comprise states with similar cultures, languages and ethnic groups.

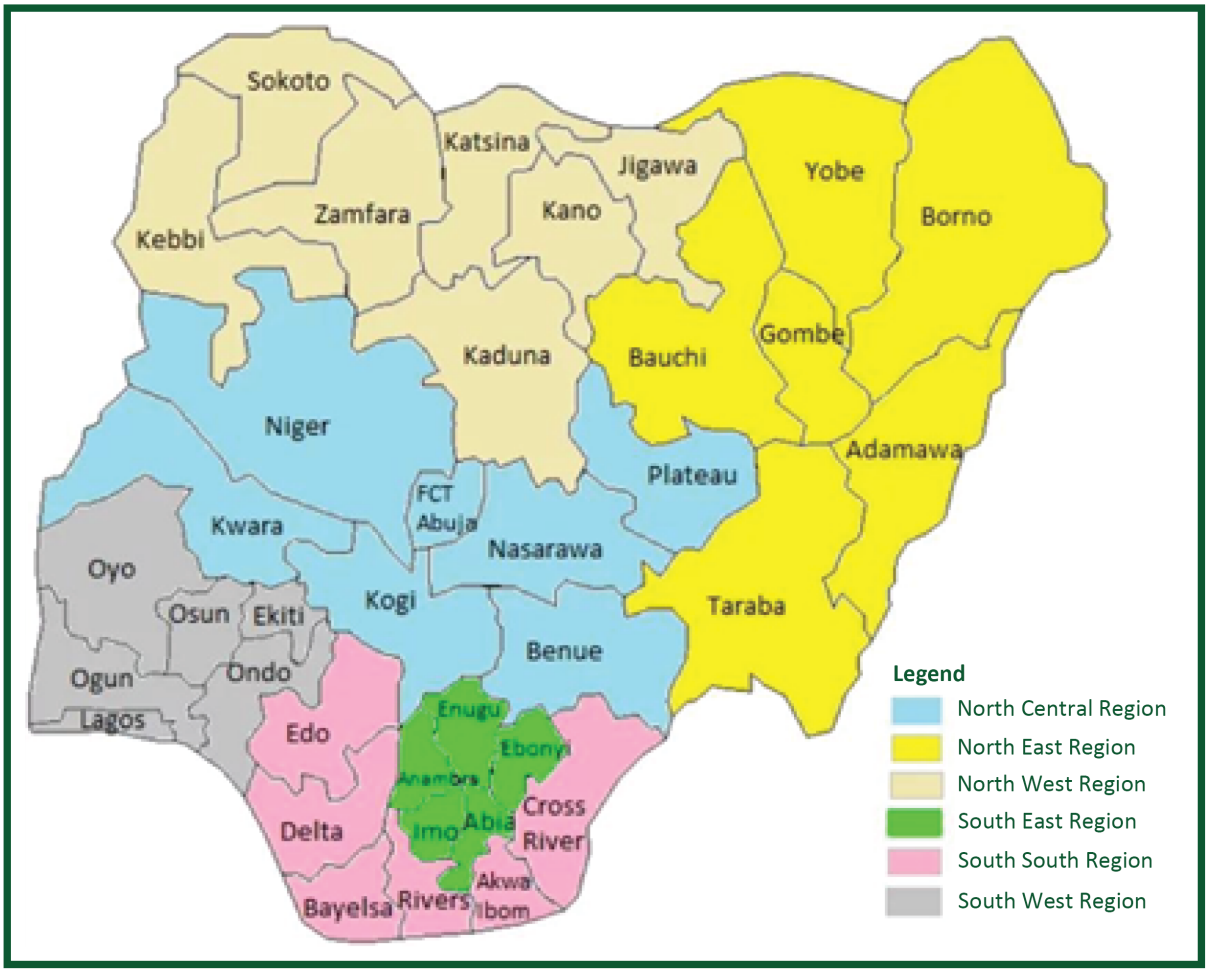

Figure 2: Map of Nigeria and its Geopolitical Zones

Source: Federal Government of Nigeria NSHDP II (2018-2022)

1.4.2 Population

According to the World Bank,[2] Nigeria has a population of over 206 million multi-ethnic and culturally diverse people. The country is the most populous country in Africa and currently the seventh most populous country in the world. Nigeria's population is projected to grow to 264 million by 2030 and over 401 million by 2050, anticipated to make Nigeria the third largest population in the world.[3] High rates of population growth tend to place a strain on the resources available for health care and the quality of health care delivery. The population of children aged under 15 years make up approximately 43 percent of the population while the older population of persons aged between 15 to 64 make up about 54 percent and those over 65 make up approximately 3 percent of the population.[4] Nigeria's population is one of the youngest in the world with an average age of 18 years. The younger the population of a country the higher the need for provision of child and adolescent health services.

Based on World Bank data, approximately 40 percent of Nigerians lived below the poverty line of a dollar and ninety cents ($1.90) a day in 2020 and this percentage is estimated to rise to 45.2 percent in 2022 due to the economic effects of the COVID-19 pandemic, which implies that almost 100 million Nigerians are estimated to be living in poverty by 2022.[5] Approximately 48 percent of the country's population live in rural areas where poverty is more prevalent, which hinders access to adequate nutrition, quality health care and other basic social services.[6] At the same time, Nigeria is currently undergoing one of the most dramatic urban transformations in history, which will have an impact on healthcare outcomes for generations to come. According to the WHO, Nigeria accounts for about 20 percent of all global maternal deaths[7] with a maternal mortality ratio of 512 per 100 000 live births, under-5 mortality rate of 132 per 1000 live births, infant mortality rate of 67 per 1000 live births and neonatal death rate of 39 per 1000 live births.[8]

[2] https://www.worldbank.org/en/country/nigeria/overview#1

[3] https://worldpopulationreview.com/countries/nigeria-population

[4] https://data.worldbank.org/indicator/SP.POP.1564.TO.ZS?locations=NG

[5] https://www.worldbank.org/en/news/press-release/2022/03/21/afw-deep-structural-reforms-guided-by-evidence-are-urgently-needed-to-lift-millions-of-nigerians-out-of-poverty

[6] https://link.springer.com/article/10.1007/s12132-018-9335-6

[7] https://www.who.int/news/item/25-06-2019-maternal-health-in-nigeria-generating-information-for-action

[8] https://dhsprogram.com/pubs/pdf/SR264/SR264.pdf

Trends in Childhood Mortality

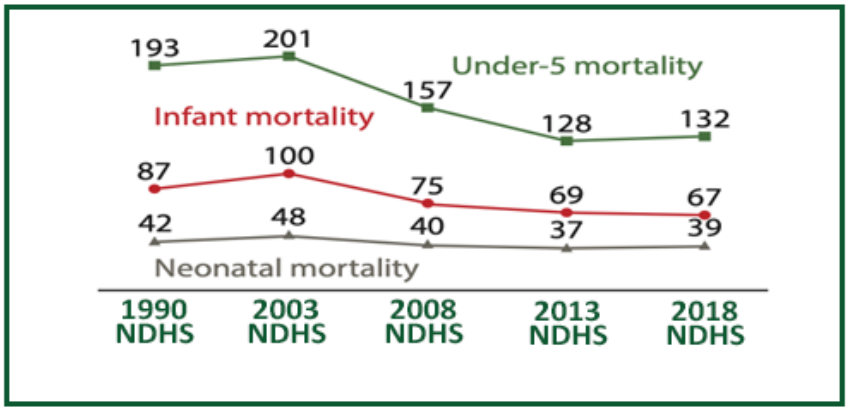

Figure 3: Deaths per 1000 live births for the five-year period before the survey

Source: 2018 Nigeria Demographic and Health Survey (NDHS)

1.4.3 Socio-Economic and Political Context

Nigeria is Africa's largest economy with an estimated 2020 gross domestic product (GDP) of US$ 432,294 billion, a GDP per capita of US$ 2,097 and a Gini coefficient (income inequality) of 35.1. In 2020, Nigeria experienced its worst recession in twenty years, but growth returned in 2021 as some COVID-19 restrictions were lifted and policies were enacted to mitigate the economic effects of the pandemic. Nigeria was exposed to the global impact of the pandemic, mainly due to the decline in oil prices as oil revenue contributes to about half of government revenues. The decline in earnings from oil negatively affects Nigeria's public finances, including healthcare expenditure. This has grave implications for financing health development and tackling health challenges facing the country such as poor healthcare coordination, fragmented services, inadequate medicines and medical supplies, poor infrastructure, limited healthcare access and poor-quality service delivery. In addition, high inflation rates also adversely affect household welfare and the ability to access care when needed leading to negative health outcomes. In response to the pandemic, the government carried out policy reforms in areas such as exchange rates management, adjustment of electricity tariffs and improvements in debt management and transparency in the public sector. However, Nigeria still faces challenges in the areas of reducing over-dependence on oil and diversifying the economy, tackling inadequate infrastructure, building resilient and effective institutions, managing governance issues and strengthening public financial management systems.

Nigeria's political landscape is relatively governed by the ruling party, which controls the executive arm of government. Nigeria currently faces a high level of insecurity and some established implications of security issues for the health sector include deprioritization of healthcare in crisis-ridden areas by the

government, fragmented services, limited supply of medicines and medical supplies, inadequate infrastructure, unequal access to healthcare and poor quality of healthcare service delivery.[9]

1.4.4 Health System Organization and Governance Structure

Health services in Nigeria are provided by healthcare providers in the public and private sectors. As of 2019, the Nigerian health facility register listed a total of 40,821 health facilities in Nigeria comprising 34,675 primary health care (PHC) facilities, 5,780 secondary care facilities and 166 tertiary facilities.[10] Over 66 percent of health facilities are public-owned; however, healthcare in Nigeria is largely driven by the private sector, which delivers care to over 60 percent of the population and serves as the first point of contact for over 80 percent of patients.[11]

The Nigerian healthcare sector has several challenges resulting in poor outcomes such as its mortality rate being one of the highest in the world due to a myriad of issues including inadequate secondary health facilities, non-functioning and obsolete diagnostic and investigative equipment in tertiary institutions, prevalence of fake drugs, low public health care expenditure, limited partnership between the private and public health sectors, mismanagement of limited health resources and poor coordination of donors and development partners.[12,13] In addition, brain drain is high due to Nigerian trained medical doctors and nurses being offered better remuneration and improved working conditions in other countries. Health worker migration has risen substantially in the context of the COVID-19 pandemic.

According to the WHO, Nigeria's health system has improved from 187 out of 191 countries two decades ago to 163 out of 191 countries. This slight and slow but positive improvement underscores the need to catalyze the improvement by further understanding the root causes of healthcare challenges, identifying the opportunities and assets in the country and highlighting areas of prioritization for possible intervention (see Table 1 for basic information on Nigerian health system).[14]

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5637047/

[10] https://hfr.health.gov.ng

[11] alliancehpsr_nigeriaprimasys.pdf

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5637047/

[13] alliancehpsr_nigeriaprimasys.pdf

[14] http://apps.who.int/gho/data/node.cco

Indicator	Result
Total health expenditure as a portion of GDP (in percentages)	3.67
General government expenditure on health as a percentage of total government expenditure (in percentages)	8.17
Private expenditure on heath as a percentage of total expenditure on health (in percentages)	74.85
Out of pocket healthcare expenditure as a percentage of total expenditure (in percentages)	77
Number of Physicians (per 1000 population)	0.38
Number of nurses and midwives (per 1000 population)	1.49

Table 1: Basic Information on Nigeria Health System

The provision of public health services in Nigeria is the responsibility of all three tiers of government. Specifically, the primary, secondary and tertiary levels of care are the responsibilities of the local government areas, state government and federal government respectively. The federal government through the FMoH is chiefly responsible for the leadership and supervision of tertiary healthcare delivery. Besides tertiary health care provision, the federal government leads the development and implementation of specific public health programs at all levels. The state governments through the state ministries of health control secondary health care delivery of specialized services to patients through the outpatient and inpatient services of hospitals. The LGA health departments are responsible for managing PHC facilities at the primary level, which is the lowest level of care and the entry point to health services. Rural areas are mainly served by PHC facilities while secondary and tertiary health facilities are mostly found in urban regions.

Figure 4: Nigeria's Health System

Source: Federal Government of Nigeria NSHDP II (2018-2022)

Based on the NSHDP II (2018-2022), Nigeria's health governance and policy framework includes:

- National Health Policy
- National Council on Health
- National Health Act
- Basic Health Care Provision Fund
- Specific policies to strengthen PHC such as Primary Health Care Under One Roof.
- Institutional structures including MDAs, Health Management Boards, Regulatory Committees and other complementary committees.

1.5 Health Situation of the Population

According to a Lancet ranking of health systems performance, Nigeria ranks 142 out of 195 countries regarding healthcare access and quality. Though Nigeria has shown some improvement in its health indicators, the country is still plagued with the burden of communicable and non-communicable diseases and maternal and child morbidity and mortality. As reported by the WHO, neonatal conditions are the leading causes of disease burden and mortality in Nigeria followed by lower respiratory tract infections.[15] Disease burden is measured in disability-adjusted life years (DALYs), which describes the loss of the equivalent of one year of full health. Table 2 shows the top ten causes of DALYs in Nigeria.

[15] https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys

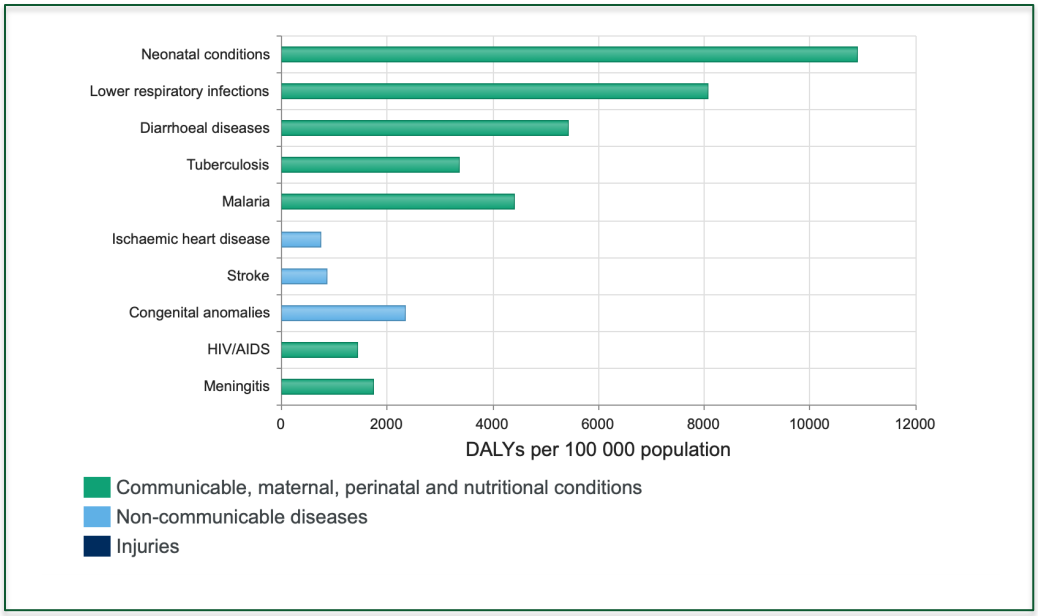

Table 2: Top ten causes of disability-adjusted life years in Nigeria

Source: WHO Global Health Estimates (2019)

Noncommunicable diseases (NCD) account for about one quarter of total deaths in Nigeria.[16] Based on a systematic analysis of data and results of the Global Burden of Diseases, Injuries, and Risk Factors Study 2019,[17] malaria was the leading cause of years of life lost (YLLs) in Nigeria while neonatal disorders, lower respiratory infections, and HIV and AIDS were other major drivers of YLLs in Nigeria between 1998 and 2019. Although they remain the main drivers of mortality in Nigeria, improvements were made in reducing the rate of YLLs for infections and neonatal conditions between 1998 and 2019 in the YLLs caused by tuberculosis, diarrhoeal diseases, lower-respiratory infections, malaria, and HIV and AIDS.[18] However, HIV/AIDS contributed largely to YLLs, accounting for 4113·6 YLLs per 100000 people aged 20 to 54 years.[19] Overall, progress was made in reducing the rate of YLLs caused by infectious diseases over this period, however, YLLs associated with many NCDs have grown in importance.[20]

[16] https://www.emerald.com/insight/content/doi/10.1108/JHR-02-2020-0039/full/html

[17] https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(21)02722-7.pdf

[18] Ibid

[19] Ibid

[20] Ibid

2.0 Methodology

The SITAN methodology is based on a participatory and collaborative effort, fully owned and led by the FMoH, Department of Health Planning, Research and Statistics (DPRS) with support from the WHO Nigeria Office, Regional Office and Headquarters as well as national and international consultants.

The SITAN involves a three-pronged approach for data collection and synthesis comprising a desk review, key informant interviews and a stakeholder consultation workshop to collate information and validate evolving themes that will inform priority areas for the NQPS. The activities were organized in a sequential manner, such that each approach built on knowledge and insights from the preceding with the desk review being the first.

Prior to the commencement of the data collection exercise, a virtual inception meeting was held by the FMoH with leaders and stakeholders within FMoH departments, selected state ministries of health, parastatals, regulatory agencies, donor agencies and implementing partners, professional societies, academic institutions, multilateral organizations, private sector organizations and representatives from the communities (see Appendix A for a list of stakeholders at the inception meeting). The purpose of the inception meeting was to provide a road map for the development of the NQPS with the aim of ensuring ownership of the development process and commitment to the NQPS when developed.

A stakeholder mapping from national to community levels of key entities responsible for governing, regulating, enforcing, delivering and improving quality was also carried out. The objective of the mapping was to identify agencies and organizations that are currently implementing or involved in quality planning, assurance or improvement approaches, map their roles and relationships, and assess what could be learnt from their experience. Agencies and organizations currently involved in quality were also identified by the FMoH, WHO and stakeholders to determine the impact of existing quality initiatives on key dimensions of the health system. The stakeholders were engaged throughout the situational analysis process either through interviews or workshops.

2.1 Desk Review

A desk review was carried out from November 2021 to April 2022 as the first and continuous step in the data collection exercise for the SITAN, upon which other data collection activities were based. The review of selected national and sub-national documents aimed to identify and explore current data on quality of care, national quality goals and priorities, past and existing policies, strategies and quality initiatives. It also considered health system stakeholders, organograms, coordinating mechanisms, healthcare assets and health and healthcare gaps that could be addressed by the presence of a policy and strategy on quality.

Key policy and strategy documents related to quality of care in Nigeria were identified by subject experts within the FMoH and WHO. This was supplemented by additional keyword searches of Pubmed, Google Scholar, Google and Medline. Keywords that were combined to search for relevant online literature

include: health, quality of care, health systems, strategic plan, policy, challenges, solutions, Nigeria, national, ministry of health, governance, human resources, information, research, finance and monitoring and evaluation. Overall, relevant articles that were specific to the Nigerian context were prioritized for inclusion in the desk review. The full list of documents and websites reviewed can be found in Appendix B.

2.2 Key Informant Interviews

Key Informant Interviews (KIIs) with select expert stakeholders were conducted to map the current system for regulating, delivering and monitoring quality and to understand accountability, coordination and organization across entities. The information obtained from the desk review was used to guide the design and development of the interview guide. The interview guide was used in the conduct of the KIIs, structured to obtain the definition and current state of quality of care in the Nigerian health system, major gaps or challenges in delivering quality of care in Nigeria, and major facilitating factors or opportunities available to improve the quality of care in Nigeria. There was a concerted effort to glean insights into challenges and successes of the existing system for governing quality healthcare delivery as well as current and past initiatives and their associated challenges and successes. The interviews were centered on understanding the overall health care quality landscape in Nigeria from the perspectives of stakeholders.

2.2.1 Selection Criteria for Key Informants

To maintain diversity among the stakeholders, a list of potential interviewees was created with input from representatives from the FMoH - DPRS, WHO Headquarters, WHO Regional Office for Africa, WHO Nigeria, and the national and international consultants supporting the process. Potential interviewees were divided into the six stakeholder groups consisting of:

- Policy makers
- Regulatory bodies
- Development partners
- Academia/researchers
- Healthcare providers
- Users of healthcare/community

Individuals were identified and their willingness to participate sought through email. A list of individuals who responded and declared their willingness to participate in the survey was made and the interview dates were fixed. A deliberate attempt was made by the FMoH and WHO to ensure the right mix and

participation of stakeholders from the six (6) stakeholder groups (see Appendix C for a list of interviewees).

2.2.2 Key Informant Interviews Protocol

The interviews were conducted using a standard interview protocol, which included an exploration of the participants' understanding of quality of care, major gaps or challenges in delivering quality of care in Nigeria, and major facilitating factors or opportunities available to improve the quality of care in Nigeria. The interviews began by the participants being asked to state their role within their organizations and to describe the role as it relates to quality of care. Subsequently, the interviews were adapted according to the interviewees background and expertise (see Appendix D for the interview protocol).

2.2.3 Interview Sessions

The objective of the interviews was to understand major initiatives, challenges and opportunities across the Nigerian healthcare system. The team of interviewers consisted of an interviewer, a notetaker and a quality observer. The interviewers were selected from the team of consultants, while the note taker and the quality observer were from the FMoH and WHO. Both physical and virtual interviews were conducted. The virtual interviews were conducted via Zoom online platform due to the spread of the different locations of these respondents, coupled with pandemic restrictions. Each interview lasted between 40 minutes to 90 minutes. Most interviews were audio-recorded (with the consent of the interviewees). Confidentiality was maintained and the audio-records saved with a password. A total of 26 KIIs were conducted and the interview notes from all sessions were drafted and uploaded within 24 hours of the interviews and stored in a Google drive, a secure, password-protected centralized cloud-based server.

2.3 Stakeholder Consultation Workshop

A stakeholder consultation workshop was held in Abuja from February 10th to 11th, 2022 with 49 stakeholders attending in-person and seven stakeholders attending online. The workshop aimed to understand from a diverse group of stakeholders, the opportunities and challenges in quality of care in the Nigerian health system; to pressure test the emerging themes of the desk review and KIIs; to determine a local definition of quality of care; to obtain ideas on potential priority areas for the NQPS; and to define potential quality ambitions for different areas of quality under the NQPS. The workshop involved stakeholders selected from the six stakeholder groups of policy makers, regulatory bodies, development partners, healthcare providers, users of healthcare/community and academia/researchers spread across the 36 states and Federal Capital Territory (FCT) (list of stakeholders at the consultation workshop is included in Appendix E).

Facilitators for the consultation workshop were representatives from the team of consultants, FMoH and WHO. The workshop was organized as a combination of plenary and parallel group sessions. The attendees were split into five groups based on their capacities and expertise, with each group discussing the findings in one of five thematic areas: systems environment; reducing harm; improving effectiveness

of clinical care; patient, families and community engagement; and monitoring, evaluation and learning systems.

2.4 Ethical Considerations

Ethical approval was sought and obtained for the SITAN from the National Health Research and Ethics Committee, of the FMoH, Nigeria. Informed written consent was obtained for the physical interviews, while informed verbal consent was obtained from all participants for virtual interviews. Interviewees were informed that participation was voluntary and given the opportunity to seek clarification on any grey areas. To protect the privacy of the interviewees, measures were taken to prevent the disclosure of identifiable information at any point in time.

