Analysis of Accountability Challenges in the Health System in Nigeria

June 2021

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AUTHORS AND ACKNOWLEDGEMENTS

This report was prepared by Dr. Abdullahi J. Mohammed, Convener/CEO, Initiative for Health accountability and Transparency (IHAT). Dr Abdullahi J. M. is a public health physician with experience in health systems strengthening and accountability. He was assisted by members of IHAT team comprising Dr Adeyemi Adedoyin, a public health physician and provider payment expert; Miss. Monica Oche, a quality assurance expert; and Mrs. Maimuna Abdullahi-Zubair, a Health Economist. The authors take sole responsibility for the final content, views and opinions expressed in this report.

This study was commissioned by the Africa Health Budget Network (AHBN) which serves as the COPASAH West African Regional Hub with funding from the COPASAH Grant via PAI. The authors wish to thank Dr Aminu Magashi Garba, Mr Salisu Muhammad Musa, Mrs Maimunat Abdullahi and Honourable Muhammad Usman, all of AHBN, for their valuable guidance and comments during the drafting of this report.

ACRONYMS

AHBN	Africa Health Budget Network
AHPSR	Alliance for Health Policy and Systems Research
AM	Aide Memoire
BHCPF	Basic Health Care Provision Fund
BOF	Budget Office of the Federation
BPP	Bureau of Public Procurement
BVN	Bank Verification Number
CEO	Chief Executive Officer
COVID-19	Corona Virus Disease 2019
CPTG	Constituency Projects Tracking Group
CSO	Civil Society Organisation
DAH	Development Assistance for Health
EFCC	Economic and Financial Crimes Commission
EMR	Electronic Medical Records
FCT	Federal Capital Territory
FMOF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
FOI	Freedom of Information
GF	Global Fund
GIFMIS	Government Information Financial Management Information System
HCP	Health Care Provider
HFMC	Health Facility Management Committee
HMO	Health Maintenance Organisation
HSRC	Health Sector Reform Coalition
ICPC	Independent Corrupt Practices and Other Related Offence Commission
ICT	Information and Communications Technology
IEC	Information, Education, and Communication
IPPIS	Integrated Payroll and Personnel Information System

KII	Key Informants' Interview
M&E	Monitoring and Evaluation
MDA	Ministry Departments and Agency
MDCN	Medical and Dental Council of Nigeria
MDG	Millennium Development Goal
NACC	National Ant-Corruption Committee
NASS	National Assembly
NGN	Nigerian Naira
NGO	Non-Governmental Organization
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
OAGF	Office of the Accountant General of the Federation
OAuGF	Office of the Auditor General of the Federation
OGP	Open Government Partnership
OOPE	Out of Pocket Expenditure
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SERVICOM	Service Compact with all Nigerians
SHA	State House of Assembly
SSA	Sub-Saharan Africa
TSA	Treasury Single Account
UHC	Universal Health Coverage
UNICEF	United Nation's Children Fund
WB	World Bank
WDC	Ward Development Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

Accountability is critical in all aspects of the health system. Without accountability, healthcare delivery risk efficiency, poor productivity, and ultimately reducing quality of care and health outcomes. All health systems contain accountability relationships of different types, which function with varying degrees of success.

Improved accountability is often called for as an element in improving health system and using an accountability lens can help to: (1) generate a system-wide perspective on health sector reform, and (2) identify connections among individual improvement interventions. The results can be used to enhance system performance, support synergistic outcomes, and contribute to sustainability.

Analysis of accountability challenges in the health system aims at identifying and understanding the various categories of accountability, accountability mechanisms, gaps, and challenges, and also proffer recommendations. The objectives of the study are as follows:

1. To identify the various forms or categories of accountability, accountability actors and their roles in the health system in Nigeria, with emphasis on financial accountability, social accountability, provider accountability and political accountability.
2. To examine the accountability gaps and barriers that constitute significant challenges to the various categories of accountability in the health system performance.
3. To make recommendations on the strategies and interventions, with the potential to address the gaps, barriers and challenges identified.

A qualitative approach was used to conduct the study in the Federal Capital Territory, Abuja, Nigeria. The process involved an in-depth desk appraisal of published peer-reviewed and grey literature; government reports and documents; and Key Informants' Interview (KII) of selected respondents to reflect the different actors in health system governance using a semi structured guide.

Key findings from the study include:

1. There is considerable diversity in the understanding of accountability among the different actors in the health system. Therefore, accountability should not be presumed to mean the same thing to every actor.
2. There exist diverse accountability mechanisms in the health system such as use of standard protocols and guidelines for public expenditure management and procurement, regular financial reporting of expenditures and budget performance. Others include financial and performance audit of MDAs, monitoring of financial transactions through digital platform, establishment of anti-corruption agents in the MDAs.
3. There are also considerable gaps and challenges which constitute significant drawback to the performance of the health system and healthcare delivery. They include contraventions/violations of financial guidelines and procedures, and exceptions in procurement and programme management, irregularities in expenditures and contract award, execution and payments, non-compliance with professional ethics, standards and code of conduct, medical abuses, frauds and wastes.
4. Despite the presence of the National Health Act and other policy documents, there are considerable challenges to the Federal Ministry of Health's efforts in the discharge of its stewardship role which is a key enabler of accountability in the national health system. In this regard, many provisions of the National Health Act remain largely unimplemented.

1.0 INTRODUCTION

1.1 Background

Globally, accountability in the health system has emerged as a high-profile issue and attracted considerable interest among policy makers, managers, and stakeholders. [1] [2] The drive to strengthen accountability is encouraged by three closely related factors. [3] The first is the general discontent with health system performance. There are significant concerns about availability and distribution of basic health services in terms of poor access, poor quality, high costs, abuses of power, financial mismanagement and corruption, and lack of responsiveness. The stakeholders want a health system that is responsive to the needs and demands of the people and that healthcare providers exercise their responsibilities professionally and correctly, according to laid down regulations and norms, and with respect for patients.

The second factor why accountability is a matter of great importance is because of the high level of professionalism and specialized knowledge requirements, the size and scope of healthcare bureaucracies, which accord health system actors significant power to affect people's lives and well-being. The third factor is that healthcare constitutes a major budgetary expenditure, and thus proper accounting for the use of such resources is a high priority. This is more so in view of the fiscal challenges of today, and the current reality of ensuring value for money.

Accountability improves efficiency and outcomes, and many health systems would not be effective and efficient without accountability. [4] Weak accountability is frequently cited as contributing to dysfunctional governance and inability of national health systems to deliver services and improve the health of citizens. Challenges in accountability are known to cause considerable inefficiency and negative impact in the health system in Nigeria. [5] The burden of lack of accountability cannot be fully imagined in monetary terms. It is associated with considerable loss of lives, quality of life, and productivity. [6] It is also a considerable limiting factor to the realization of UHC. [7]

In light of the highlighted factors, many governments are facing pressure to provide healthcare services effectively, efficiently, and equitably through approaches which converge on emphasizing accountability as a core element in improving health system performance.

In many healthcare organizations, accountability tops the list of management challenges. However, it has not been accorded sufficient attention in the health system. Like in many systems, results and accountability are inextricably linked, and the culture of accountability is frequently seen as the secret of a high-performing system.

Despite long-standing commitment to legislative, policy and programmatic reforms and international health goals in Nigeria, accountability deficits are essentially commonly reported in public finances and procurement management, health programme implementation and service delivery.[8] These developments constitute significant obstacles in the health system operations and the underlying cause of mismanagement, inefficiency, and poor performance, making accountability a significant factor in programme failure.

Over the years, the Nigeria health system has remained weak and the outcomes dismally poor with more than 2,300 under-five children and 145 women of childbearing age dying every single day due to preventable and treatable diseases such as malaria, pneumonia, diarrhoea, and other preventable

conditions such as bleeding, anaemia and obstructed labor. [9] [10] [11] This is not surprising, considering the strong correlation between accountability and health outcomes.

Nonetheless, there are emerging windows of opportunity for health system strengthening through the Basic Health Care Provision Fund and the State Social Health Insurance Schemes. [12 [13] The two initiatives have clearly defined structures and mechanisms conceived to ensure effective governance, strong accountability, and mitigate general inefficiency in financial and programme management.

1.2 Accountability Definition, Context, Forms and Actors

Accountability is defined in terms of answerability and sanctions. It is the obligation of duty-bearers (individuals or agencies) to provide information about, and/or justification for, their actions to other actors, along with the imposition of sanctions for failure to comply and/or to engage in appropriate action. All accountability systems are characterized by two core elements. [1] [2] [3] The first is answerability which is the obligation to answer questions regarding decisions and actions taken. The second is sanctions which implies some form of punishment for transgression or failure, or of positive reward for proper behavior and actions. In general, the context is built around capacity to demand for information or impose sanctions and supply information or respond to sanctions.