2.5 Limitations

The methodology for the SITAN was rapid with limited searches and reviews of all relevant literature related to quality of care in Nigeria. There was also limited availability of information on quality in fragile, conflict-affected and vulnerable settings and progress reports on some identified quality interventions. However, a pragmatic approach was adopted by leveraging upon the experience and expertise of expert staff at the FMoH and other SITAN technical team members to identify and obtain the most critical documents for review. The review also included draft national reports that helped to provide insights into the major structures and challenges relating to quality of care in Nigeria.

The desk review focused mainly on Nigerian health documents, policies and reports to understand the current situation of quality of care. However, the review was extended to WHO health systems reports and documents of other countries in defining quality and understanding the SITAN process. The desk review also prioritized key documents to replace the insights that would have been gleaned during site visits.

The stipulated time for the KIIs was limited to one month due to interviewee availability. However, key interviewees with vital insights into quality of care in Nigeria were contacted after the one-month period. Due to resource limitations, the KIIs were recorded with consent but not fully transcribed. However, during the interviews and while listening to the recordings, interviewers noted key points, which were later analyzed and synthesized.

There was the exclusion of a facility-based survey during data collection to understand the availability and functionality of support equipment, physician-patient interaction, and overall quality of healthcare delivery. However, publications found during the desk review were used to glean insights about support services in healthcare facilities.

3.0 Findings

3.1 Whole System Quality

Definition of Quality

There is no universally accepted definition of the term 'quality' in the literature. However, the National Academy of Medicine (NAM), formerly known as the Institute of Medicine, defines healthcare quality as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".[21]

The NAM characteristics of quality include safe, effective, patient-centered, efficient, timely, and equitable.

- Safe: avoiding preventable injuries and reducing harmful errors
- Effective: providing services based on scientific knowledge, clinical protocols and guidelines
- Patient-centered: care that is respectful and responsive to individual needs
- Efficient: avoiding wasting time and other resources
- Timely: reducing wait times and delays and improving the practice flow
- Equitable: same quality of care regardless of patient characteristics and demographics

[21] https://www.ncbi.nlm.nih.gov/books/NBK222274/

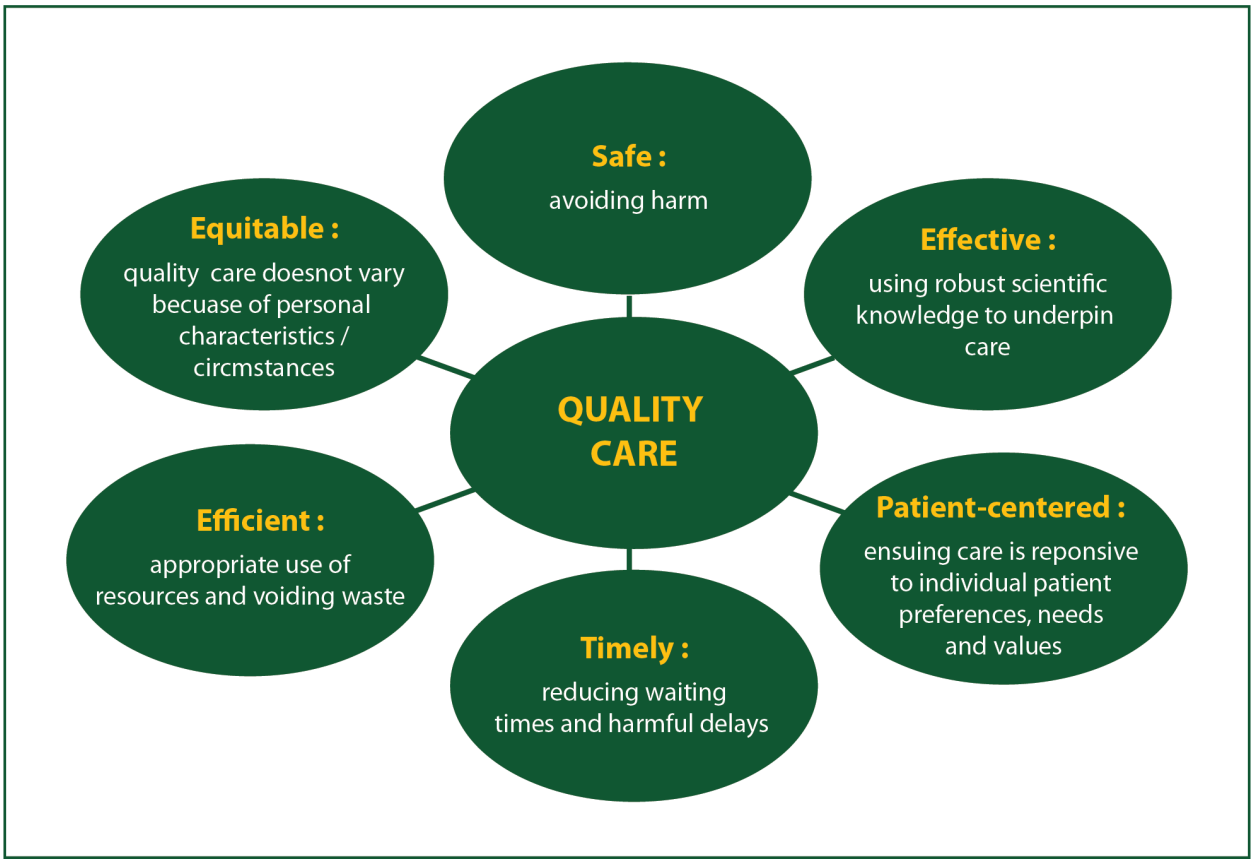

Figure 5: Six Characteristics of Quality Care

Source: National Academy of Medicine

From the Key Informant Interviews (KIIs), participants generated multiple interpretations, explanations and themes on quality of care. The key characteristics of quality of care highlighted by the participants include effective, user satisfaction, compassionate care, affordable, accessible, equitable, accurate, timely and safe.

Interviewees noted effectiveness as a key component of quality of care. Effective care was generally described to be achieved using protocols, guidance and standards. For interviewees, consistency was a key component of effective care, that is, the same high standard of care is delivered for all people over time. User satisfaction was also highlighted by interviewees to be a critical element of quality health services. Interviewees noted the importance of a caring or professional attitude of health staff towards patients as an important component of quality of care. Affordability is closely linked to accessibility and equity of which interviewees noted that for healthcare to be considered good quality, it must benefit all

people, including the poor. Interviewees noted that importantly, quality healthcare can only be provided when care is available and accessible to those who need it.

Other prominent themes identified by a few interviewees on key components of quality healthcare were accurate information, safe and timely care. Patients should be attended to promptly and be given the right medication, advice and answers to questions raised. An interviewee felt that care should also be delivered efficiently and safely and cause patients no harm.

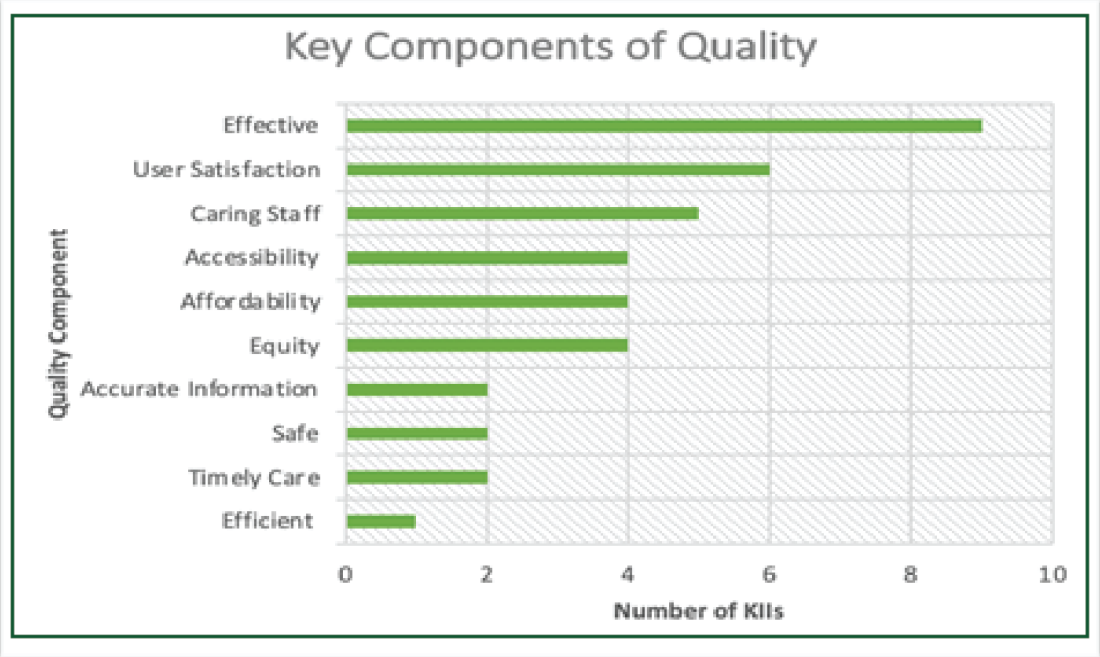

Figure 6: Key Components of Quality

During the stakeholder consultation workshop, a definition was culled from the key components of quality that emerged from the KIIs and an initial definition of quality of care was drafted. The drafted definition was examined, and each word was intentionally chosen to reflect the opinions of the diverse stakeholders. The discussion during the stakeholder workshop generated a consensus local definition of quality of care as:

"Care that is accessible, acceptable and affordable to all individuals and uses cost-effective interventions that are patient-centered and offer satisfactory services that are timely and safe."

Figure 7. Key Components of Local Definition of Quality

3.2 Quality Management

Quality Management in healthcare refers to the organization of structures, policies, and processes that minimize or eliminate harm to patients and enhance patient care and health outcomes.[22] Effective quality management of health systems help to carry out the following:[23]

- Plan, maintain and improve quality of care
- Ensure public safety
- Establish entry requirements and legal recognition
- Verify that equipment design or maintenance specifications are met
- Document healthcare professional or institution capability
- Ensure risk management
- Monitor private sector
- Implement new modes of healthcare delivery
- Address public health issues
- Allocate limited resources
- Establish a coordinated system of healthcare delivery

The Juran trilogy categorizes the components of quality management into quality planning, quality assurance and quality improvement.[24] These three components are adopted in subsequent sections as a framework to understand from the findings the needs, gaps and opportunities of quality of care in Nigeria.

3.2.1 Planning for Quality: Healthcare Quality Policies, Plans and Strategies

3.2.1.1 *Healthcare Quality Policies*

Planning for Quality involves determining the requirements that a health care system must meet and establishing a framework of plans, goals and strategies that coordinates and provides the right care to the right patient at the right time.[25]
Nigeria has implemented six (6) consecutive national health policies and over twenty-four (24) sectoral health policies since the country gained independence in 1960.[26] The first four policies were incorporated into national development plans formulated between 1960 and 1985 based on the assumption that improving population health depended on the availability of health providers and access to health facilities.[27] Nigeria launched a National Health Policy in 1988, which was anchored on the principles of

[22] https://www.ncbi.nlm.nih.gov/books/NBK557505/

[23] https://www.globalhealthlearning.org/sites/default/files/reference-files/rooneu.pdf

[24] Juran JM (1998). Juran's quality handbook. New York: McGraw-Hill, pg. 15

[25] https://www.hanshep.org/member-area/programmes/healthcare-quality-self-regulating-body-in-nigeria/feb-2014-survey-report-on-quality-management-in-nigeria.pdf

[26] https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/Nigeria%20National%20Strategic%20Health%20Development%20Plan%20Framework%202009-2015.pdf

[27] https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/Nigeria%20National%20Strategic%20Health%20Development%20Plan%20Framework%202009-2015.pdf

primary health care and based on evidence of the country's health challenges including the burden of disease burden; the 1988 NHP was revised in 2014.[28]

The 2014 National Health Act (NHAct) was enacted and signed into law on October 31, 2014, to organize the health care system, the healthcare providers and the relationship between various levels of healthcare. The Act comprises seven parts that are structured to impact healthcare access, cost, quality and standards, healthcare provider practices and patient and health outcomes. The seven parts of the NHAct include[29]:

1. Defining the flow of authority and responsibility within the health system and establishing the framework for standards and regulation of health services
2. Providing ministers with the power to regulate and coordinate healthcare organizations and technologies
3. Making provisions for the rights and obligations of healthcare users and workers
4. Providing for research, data and information collection and organization within the health sector
5. Developing a policy and guidelines through the minister for adequate recruitment, capacity building and distribution of trained healthcare staff at all levels
6. Specifying the rules, principles and sanctions regulating the collection and prescription of blood products and handling of vital tissue
7. Citing the powers of the minister to make regulations, form committees and assign and delegate duties

The Act details the establishment of a National Council on Health, which serves as the highest policy making body for the federation and comprises the Minister for Health, the Minister of State for Health, the Commissioners of Health for all 36 states of the federation as well as the Secretary for Health in the Federal Capital Territory.[30] The National Council on Health approved the Nigerian National Quality Strategy in 2015 and would likely be responsible for approving the 2022 National Quality Policy and Strategy.

National Health Policy

The NHAct provides the structure for the implementation of the National Health Policy (NHP), which was launched in April 2016. The 2016 NHP was launched to reflect current healthcare realities in strengthening Nigeria's health system, particularly the PHC, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians. The policy notes that quality of healthcare services in Nigeria is generally poor and details several issues including poor adherence to clinical guidelines, a low competence in clinical management of illnesses, limited monitoring

[28] https://naca.gov.ng/wp-content/uploads/2019/10/National-Health-Policy-Final-copy.pdf

[29] https://www.premiumtimesng.com/health/health-features/296422-dissecting-national-health-act-what-nigerians-need-to-know-1.html

[30] National Health Act, 2014, Abuja, Nigeria: Federal Government of Nigeria.

of quality across the private healthcare sector and a lack of an institutional framework for regulating quality and standards. Priority objectives of the 2016 NHP focus on the following areas:

I. Priority Public Health
   - Reproductive, Maternal, Neonatal, Child and Adolescent Health
   - Prevention and Control of Communicable Diseases
   - Prevention and Control of Non-Communicable Diseases (NCDs)
   - Public Health Emergency Preparedness and Response
   - Other Health Problems such as mental health, oral health, eye health and disabilities
   - Health-related Problems and Issues such as nutrition and water and sanitation

II. Health Systems
   - Governance and Stewardship
   - Health Service Delivery
   - Health Financing
   - Human Resources for Health
   - Medicines, Vaccines, Other Health Technologies
   - Health Infrastructure
   - Health Information System
   - Health Research and Development
   - Community Ownership and Participation
   - Partnerships for Health

The policy also states as a guiding principle that the government shall ensure quality healthcare across all levels of the healthcare system. Although there has been some improvement in the health status of Nigerians, the difference is insignificant when compared to the progress toward achieving Sustainable Development Goals (SDGs). The health challenges of equity, accessibility, affordability, quality, effectiveness and efficiency, which are objectives of the revised NHP still remain. There are scarce interventions for priority public health issues such as non-communicable diseases and maternal and child health. Inter-sectoral collaboration between the health-related ministries, development partners, private sector partners and donors remains a major challenge.

Interviewees confirmed that health policies and strategies are perceived to be driven by senior ministry officials with minimal stakeholder engagement, which impacts on policy ownership at the state and local levels. Another issue raised was a lack of evidence-based decision making in health policy and strategy formation.

> *"Policy makers will sit down and make policies without adequate evidence and without involvement of key stakeholders"*

"Most policies are funded by international organizations and may not have direct bearing to the needs of the people"

"The priorities of the federal ministry are also misplaced. They should be involved in policy creation and not implementation"

Interviewees also described a lack of trust and confidence in government policies and interventions, which creates challenges in motivating communities to participate in issues concerning their health and strengthening the health system.

"There is no community participation: people have lost confidence in government, so for any government policy the community handles it with a pinch of salt"

Stakeholders agreed with the findings from the interviews and added that a lack of political will and poor policy implementation and enforcement are key health system issues in Nigeria.

"*It's not the making of policies but the implementation of those policies … it's usually a case of talk but no action*"

Healthcare Financing Policy

Health service providers in Nigeria receive funding from different health financing mechanisms including government budgets, health insurance, out-of-pocket (OOP) payments, donor funding, and others as shown in Figure 8. Each financing mechanism is characterized by different "payment mechanism, provider payment rates, contractual agreement, reporting requirement, decision space and accountability mechanisms".[31]

[31] https://www.frontiersin.org/articles/10.3389/fpubh.2019.00403/full

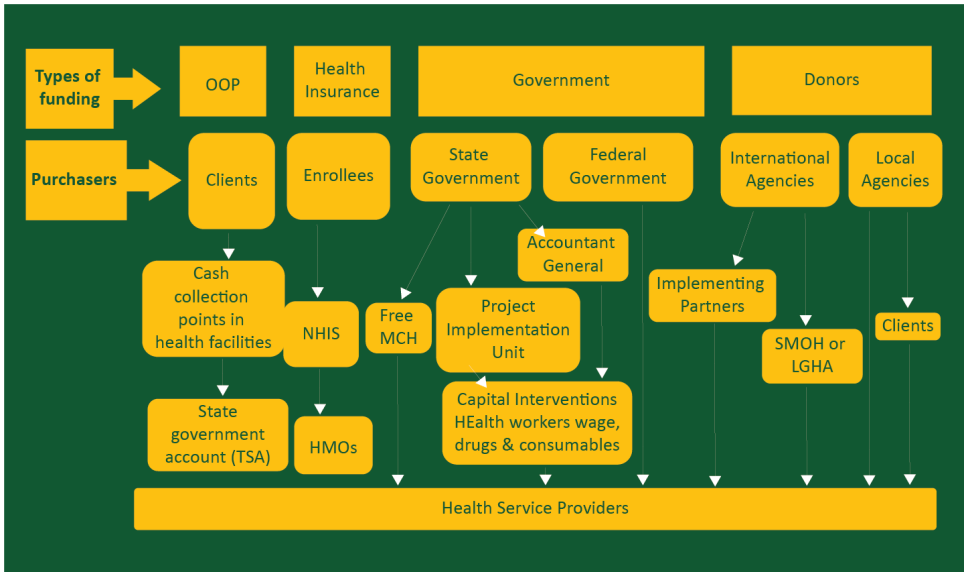

Figure 8. Health System Funding Flows in Nigeria[32]

Funding for the public health sector includes funds from the state and local governments, direct allocations from the federal government as well as funding from non-governmental organizations including the private sector and international donors. However, since independence, Nigeria's healthcare financing model has evolved to focus on generating revenue by charging user fees. Public health service providers or centers have been shaped to be pseudo-commercial facilities as they are restructured to generate the funds they need to work efficiently and independently.[33] Both the public and private health sectors are more market-oriented although a large majority of Nigerians are estimated to have little to no disposable income.

About 77 percent of total healthcare expenditures are through out-of-pocket spending, which creates a barrier to accessing healthcare and leaves poor Nigerians unable to access quality healthcare or leads them to financial hardship due to payment for healthcare services.[34,35]

Financing mechanisms to ensure maximum utilization of health services have been established to eliminate financial barriers to access health care. To improve healthcare access and reduce the burden of out-of-pocket payments, the Nigerian government established healthcare financing mechanisms such as the National Health Insurance Scheme (NHIS) and State Social Health Insurance Scheme (SSHIS). However,

[32] Ibid

[33] The Lancet Nigeria Commission: investing in health and the future of the nation

[34] Odunyemi, A. E. (2021). The Implications of Health Financing for Health Access and Equity in Nigeria

[35] http://apps.who.int/gho/data/node.cco

the NHIS covers only about 5 percent of the Nigerian population, majority of whom are individuals working in the formal sector particularly federal civil servants. Challenges to NHIS expansion include optional enrollment for all Nigerians and a lack of adoption by state governments. To address these issues and hasten Nigeria's progress towards achieving universal health coverage, the NHIS decentralized its implementation to the states in 2014.[36]

In 2015, Lagos became the first state to pass its own State-Based Health Insurance Scheme into law, creating the Lagos State Health Scheme (LSHS).[37] The LSHS was structured as a compulsory health insurance scheme to enroll all Lagos state residents and minimize the financial burden of getting care by improving access to quality care.[38] Prior to the LSHS, Lagos state deployed three community-based health insurance (CBHI) schemes, which enrolled almost 40,000 community members.[39] Evaluations carried out on the impact of the schemes in 2010 reported some positive outcomes relating to quality of maternal and neonatal services and patient satisfaction.[40] However, the evaluations also noted high turnover rates among participating enrollees and healthcare providers.[41] Other states in Nigeria have since passed a State Insurance Scheme into law.

Health insurance is also provided through Health Maintenance Organizations (HMOs) who play a key role in health financing in Nigeria. HMOs serve as an intermediary between the NHIS and healthcare providers. HMOs receive payments from the NHIS and are required to pay these funds to healthcare providers based on the volume of insured patients.[42] The mode of payment differs amongst the different levels of the healthcare system. Providers in the PHC are paid via a capitation model while providers at the secondary level are paid via a fee-for-service model. This differs from the payment system in the private healthcare sector where the HMOs collect a premium from individuals or groups and then negotiate with healthcare facilities to determine a service rate at which they will pay for services provided to people seeking healthcare services.[43] The NHIS also regulates HMOs and inspects and accredits facilities seeking to enroll in the NHIS while the HMOs provide supervisory visits to PHC facilities accredited by the NHIS.

The FMoH established the Basic Health Care Provision Fund (BHCPF), which is financed by sources including grants from the federal government and international donor partners as described in the National Health Act. The BHCPF was created to finance the following:[44]

i. Provision of a Basic Minimum Package of Healthcare Services (BMPHS) through the National Health Insurance Scheme (NHIS).
ii. Provision of essential drugs, vaccines and consumables for eligible primary healthcare facilities.

[36] Shobiye, H. O., Dada, I., Ndili, N., Zamba, E., Feeley, F., & de Wit, T. R. (2021). Determinants and perception of health insurance participation among healthcare providers in Nigeria: A mixed-methods study. *Plos one*, *16*(8), e0255206.

[37] Ibid

[38] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0255206

[39] http://health.lagosstate.gov.ng/lagos-state-health-insurance-scheme/

[40] https://www.healthpolicyproject.com/pubs/97_communitybasedhealthinsurance.pdf

[41] Ibid

[42] Shobiye, H. O., Dada, I., Ndili, N., Zamba, E., Feeley, F., & de Wit, T. R. (2021). Determinants and perception of health insurance participation among healthcare providers in Nigeria: A mixed-methods study. *Plos one*, *16*(8), e0255206.

[43] Ibid

[44] Implementation of the Basic Health Care Provision Fund (BHCPF) in Nigeria, Human Capital Development Network

iii. Provision and maintenance of infrastructure of eligible primary healthcare facilities.
iv. Development of human resources for primary healthcare.
v. Provision of emergency medical treatment.

Through the NHA, the federal and state governments are required to fund the BMPHS. The federal government does this with at least one (1) percent of the FG Consolidated Revenue Fund (CRF) and twenty-five (25) percent counterpart funding. The state governments are also required to meet eligibility requirements for accessing the BHCPF, which includes payment of the counterpart funding of twenty-five (25) percent of the total funds disbursed by the BHCPF[45,46].

However, delays in the implementation of the BHCPF have left citizens unable to access the basic package of healthcare services through the NHIS.[47] In addition, there is a lack of readily available information on the disbursement and utilization of the BHCPF across federal and state levels. The state governments also experience delays in setting up State Social Health Insurance Agency management teams and in signing of the Service Level Agreement between the State Primary Health Care Management Board and health facilities.[48]

The federal government achieved promising results with support from the World Bank on performance-based financing (PBF) and decentralized facility financing (DFF). Due to autonomy, community engagement, and strengthened supervision positive effects were observed in health service utilization, improved coverage and quality of care.[49] Under DFF, funds are transferred to primary healthcare facilities to cover operational expenses such as procurement of drugs and supplies, facility maintenance and outreach costs. On the other hand, PBF provided funds to facilities based on the quantity and quality of specific services rendered.[50] However, there is still much room for innovation and further improvements in integrating both approaches. [51]

The challenge of inadequate government financing of healthcare at all levels has been identified and a goal of the National Strategic Health Development Plan (NSHDP) II is to ensure that "all Nigerians have access to health services without any financial barriers at the point of accessing care" by increasing the percentage of health budget allocated to primary health care (target of 35 percent) and the percentage of the national budget allocated to the health sector (target of 15 percent). However, these targets are yet to be met. For instance, the average budget allocation to the health sector was 4.7% across the last twenty years with the highest allocation of 6.1% in 2012.[52] Figure 9 shows a comparison between the

[45] Implementation of the Basic Health Care Provision Fund (BHCPF) in Nigeria, Human Capital Development Network
[46] https://www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html
[47] Implementation Of The Basic Health Care Provision Fund (Bhcpf) In Nigeria, Human Capital Development Network
[48] Ibid
[49] https://documents1.worldbank.org/curated/en/102621580321213128/pdf/Nigeria-Immunization-Plus-and-Malaria-Progress-by-Accelerating-Coverage-and-Transforming-Services-Project.pdf
[50] Ibid
[51] https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-021-02092-4#Sec1

[52] https://www.devex.com/news/sponsored/2-decades-on-nigeria-falls-short-of-landmark-health-pledge-99555

FMoH budget and other allocations to the health sector budget under the Service-Wide Votes (SWV). The SWV comprises counterpart funding for health, Gavi/Immunization, Zonal Intervention Projects (ZIP) for Health amongst others.[53]

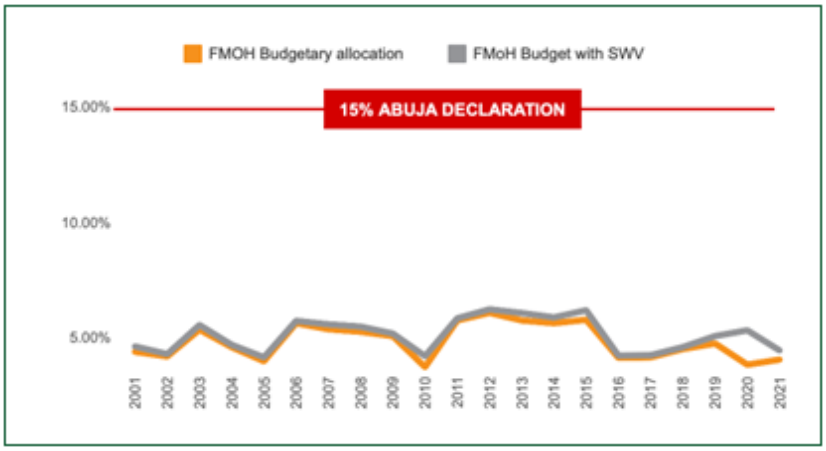

Figure 9. Health Budget - Deficit in the 15 Percent Benchmark[54]

To provide insurance coverage for all Nigerians, the federal government recently signed into law the National Health Insurance Authority Bill 2022 on May 19, 2022. The law repeals the NHIS, which has been in existence since 2004. The National Health Insurance Authority will collaborate with State Government Health Insurance Schemes to accredit primary and secondary healthcare facilities and ensure the enrolment of Nigerians. Based on the law, a fund will be set up to ensure the coverage of 83 million poor Nigerians who cannot afford to pay premiums as recommended by the Lancet Nigeria Commission.[55]

From the KIIs, participants commented on the impact of the under-funded healthcare environment on the quality of healthcare delivery. Specifically, interviewees confirmed that in the Abuja declaration it states that 15 percent of the national budget should be allocated to health but in reality, budget allocation is only about five percent. Interviewees commented that disbursement of funds is slow even when the budget is allocated. Furthermore, interviewees commented that budget allocation is variable between the tiers of the healthcare system, with tertiary levels receiving proportionally more funding from the federal government than secondary or primary care. It was suggested that this resulted in wastage at tertiary levels and deficiencies in care at lower levels of the system. It was also noted that the government should not only work to allocate funds but also ensure that the funds are actually distributed to the relevant initiatives.

[53] Ibid

[54] https://www.devex.com/news/sponsored/2-decades-on-nigeria-falls-short-of-landmark-health-pledge-99555

[55] https://www.premiumtimesng.com/news/headlines/531087-updated-buhari-signs-health-insurance-bill-into-law.html

"Annual operational plans are done yearly; approval is given but funds are never released"

"*Lack of funding and variation in allocation between tiers of healthcare facilities. Tertiary is heavily funded and great chunk of federal fund goes to the tertiary"*

"Health insurance should be made compulsory, increase demand side intervention and result based financing that will stimulate supply side"

"There is an opportunity to strengthen existing health insurance models which would also do well in improving health promotion"

"Health insurance schemes such as the one in Lagos state can create more funding for healthcare and lead to greater access and affordability for Nigerians. If the healthcare system was improved, the vast amount of money spent on medical tourism could be spent within Nigeria leading to greater improvement and greater remuneration for healthcare workers"

Others noted that there are weak systems for pooling of resources for healthcare. The NHIS is currently poorly utilized with enrollment of those with a low risk of being ill being impacted by predetermined fixed prices. Purchasing of services to meet population needs was also highlighted to be inefficient by the interviewees. It was noted that purchasing is not strategic and mass purchasing practices are inefficient. Interviewees mentioned that budgeting processes were weak, with no linkage of budgets to purchasing activities and priorities.

Strategic planning was noted to be problematic with plans most often not linked to the available budget. It was noted that many strategic plans and policies remain funded by international organizations, which undermines continuity of healthcare interventions as well as often resulting in a mismatch between the needs of the people and the funding provided.

"*Getting resources to support policy and strategy roll out is a failure. We are still relying on donors to support policy and strategy. There needs to be government provision for the strategic plans. This is vital to support roll out and continuity"*

Overall weak healthcare financing in resource mobilization, pooled funding and purchasing was linked in part to health being under-prioritized at the national and state level, with limited political will to focus on healthcare. Ultimately patients are impacted by weak healthcare financing through experiencing large out of pocket payments and inefficient or ineffective care. It was noted that patients often pay for services that are meant to be free in general hospitals.

Stakeholders at the workshop confirmed the key issues in healthcare financing that were highlighted during the KIIs:

> *"Lack of budgetary provision for health system"*
>
> "*Insufficient financial investment at sub-national and national levels. PHC, LGA hospitals are not properly funded. The amount for health budgeted in the national budget is incredibly low*"
>
> *"One of the main challenges under healthcare financing is the issue of underfunding or poor funding for health care. As we all know, in 2014 there was the Abuja Declaration where health care financing was supposed to be around 15 percent of the GDP or the annual budget … The budget of Nigeria has been less than five per cent which shows how far we are from the 15 per cent mark. So, the question is, how do we increase funding?"*
>
> *"The Abuja Declaration for AU states that African countries should mark out 15 per cent for health and many of them have not achieved this for now and that is the major problem of poor health care allocation or budgetary allocation on health which makes it difficult to meet the Declaration."*

Stakeholders agreed that health insurance coverage in Nigeria is poor even though some states are very keen on the SHIS, which may be a driver to attaining better health care outcomes once health insurance expands widely. However, it was emphasized that many health insurances plans in the country do not cover many critical infectious diseases services, which increases the burden of out-of-pocket expenditure.

> *"The current establishment of SHIS in Jigawa State have seen an entire coverage of the formal sector, however, the formal sector in my state is not up to 10 percent of the population which means the SHIS is not covering much of the population making the coverage poor in the state"*
>
> "*When we are talking about health insurance coverage especially for many disease conditions. I have noticed that even if the population is covered, there is still an increase*

in out-of-pocket expenditure...health insurance in Nigeria should target covering many disease conditions in order to reduce out-of-pocket expenditure."

National Health Promotion Policy

The Nigerian government revised the National Health Promotion Policy 2019 and launched four other policies in November 2022 to address the increasing burden of communicable and non-communicable diseases in the country. The aim of the policy was to actualize the government's commitment towards improving the health and well-being of the citizens of Nigeria and educate the citizens on the negative impact of certain diseases.

Other strategic documents launched were:

- National Strategic Plan for Health Promotion 2020-2024
- Knowledge Management Guideline for Health Promotion 2020-2024
- Counselling Flip Chart on Key Household Practices
- Counselling Flip Chart on Family Planning/Childbirth Spacing

Nigeria has other sub-sectoral health policies including but not limited to:

- Reproductive Health Policy
- National Human Resources for Health Policy
- Health Information Systems Policy

3.2.1.2 *Healthcare Quality Plans*

National Strategic Health Development Plan I (NSHDP I) 2009-2015

The NSHDP I was developed to standardize the costed plans at the federal, states and local government levels and serve as a foundation for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria and outline requirements for future health investments for achieving sustained universal access and coverage within the period.[56]

Second National Strategic Health Development Plan II (NSHDP II) 2018-2022

[56] https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/Nigeria%20National%20Strategic%20Health%20Development%20Plan%20Framework%202009-2015.pdf

The NSHDP II is hinged on the NHP and builds on the successes and challenges of the NSHDP I. Some of the successes achieved include state domestication of the Primary Healthcare Under One Roof policy, passage of the National Health Act and the launch of a National Health Policy. On the other hand, some lessons learned from the NSHDP I include weak political will and low programme ownership at the state and local government levels, weak donor coordination and alignment, inadequate government funding, weak monitoring and evaluation systems and primary healthcare structures.[57] The NSHDP II has five strategic pillars and 15 priority areas, which translate into 15 goals.[58] It comprises the first seven priority areas of the NSHDP I and eight additional priorities. Table 3 shows priority areas for the NSHDP I and NSHDP II.

National Strategic Health Development Plan 2009-2015	Second National Strategic Health Development Plan 2018-2022
Priority Areas	**Priority Areas**
1: Leadership and Governance for Health	1: Leadership and Governance for Health
2: Human Resources for Health	2: Human Resources for Health
3: Health Financing	3: Health Financing
4: National Health Information System	4: National Health Information System
5: Community Participation and Ownership	5: Community Participation and Ownership
6: Partnerships for Health	6: Partnerships for Health
7: Research for Health	7: Research for Health
8. Health Service Delivery	8: Communicable Diseases and Neglected Tropical Diseases

[57] Second National Strategic Health Development Plan 2018-2022.pdf

[58] Ibid

	9: Non-Communicable Diseases, Elderly, Mental, Oral and Eye Health Care
	10: Reproductive, Maternal, New-born, Child and Adolescent Health plus Nutrition (RMNCAH+N)
	11: Medicines, Vaccines and other Health Technologies and Supplies
	12: Emergency Medical Services and Hospital Care
	13: Health Promotion and Social Determinants of Health
	14: Public Health Emergencies Preparedness and Response
	15: Health Infrastructure

Table 3: Priority Areas for National Strategic Health Development Plans I and II

As evidenced by the NHP and the NSHDP II, the FMoH has developed policies and plans where the governance and provision of quality care are emphasized, however there are no discrete frameworks or mechanisms described that provide detailed guidance on how to achieve a unified, integrated quality healthcare system.

During the KIIs, participants discussed challenges in healthcare leadership in Nigeria. Interviewees noted that many leaders within the health system have not been specifically trained on leadership and management, financial or administrative components of their jobs. The leaders also have limited training on quality although some states such as Kaduna and Lagos have enrolled their health system leaders in quality, financial and leadership training. It was noted that leaders may be elevated to their positions through clinical experience or time served within the health system and may not have the training or experience in leadership to occupy their positions. It was mentioned that the poor leadership skills had a negative impact on quality of care, particularly at the facility level.

"Leaders in the healthcare sector need to be properly trained with leadership and management skills. Medical training is not enough."

"They don't always have these more general managerial skills to run hospitals, even though they may be competent clinicians".

"Many people occupying positions are unqualified persons in position…. There is a lack of strategy by those in governance … There are issues with favoritism"

"Paper qualifications are insufficient… leaders need soft skills in the management of health institutions. We need to encourage leaders to develop soft skills through leadership training and supportive supervision to facilitate change in the public sector"

"Qualifications of people in governance are often unchecked"

Interviewees also highlighted that corruption was associated with poor quality of care within the Nigerian health system such that money budgeted and distributed did not reach the areas of need for which it was intended. It also included invisible costs to patients paying out-of-pocket thereby reducing the trust patients have in the health system.

"*The managers of the health system cannot be trusted with money…Sending money to the facilities to manage has not worked*"

"*Corruption is also a big problem. Even if funding increases, corruption prevents the funds from being used appropriately*"

"Costs for out-of-pocket patients are not transparent, reducing trust. Corruption exists, for instance, some things which should be free end up costing the patients at the facility"

"*Corruption is a major issue. Resources do not get to people that should benefit from it… Funding is not adequately utilized and so does not have impact*"

"Corruption is the main bane of the health system, government broken promises and the LGA chairman is not committed"

Stakeholders noted leadership and governance, specifically the lack of political will, as a challenge to providing good quality of care in Nigeria. It was highlighted that many politicians within the country pay lip service to advocate for health rather than take policy action, which adversely affects healthcare policy implementation even though these policies abound.

> "*Poor political will at all levels of the health system. For instance, a politician will rather build an empty health facility than addressing the health needs of a community, so it can improve campaign popularity. It is all about projecting their political interest, paying lip service to hang on to power rather than targeting improvements in health care indices.*"

> "*The ability to implement health care policies on ground, in most cases especially at state level, you would have a comprehensive development framework that will drive all the activities from midterm to the end of the year, but everything changes once there is a new administration. Hence the lack of political will to implement health policies and health programs.*"

The group advocated the reintroduction of health care administrators to take charge of various health facilities and institutions, reduce professional and administrative biases among health workers and have efficient health system structures in place.

> "*Poor administrative structures for leadership, for hospitals, there is the need to re-introduce hospital administrators in each professional cadre with clearly defined job descriptions. Decades ago, with hospital administrators the Nigeria health sector rarely had health care strikes which preserved the quality of care and prevented professional bias among cadres.*"

Nigeria has other sub-sectoral plans that include but are not limited to:

National Human Resources for Health Strategic Plan (NHRHSP)

Human Resources for Health (HRH), the National Health Act, National Human Resources for Health Policy (NHRHP) and National Human Resources for Health Strategic Plan (NHRHSP) provide the policy framework to guide the 36 states plus FCT on developing their human resources for health. The National Task Shifting and Task Sharing (TSS) Policy with standard operational procedures (SOPs) aim to enhance the performance of the available HRH.

Furthermore, the FMoH established a National Health Workforce Registry (NHWR) to achieve the Global Strategy on Human Resources for Health (HRH): Workforce 2030 milestone of reducing inequalities in access to healthcare workers by effectively tracking health workforce dynamics and sharing health workforce data annually. The NHWR provides a database of accurate health workforce information that helps to ensure the equitable distribution of qualified and skilled health workers available to provide quality services at all levels of healthcare delivery.

The timely information helps to connect health workers with health facilities, and it is expected that data from all the 36 States and FCT in Nigeria will be added to make it a complete NHWR. However, the registry is currently not fully functioning due to lack of updated data in the registry.

During the KIIs, interviewees discussed the difficulties with inadequate numbers of health workers, or poor distribution of health workers between urban and rural locations. This was partly attributed to poor recruitment of the health workforce where states were noted to have inadequate funding for recruitment and infrequent recruitment for empty positions. It was noted that inadequate staffing issues are worse within the PHC facilities than the other levels of the system.

"*The states do not have adequate funding for recruitment and do not recruit often enough*"

Attrition of healthcare staff was highlighted to significantly contribute to inadequate staff numbers. It was noted that recruiters come to Nigeria from abroad to recruit medical staff with between 40 and 70 Nigerian doctors each month applying to the Medical and Dental Council of Nigeria (MDCN) for certificates of good standing, which are needed to practice medicine abroad. One interviewee recalled an instance where a department in a teaching hospital had to shut down because its specialist doctors were moving abroad.

> *"There are health facilities in many places but there are no health workers recruited. Very large issues with attrition of health workers"*

> *"High level of attrition… trained health workers are leaving"*

Attrition of healthcare staff, particularly in rural areas and at primary care level, was also linked to challenging workplace environments. Issues included lack of adequate remuneration for staff, poorly maintained facilities, and lack of medical equipment and other working tools for staff to fully apply themselves according to the standard to which they have been trained. These issues make it hard to retrain health workers in the areas where they are most needed.

> *"Incessant industrial action, poor salaries and promotions not directly linked to performance so the workers are not motivated"*

> *"Lack of motivation to want to remain in the job"*

"Lack of availability of working tools"

Overall, the lack of medical personnel was noted to have a significant impact on patient care due to increased patient to staff ratios and service closures. Long waiting times in hospitals are reported to be common. Repeated strike action by medical staff was linked to service disruption and low staff morale.

Stakeholders at the workshop agreed that there are shortages of healthcare workers across the health system, and that the density of the health workforce impedes the quality of care in Nigeria.

> "*Urban/Rural disparities or disproportion in the distribution and allocation of health care workers … there are more health workers concentrated in urban areas than in rural areas across the country"*

The stakeholders highlighted the importance of having a reliable health workforce registry that can capture the number of health workers in both the private and public health sector, assist in the redistribution of workers from urban to rural or across health services delivery and guide health workforce policies to meet the demand of the health system.

> *"Lack of credible and valuable health workforce registry. With the registry, a state like mine (Jigawa) can get staff distribution right and make policies to improve the health workforce*"

The impact of health workforce migration on quality of care was mentioned. Emphasis was placed on the adverse effect of high levels of attrition of well-trained medical professionals on quality of care and the need to prevent the early redeployment of well-trained quality staff from health facilities.

> *"You can train a staff at a particular centre later to find out this person has been posted away from the health centre to another health care facility, which will affect the quality of care"*

Health Infrastructure Plan

Health infrastructure consists of buildings, equipment, furniture and plants, communications equipment, transportation systems (such as ambulances, cars, vans and trucks), water, power supply and sanitation facilities required for healthcare service delivery at the different levels.[59] The NSHDP II notes that

[59] https://www.health.gov.ng/doc/NSHDP%20II%20Final.pdf

Emergency Medical Services (EMS) in Nigeria is poorly developed with no formal structure for coordinating and regulating ambulance services. In 2005, the FMoH established basic requirements for delivery of the Essential Package of Healthcare Services (EPHS) across the tiers of healthcare services, but this standard is not being followed in most health facilities in the country.[60] According to the NSHDP II, the priority areas for health infrastructure include:

a. At least 1 functional primary health care (PHC) facility per ward connected to a functional secondary health facility in each local government area (LGA).
b. At least 1 functional secondary health facility in each LGA with qualified healthcare workers and the establishment of a strong referral system to a tertiary health facility.
c. Upgrade tertiary hospitals to meet local needs and establish an efficient referral system.

During the KIIs, interviewees confirmed that infrastructure remains poor at many health facilities. This included a lack of basic amenities such as electricity and water at some facilities making it extraordinarily challenging to provide safe patient care. Weak waste management was also noted to be a problem impacting on staff and patient safety.

Other infrastructure challenges included lack of or ineffective ambulance services, resulting in inefficiencies and resulting in significant and harmful delays in care in some emergency situations. The design and layout of the facilities can in some cases cause patient safety concerns including challenges in isolating patients with infectious diseases. Nosocomial (hospital-acquired) infections were noted to be a significant challenge in Nigeria, related to multiple factors such as water, sanitation and hygiene (WASH), layout of facilities and staff training.

"Infrastructures are usually poorly designed structures"

"Environment is not conducive to medical doctors... Facilities themselves are not being maintained to standards-- equipment issues-- practitioners cannot apply themselves in this setting"

"Lack of amenities such as electricity, water etc."

"No effective ambulance services for smooth flow of patients"

"They have challenges with waste management"

The stakeholders at the workshop corroborated the issues of poor infrastructure, ambulatory services, and waste management systems. On the issue of ineffective ambulance services, it was highlighted that paramedics were poorly trained, and that referral services and linkages were poor. Stakeholders mentioned that facilities were inadequately designed with layouts that were unconducive for infectious

[60] Ibid

disease control and patients with disabilities and their families. It was highlighted that equipment were poorly maintained with limited biomedical technicians to service the equipment.

Health Information Systems Strategic Plan

The Health Information System (HIS) policy provides a framework for collecting, collating, analyzing, storing, disseminating and using health and health-related data and information. The development of the HIS Strategic Plan 2014-2018 was guided by the policy with the following objectives:[61]

- Improving data governance in Nigeria
- Improving political commitment and leadership responsibilities to functional HIS at all levels for evidence-based decision making
- Improving data management, dissemination and use
- Improving data security
- Monitoring and evaluating health information system performance

According to the NSHDP II, investments in HIS across the three levels of government have been inadequate to meet the minimum requirements of human resources and infrastructure. The roles and responsibilities of all stakeholders in the National Health Management Information System (NHMIS) are not clearly defined in the national HIS policy.[62] Overall, there exists poor data quality at all levels. There is limited analysis of HMIS data and feedback to health institutions thereby limiting the use of HMIS data for planning and decision-making.

During the KIIs, it was mentioned that there were multiple platforms for capturing data by the FMoH but that these platforms were not integrated. It was also noted that although disease surveillance systems exist in Nigeria, the capacity of these systems needs strengthening. Moreover, there are inadequate surveillance officers to undertake regular active surveillance in communities and notification of infectious diseases by medical professionals can be challenging with very little data on infectious disease or issues of public health concern emanating from private facilities.

Interviewees also noted that data sharing and the passage of information can be poor between different levels of the health system. This includes information exchange in patient referrals where information is often not adequately shared between professionals providing patient care at different levels of the system. Furthermore, dissemination and information sharing on important policy content often fail to reach facilities or professionals required to implement changes. Private facilities often do not publish or report health data. Regarding quality of health data, interviewees noted that there is a lack of harmonized structure for health information gathering. It was highlighted that the quality of data within the current health information system is worrisome, especially where a strong reliance is on manual rather than electronic forms of data collection. On the use of health information, interviewees expressed concern that data is not being adequately used and translated into action and decision making, especially at the state

[61] https://www.health.gov.ng/doc/National%20HIS%20Strategic%20Plan.pdf

[62] Second National Strategic Health Development Plan 2018-2022.pdf

and federal levels. It was noted that there is a lack of connectivity and understanding between the frontline facilities that generate the data and the FMoH.

Stakeholders at the workshop mentioned that there exist technical working groups in almost all states, which investigate quality issues in the area of monitoring and evaluation. However, it was highlighted that hospital acquired infections were a major challenge in the health system with low levels of research and poor surveillance within the hospital environments. On the issue of poor quality of health data, stakeholders added the attitude and availability of staff to capture relevant health information at the PHC facilities.

> "M*ost times you discover that most staff don't take this work very serious, there sometimes when I have visited some facilities where records were not entered and upon enquiry, I was told there was no record books available; I personally checked the store only to discover packs of record books that were in use*"
>
> *"Most of the facilities, especially at the PHCs, you don't see any health record officers. Sometimes the available ones prefer the urban areas"*
>
> *"HMIS has a lot of challenges in terms of access, you will find out that data gotten from the PHCs are taken to the Local Governments, they don't have access to the HMIS and those that do, most times have issues of internet or server not responding"*

Stakeholders confirmed the poor harmonization of the HMIS and mentioned issues around the use of multiple forms for data collection, lack of adequate funding to extend the HMIS to PHCs in some states, and the use of health workers rather than monitoring and evaluation officers to ensure good quality health data capture and information.

> *"In some cases, the NGOs will introduce a different form to health record officers for data collection with financial inducement. In this circumstance, the workers usually abandon their primary responsibility in order to satisfy that of the NGOs*"
>
> *"HMIS is operational in about 8 general hospitals in the FCT but lacks adequate resources to extend same to the PHCs"*
>
> "*There are clear differences between the two [health workers and M&E officers] but over time we have continually used the latter for tasks clearly meant for M&E officers leading to all manners of poor data management"*.

Infection and Disease Control Plan/Guideline

In the context of the COVID-19 pandemic, the federal government and Nigerian Centre for Disease Control (NCDC) created a guideline on infection prevention and control (IPC) recommendations during health care provision for suspected and confirmed cases of COVID-19.

The guideline is intended for all health staff, facility management teams and IPC teams at all levels of healthcare in Nigeria. The five strategies required to prevent or check the transmission of COVID-19 in health care facilities include:[63]

1. Early recognition and source control of COVID-19
2. Always apply standard precautions for all patients
3. Implement empiric additional precautions
4. Implement administrative controls
5. Use of environmental and engineering controls

Interviewees pointed out that though some states displayed innovative interventions in preventing and checking the transmission of COVID-19 community engagement seemed to be limited during the pandemic.

> *"Lagos state, during COVID especially, increased hazard allowances, recruitment and leadership training to improve innovation"*

> *"The people and community should not be taken for granted. Efforts should be made to make their opinions count. For example, during COVID, there were no health promotion activities and people were expected to take the vaccine. Community structures should not be neglected, Grassroot mobilization"*

[63] https://COVID19.ncdc.gov.ng/media/files/IPC_GUIDELINE_version_2.pdf

"There is a need to make a diagnosis at various levels on how best to engage the community. The COVID vaccine was a good eye opener. The immunization intake of routine vaccines was adequate in the South-East, but when COVID vaccine came, the uptake was lowest in the South-East. Lack of community level advocacy"

Stakeholders added that from the perspective of occupational health and safety there were complaints about the psychological and physical effect of the pandemic on health workers. These were evident from feedback obtained that some health workers were psychologically affected and others complained of being overstretched by the workload.

3.2.1.3 Healthcare Quality Strategies

Nigerian National Quality Strategy

The process for developing the National Quality Strategy for Nigeria started in February 2013 due to a sequence of events including an event at a teaching hospital in 2011, which revealed a need for the federal government to focus on the quality of care provided. This led to the then Minister of State for Health (HMSH) – Dr. Muhammad Ali Pate through a partnership with the Institute for Healthcare Improvement (IHI) and funded by the World Bank to embark on the process for developing the National Quality Strategy for Nigeria in 2013.[64] In February 2013, the FMoH, partnered with key stakeholders including the IHI to present the vision for quality of care, get feedback based on focus group discussions and gain a consensus on the path forward. The final version of the Nigeria NQS was linked to the National Health Strategic Development Plan I and was approved in 2015 with the aim of improving patient safety, clinical outcomes and client satisfaction. Intervention areas for the NQS include:

- Capacity building and training of health workers in quality improvement
- Development of standard operating procedures and protocols especially in maternal and newborn care, accident and emergency and infectious disease control
- Establishment of patient safety or practices learning collaborations to address challenges in maternal and newborn care, accident and emergency and infectious diseases

Interviewees expressed concerns about the integration of the public and private health systems, noting that they acted in parallel with very little integration between the sectors. It was highlighted that the private sector forms a large proportion of healthcare service delivery but is given little consideration in the formulation of strategies. An interviewee noted that the government did not have the ability to fill the gaps in the Nigerian healthcare system by itself. Interviewees expressed a wish for closer integration

[64] NQS case study

between the two sectors. However, it was noted that as a PHC quality revitalization drive and to enhance private sector engagement some private sector organizations are being given PHC facilities to run in some states. Interviewees also mentioned the need to involve political leaders in health care quality strategy discussions to get their commitment in ensuring quality improvements.

"We need to consider strategies that are mutually beneficial to the public and private sector. We need to co-develop with the private system interventions that can be delivered to promote integration."

"[We] don't pay enough attention to the private sector. 60% of doctors are in the private sector and therefore it is incredibly important"

"Grossly, grossly unregulated: private sector should be carried along"

"Private sector needs to be shown the clear benefits and link provision of quality care to increase their income. The need to evaluate the cost of quality care versus the cost of no quality care… generate the market for quality care and financial motivation to invest in quality"

"Private sector is being invited to take over some PHCs to run it: Delta state and Lagos state are already piloting the model. Adopt your PHC and identify the criteria, as an approach to Revitalization of PHCs"

"Involve the private sector during the planning process of any government intervention"

"Quality interventions: training in service, task sharing, shifting policy, capacity building, mentoring and coaching"

"There is need to discuss quality in a way the political leaders can appreciate it"

"Attitude towards healthcare delivery in Nigeria. We don't take health very seriously as a population and our political leadership do not take it seriously. If the politicians took it seriously this would be an important step towards QoC"

Stakeholders at the workshop corroborated that most private health facilities in Nigeria are not providing quality care to patients. It was agreed that associations such as the Nigerian Medical Association (NMA) and Association of Private Health Services sometimes fail to monitor members of the associations to ensure adherence to guidelines for the dispensation of quality of care. It was noted that health workers are not well-trained, tend to be overworked and in most cases are insufficient and inequitably distributed to ensure effective and efficient quality healthcare delivery. It was also noted that health workers hardly follow protocols and guidelines and find it challenging to deliver quality care with obsolete equipment.

"There's inadequate capacity building of QoC workers"

"Inadequate capacity building in QoC issues"

"Poor adherence to the use of protocols, service guidelines and SOPs"

"There is need for monitoring of health workers to make sure they adhere to the guidelines, protocols and regulations"

"Most hospitals have outdated and obsolete equipment. If new and quality equipments are provided and well maintained, the quality of care of hospitals will improve"

Other sub-sectoral health quality strategies include but are not limited to:

Maternal Newborn and Child Health Quality of Care Strategy

The Maternal Newborn and Child Health (MNCH) strategy was developed in 2018 with a focus on strengthening the capacities of health workers with skills to provide basic emergency obstetrics and newborn care to pregnant and postpartum women and newborns and achieve the following:[65]

- Improve the prevention and management of postpartum hemorrhage
- Improve the treatment of eclampsia and reduce the occurrence of sepsis
- Foster respectful maternity care
- Increase the practice of skin-to-skin contact
- Reduce birth asphyxia

Integrated Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategy

The Nigeria National Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) is a priority area under the NSHDP II to promote the integration of reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH+N) services and programs and provide a framework for the delivery of high-quality integrated care. The goal of the RMNCAH+N is to '*reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria and promote universal access to comprehensive MCH, sexual and reproductive health services for adolescents and adults throughout their life cycle'.*[66] To operationalize the NSHDP II, the FMoH developed the Integrated Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (IRMNCAH+N) 2018 - 2022 Strategy, which comprises priorities and targets for improving newborn and child health.[67]

Although modest improvements have been made in RMNCAH+N outcomes over the years, people, especially the poor, still suffer from limited access to health services and bad health outcomes.[68]

Reproductive Maternal, Newborn, Child, Adolescent and Elderly Health Plus Nutrition Quality of Care Strategy

The FMoH launched a Reproductive Maternal, Newborn, Child, Adolescent and Elderly Health Plus Nutrition (RMNCAEH+N) multi-stakeholder partnership coordination platform in October 2020 to improve the health and wellbeing of women, children, adolescents and the elderly by providing an enabling environment and the required partnership to improve the quality of RMNCAEH+N services in Nigeria.[69] The platform aims to leverage on the relative strengths of diverse stakeholders, including "governments, parliamentarians, the media, regulators, philanthropists and donors, organizations of development,

[65] https://www.qualityofcarenetwork.org/country-data/nigeria

[66] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Nigeria-Investment-Case.pdf

[67] https://www.childhealthtaskforce.org/sites/default/files/2020-05/Nigeria%20Rapid%20Desk%20Review.pdf

[68] https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Nigeria-Investment-Case.pdf

[69] https://business247news.com/2020/10/09/fg-unveils-new-universal-health-coverage-platform/

universities and professional bodies", and create opportunities to harness resources and maximize impact.[70]

Water, Sanitation and Hygiene Revitalization Strategy

Although there has been some progress in Water, Sanitation and Hygiene (WASH) in Nigeria, access to good quality and dependable services remains low. There are dire consequences associated with poor WASH including increase in cases of infections and diseases such as diarrhea, which can lead to undernutrition and low immunity, and the likelihood of contracting other infections and diseases.[71]

The Action Plan for the Revitalization of Nigeria's WASH Sector established a 13-year Revitalization Strategy in 2018 to ensure that all Nigerians have access to sustainable and well-managed WASH services by 2030. The revitalization strategy comprises an emergency plan for the first two years (2018-2019) to improve the management of existing water supply and sanitation services and engage key stakeholders in the expansion of services. The recovery program of the revitalization strategy runs for four years (2019-2022) to establish and foster the enabling environment required to support the effective management of Nigeria's WASH services through the implementation of sound policies and laws needed to attain the overall objective of the Revitalization Strategy (2018-2030).

3.2.2 Assuring for Quality

3.2.2.1 *Regulatory Systems for Healthcare Quality*

Quality Assurance (QA) is a framework for the systematic monitoring and evaluation of the various aspects of a country's healthcare quality delivery to ensure that quality standards are met or are above baseline expectations.[72] Quality Assurance includes standards, guidelines and protocols, regulations, accreditation and licensing. It is a key component of a quality strategy and must be tightly integrated with quality planning and improvement efforts.[73]

The NSHDP identifies quality assurance as a priority area through the strategic goals to strengthen professional regulatory bodies and institutions and develop and institutionalize quality assurance models.[74] There are several organizations involved in the regulation of healthcare and different components of healthcare quality across the system. Broadly speaking, public PHC facilities are state regulated, secondary level facilities, which may be public or private, are also state regulated and tertiary facilities are owned and regulated by either the state or the federal ministry. Teaching hospitals fall under the regulation of the FMoH, which is responsible for accreditation of the hospitals. The Nigerian

[70] https://nnn.ng/priotises-quality-care-improve/

[71] https://www.wateraid.org/ng/sites/g/files/jkxoof381/files/nigerias-national-action-plan-for-the-revitalization-of-the-wash-sector.pdf

[72] https://www.hanshep.org/member-area/programmes/healthcare-quality-self-regulating-body-in-nigeria/feb-2014-survey-report-on-quality-management-in-nigeria.pdf

[73] Ibid

[74] http://sqhn.org/wp-content/uploads/2014/10/5.-SQHN-Accreditation-Journey-Olub.pdf

government has an obligation to provide quality healthcare at all levels to citizens. The major legislations that regulate quality healthcare delivery in Nigeria are:

- National Health Act
- Medical and Dental Practitioners Act
- Pharmacists Council of Nigeria Act
- Nursing and Midwifery Act
- Nigeria Centre for Disease Control and Prevention Act
- The Compulsory Treatment and Care for Victims of Gunshot Act
- The Code of Medical Ethics in Nigeria
- National Health Insurance Scheme Act

Nigeria also has several ad hoc institutions and agencies that are tasked with the responsibility of maintaining quality of care. These institutions are largely endorsed by either governmental (federal and state) or non-governmental organizations. Generally, healthcare regulatory agencies are responsible for carrying out the following:

- Regulating and maintaining the standards of training and practice for health workers
- Ensuring capacity strengthening for practicing health workers to enhance and update their knowledge, skills, and abilities through Continuing Professional Development (CPD) programmes in accredited institutions
- Keeping valid and valuable health worker information such as a register of names, addresses and professional performance of health workers
- Limiting avenues for fake health workers to operate by registering and issuing annual licenses to registered health workers
- Accrediting, inspecting and monitoring health facilities to ensure that minimum standards of practice are maintained

Examples of health regulatory bodies In Nigeria are shown in Figure 10.

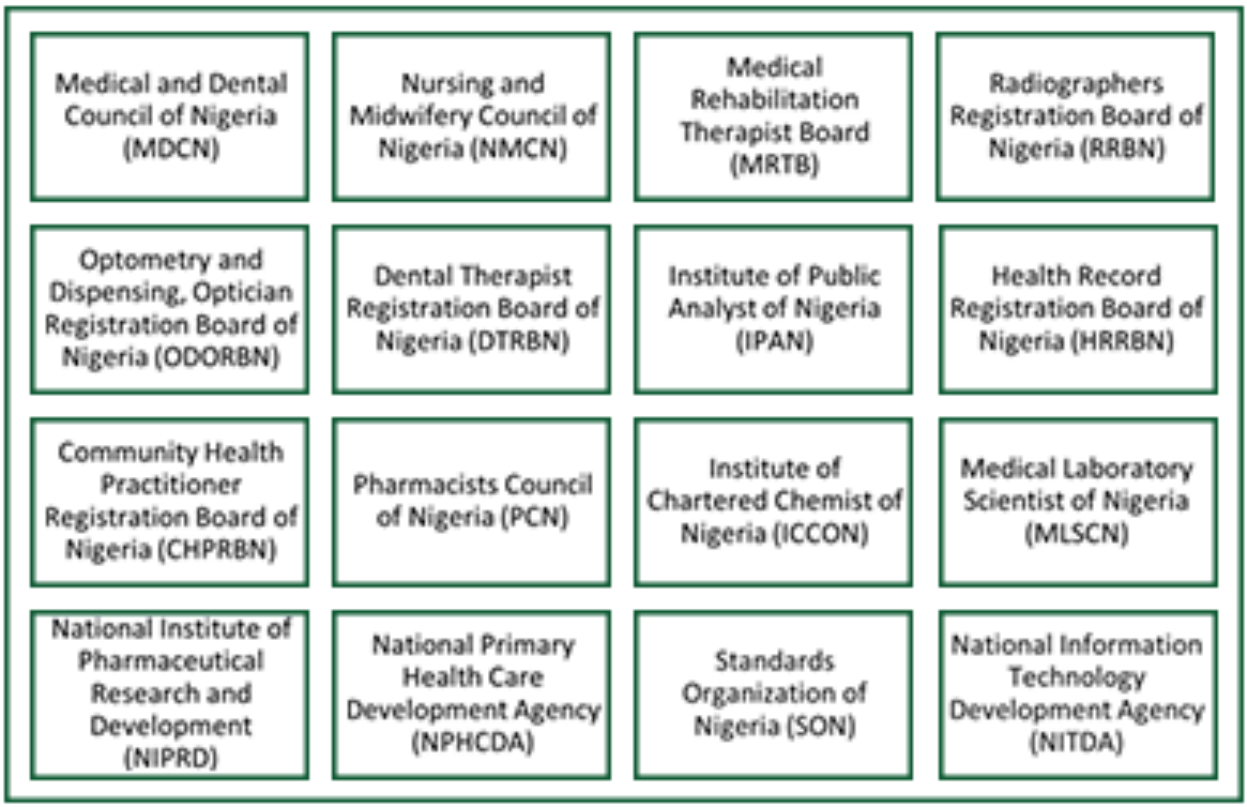

Figure 10: Examples of Health Regulatory Bodies in Nigeria

In addition to establishing regulatory bodies to assure quality of health care delivery, the federal government formulated a National Policy on Quality Assurance for Medicines and Other Health Products 2015 with the aim of establishing *'a uniform system that works in conjunction with other applicable guidelines, rules, regulations, and policies to ensure the quality, safety and efficacy of medicines and other health products within Nigeria.'*[75]

Nigeria's QA structure is complex and regulatory agencies both within and outside the FMoH have a role within the healthcare QA structure, for instance:

[75] https://pdf.usaid.gov/pdf_docs/PA00M8MM.pdf

Standards Organization of Nigeria (SON) is responsible for standardizing and regulating the quality of all products in Nigeria. The organization was introduced by the federal government to address the issue of unsafe products imported into the country.[76]

The National Primary Health Care Development Agency (NPHCDA) is a government parastatal tasked with creating policies regarding primary healthcare.[77] The FMoH places great emphasis on the primary healthcare system calling it the "bedrock" of the national healthcare system within the National Health Policy. Through the NPHCDA's Minimum Standards for Primary Health Care in Nigeria, the organization sets standards for health infrastructure, human resources for health and service provision at the primary healthcare level. These standards set the basis for further quality assurance into primary healthcare. Historically, the organization has also run programs such as the Midwife Service Scheme (MSS), and the Subsidy Reinvestment and Empowerment Program (SURE-P) for maternal and child health at the primary care level. SURE-P was created to reduce maternal mortality and morbidity and was leveraged by the FMoH as part of its Saving One Million Lives (SOML) initiative.

The National Agency for Food and Drug Administration and Control (NAFDAC) regulates food, drugs, and medical devices.[78] NAFDAC is also an agency that engages in the best practices of collaborating with international counterparts, separating enforcement and inspection from standard-setting and participatory feedback as well as sensitizing the public to regulatory issues. NAFDAC works closely with its international counterparts to monitor and regulate drug importation. It also works with international food and drug agencies for capacity building and best-shared practices. Like the NPHCDA, NAFDAC has minimum standards that must be adhered to for product licenses to be issued and it also provides feedback to applicants who do not meet these standards with recommendations.

The NSHDP II notes that Nigeria has outdated regulations and standards related to the quality of food and food additives. It also notes that the nutritional quality of the food sold in markets is well below an acceptable standard and does not help in Nigeria's quest to end malnutrition. Despite the existence of NAFDAC and the Nigeria Institute for Pharmaceutical Research and Development (NIPRD), biological products and pharmaceutical raw materials from indigenous resources, essential medicines are underfunded and often unavailable. There is also irrational drug use as well as inadequate warehousing.

The National Health Policy notes the need to strengthen relevant regulatory bodies, that is, NAFDAC and SON to reduce the supply of fake and substandard medicines, vaccines and other technologies for healthcare delivery. However, there are still quality assurance challenges due to continuous importation of medicines and health products and the risk of poor quality, fake, and substandard products entering Nigeria.[79] In addition, the National Health Act provides for the regulation of private and public health organizations, however, regulation of private facilities remains a major challenge in Nigeria with the activities of several private facilities remaining unregulated and scoring poorly on standard disease management guidelines.[80] The challenges may be associated with uncoordinated and ineffective public-

[76] https://www.exports-to-nigeria.com/en/about

[77] National Primary Health Care Development Agency Minimum Standards for Primary Health Care in Nigeria

[78] Second Strategic Health Development Plan 2018-2022

[79] Ibid

[80] https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0205-4

private partnerships that are required to support the enactment and enforcement of regulations in the private sector.[81] In addition, more collaboration among healthcare regulatory bodies and agencies is required for the health system to be effectively regulated.[82]
Quality Assurance for healthcare professionals is under the purview of the respective parastatals. The Medical and Dental Council of Nigeria (MDCN) covers medical doctors, dentists and traditional medicine practitioners, all cadres of nurses and midwives fall under the purview of the Nursing and Midwifery Council of Nigeria (NMCN); pharmacists are regulated by the Pharmacists Council of Nigeria (PCN) and medical laboratory scientists, medical laboratory technicians, and medical laboratory assistants by the Medical Laboratory Science Council of Nigeria (MLSCN). These organizations influence quality by managing licensure for the respective professions at a national level. However, their capacity to enforce professional standards is limited and thus this enforcement is often left to the states and facilities that hire these health professionals.

The National Information Technology Development Agency (NITDA) is a non-health agency that is tasked with regulating, monitoring, evaluating and verifying organizations to foster the development and growth of Information Technology (IT) in Nigeria. It does so under the supervision and coordination of the Federal Ministry of Communications and Digital Economy. The NITDA has created and implemented the Nigerian Data Protection Regulation (NDPR) which is designed to protect the data of Nigerians including health related data.

Pharmaccess/SafeCare developed "SafeCare Standards" that are accredited and focused on implementation in resource-controlled settings. The standards currently focus on the areas of management and leadership, human resource management, patient rights and access, risk management, primary healthcare services, laboratory service, medication management, and support services. Healthcare facilities are rewarded for complying with pre-defined quality improvement steps and standards. SafeCare is currently engaged with the FMoH to implement the SafeCare standards and methods in primary healthcare facilities in six states in Nigeria, which demonstrates efforts geared towards improving regulation through standards development and enforcement in PHCs.

Regarding accreditation of healthcare facilities, the Society for Quality in Healthcare (SQHN) in Nigeria, is an internationally recognized health facility accreditation organization that has undergone the review and certification process of the International Society for Quality in Healthcare (ISQua).[83] The SQHN's mission is to '*lead, advocate and facilitate the continuous improvement of quality and safety in healthcare in Nigeria through education, collaboration, training and accreditation*'.[84] SQHN accreditation gives a

[81] https://shopsplusproject.org/sites/default/files/resources/Nigeria%20Private%20Health%20Sector%20Assessment%2009_10_2012.pdf

[82] https://www.researchgate.net/profile/Ibrahim-Jatau-Abubakar/publication/324216798_Role_of_selected_healthcare_regulatory_agencies_in_Nigeria/links/5dc8ee7492851c818043615b/Role-of-selected-healthcare-regulatory-agencies-in-Nigeria.pdf

[83] http://sqhn.org/wp-content/uploads/2014/10/5.-SQHN-Accreditation-Journey-Olub.pdf

[84] ibid

foundation for assessing performance expectations, structures, or processes that are required for healthcare organizations to provide safe and high-quality healthcare service in Nigeria.

There is a need for Nigerian regulatory bodies to augment existing efforts to enforce adherence to professional standards and heighten enforcement of Continuing Professional Development (CPD) attainment. Most agencies have zonal offices, and some have state offices to ensure adequate coverage but resources to adequately staff these offices are limited. However, there are situations where trained providers have not kept up to date with their licensing or CPDs or pay people to attend training on their behalf.

During the KIIs, interviewees mentioned regulation of health facilities as a key challenge and noted that poor accreditation exercises by regulatory bodies were a hindrance to quality of care. It was again noted that the private sector remains minimally regulated by the state and the quality of care delivered is highly variable. Regulation is viewed as problematic due to the sometimes conflicting interests of the government (in taxation) and the private sector (in profit requirement). There are challenges with financing the private sector such as poor financial transparency, inadequate capital investment and inability to secure loans for private hospitals, making it difficult for them to invest in infrastructure or costly medical equipment. The profit motive of the private sector and the lack of regulation mean that without stronger litigation mechanisms, the private sector would have little liability.

Interviewees reiterated that there were challenges in coordination between regulatory bodies and agencies involved in quality of care. It was noted that there is a lack of overall strategy on quality of care and many agencies are working in parallel.

> *"Regulation is also a problem. Including quackery and the low regulation of traditional health workers"*

> *"There are 14 regulatory bodies all doing their own thing in their own way"*

> *"Regulatory bodies should stop working as islands, there is need to collaborate with other bodies"*

> *"Private sector sees government as only interested in them on issue of taxation, government sees private sector as doing their thing not wanting to be involved, government has not invested much in private sector"*

Interviewees mentioned that it is challenging to persuade those in power at the state level to prioritize regulation of health facilities. Interviewees related this lack of political will with health being on the concurrent list for states in the constitution, meaning some states were not willing to invest and prioritize licensing, accreditation and maintaining standards in health facilities. In several states there are major gaps in regulatory activities and significant uncertainty around the extent these activities are being carried out. It was noted that when issues are discovered, there are a lack of adequate sanctions to address problems.

> *"It is a challenge at state level to get those in power to prioritize registration and licensing of medical professionals (and facilities)"*

> *"FMoH or states have responsibilities for licensing of health facilities. However, there is a big gap-- we don't know who is really regulating the tertiary hospitals. We are unsure how often this is happening, what the process is for this. Health is on the concurrent list-- so states are not willing to invest in accreditation of the facilities and maintaining standards"*

> *"There is a need for the cooperation of stakeholders in the state. The state governments are often disengaged from this process (especially as they feel it is a federal system). So often, the situation of identifying poorly performing medical practitioners is not working well"*

Interviewees noted that medicines regulation can be particularly challenging. False declarations can be made on imports and illegal borders can be used to import counterfeit medications. NAFDAC has insufficient human resources meaning staff members have to cover large geographical areas each containing a high number of health facilities. The lack of technology and digitalization of the medicines regulatory system exacerbates current challenges. However, interviewees noted that some states such as Lagos regulate healthcare better than others.

> *"MDCN is unable to exercise full control over regulation of health facilities". Remit is medical and dental professionals only (not facilities themselves where many of the challenges can originate and can prevent medical professionals from being able to perform adequately)"*

Interviewees agreed that there have been capability building programs in quality improvement and clinical governance as well as convening efforts, led primarily by state governments (for example, Lagos state government) and non-governmental organizations, to align quality-related initiatives. However, there were concerns raised about the skills mix and knowledge of some healthcare workers and the impact on the quality of patient care. It was noted that in rural areas it can be difficult for health staff to

maintain their skills due to decreased access to continuing professional development, education and medical equipment. Interviewees highlighted that the skills mix and competencies are particularly lacking at the PHC levels due to the increased challenges recruiting into these roles. One interviewee noted that training and capacity building of staff can also be especially poor in the private sector. Other interviewees noted that supervision and on-the-job training was not prioritized and was lacking in many settings.

> *"There is a training programme currently ongoing, and several structures have been put in place to address issues around quality"*
>
> **"***Lack of proper supervision … especially tertiary facilities, No adequate sanctions"*
>
> ***"****People who are supposed to be supervised are not supervised … Supervisors who visit are also seeking for money"*
>
> *"Lack of supervision of health care workers and lack of qualified personnel in the health facilities"*

Stakeholders at the workshop confirmed that there is a need for effective implementation of regulatory requirements to ensure the public is protected from fake, non-credentialed, or minimally certified health providers and from healthcare facilities that do not adhere to the minimal essential standards of care. An example was given of an unqualified doctor who carried out a surgery on a female patient and ended up performing the wrong surgical procedure causing fatal bodily damage to the patient. It was, however, confirmed that regulatory bodies and agencies exist to monitor private and public healthcare organizations. Some stakeholders confirmed the existence of capability building programs on quality while others had an opposing view on the existence of quality improvement capability programs in the private sector.

> *"In terms of quality of care, there is poor regulation of health care practice in Nigeria and that is why we have the proliferation of chemists (quacks) operating as pharmacists and hospitals".*
>
> *"I have experienced where many unqualified medical professionals are carrying out certified medical services that they were not certified to perform"*
>
> *"I have come across certain situations where an unqualified medical professional assumes multiple medical job descriptions (for example a nurse playing as a doctor, pharmacist, laboratory technician and so on), so there is a poor regulatory system."*

"We have created a regulatory agency tasked with monitoring and evaluating the conduct of private and public health institutions in collaboration with National Regulatory Agencies with their respective medical bodies."

"Lack of training and capacity building especially in the private sector"

3.2.2.2 *Federal Institutions for Regulating Healthcare Quality*

These include quality committees and parastatals set up for the implementation of strategic plans and policies:

- DPRS Research Division: The division oversees coordinating and documenting of all health research issues. It also oversees the activities of various research committees. Other stakeholders in research from the federal, state and LGA levels include the FMoH, SMoH and the local government councils.

- Service Compact (SERVICOM): The federal government of Nigeria set up SERVICOM to provide quality services that are designed to meet customers' needs; to ensure that customers are served by trained staff who are sensitive to the needs of their clients; to set out entitlements of citizens and list the fees payable; and to prohibit the request for and making of additional payments that are irrelevant. It oversees the provision of timely services, maintains a feedback system, which enables the public to make suggestions for better service and provides details of erring agencies and government officials for the appropriate sanctions.

- Boards of Health Regulatory Bodies: The federal government set up five governing boards of professional health regulatory bodies to set the standards of discipline, practice and capacity development of professional skills. The boards include Community Health Practitioners Registration Board of Nigeria, Health Records Officers Registration Board of Nigeria, Medical Laboratory Science Council of Nigeria, Medical Rehabilitation Therapists Board of Nigeria and Optometrists and Dispensing Opticians Registration Board of Nigeria.

3.2.2.3 *State Institutions for Regulating Healthcare Quality*

- Health Facility Monitoring and Accreditation Agency (HEFAMAA): HEFAMAA is an agency that was commissioned by the Lagos State Government to monitor private and public health facilities in the state to assure registration and accreditation of all health facilities. Since its establishment, HEFAMAA has shut down facilities across the state mainly due to non-compliance with regulatory requirements, lack of basic equipment, inadequate staff qualifications, operating without licenses, practicing beyond the schedule and training of auxiliary nurses who could become a threat to society in the future by setting up and running illegal facilities.

- Private Health Institutions Management Agency (PHIMA): PHIMA was established to serve as a state government agency to provide regulations, facilitate the establishment of private institutions and ensure quality service provision in Kano state.

Most states have structures in the Department of Medical service for yearly registration/licensing of practice for the different private health facilities in the states. Examples of institutions relevant to quality of care in Nigeria are shown below in Figure 11.

Figure 11: Examples of Institutions Relevant to Quality of Care in Nigeria

3.2.3 Improving for Quality

3.2.3.1 *Interventions for improving quality of care within the health system in Nigeria*

Quality Improvement (QI) refers to the combined and systematic effort by healthcare institutions to make changes that may lead to improvements in quality of care delivery and health system performance. QI is a continuous process of repetitively testing and assessing changes, achieving quality aims, and increasing

best practices.[85] Improvement in quality care refers to positive changes in care delivery such as fewer errors, reduced delays in care delivery, less harm to patients, improvement in efficiency, increased market share and lower costs. [86]

There have been reported progress and investments made to improve the quality of health care in Nigeria by the federal government, United States Agency for International Development (USAID), JICA, Global Fund, Global Alliance for Vaccines and Immunizations (GAVI), United Nations Children's Fund (UNICEF), Bill and Melinda Gates Foundation (BMGF), Department for International Development (DFID) and other bilateral donors. However, Nigeria still records poor health outcomes when compared to counterpart low- and middle-income countries. This disconnects highlights broader systemic issues in the delivery of care.

At the federal level, fragmentation between program verticals is still a challenge, with a lack of coordination and visibility while at the state level, program partners typically set up parallel quality monitoring and evaluation systems and bypass government systems, which manifests in multiple parallel delivery channels that duplicate efforts but fail to ensure overall impact and sustainability of the interventions.

There are various historical and current QI activities across the breadth of the Nigerian healthcare system. These activities have leveraged a broad range of QI tools, terminology and methodologies with the unifying aim to improve the quality of health care. It is worthy to note that COVID- 19 pandemic on its part has not only delayed quality of care implementation activities and impacted the collection of quality of care data but also tested the relevance of the collaboration and learning functions of collaborative quality efforts.

This is not a comprehensive list, however, a selection of QI activities are highlighted below:

- Saving One Million Lives Initiative (SOML): The Saving One Million Lives Programme (SOML) was launched to save one million lives of under-fives and mothers through improving quality and expanding access to high impact Reproductive Maternal Newborn Child Adolescent Health plus Nutrition (RMNCAH+N) interventions. During the last quarter of 2016, the Federal Ministry of Health started actively tracking the implementation at Primary Healthcare centres across rural communities in Akwa Ibom, Enugu, Kano, Kogi, Osun and Yobe States (SOML PforR, 2017).

- The National Health Insurance Scheme (NHIS)-MDG Free Maternal and Child Health (MCH) programme: The National Health Insurance Scheme (NHIS)-MDG Free Maternal and Child Health (MCH) programme was initiated against the backdrop of Nigeria's poor performance on maternal and child health indices. The Free MCH was a special intervention to increase access to MCH services through removal of financial barriers through exemption of user fees. The project ran from 2008 and 2015 in 115 LGAs in six states and was subsequently expanded.

[85] https://www.hanshep.org/member-area/programmes/healthcare-quality-self-regulating-body-in-nigeria/feb-2014-survey-report-on-quality-management-in-nigeria.pdf
[86]

- The Nigerian Government's Midwife Service Scheme (MSS): The Nigerian Government's Midwife Service Scheme (MSS) was aimed at bridging human resource gaps in MCH by recruiting and deploying skilled birth attendants to underserved rural communities. It was upscaled by the government-led Subsidy Reinvestment and Empowerment Programme (SURE-P).

- National Reproductive, Maternal, Newborn, Child and Adolescent health plus Nutrition Quality of care (RMNCAH+N QOC)**:** In February 2017, Nigeria connected with ten other first wave countries as well as partners to join the WHO-led Quality, Equity and Dignity (QED) global network to improve Quality of Care to mothers and newborns. The aim of the QED network is to reduce maternal and newborn mortality and improve the experience of care by half in 2030. Consequently, Nigeria has set up a RMNCAH+N Quality of Care National Technical Working Group and Steering Committee tasked to lead the implementation of the initiative. A notable outcome of this network is the development of the National Strategy for Reproductive, Maternal, Newborn, Child, and Adolescent Health Quality of Care in Nigeria, Volume I Maternal and Neonatal Health in 2018 by the Federal Ministry of Health, Abuja.[87] Facility level implementation kicked off in 2019 across 12 States and 112 health facilities with the aim of halving maternal mortality and neonatal mortality and stillbirth by 2030. The program is being scaled up to more states and more health facilities in implementing states with support of development partners including WHO, UNICEF, JHPIEGO, USAID/Integrated Health Partners (IHP), Clinton Health Access Initiative (CHAI), Newborn Essential Solutions and Technology 360 (NEST360) and Pathfinder International. In addition, the Aliko Dangote Foundation, Bill & Melinda Gates Foundation and the USAID have set up basket funding with six northerns state - Bauchi, Borno, Kaduna, Kano, Sokoto, and Yobe to improve the quality of Routine Immunisation and Primary health care services in the states.[88]
  Riding on the momentum for quality improvement generated as a result of these series of activities, the FMoH and state ministries have since partnered with organisations such as GE Healthcare, the World Bank, PharmAccess and SafeCare to provide capacity building trainings for selected tertiary facilities, benchmarking exercises for health facilities across the country and quality improvement assessments and plans for primary health care centres respectively.[89] Faith-based organisations such as Catholic hospitals have been included in quality collaboratives to drive improvement.

- Reducing the Indirect Causes of Maternal Morbidity and Mortality (RICOM3): This project involves a consortium of partners (Jhpiego, HSDF, mDoc Healthcare) funded by MSD for Mothers in collaboration with the Lagos and FCT SMoHs that have come together to support women to reduce their risk of maternal morbidity and mortality due to indirect causes via an integrated quality of care (QoC) model that augments maternal and reproductive services to deliver woman-centred interventions for prevention, detection and treatment of the indirect causes of maternal morbidity and mortality across a woman's reproductive life cycle.

[87] Nigeria National Quality of Care for RMNC EH+N- Costed Annual Operational Plan(2021-2022)

[88] Implementing a Memorandum of Understanding with Basket Funding to Improve Routine Immunization Systems

[89] NQS Case Study

- 10,000 PHC Initiative: The ongoing 10,000 PHC initiative will increase access to MNCH services by upgrading at least one PHC per ward to be capable of providing Basic Emergency Obstetric and Newborn Care (BEmONC) services. In addition, one comprehensive PHC per LGA will be upgraded to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services.

- Healthcare Quality Initiative (NHQI): Nigeria Healthcare Quality Initiative (NHQI) was a collaboration between the Health Strategy and Delivery Foundation (HSDF), Private Sector Health Alliance of Nigeria (PSHAN) and Bill and Melinda Gates Foundation. The initiative sought to (i) improve the quality of MNH service provision; (ii) empower healthcare leaders and frontline workers; (iii) increase patient engagement in healthcare; and (iv) improve governance and advocacy for quality improvement in the country by moving the focus of engagement from inputs to the processes and outcomes of care delivery. The NHQI posited that empowering healthcare workers to continuously improve care processes and institutionalising quality improvement methodologies would result in pregnant women and newborns receiving reliable high-quality care, which in turn would reduce facility-based maternal and neonatal morbidity and mortality while leading to improved patient experience and satisfaction. Over the past five years, the NHQI was implemented in 130 primary and secondary (public and private) health facilities in Lagos, Imo and Niger State.

- Hygeia Community Healthcare (HCHC): HCHC is implemented on behalf of the Health Insurance Fund (HIF) by PharmAccess and in Nigeria, Hygeia Nigeria Limited has been contracted as the local implementing partner. The benefits package provides coverage for the most common medical problems found among the target groups and consists of primary care, limited secondary care and medication, including HIV/AIDS treatment. The scheme currently has over 100,000 enrollees. HCHC has contracted 21 healthcare providers to deliver healthcare to the enrollees. The provider network is involved in a continuous quality improvement program. Through the quality improvement program, HCHC and PharmAccess support the providers to continuously improve the quality of care.

- National Quality Improvement Programme On HIV/AIDS Services and Care (NIGERIAQUAL): As stated in the 2014 National Framework and Guidelines for the National Quality Improvement Programme On HIV/AIDS Services and Care, NIGERIAQUAL, was established by the FMoH to improve the quality of care for people obtaining care at HIV/AIDS care and treatment facilities through quality improvement infrastructure, performance measurement and continuous quality improvement activities. The programme evolved from the HIV Quality Improvement Programme and was created with the support of the United States President's Emergency Plan for AIDS Relief (PEPFAR) and technical assistance from the Nigerian Alliance for Health Systems' Strengthening (NAHSS).

Other interventions include but are not limited to:

- Control of Ebola outbreak in Nigeria in 2014 by the NCDC

- Establishment of the Nigeria Field Epidemiology and Laboratory Training Programme (FELTP) to build a critical mass of field epidemiologists
- Establishment of a national Emergency Operations Centre (EOC)
- Deployment of the Demographic Health Information System 2.0 (DHIS 2.0) which harvests data from private and public primary and secondary facilities
- National Tuberculosis and Leprosy Control Programme (NTBLCP) to control tuberculosis, leprosy and Buruli ulcer in Nigeria
- National Agency for the Control of AIDS (NACA) quality assessment of antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) care in healthcare facilities
- National Malaria Elimination Programme (NMEP) to provide equitable, comprehensive, cost effective, efficient and quality malaria control services

In addition to the initiatives highlighted above, there have been numerous efforts to improve quality of care at the facility level. The findings from the Oyo and Kaduna Healthcare Facility Assessment for the Quality Improvement of Integrated HIV, Tuberculosis, and Malaria Services in Antenatal and Postnatal Care suggest that while a strong delivery platform for quality improvement exists, (up to 83 percent of health facilities had a QI team), there are opportunities for optimization.[90] For instance, strengthening the ongoing routine review and improving standards monitored by the in-facility teams, can play a vital role in embedding facility-based focus on improving quality of care.

Regarding data quality, organisations have partnered to support the federal government in improving data quality. For instance, according to the IHI's National Quality Strategy Country Case Studies, partners such as HSDF as well as the London School of Hygiene & Tropical Medicine (LSHTM) and the Clinton Health Access Initiative (CHAI) have worked with governmental and non-governmental partners such as state management boards to strengthen data collection systems. For instance in Gombe state, LSHTM worked with the state's Ministry of Health to identify 14 priority maternal and neonatal health indicators that could be tracked through facility-based data and included 12 of them into Gombe's DHIS2. This led to a one year assessment that identified the variation in quality of reporting and ultimately interventions to improve the quality of reporting and healthcare services. While these efforts are showing improvements, there is a need for the NQPS to facilitate large scale improvement of the national data systems for quality.

The World Bank and Ministry of Health (MoH) have implemented a Results-Based Financing program which harnesses financial incentives to states and local government agencies based on the improvements in the quality of care at selected facilities and the results achieved in increasing delivery and use of high-

[90] Quality Improvement of Integrated HIV, TB, and Malaria Services in Antenatal and Postnatal Care in Nigeria, Oyo & Kaduna States: Findings from Healthcare Facility Assessment – Kaduna and Oyo Report

impact maternal and child health interventions. The goal of this program is to institutionalise key habits that drive a quality culture and optimise performance in Nasarawa and Ondo States as well as in all Northeastern States. Under this scheme, the FMoH through the NPHCDA provides technical assistance to the SPHCDAs. The SPHCDA contracts selected primary and secondary healthcare facilities to deliver a predefined package of MCH services, improve the quality of care and enhance equity. Based on performance, the State Project Financial Management Units (SPFMUs) disburses Performance-Based Financing (PBF) payments on a quarterly basis after verification. Health facilities can autonomously use these payments to (i) cover operational costs (i.e. about 50 percent); (ii) invest in quality-enhancement measures (i.e. maintenance and repair; drug supply; outreach activities); and to (iii) incentivize health workers (i.e. up to 50 percent). An impact evaluation to understand the effect of this financing mechanism and quality is underway.

Other examples of approaches being applied in the Nigerian Health System for improving quality of care include:[91]

- *Use of financial and non-financial incentives for improved quality:* Financial incentives for improved quality have not been proven to be sustainable. However, non-financial incentives such as rewards and recognition exist.
- *Education and training*: As part of quality improvement initiatives, facilities can sponsor continuous professional development for their staff and can influence the quality improvement training attendance of their staff
- *Patient complaint systems*: Many tertiary and secondary hospitals have a way for patients to leave their feedback at the facility but how this feedback is incorporated into the health system depends heavily on the facility that receives the feedback.
- *Healthcare financing*: Facilities are able to influence healthcare quality via innovative financing mechanisms. For instance, the National Hospital, Abuja is a self-funded facility, gaining funds via user fees and revolving funds for labs, pharmacy and consumables. The facility receives discounts on equipment through its sole-source supply and service agreement contract with an equipment and reagent manufacturer. This allows the facility to set its own priorities for more efficient revenue generation which in turn affects the quality of the healthcare services it renders.

Despite interventions aimed at improving quality in healthcare facilities, interviewees highlighted issues that affect the effective implementation of these activities particularly at the PHC facility level such as patient and health worker safety issues, ineffective delivery of person-centered care and poor patient, families and community engagement. It was mentioned that underfunding of PHCs suggests that patent and proprietary medicine vendors (PPMVs) and traditional healers would likely be patronised rather than the health system.

[91] https://www.hanshep.org/member-area/programmes/healthcare-quality-self-regulating-body-in-nigeria/feb-2014-survey-report-on-quality-management-in-nigeria.pdf

"Even if it was fake drugs you were going to get at the primary healthcare centres, they're not even there"

"Patients' safety should not cause more harm than good"

"Ensuring that a patient who came in with a malaria infection will not be infected with TBD at the health Facility"

"COVID-19 is also driving people away from health facilities"

"How do we ensure patient safety? What are the key opportunities and challenges in areas such as infection, prevention and control?"

"They [women] don't want to deliver at a hospital because there is no water to bathe after their deliveries"… because of this issue, they prefer to deliver in their houses"

Interviewees also noted that staff safety can be a real challenge in some parts of the country. Killings and kidnappings of medical professionals were highlighted as being a disturbing challenge faced in some parts of the country. Workforce challenges were noted to adversely affect the effective delivery of person-centred care. A lack of medical equipment and medicines in some facilities resulted in challenges in delivering quality care. Furthermore, as noted previously, issues with infrastructure and environment impact on staff morale and motivation, which has a direct impact on the quality of care staff are able to deliver to patients. Medical mal-practice often goes unreported with state governments being poorly engaged with the reporting system, meaning poorly performing medical practitioners continue to deliver patient care with few consequences. An important challenge noted was the lack of empathetic care delivered through the Nigerian health system. Interviewees noted that staff can have a poor attitude and poor communication skills. This perceived lack of being able to provide compassionate care was linked to poor working conditions and low staff motivation.

"Staff at the hospital are also rude and prone to abuse of power… Staff members often have poor communication skills"

"Empathic care is lacking in the Nigerian health system"

"Healthcare workers need to be more empathetic especially in General Hospitals. They should be selfless and have commitment and sympathy to patient populations."

"HCW should not focus on money but on their dedication to health care delivery and services"

On the issue of patients, families and community engagement, the interviewees highlighted that there can be significant issues in equity in access to clinical care for those in the rural areas. It was also highlighted that in some communities, those patients who did not support the incoming government can be discriminated against at health facilities. Some patients have to travel a significant distance to avoid political discrimination in recieving healthcare. Nepotism was also considered problematic for equitable care. Interviewees noted that family and friends of staff members can receive superior treatment to that of the general population.

"Secondary hospitals are especially untimely except you know a staff member who can expedite your treatment"

More broadly, out of pocket payments cause significant issues for those on low or no incomes to access the healthcare they need. In these circumstances, it was noted there are little or no system-wide financial safety nets to support those people living in poverty being able to access the care they need.

Interviewees noted that there is significant variation in the level of organized community interaction between the community, Ward Development Committee's (WDC'S) and facilities to effectively lobby for improvements in quality care delivery. The depth and effectiveness of community engagement with PHC and the LGA health office is inconsistent.

Although some examples of active patient and community engagement occur in Nigeria, overall the extent of community engagement is very limited. It was noted that there is a high degree of health illiteracy in the population. Community members are unfamiliar with their rights regarding healthcare and often do not have the skills to take responsibility for their own health and wellbeing. This makes navigating the healthcare system challenging for community members, particularly in choosing the most appropriate private health service to access.

"There is huge asymmetry of information between HCWs and the community. This has led to market failure in the health market. Consumers are irrational in their decisions and not informed"

It was noted that there is a real disconnect between communities and facilities. Ward development committees (WDCs) who should facilitate connections are often inactive or unmotivated. These WDCs were not built as a community-driven initiative and health facilities and the government often do not actively share health information with the community. It was specifically highlighted that the illiterate are often ill considered in health information dissemination and campaigns.

The design of health policies and interventions needs to be strengthened to better consider community perspectives and voices. It was noted that health interventions need to strengthen existing community assets and should be acceptable to the community to ensure that resources are well spent. It was noted that to develop interventions that are culturally appropriate and acceptable to communities, money needs to be invested in community engagement.

"Communities are seen as receptors of policy and intervention but not as participants"

Interviewees described a lack of trust in the communities for government-related solutions. There is a lack of confidence in government policies and interventions, which creates challenges in motivating communities to participate in issues concerning their health and strengthening the health system. Presently, there is low community participation in areas such as health research. The lack of timely care in health facilities also reduces the trust that patients have in the system.

"There is no community participation: people have lost confidence in government, so any government policy the community handles it with a pinch of salt"

Interviewees discussed patterns of use of health facilities. It was noted that while primary healthcare attends to most of the Nigerian populace, service delivery at the primary healthcare level is poor and there is little guidance on what each level (primary, secondary and tertiary) should be providing. People often do not go through referral systems and go straight to tertiary care.

It was also viewed that traditional birth attendants, chemists and traditional practitioners were favoured by communities and that care was often sought from these sources first before attendance at a health facility. It was noted that health facilities attached to mosques or churches were often preferred or well utilised due to the increased trust communities had in these services due to their linkage with their religious beliefs.

Community facilities seem particularly mistrusted and underused with tertiary health facilities being accessed more frequently, even if this was not clinically indicated. Some of this was associated with poorly located primary health facilities or a perception amongst healthcare staff and communities that primary care is only to be used for immunisation.

"There is a status symbol attached to some facilities especially tertiary health facilities"

Stakeholders added that patient safety issues such as inadequate basic amenities like water and electricity, weak waste disposal management and lack of effective ambulance system affect the effective delivery of quality care. It was confirmed that kidnappings and killing in many parts of the country affect health workers and that health workers are also assaulted by patients and relatives of patients, experience burn-out syndrome and have poor insurance coverage. Stakeholders corroborated the issues of low buy-in of programs and intervention from the communities and non-activation and creation of village development committee (VDC) and ward development committee (WDC) in some communities.

3.3 Data Systems for Quality

3.3.1 Quality Measurement and Learning Systems

The FMoH has been intentional about planning for quality data infrastructure as stated in the National Health Management Information System (NHMIS) Annual Report, which states that "... the quality of life of the Nigerian population can only be assessed based on adequate and complete information.". The report notes that the goal of the NHMIS is to establish an effective Health Management Information System at all levels of government across Nigeria. The NHMIS is managed by the Department of Planning, Research and Statistics (DPRS) but as noted in the 2015 National Quality Strategy and the 2014 review of the NHMIS policy, the NHMIS has not been utilised as well as planned; data availability and the use of data in decision making continue to be poor.[92]

The issues were echoed in the Monitoring And Evaluation Plan For The NSHDP II, which detailed data quality gaps including:

- Non availability of standardised or updated data reporting tools
- Low reporting rates from the private health sector
- Delayed and incomplete financial data reporting
- Inadequate number and capacity of M&E and HMIS Officers
- Multiple vertical and fragmented reporting systems
- Inadequate capacity and practice in data analysis, synthesis, dissemination and use at all levels
- Lack of linkages between civil and vital registration and NHMIS

Another data quality gap is the widespread lack of digitization of the health information systems in Nigeria.

The 56th National Council of Health (NCH) resolved to have a single data management tool for reporting routine health data to the NHMIS. To this end, the District Health Information System 2 (DHIS2) was introduced by the FMoH as a single data management tool for the NHIS. The 2014 National Health

[92] The Nigerian health information system policy review of 2014 – the need, content, expectations and progress

Research Policy and Priorities document notes that the DHIS 2.0 harvests data from 38,500 private and public primary and secondary facilities.

The Integrated Supportive Supervision (ISS) is conducted by the FMoH to ensure efficient management of resources and quality healthcare delivery.[93] It serves as both a QA and QI mechanism, which involves inspecting and providing capacity building support to healthcare workers in a bid to improve the healthcare services rendered. However, there are several ISS tools being used across the healthcare system leading to a waste of limited resources by the FMoH and its partners. To address the problem, the FMoH has worked with health partners including the WHO and UNICEF to develop comprehensive national ISS tools at the primary, secondary and tertiary health levels.[94]

3.3.1.1 *Data Regulation*

As mentioned previously, the Nigerian government through the NITDA issued the 2019 Nigerian Data Protection Regulation (NDPR). The NDPR, which is modelled on the EU General Data Protection Regulation, has created greater awareness of data protection among different stakeholders. However, it is limited in its enforcement and effectiveness.[95] The NITDA also recognises the role of the SMoHs in regulating and protecting medical data and calls for the full implementation of the NDPR to increase patients' trust in the ability of the healthcare sector to keep their personal information private.[96]

3.3.1.2 *Quality Data and Indicators*

The monitoring and evaluation (M&E) plan for the NSHDP II notes that the success of the policy would require a comprehensive M&E strategy, which would use input, output, outcome and impact indicators to create information that policy makers and implementers could apply to make informed decisions.
Table 4 is a selection of indicators used by different stakeholders in the Nigerian healthcare sector to track the quality of healthcare services provided. As it is important to view how quality is tracked along the six domains of quality (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity), the indicators have been organised to show which domain they most closely align with. While quality indicators are collected for key vertical initiatives and projects, there are no core quality indicators collected and reported across all levels of the healthcare system to help improve performance

[93] https://fmohconnect.gov.ng/iss-dqa.html

[94] Ibid

[95] How (Not) to Regulate Data Processing: Assessing Nigeria's Data Protection Regulation 2019 (NDPR)

[96] https://worldstagenews.com/nitda-charges-lagos-to-implement-data-protection-in-health-sector/

measurement. Table 5 shows an illustrative list of quality indicators provided as part of the 2015 National Quality Strategy.

Figure 12 below illustrates health indices across the six health domains which point to quality. Currently there is no core set of data or indicators that are being used to track the state of quality holistically across the nation. This underscores a need for a more intentional focus on key health indicators and their link to quality of care as well as the learning and feedback systems to facilitate the use of data for improvement.

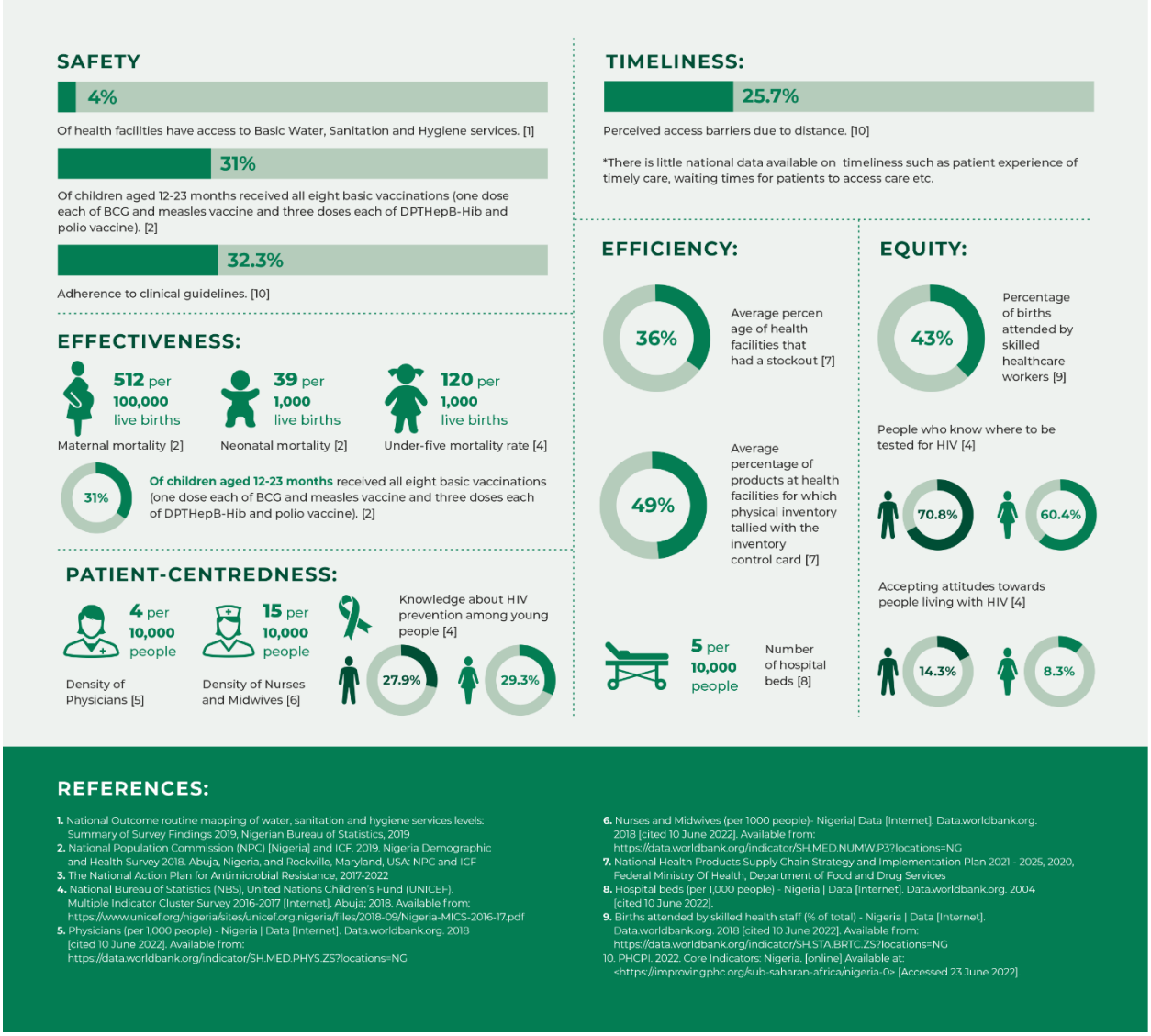

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Figure 12: A selection of health indices across the 6 domains of quality

Quality Dimension	Focus	Process Indicator	Outcome Indicator	Data Source	Document Source
Effectiveness	Maternal Service	Number of women (who delivered in the facility) received a prophylactic uterotonic within 1 minute after birth for prevention of PPH	% of Quality ANC	HMIS/facility register	National RMNCAEH+N Quality Of Care MEAL Plan 2022-2027
	NCD Services	Number of PLHIV screened for ADR at every clinical visit or encounter within the reporting period	Proportion of PLHIV screened routinely for ADR within	Client folder, ADR screening form	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
Safety	Neonatal Services	Number of HIV exposed infants who had EID samples collected at birth or before 8 weeks.	Proportion of HIV exposed infants who had sample collected for EID by 8 weeks	Child follow up register, EMR	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care

	Child Services	Number of HIV exposed infants aged 10 weeks who had their DNA PCR test result by 10 weeks of age.	Proportion of HIV exposed infants who received their DNA PCR results by 10 weeks of age	National PMTCT child follow-up register and EMR	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
Patient-Centeredness	Maternal Services	Number of women who wanted and had a companion supporting them during labour and childbirth in the health facility	The proportion of women who wanted and had a companion supporting them during labour and childbirth in the health facility	Client questionnaire (sample of women) (e.g. exit interview)	National RMNCAEH+N Quality Of Care MEAL Plan 2022-2027
		Pre-discharge counselling for the mother and the baby	Proportion of women who received pre-discharge counselling for the mother and the baby (as per the WHO standards) in each period	Client questionnaire (sample of women) (e.g. exit interview)	National RMNCAEH+N Quality Of Care MEAL Plan 2022-2027
Timeliness	Neonatal Services	Number of infants born to HIV positive high risk pregnant women who received NVP and ZDV syrup within 72 hours of delivery	Proportion of infants born to HIV positive high risk pregnant	EMR/Child follow-up register/Pharma	National Indicator Framework And Guidelines For The National Quality Improvement

			women who received NVP and ZDV syrup within 72 hours of delivery	cy daily worksheet	Programme On HIV/AIDS Services And Care
	NCD Services	Number of adults who tested HIV positive with same day ART initiation	Proportion of eligible HIV positive adults with the same day ART initiation within the review period	Adult ART register, Lab HIV testing register, EMR	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
Equitable	NCD Services	Number of HIV patients with at least one clinical visit or contact who were screened for clinical symptoms (cough, fever, night sweats and weight loss).	Proportion of PLHIV with at least one clinic visit or contact who were clinically screened for TB	Adult ART register, EMR	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
		Number of patients on ART eligible for viral load with at least one documented viral load test	Proportion of PLHIV eligible for viral load test having a documented VL test	Laboratory VL register, EMR	National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
Efficiency	Maternal Services	Number of HIV Positive pregnant women who had a suppressed viral load result following viral load test at 32-36 weeks.	Percentage of HIV positive Pregnant women that	Maternal Cohort Register /EMR	National Indicator Framework And Guidelines For The National Quality Improvement

			were virally suppressed by 32-36 weeks		Programme On HIV/AIDS Services And Care
		Number of women who are admitted to a facility with obstetric complications (both direct and indirect) or who develop such complications after admission in the facility and die from these complications before discharge; excluding accidental or incidental deaths.	Proportion of women who are admitted to a facility with obstetric complications (both direct and indirect) or who develop such complications after admission in the facility and die from these complications before discharge; excluding accidental or incidental deaths	HMIS/facility register	National RMNCAEH+N Quality Of Care MEAL Plan 2022-2027

Table 4: Selection of Indicators Used to Track the Quality of Healthcare Services

Table 5 shows an illustrative list of quality indicators provided as part of the 2015 National Quality Strategy.

Measure Dimension	Suggested Measure	Indicator Type	**Discussion Needed for NQPS Working Group**
Access	Access to PHC services within two hours using normal mode of transport	Process	Defining numerator and denominator, including "normal mode" of transport
Access	Local/regional variation of time to emergency care	Process	Defining numerator and denominator, including definition of "emergency care" and what will be included
Access	Waiting time to access care for victims of severe motor vehicle collisions	Process	Defining numerator and denominator, including definition of "severe motor vehicle collisions"
Access	Waiting time for patients with life-threatening conditions	Process	Defining numerator and denominator, including inclusion criteria for "life-threatening conditions"
Access	ANC coverage: Percentage of pregnant women who attended 4 ANC visits	Process	Defining numerator and denominator
Access	Routine immunisation coverage: Percentage of children < 1 year of age who received routine immunisation	Process	Defining numerator and denominator

Access	Regional variation in routine immunisation coverage	Process	Defining numerator and denominator
Health System Infrastructure	Days of no power	Structure	Defining numerator and denominator, including stratification by facility type
Health System Infrastructure	Days without access to clean water	Structure	Defining numerator and denominator, including defining "access to clean water," including stratification by facility type
Patient Experience	Satisfaction of patient and his/her relatives	Outcome	Defining how patient and relative satisfaction will be measured
Patient Experience	Compliance to hand hygiene	Process	Defining numerator and denominator, as well as defining standards for hand hygiene
Staff Experience	Facility staff absence rate, stratified by type of facility	Process	Defining numerator and denominator, as well as what comprises absence

Clinical Effectiveness	Major inpatient complications fatality rate	Outcome	Defining numerator and denominator
Clinical Effectiveness	Obstetric major complication case fatality rate	Outcome	Defining numerator and denominator
Clinical Effectiveness	Number of days since last maternal death	Outcome	Ensuring common understanding of definition, including stratification by facility type
Clinical Effectiveness	Neonatal major complication case fatality rate	Outcome	Ensuring common understanding of definition, including stratification by facility type
Clinical Effectiveness	Number of days since last neonatal death	Outcome	Ensuring common understanding of definition, including stratification by facility type
Clinical Effectiveness	Number of health facilities that have clinical guidelines for: ● Maternal health ● Family planning ● Immunisation guidelines/schedule ● Malaria	Structure	Defining expectations and standards in more detail

Clinical Effectiveness	Per cent adherence to clinical protocols/guidelines	Process	Defining numerator and denominator and how to collect this information (e.g., audits of past clinical records)
Patient Safety	Post-operative wound infection rate	Process	Defining numerator and denominator
Efficiency	Days of stock-outs of essential/obstetric medicines	Process	Defining numerator and denominator, as well as defining universe of essential/obstetric medicines
Efficiency	Length of stay	Process	Defining numerator and denominator

Table 5. Illustrative List of Quality Indicators for the 2015 National Quality Strategy+

4.0 Discussion

4.1 Challenges, Opportunities and Implications for Strategy

The findings discussed above accentuated challenges to implementation (see Figure 13) and revealed possible opportunities and implications for the development of the NQPS using five themes namely: (i) Transforming the systems environment; (ii) Reducing harmful practices on patients and staff; (iii) Improving the effectiveness of clinical care; (iv) Engaging patients, families and communities; and (v) Improving monitoring, evaluation and learning systems.

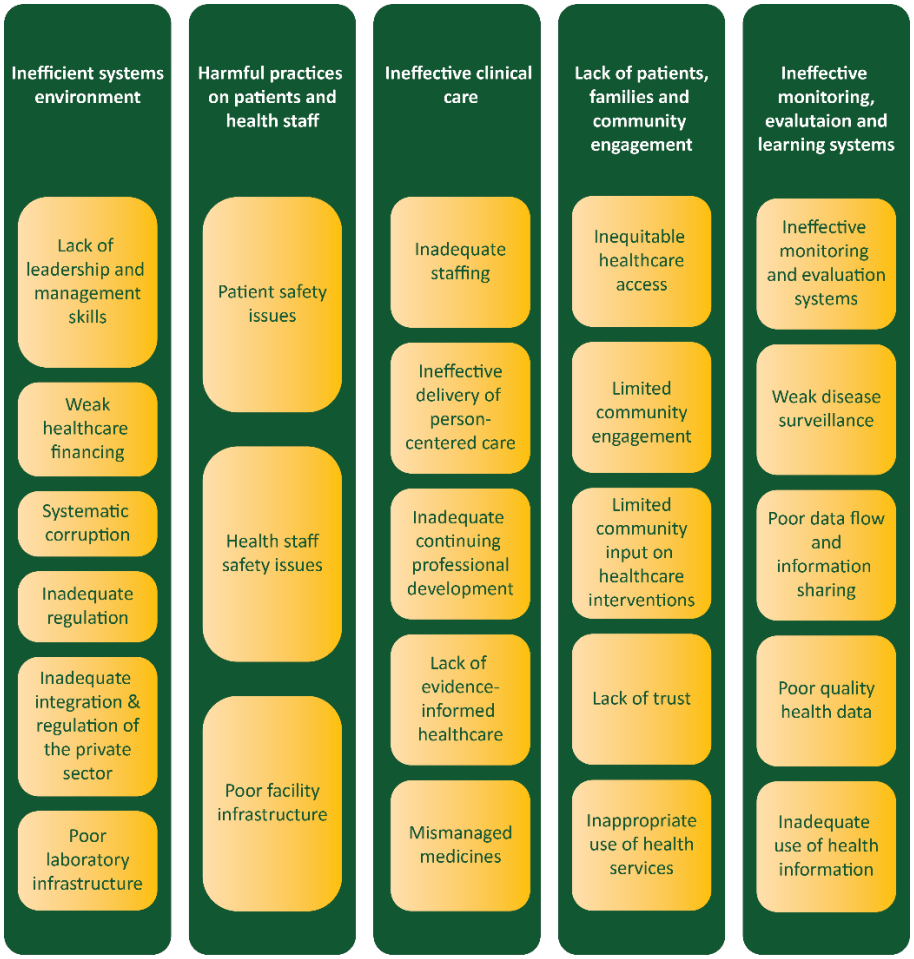

Figure 13: Summary of Challenges to Quality of Care in Niger

4.1.1 *Transforming the Systems Environment*

The Nigerian Health System despite being multi-layered and complex has many gaps that impede quality of care. The National Health Policy of 2016, presented a situational analysis that showed that the country's health system was antiquated and has still been barraged by myriads of challenges such as: poor governance in the health system, unresponsiveness of the health system, health inequity across board amongst others.

While there is no dearth of health policies and strategies - of which many are aligned on the intention to create a quality healthcare system - a persistent problem is a lack of available resources to enact change, deliver high-quality care and implement QA and QI initiatives. In addition, limited governance and accountability structures inhibit the enforcement of these policies. As an example, strategies to improve hand hygiene would be irrelevant unless the infrastructural problem of a lack of clean water is addressed. It is important, therefore, that in developing an NQPS, the resource and infrastructural changes needed to serve as a basis for QA and QI activities must be taken into consideration.

The Federal QA structure is large, diffuse, and complex. The different actors in the quality management infrastructure all use different tools and methodologies to drive quality. For instance, a single federal tertiary hospital will be directly overseen by the FMoH Department of Hospital Services (DHS), but will report data using the NHMIS developed by the Department of Health Planning, Research and Statistics

(DPRS), and may be evaluated by the Department of Family Health (DFH) using Integrated Supportive Supervision (ISS); its doctors will be regulated by the MDCN, its nurses by the NMCN, its lab technicians and laboratories by the MLSCN, its pharmacists and pharmacies by PCN; it will be accredited by the NHIS to receive NHIS enrollees, and it will receive referrals from secondary hospitals managed by SMoHs and PHCs managed by the Primary Healthcare Board using policy set by the NPHCDA.

As the constitution provides the FMoH with limited influence over the fiduciary duties of the state and local governments, plans, budgets and procurements are not subject to federal review. This complex structure hinders the implementation of QA and QI initiatives and complicates the role of the FMoH to create unified policies and strategies that deliver quality health care. A lack of attention to implementation is also problematic with state-level facilities slow on the uptake of federal strategies without the formal adoption of these strategies by their state governments. The priorities of the FMoH may not be the priorities of the different SMoHs and thus the FMoH should focus on motivating the SMoHs to align with its goals as well as on QA and QI initiatives within its direct scope of influence.

There is also the problem of the poor allocation of the National Budget for Health. The budgetary allocation for health is pegged at 15 percent of the country's national budget. However, Nigeria still falls short. To date, there is no budget line item for healthcare quality at the national level nor in most state health budgets. In addition, the percentage allocated for health promotion is quite small and does not come promptly most times despite a plan in place to partner with several ministries, stakeholders, and private organisations to facilitate the health promotion activities (National Health Policy, 2016). The

National Health Research Policy and Priorities 2014 highlights the meagre funding for health research with the document noting that funding by the government was at most 0.08 percent of health expenditure instead of 2 percent prescribed by the WHO. Further, the high level of out-of-pocket expenditures worsens health inequities and exposes Nigerians to poverty due to catastrophic health spending. The role of Health Management Organisations (HMOs) as a purchaser and provider of health services under the NHIS creates an asymmetrical relationship with the users of the fund. At the same time, efforts are being made by key states to implement state health insurance schemes to address the access and coverage gap, with 19 states at different stages of their implementation journey. These schemes, if successfully implemented with demonstrable value to both patient and provider, could be a key tool in ensuring accessible and affordable quality care across the country.

Opportunities exist through regulatory bodies to embed QI into the different healthcare professions. As an example the different standards of these regulatory bodies could be distilled and the registration and licensing of healthcare providers could be more streamlined and transparent. Through an NQPS that is built on a truly participatory process, embedding quality as an operating principle within the regulatory agencies, can dramatically improve communication, accountability, transparency and inter-agency collaboration. There needs to be a change in the current regulatory operational model so that healthcare providers are more likely to see regulatory bodies as trusted partners in providing quality care. Some regulatory bodies are reactive in their approaches only providing solutions in response to specific complaints. Avoidable deaths may go undetected in a system and the regulatory bodies miss out on any analysis or learnings that can be made from them. Some healthcare professionals fall under the regulation of multiple regulatory bodies. For instance, lab personnel are governed by the QA activities of the MDCN and the MLSCN; the MDCN focuses more on preventing fraud and remedying the effects of malpractice while the MLSCN focuses on participatory feedback and support from the improvement of service provision. Greater transparency and coordination between regulatory bodies would reduce confusion among consumers and providers and give providers clarity on what is expected of them.

There is a need to improve the registration and accreditation of facilities across Nigeria. Thus it is important for states to utilize their facility management boards and push for an increase in this accreditation and requisite support to build the capability of facilities to achieve accreditation status. There has been some progress regarding this as some private healthcare facilities have received Joint Commission International (JCI) or Council for Health Service Accreditation of Southern Africa (COHSASA) accreditation while MLSCN has provided national accreditation to seven qualified laboratories (out of over 5,000) in the country.

4.1.2 *Reducing Harmful Practices on Patients and Staff*

A more cohesive and effective approach to setting professional standards that define the requirements for clinical practice is needed and could be realised through increased cooperation between professional associations, federal and state MOH departments, regulation agencies and the separation of fraud prevention activities from QA activities. This increased cooperation could also help address the problem of a lack of continuous oversight, monitoring and sanctions against fake medical professionals. There

exists a need for the effective implementation of regulation to protect Nigerians from both unqualified health providers and health facilities that do not meet the minimum standards of care such as those provided by the NPHCDA's Minimum Standards for Primary Healthcare Delivery document.

Health workforce supply shortages and the inequitable distribution of staff and facilities across Nigeria increase patient harm, reduce staff job satisfaction and motivation to work and worsen patient outcomes. The NQPS could build on current investments in addressing these workforce challenges to ensure an integrated approach.

While NAFDAC receives reports of adverse events through the National Pharmacovigilance Centre (NPC), less than 10 percent of urban physicians are currently reporting into this system. While pharmaceutical manufacturers do have their own adverse effects (AE) reporting systems which link with NAFDAC, and some facilities implement adverse event reporting systems, there is a clear opportunity to build on these discrete systems and establish a recognized and available system that is reliable for patients and facilities across the different levels of care. The lack of a nationally endorsed list of serious adverse events, which facilities could use as a standard by which they can measure their performance in reducing preventable harm also affects the quality of healthcare in the Nigerian health system.

For occupational health and safety, the NSHDP II notes that there is no established programme dedicated to tackling this issue and while there is a policy in place, it is not well implemented meaning that healthcare organisations may not be providing adequate workplace health and safety measures.

4.1.3 *Improving the Effectiveness of Clinical Care*

Quality issues affect Nigeria's efforts to provide integrated person-centred care across the value chain for its citizens from prevention to screening to diagnosis to care and treatment. The NQPS will need to build on efforts to address the infrastructural and resource gaps impeding the provision of effective clinical care across this value chain.

To facilitate the delivery of person-centred, highly reliable and effective care at all levels of the healthcare system, the NQPS could build on the QA and QI work that has been done at the national and subnational level which has led to demonstrable improvement in population health outcomes at scale. Many of these initiatives have made significant impact on processes and systems to drive improvements in person-centred care, patient safety and clinical outcomes but require investment in resources and governance structures for sustainability.

The Minimum Standards For Primary Health Care document shares that there is an inadequate number and distribution of necessary healthcare workers within the PHC system. There is also a poor knowledge of the National Health Act and what it entails probably due to the fact that only a small minority have seen a copy of the Act and only a small fraction of those who have seen it have read it: if this is so, it then stands

to reason that health care professionals might not understand what is fully expected of them in terms of quality of health care delivery.[97]

To maintain and improve the quality of services provided by staff, healthcare facilities should invest in continuous learning programs for their staff especially on quality improvement. In cases where practitioners have received appropriate clinical education but have not updated licensing or CPD requirements, regulatory bodies need to provide a supportive system that provides practitioners with opportunities for improvement before punitive action is taken. These actions will ensure that patients are not attended to by practitioners who are quacks or those who have not met the requirements of licensing. However, a challenge on the PHC level, is that the degree to which PHC staff can receive this type of capability building support is dependent on its geographic location, whether there is implementing NGO partner support, and their relationships with the LGA HQ office.

As noted by the National Tuberculosis, Buruli Ulcer, and Leprosy Control Programme (NTBLCP) in its 2015 National Guidelines on External Quality Assessment for Acid-Fast Bacillus (AFB) Smear Microscopy, Xpert Mycobacterium Tuberculosis Complex (MTBC) and Resistance to Rifampin (RIF) MTB/RIF Assay, Line Probe Assay, Culture and Drug Susceptibility Testing, the laboratories that Nigeria needs to make evidence-based diagnostic decisions are plagued by weak lab systems and poor quality standards.

The NSHDP II notes that there is poor quality assurance and control of laboratory services and ineffective regulation of laboratory services across Nigeria. In addition, the minimum standards guide for PHC shares that drug management is an issue with a lack of essential drugs in most PHC facilities as well as a wastage and expiry of the medicines that are present. Supporting existing facility quality improvement teams to make investments in process improvement and supply chain management will augment current efforts in this arena.

Providers and the facilities they work in are important especially in improving quality and ensuring the effectiveness of clinical care. Based on efforts in Nigeria, some of the interventions below for inclusion in the NQPS could target:

- The use of finance for improved quality in line with the World Bank's use of performance-based financing. An important policy implication from the PBF initiatives is that PBF should be carefully harnessed for specific service delivery indicators. Non-financial incentives such as non-financial rewards and recognition also exist that can be leveraged.
- Education and training: As part of quality initiatives, ministries of health and facilities can sponsor continuous professional development for their staff and can protect time for their staff to attend QI training.

[97] Enabulele, O., & Enabulele, J. E. (2016). Nigeria's National Health Act: An assessment of health professionals' knowledge and perception. *Nigerian Medical Journal: Journal of the Nigeria Medical Association*, *57*(5), 260

- Patient complaint systems: Many tertiary and secondary hospitals have a way for patients to leave their feedback at the facility but the NQPS could provide guidance on how this feedback is incorporated into the health system as currently this process depends heavily on the facility that receives the feedback.
- Healthcare financing: The NQPS can guide facilities on how to influence healthcare quality via innovative financing mechanisms.

4.1.4 *Engaging Patients, Families and Communities*

Achieving improved and sustainable quality care necessitates investing in not only a supply side of providing policies, available human resources, infrastructure but also the investing in the demand side which includes patient empowerment, health seeking behaviour support and so on. Therefore, it is critical to explore opportunities to engage communities across geographical and people groups for sustained progress.

NAFDAC, through its public awareness initiatives, educates and empowers vulnerable patients to know their rights and ask about the authenticity of their medication. If more regulatory agencies can create patient and community demand for quality and patient centred care, there is an opportunity to create a demand for quality care and a focus on regulatory agencies to promote quality.
There is also an opportunity for the State Primary Healthcare Boards (SPHCBs) to fully engage members of the communities they serve as just appointing community members to the boards is not enough. Local engagement through state and local government politicians as well as service providers at the PHC level can communicate the benefits of the new PHC system to members of the community, which includes traditional and religious leaders as well as professional unions.[98]

Revitalization of WDCs to drive a community-led engagement and participation in health is an opportunity to explore in the NQPS. A study conducted in Edo state revealed that some WDCs in the LGAs were not fully functional but noted that WDCs were vital for community ownership of the health projects in the community. It noted that a community led approach was useful in scaling up and sustaining the use of PHCs for pregnancy care especially in the rural areas of Nigeria. This community-led approach could also be useful in expanding beyond pregnancy care and in increasing the use of PHC for all types of preventive and promotive care.[99] Ensuring the patient voice through community health communities or the adoption of digital technologies such as NaviHealth.ai, a digital directory of health facilities, providers and services with a quality-focused patient review system can ensure a more inclusive approach which galvanises providers responsiveness and improvement. Community health committees are also important in

[98] Health Partners International (2014) Bringing primary health care under one roof: 9 factsheets for implementation in Nigeria

[99] Ntoimo, L. F. C., Brian, I., Ekwo, C., Yaya, S., Imongan, W., & Okonofua, F. E. (2021). Building community ownership of maternal and child health interventions in rural Nigeria: A community-based participatory approach. *African Journal of Reproductive Health*, *25*(3s), 43-54

empowering their communities to comment on the quality of the health services they receive at the PHCs.[100]

4.1.5 *Improving Monitoring, Evaluation and Learning Systems*

The National Health Research Policy and Priorities (2014) policy document notes the lack of "basic, reliable, and adequate information on health", which also includes monitoring outcomes of programme implementation. While the DHIS2 exists as a single data management tool for the NHMIS, there is little reporting on the DHIS2 from the private sector despite the fact that the private sector provides over 60 percent of healthcare services in the country. Efforts by non-governmental partners have led to improvements in reporting rates from the private sector and these interventions can be built upon in the NQPS. The NSHDP II, has also noted that primary and secondary health care facilities reported to the DHIS2 more than tertiary care facilities which were said to "significantly under-report into DHIS2".

According to the NSHDP II and the 2015 National Quality Strategy, significant problems with the NHMIS also include the multiplicity of HIS that exist within the country, poor data reporting and the fragmentation that results from these. For data from a PHC to get to the FMoH, it must be collected from WDCs and VDCs, reported to the LGAs PHC oversight bodies who then report the data to the SMoH and finally through the NHMIS to the FMoH. This process becomes problematic as these channels do not function reliably and there are only few feedback systems in place to improve quality. Also, numerous, often donor-driven programmes run parallel HIS that are not integrated with one another.
Overall, poor data quality still persists at all levels. There is no systematic analysis of HMIS data and feedback to health institutions thereby limiting the use of HMIS data for health planning and decision-making. The National Health Research Policy and Priorities (2014) notes how health research in Nigeria has been uncoordinated, lacking synergy, harmonised efforts and a prioritisation of activities. There is also the issue where most research studies are donor-driven which focuses on the interests of the donors. It calls for the need for clear policy guidelines and direction on health research.

The IHI's National Quality Strategy Country Case Studies note, however, that the FMoH has strengthened its data reporting system recently and that reporting into the NHMIS is now compulsory across the country.[101] There are a number of indicators that are currently being collected through the NHMIS and through discrete initiatives that can be included in a core set of standardised quality indicators that should be tracked on a regular basis to assess the quality of care across all levels of the Nigerian Health System. There is a large opportunity to integrate structure, process and outcome indicators for a whole quality lens approach. The NQPS should include in its implementation plan guidelines on the process for developing these core quality indicators across multiple key stakeholders. These stakeholders should

[100] Karuga, R., Kok, M., Luitjens, M., Mbindyo, P., Broerse, J. E., & Dieleman, M. (2022). Participation in primary health care through community-level health committees in Sub-Saharan Africa: a qualitative synthesis. *BMC public health*, *22*(1), 1-17.

[101] National Quality Strategy Country Case Studies Learning from Ethiopia, Ghana, Mexico, Nigeria and Scotland, IHI, 2018

include clinical, patient, policy, regulatory, academic and political stakeholders in the decision-making process. These core quality indicators should be linked to the specific goals laid out in the NQPS.

The way the core indicator data is ultimately utilised and benchmarked is crucial to improving quality. For instance, whether these core quality indicators are publicly reported is important for transparency and accountability. Public opinion of these core indicators is important, as demand from the public or civil society is a strong influencer. A balanced set of system-level measures not only reports on the health system's performance over time, but also serves as inputs to quality planning, allows a system to see how it is performing based on its Interventions for improvement, and allows comparisons across similar systems for benchmarking and improvement.

Thus to improve quality at a national level, data for these core quality indicators must be easy to report and to feed back into the system at all levels, particularly at the facility level. In this way, data can be harnessed in QI approaches such as appreciative inquiry and root cause analysis to promote continual improvement.

4.2 Strengths, Weaknesses, Opportunities and Threats

A strengths, weaknesses, opportunities and threats (SWOT) analysis of healthcare quality in Nigeria is shown in Table 6. The SWOT analysis highlights strategic options through an evaluation of internal capabilities and external developments for healthcare quality in Nigeria.

SWOT Dimension	Factors
Strengths	• **Transforming the health systems environment** -Existing regulatory institutions for quality at the federal and state levels; existing legislations, health policies and strategies on quality healthcare delivery • **Reducing harmful practices on patients and health staff** – Existing National Health Workforce Registry; existing adverse events reporting through the National Pharmacovigilance Centre (NPC); adverse events reporting for pharmaceutical manufacturers; and existing occupational health and safety policy • **Improving effectiveness of clinical care** - Established RMNCH Quality of Care Technical Working Groups in virtually all the states; existing QA and QI interventions at the national and subnational level; existing efforts to address the infrastructural and resource gaps impeding the provision of effective clinical care; review of morbidity and mortality using Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) in all the tertiary and secondary health care levels and some PHCs in 21 states; existing Network for Improving quality of care for Maternal, Newborn and Child Health (QED Network); National Quality of Care Strategy for New-born and Maternal Health; 112 learning sites across the country which focus on improving the quality of MNCH; and maternal and perinatal database used in 54 facilities to support continuous quality improvement activities, existing integrated models of quality care as evidenced by RICOM3 which can be scaled • **Engaging patients, families and communities** - Existing WDCs at the ward level for community participation; existing stakeholder participation and commitment to improving quality of healthcare; NAFDAC educates and empowers vulnerable patients to know their rights and ask about the authenticity of their medication. • **Improving monitoring, evaluation and learning systems** – Existing DHIS2 data management tool for the NHMIS; established monitoring and evaluation structures across the three tiers of government; efforts by non-governmental partners have led to improvements in reporting rates from the private sector; strengthened FMoH data reporting system and compulsory reporting into the NHMIS; quality indicators are collected through the NHMIS

Weaknesses	• **Transforming the health systems environment** – Inadequate resources to deliver high-quality care and implement QA and QI initiatives; limited governance and accountability structures inhibit the enforcement of policies; complex health structure hinders the implementation of QA and QI initiatives and complicates the FMoH's role to create unified policies and strategies; poor allocation of the national budget for health; percentage allocated for health promotion is small and its release is slow; poor transparency and coordination between regulatory bodies; inadequate integration and regulation of the private sector • **Reducing harmful practices on patients and health staff** - Inadequate cooperation between professional associations; federal and state MoH departments and regulatory agencies; lack of continuous oversight, monitoring and sanctions against fake medical professionals; health workforce supply shortages and inequitable distribution of staff and facilities; less than 10 percent of urban physicians report into the National Pharmacovigilance Centre (NPC) system; prevalence of hospital-acquired infections; lack of a nationally endorsed list of serious adverse events that facilities could use as a standard; kidnappings and killing of health workers; no established programme dedicated to tackling occupational health and safety issues • **Improving effectiveness of clinical care** – inadequate number and distribution of healthcare workers within the PHC system; poor health worker knowledge of the National Health Act and what it entails; degree to which PHC staff can receive capability building support depends on the location, implementing NGO partner support, and relationships with the LGA HQ office; weak lab systems and poor quality standards; poor quality assurance and control of laboratory services; lack of essential drugs in most PHC facilities as well as a wastage and expiration of medicines; lack of evidence-informed healthcare • **Engaging patients, families and community engagement** – Inequitable healthcare access; limited community engagement; limited community input on healthcare interventions; lack of trust; patient and community demand for quality and patient centred care • **Improving monitoring, evaluation and learning systems** – Weak disease surveillance; poor data flow and information sharing; poor quality health data; inadequate use of health information; limited reporting on the DHIS2 from the private sector; tertiary care facilities significantly under-report into the DHIS2; poor data reporting and fragmentation from multiple health information systems; no systematic analysis of HMIS data and feedback to health institutions; health research has

	been uncoordinated, lacking synergy and harmonised efforts; most research studies are donor-driven and tend to focus on the interests of the donors
Opportunities	• **Transforming the health systems environment** - Health insurance funding of health services at federal, state and local government levels, existing state health insurance schemes to address the access and coverage gap, with 19 states at different stages of their implementation journey; Basic Health Care Provision Fund can help support the improvement of ambulance service; regulatory bodies could embed QI into the different healthcare professions; different standards of regulatory bodies could be distilled and the registration and licensing of healthcare providers could be more streamlined and transparent • **Reducing harmful practices on patients and health staff** - The COVID-19 response saw an improvement in staffing, task shifting and sharing policy, equipment and logistical supplies; national standard treatment guidelines are available but need to be reviewed; sustainable capacity building introduced during the federal/state government interventions by partners/donor organisations working in the areas; improve communication on availability of protocols and on-the-job training of their uses; leverage ongoing infrastructure funding by government; utilisation of solar energy for improving power and water supply; need for the effective implementation of regulation to protect Nigerians from both unqualified health providers and health facilities that do not meet the minimum standards of care • **Improving effectiveness of clinical care** – National standard treatment guideline is available but not frequently reviewed; initiatives have made significant impact on processes and systems to drive improvements in patient and clinical outcomes and require investment in resources and governance structures for sustainability; opportunities to build on efforts to address the infrastructural and resource gaps that hinder the provision of effective clinical care • **Engaging patients, families and communities** – Community-led monitoring initiatives - a patient satisfaction assessment which gives a better understanding of the enablers and barriers to accessing quality health services by individuals; patient education and empowerment program led by Network of People Living with HIV/AIDS in

	Nigeria (NEWPHAN) to empower its members with capacity building in areas such as health literacy and advocacy, strengthen and reactivate WDCs; regulatory agencies can create a patient and community demand for quality and patient centred care; the SPHCBs could engage members of the communities they serve; local engagement through state and local government politicians as well as service providers at the PHC level can communicate the benefits of the new PHC system to members of the community. Digital platforms such as NaviHealth.ai to collect patient reviews and feedback aligned with the 6 quality domains. • **Improving monitoring, evaluation and learning systems** – Integrate structure, process and outcome indicators for a whole quality lens approach; include guidelines on the process for developing core quality indicators across multiple key stakeholders; link core quality indicators to specific goals;.review morbidity and mortality data using MPCDSR, utilize a unified data platform such as the HMIS; opportunities for public health surveillance system and NCDC national surveillance identifying infectious diseases within the communities
Threats	• **Transforming the health system environment** - Budget allocation disproportional between tertiary, primary and secondary care; weak systems for pooling resources for healthcare; strategic planning is weak and not linked to budget; heavy reliance on donor funding which is not always reflective of the population's needs due to limited scope and sustainability; poor healthcare financing leading to large out of pocket payments; lack of public-private sector integration • **Reducing harmful practices on patients and health staff -** Insecurity issues – kidnappings and killings affect safety of health workers; health workforce supply shortages and the inequitable distribution of staff and facilities increase patient harm, reduce staff job satisfaction and motivation to work and worsen patient outcomes. • **Improving effectiveness of clinical care - I**nefficient and ineffective care due to healthcare under prioritized at the national and state level, with limited political will to focus on healthcare

	• **Engaging patients, families and communities -** Lack of trust in government healthcare interventions • **Improving monitoring, evaluation and learning systems** – Public opinion of the core indicators is important, as demand from the public or civil society is a strong influencer.

Table 6: SWOT Analysis of Healthcare Quality in Nigeria

4.3 Proposed Priority Areas and Quality Ambitions for the National Quality Policy and Strategy

Based on the interventions and gaps highlighted, the stakeholders listed potential priority areas for the NQPS, voted on the areas, and developed a quality ambition for at least one of the areas on the prioritised list. However, the priority areas are not final but will inform the development of the forthcoming NQPS alongside further prioritization processes.

Table 7 shows a selection of thematic quality dimensions, their priority areas and quality ambitions that are related to recommendations by interviewees and stakeholder workshop discussions. Further deliberations and prioritization exercises are required for the final NQPS development.

Quality Dimension	Priority Areas	Quality Ambition
Transforming the Systems Environment	1. Address healthcare financing challenges that lead to large out-of-pocket payments, inefficient and ineffective care. 2. Reduce the proliferation of counterfeit drugs, vaccines and medical technology by 10 percent by 2030. 3. Address challenges in coordination between regulatory, local governments, programmatic departments working to ensure quality of care. 4. Build health strategies that improve the shortages of human resources for health.	• Institutionalised community health care system with a functional community structure in the country • Increased proportion of people seeking health care services in the community • Sustained ownership of the healthcare system by the community in the 36 states and FCT
Reducing harmful practices on patients and staff	1. Ensure skilled human resources for health facilities to provide infection prevention and control (IPC) and ensure patient safety. 2. Provide adequate basic amenities such as water, sanitation and hygiene and electricity for IPC/sterilization equipment and lighting of the health facilities 3. Ensure adherence to the use of protocols and guidelines	• Institutionalised IPC in health facilities in all states of the country • Reduced harmful practices on health care workers and patients • Implemented task shifting and sharing for health workers to reduce burnout and workloads

		• Implemented performance evaluation and rewards systems • Provision of basic amenities to facilitate and reduced harm for patients and health workers
Improving the effectiveness of clinical care	1. Improve delivery of person-centered and effective care 2. Address inadequate staffing due to brain drain and inadequate remuneration 3. Reduce the irrational use of medicines at the facility level	• Provision of adequate medical equipment with efficient drug and health commodity supply chains across all levels of care to support timely and effective care
Engaging patients, families and communities	1. Address poor demand for health care services due to unavailability and unaffordability of services 2. Address poor community participation in healthcare planning and implementation of health care delivery	• Increased proportion of people seeking health care services in the community
Improving monitoring, evaluation and learning systems	1. Create a system for adequate recruitment and allocation of monitoring, evaluation and learning system staff based on needs. 2. Build capacity and track performance indicators of staff for collection and analysis of high-quality data and improved monitoring, evaluation and learning processes.	• Adequate numbers of monitoring, evaluation and learning staff, properly allocated across the country who have access to job aids and regular capacity building on data management and are properly evaluated for the collection and analysis of high-quality data.

Table 7: Selection of Thematic Quality Dimensions, Priority Areas and Quality Ambition

5.0 Recommendations

The priority areas recommended for inclusion in the National Quality Policy and Strategy include but are not limited to the following:

Transforming the Systems Environment

- Improve coordination between actors working to ensure QoC through increased cooperation and partnership between professional associations, private sector, federal and state MoH departments and regulatory agencies. This may necessitate the creation of a quality governance architecture and system which lays out clear (reporting) linkages between local, state and federal agencies. Address healthcare financing challenges by strengthening State Health Insurance Schemes and establishing strategic policies and plans based on the new National Health Insurance Act.

- Improve the shortages of human resources for health by ensuring that the number of health workers in both the private and public health sector workers are adequately distributed across the country and have access to continuous professional development and retention initiatives that reduce migration and guide health workforce policies to meet the demand of the health system. Specifically, build on existing HRH supply and retention efforts and partner with academic institutions to develop educational curricula in quality improvement for pre-service, in-service and post-graduate training for all cadres of staff. In addition, ensure skilled human resources for health in facilities to provide infection prevention and control (IPC) through the development and execution of an IPC programme that could enhance the required health workers' skills, knowledge and abilities for infection prevention and control.

Reducing Harmful Practices on Patients and Staff

- Build on the current adverse event reporting system established by NAFDAC to ensure a more robust federal and state linked voluntary patient safety reporting system that facilitates the identification of harmful and near miss events. Disseminate the Patients' Bill of Rights (drafted by the CPC) for the protection of all Nigerian consumers. This bill should be widely disseminated to patients and communities through a multitude of channels including social media platforms where many citizens access information to inform people of their rights.

- Provide adequate basic amenities such as water, sanitation and hygiene and electricity for IPC/sterilization equipment and lighting of the health facilities by building on efforts to address infrastructure and resource gaps that impede the provision of effective clinical care across this value chain. Promote collaboration with water and sanitation agencies for the development and implementation of policies and guidelines on water and sanitation. Enhance public education and community awareness of sanitation, health risks of contaminated water, and promote proper hand washing techniques.

Improving the Effectiveness of Clinical Care

- Improve delivery of person-centered and effective care by ensuring adherence to the use of protocols and guidelines through tested and scaled quality improvement methodologies. Reduce the irrational use of medicines at the facility level by frequently updating or developing and disseminating Standard Treatment Guidelines (STGs) and educating officers in charge of facilities on appropriate use of medicines. Build training and mentoring programs on adverse event reporting by healthcare providers, staff and patients and create transparent bilateral feedback systems to inform facilities on their patient safety performance.

- Facilitate the provision of adequate medical equipment with efficient drug and health commodity supply chains across all levels of care. Reduce the proliferation of counterfeit medicines and technology through enhanced political will to enforce regulations and collaboration with regulatory agencies to ensure routine inspection of drugs, vaccines and medical technology. Existing initiatives for improving the quality of care could also be leveraged for interventions such as the use of performance-based financing initiatives, non-financial rewards and recognition, patient satisfaction surveys and patient complaint systems.

Engaging Patients, Families and Communities

- Address poor community participation in healthcare promotion, planning and implementation by building the capacities of members of the Ward Development Committees (WDC) and Community Based Organisations (CBO). Work with multi-sectoral partners to build systems for local community actors and quality champion networks that can feed into the national quality architecture to ensure patient and community voices are included in all health interventions.

- Prioritize inclusion of patient-reported outcomes in the national set of core quality indicators. As digital health has become more ubiquitous (in the post-pandemic state), the NQPS must focus on investing in patient-centred digital platforms that can help address the information asymmetry that exists within healthcare and create an opportunity to help patients navigate the health-care system. By disseminating neutral, clear signals about basic hospital quality, digitals platforms such as NaviHealth.ai can also increase the ability of higher-quality hospitals to compete to attract market share, leading to more lives saved and more costs avoided for patients, taxpayers, and employers.

Improving Monitoring, Evaluation and Learning Systems

- Explore the development of a national (and subnational) quality measurement and reporting system with linkages to the national adverse event and incident reporting system. Define a set of core quality indicators aligned with the six domains of quality that continuously informs leaders, providers, and the public about the quality of the Nigerian health system at the national and sub-national level and can be benchmarked against other countries.

- Strengthen the capacity of staff at the sub-national level for measuring and tracking quality indicators, track performance indicators of staff, and ensure the provision of tools required for effective data collection, sharing and management at all levels of healthcare.

5.1 Next Steps for the National Quality Policy and Strategy

The next steps proposed by the FMoH include creating a quality forum ahead of the development and dissemination of the National Quality Policy and Strategy and are shown in Figure 14.

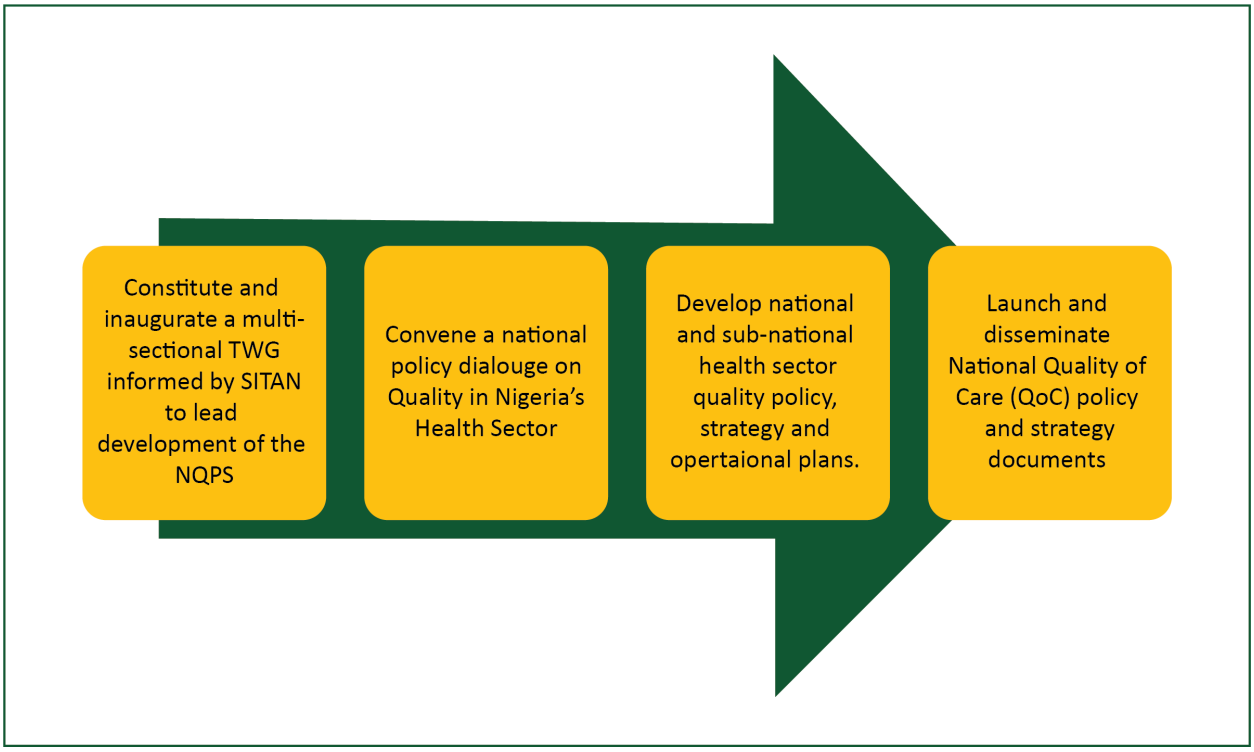

Figure 14: Next Steps for the National Quality Policy and Strategy

6.0 Conclusion

As part of the process to develop a National Quality Policy and Strategy (NQPS), the SITAN sought to examine the Nigerian landscape of quality and facilitate a shared understanding of the current state of quality, which would inform the development of an NQPS. Specifically, the SITAN sought to:

i. Develop a shared understanding of the historical and current organisation of quality in the Nigerian health system and the multi-dimensional context in which care is governed, delivered, and monitored from the national to the subnational level.

ii. Localise the definition for quality and understand the vision for the culture of quality in Nigeria.

iii. Present an overview of current healthcare quality-related indicators and key quality challenges from available data and identify relevant data sources that can be leveraged in ongoing strategic efforts.

iv. Determine the challenges and bottlenecks in the implementation of current policies on quality, understand current initiatives in quality across the public and private sector, identify opportunities and gaps in quality as well as barriers and facilitators including entry points at the national and state level to enable acceleration of progress towards national health priorities.

v. Develop a key list of priority areas that the FMoH can use to build an integrated NQPS for health and healthcare in Nigeria.

vi. Secure high-level commitment to the NQPS development, implementation and monitoring process through comprehensive stakeholder engagement and consensus-building.

To achieve the above-listed objectives, the SITAN was guided by the WHO handbook for NQPS and adopted a three-pronged approach comprising a desk review, key informant interviews and stakeholder consultation workshop to collate information and validate evolving themes that will inform priority areas for the NQPS and to secure high-level commitment to the NQPS development, implementation and monitoring. Specifically, the SITAN provides the following:

1. Contextual background of Nigeria comprising its geography and administrative structure, population, socio-economic and political context, health system organisation and governance structure, and health situation of the population

2. Local definition for quality, healthcare quality policies, plans and strategies, regulatory systems, bodies and institutions for healthcare quality in Nigeria, and interventions for improving quality of care within the health system in Nigeria

3. Healthcare quality measurement and learning systems in Nigeria, data regulation and healthcare quality-related indicators

4. Challenges, opportunities and implications for healthcare strategy and a strengths, weaknesses, opportunities and threats (SWOT) analysis of healthcare quality in Nigeria

5. Selection of thematic quality dimensions, their priority areas and quality ambitions that are related to recommendations by interviewees and stakeholder workshop discussions and subject to further deliberations and prioritization exercises for the final NQPS development

6. Recommendations and next steps for the NQPS

The findings show the need to bolster the implementation of policies and regulatory systems and leverage the strengths of existing quality improvement and quality assurance initiatives. There is also a need to identify siloed programs and consolidate the efforts of these programs to reduce the complexity of the health system and increase its efficiency. The recommendations discussed in the SITAN provide a selection of priority areas recommended for inclusion in the NQPS. The SITAN of the state of quality of the Nigerian health system will be leveraged on to inform the development of the National Quality Policy and Strategy and transform the quality of care in Nigeria.

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8.0 Annexe

Annex A: List of Stakeholders at the Inception Meeting

Public Sector Organisations:

1. Alex Ekwueme Federal University Teaching Hospital Abakaliki
2. Benue State DPRS
3. Federal Ministry of Health
4. Katsina State Ministry of Health, DPHRS
5. Lagos State Ministry of Health
6. National Food Agency for Food and Drug Administration Control
7. Nasarawa state Primary Health Care Development Agency
8. National Agency for the Control of AIDS

Private Sector Organisations:

1. African Institute of Health Policy and Health systems
2. Centre for accountability and Inclusive and Development
3. Clinton Health Access Initiative
4. Jhpiego
5. Health Strategy and Delivery Foundation
6. HFN-Healthcare Foundation of Nigeria
7. Merck for Mothers
8. mDoc Healthcare
9. Palladium
10. PharmAccess Foundation
11. Society for Quality in Healthcare in Nigeria
12. United Nations Children Fund
13. USAID Nigeria

Annex B. List of Documents and Websites Reviewed

1. Achieving Universal Health Coverage in Nigeria One State at a Time.
2. Federal Government's Economic Recovery and Growth Plan (ERGP) 2017-2020
3. Federal Ministry of Health. Second Strategic Health Development Plan 2018-2022
4. Guidelines and Standards for Improving Quality of Malaria Case Management in Nigeria (2019)
5. IHI National Quality Strategy Country Case Studies: Learning from Ethiopia, Ghana, Mexico, Nigeria and Scotland
6. Health Partners International (2014) Bringing primary health care under one roof: 9 factsheets for implementation in Nigeria

7. Joint Annual Report of National Strategic Health Development Plan 2018-2022
8. Lancet. Population health outcomes in Nigeria compared with other west African countries, 1998–2019: a systematic analysis for the Global Burden of Disease Study
9. National Action Plan for Health Security (NAPHS) 2018-2022
10. National Primary Health Care Development Agency Minimum Standards for Primary Health Care in Nigeria
11. National Guidelines for Water Quality, Sanitation and Hygiene (WASH) In Healthcare Facilities in Nigeria 2021
12. National Guidelines on External Quality Assessment for AFB Smear Microscopy, Xpert MTB/RIF Assay, Line Probe Assay, Culture and Drug Susceptibility Testing
13. National Health Act (NHAct) 2014
14. National Health Facility Survey 2016
15. National Health Management Information System Annual Report: Data analysis of selected key health indicators, January - December, 2018
16. National Health Policy (NHP) 2016
17. National Health Research Policy and Priorities 2016
18. National Indicator Framework And Guidelines For The National Quality Improvement Programme On HIV/AIDS Services And Care
19. National Reproductive, Maternal, Newborn, Child, Adolescent, Elderly Health Plus Nutrition (RMNCAEH+N) Quality Of Care Monitoring, Evaluation, Accountability And Learning (MEAL) Plan 2022-2027
20. National Quality Improvement Programme On HIV/AIDS Services and Care
21. Nigerian Data Protection Regulation
22. Nigeria's National Health Act: An assessment of health professionals' knowledge and perception
23. Nigerian National Quality Strategy 2015 (draft)
24. Quality of Care for Maternal and Newborn Health: A Monitoring Framework for Network Countries
25. Quality Improvement of Integrated HIV, TB, and Malaria Services in Antenatal and Postnatal Care in Nigeria, Oyo & Kaduna States. Findings from Healthcare Facility Assessment – Oyo Report
26. Saving One Million Lives SOML PforR
27. Society for Quality Healthcare in Nigeria (SQHN) In-Country Survey Report January 2014
28. The SERVICOM Story
29. Nigerian Patient Bill of Rights (CPC and FMOH)

Annex C. List of Interviewees for the Key Informant Interviews

1. National Primary Healthcare Development Agency (NPHCDA)
2. Healthcare Finance Unit, Federal Ministry of Health (FMOH)
3. Department of Family Health, Federal Ministry of Health (FMOH)

4. National Health Insurance Scheme (NHIS)
5. Medical Laboratory Science council of Nigeria (MLSCN)
6. Medical and Dental Council of Nigeria (MDCN)
7. NAFDAC
8. Nigeria Centre for DIsease and Control
9. Nursing and Midwifery Council of Nigeria (NMCN)
10. Bill and Melinda Gates Foundation (BMGF)
11. Jhpiego
12. Japan International Cooperation Agency (JICA)
13. MSD for mothers
14. PharmAccess for mothers
15. Society for Quality Healthcare in Nigeria (SQHN)
16. World Health Organization (WHO)
17. United Nations Children Fund (UNICEF)
18. Health Policy Research Group (HPRG)
19. Nigerian Institute of Medical Research (NIMR)
20. Nigerian Field Epidemiology and Laboratory Training Program (NFELTP)
21. 2 Users of the Healthcare system
22. 2 Private Providers of Healthcare
23. International Finance Corporation
24. Lagos Island Maternity Hospital
25. World Bank

Annex D. Interview Protocol

Brief introduction of the interviewer:

Greetings.

I am _____representing the Federal Ministry of Health (FMoH) and the World Health Organization (WHO). We are currently conducting a nation-wide interview to understand the current state of quality in the healthcare system, what is working and what can be done to improve the quality of care, which will then inform the development of a National Quality Strategy. This interview will last for about 45 - 60 minutes. This interview will be recorded, any information that can identify you will be removed during reporting and the information you will give will be handled in confidentiality. Your participation is voluntary. You are at liberty not to respond to any questions you do not want to answer. Do you have any clarification before we continue this interview?

If the response is "No" then proceed to obtaining consent, but if response is "Yes", kindly clarify before proceeding to obtaining consent.

In absence of any queries, I want to obtain your consent to proceed with the interview? If the response if "Yes", (The interviewer can now switch on the audio-recording device).

Brief Introduction of the interviewee: Please can you give a brief introduction of yourself, (we get the gender from the voice), your organisation, designation, years spent in present position?

1. Preamble:

a. Please can you tell me a little about the organisation you work for
b. Tell me a little about your role within the organisation?
c. What are the inter-linkages between your role and quality of care?
d. Who else at your organisation is responsible for delivering quality of care?
e. Have you held any previous role(s) which have had a particular focus on quality of care (QoC)?
f. What role does your organisation play in providing quality health services in Nigeria? How does your organisation work with others?

2. Definition and State of QoC

a. What does quality of care (QoC) mean to you?

b. How can you rate the performance of QoC in the Nigerian health system considering these components of quality of care obtainable. On a scale of 1 to 10, where 10 is the highest and "1" is the lowest. I would like to know the reason for the score you gave. (*Refer to brief explanations/meanings if required*)

Effective	Efficient	Equitable	People centred	Safe	Integrated	Timely
Providing evidence-based health care services to those who need them	*Maximizing the benefit of available resources and avoiding waste.*	*Providing care that does not vary in quality on account of any personal characteristics (i.e., age, sex, race)*	*Providing care that responds to individual preferences, needs and values*	*Avoiding harm to people for whom the care is intended*	*Providing care that is coordinated across levels and providers, and makes available the full range of health services throughout the life course;*	*Reducing waiting times and sometimes harmful delays for both those who receive and those who give care*

c. Can you prioritize these components: 1st, 2nd, 3rd and the two least important?

d.Within your organisation and field of expertise, what activities or programmes are being delivered to improve quality of care? What's working well in the delivery of these quality activities/interventions? What's not working well? Why?

e. From your perspective, what are the major gaps or challenges in delivering quality of care in Nigeria? Why do you think this is the case?

f. From your perspective, what are the major facilitating factors or opportunities that are available to improve quality of care in Nigeria? Why do you think this is the case?

The following questions were asked based based on the thematic group of the interviewee and their of strength shown

3.1: Leadership and governance

a. What are the major challenges and opportunities for quality of care relating to leadership and governance in health system? ***Probe for***, issues concerning trust (corruption) ***Probe for*** challenges with the regulatory bodies, ***Probe for*** *strategic planning* ***Probe for*** coordination & harmonization of activities***, Probe for*** health workers recruitment ***Probe for*** leaders adherent to standard supervision and guidelines monitoring? ***Probe for*** the quality of accreditation exercises?

b. Can you tell me more about how implementation of policies on quality and safety in the health system can be achieved? ***Probe for*** Specifics such as: evidence-based, policies guiding planning,

c. What are the governance structural arrangements for coordinating quality both at the Federal level as well as the sub-national level? ***Probe for*** at the different levels of health facilities.

3.2: Health financing

a. What are the major challenges and opportunities for quality of care relating to health financing? ***Probe for*** budget allocation, ***Probe for*** budget release, ***Probe for*** Out-of-pocket payments, ***Probe for*** Challenges with social health insurance.

b. How has funding of our health service affected the quality of services provided?

3.3 Human resource and Workforce in Health

a.What are the major strengths and weaknesses for quality of care relating to the health workforce?

b.Can you tell me more about how the current workforce in Nigeria can be harnessed to achieve improvement in QoC? ***Probe for*** *variation in regions and facility levels especially PHC on these components:* training & curriculum, annual renewal of licensing, and promotions, high staff turnover, performance feedback, supervision, standard operating procedures/guidelines, Quality Assurance and Assessment teams, medical auditing, suggestion boxes, incentives for Healthcare workers and satisfaction: promotion, regular remuneration, good work environment?

c. Do you think public health facilities are resilient in delivering quality care? ***Probe for*** reasons for the response given (Yes or No)

d. Do you think private health facilities are resilient in delivering quality care? ***Probe for*** reasons for the response given (Yes or No)

e. Do you think that the activities of the workforce in the private sector are adequately regulated? What are the reasons for the response you gave?

3.4 Infrastructure:

(i) What are the major challenges and opportunities for quality of care relating to infrastructure? ***Probe for reasons for response disaggregated into private and public, primary, secondary and tertiary***; Amenities, location of some health facilities, poor technological support , ***Probe for*** variation in different levels of healthcare and region? ***Probe for*** areas related to water, sanitation and hygiene. ***Probe for*** hospital acquired infections.

(ii) What are the challenges in maintaining the quality of the infrastructure in health system? ***Probe for*** standard requirements for registering health facilities, ***Probe for*** continuous monitoring of the performance of hospitals and clinics, ***probe for*** funding

(iii) What are your thoughts about how we could improve access to services, particularly for services in facilities that are located at a considerable distance away from patients homes?

(iv) What are your thoughts on how safety of both patients and health workers can be ensured in our facilities, especially primary health care facilities?

3.5: Health information, data infrastructure, and analytic functions

(i) What are the major challenges and opportunities for quality of care relating to data information systems? Can you tell me more how the use of health information for day-to-day decisions in Nigeria can be improved? ***Probe for*** data management across health facilities in Nigeria being pro-quality?

(collection, dissemination and utilization) ***Probe for*** challenges of DHIS, IDSR and SORMAS etc. use of modern technology and internet services on health management information system (HMIS) especially at the primary healthcare level, ***probe for*** human resource capacities ?

(ii) Is there adequate implementation and utilization of information services for notification of: adverse drug reactions; medical malpractice, equipment break down/malfunctioning,

(iii) Has our referral system supported quality of care in our health system? ***Probe for*** early referral, Community confidence on the services of the primary health care facilities, ***Probe for*** long waiting time.

(iv). Do you think medical errors are of concern in the Nigerian health system?

(v). Do you think an adverse event reporting system is in place in the Nigerian health system? If "Yes" does it help to learn from errors and improve QoC?

3.6: Community participation

(i) What are the major challenges and opportunities for quality of care relating to community participation and engagement? Can you tell me more about how trust in the health services delivered can be improved?***Probe for*** how to increase the participation of community/users of healthcare in decision-making concerning their health? ***Probe for*** roles of the consumers in the quality initiatives, ***Probe for*** users' awareness and concern about quality and safety of services, ***Probe for*** users acceptability, confidence of the community on the services of the health facilities especially primary health care facilities.

(ii) Do you think there is adequate communication between the health facilities and the community? ***Probe for*** existence and functionality of village health committees/ward development committees. ***Probe for*** Awareness campaigns.

3.7: Research and Development:

(i) What are the major challenges and opportunities for quality of care relating to research and development in the health system? Do you think the design of most research for health is solutions oriented? ***Probe for*** reasons to the response.

(ii) Please can you tell me more about how research findings have been used in policy development?

(iii) How has research in the Nigerian health system contributed to improvement in QoC? ***Probe for*** feedback of research outcomes to the community involvement in research.

3.8: Medicine, health technologies and supply

(i) What are the major challenges and opportunities for quality of care relating to medicine and medical consumables? Can you tell me more about the problem of substandard drugs in the private and public systems and its impact on QoC? ***Probe for*** what are its causes and possible solutions ***Probe for*** challenges of stock out, ***Probe for*** local drug production.

(ii) Are you aware of any interventions, activities or programmes currently working to improve the supply of medicines or other essential health products? What have been the successes and challenges of these interventions to date?

4.What do you suggest as the ideal roles and responsibilities of …… (stakeholder) towards establishing optimal quality of care. (*select based on the observed strength during the interview*)

Policy markers	User/Community	Healthcare Providers	Academia/researchers	Regulatory/Licensing bodies	Departments/Parastatals/Agencies

Annex E. List of Stakeholders at the Stakeholder Consultation Workshop

Public Sector Stakeholders

1. AKTH Kano
2. DFH/FMOH
3. FCTA
4. FMOH -DHPRS, DPH, DFH,DHS,DFDS
5. IBB Specialist
6. IT. Consultant
7. LISDEL
8. NACA
9. NANNM
10. NCDC
11. NEPWHAN
12. NMA
13. NMEP/FMOH
14. NPHCDA
15. NTBLCP
16. SHMB, Enugu

17. SMOH Ebonyi
18. SMOH Jigawa
19. SMOH Nasarawa
20. SMOH Ondo
21. SMOH Osun
22. SMOH Oyo
23. SMOH Plateau
24. SMOH Yobe
25. SMOH Zamfara
26. SMOH, Borno
27. SPHCDA

Development Partners and Private Sector

1. Co-Creation Hub
2. HERFON
3. IHP
4. mDoc Healthcare
5. MSD for Mothers
6. SANOFI
7. Society for Quality in Healthcare in Nigeria
8. UNICEF
9. USAID
10. WHO