Accountability has several different forms depending on the actors involved such as policy makers/bureaucrats, regulators, politicians, and citizens. There are financial, performance, professional, political/democratic, and social accountability. The different forms seek to protect different values, possess different characteristics, and are accompanied by varying challenges.

However, irrespective of the type, the overall purposes of accountability are reducing abuse, assuring compliance with procedures and standards, and improving performance/learning.

i) *Financial Accountability*: This concerns tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting.
ii) *Performance Accountability*: This refers to demonstrating and accounting for performance in light of agreed-upon performance targets. At the health system level, the focus is on the services, outputs and results of public agencies and programmes.
iii) *Professional Accountability*: This involves compliance with professional ethics and codes of conduct, standards, and procedures.
iv) *Political/Democratic Accountability*: This has to do with ensuring that government delivers on electoral promises, fulfils public trust, aggregates and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns.
v) *Social Accountability*: This refers to the various actions, tools and mechanisms that can be used by the citizens and communities, civil society organisations (CSOs) and the media to hold public officials and the government accountable.

See Annex 1 on Accountability Types, Purposes and Health System Focus

The health system has a wide range of accountability actors and linkages connected to each other in a complex network. In Nigeria, they include but are not limited to health consumers or users, public and private healthcare providers, ministries of health, ministries of finance, ministries or departments of budget and planning, the Office of the Auditor-General, social health insurance agencies, the National

Assembly, regulatory agencies, agencies of restraint such as the ICPC/EFCC, development partners and CSOs/NGOs.

The roles of the actors are well described in the legal and policy instruments and relevant extant guidelines directing the operations of the various MDAs in the health system governance. (14), (15) Depending on their mandate and responsibility, different actors have varying power to make connected actors accountable for their responsibilities and obligations.

For the purpose of this study, accountability actors are institutions that can:

1. Independently monitor the extent to which connected/linked actors has fulfilled their responsibility or obligations based on mandate and expected performance.
2. Consider complaints and impose sanctions for failure to discharge responsibility or obligation or expected performance.

Selected accountability actors in the health system in Nigeria, their mandates and linkages, and the capacity to demand information and impose sanctions, and which actors are charged with supplying information and are subject to sanctions is detailed in Annex 2.

1.3 Rationale

There is a strong correlation between accountability, health system performance and health outcomes. Increasing accountability is a key element in mitigating different shades of inefficiency and financial leakages, and the overall improvement in health system performance. The current state of health care delivery and continuing economic challenges demands that we put accountability at the center stage of present health system improvement efforts. Essentially, accountability could be a key enabler helping to facilitate strengthening of the health system to ensure efficiency and achieving UHC in Nigeria. (1)

While it is understandable that raising more money for health, may be crucial for Nigeria to move closer to UHC, it may not be sufficient. Nevertheless, getting value for the resources available, i.e., achieving more health for the money is a key element. (7) It may be easier to achieve than the pursuit for more and more money.

1.4 Objectives

Drawing on the Analytic Framework for Mapping Accountability, this study seeks to deepen our understanding of accountability challenges in the health system in Nigeria.

The objectives are to:

1. Identify the various forms or categories of accountability, accountability actors and their roles in the health system in Nigeria, with emphasis on financial accountability, social accountability, provider accountability and political accountability.
2. Examine the accountability gaps and barriers that constitute significant challenges to the various categories of accountability in the health system performance.
3. Make recommendations on the strategies and interventions, with the potential to address the gaps, the barriers and challenges identified.

2.0 METHODOLOGY

2.1 Study Design

This is a qualitative study conducted in the Federal Capital Territory, Abuja, Nigeria. It is a desk review of published peer-reviewed and grey literature (institutional reports, key health policy and strategic documents. It also involved review of government reports and documents and country-specific commissioned reports and media coverage) as well as Key Informants Interview (KII) of selected respondents to reflect the different actors in health system governance using a semi-structured guide.

The desk review and the interviews focused on identifying the existing accountability mechanisms and gaps and the contributing factors responsible for the gaps and the challenges, and possible solutions.

2.2 Sampling, Data Collection and Analysis

A total of fifteen (15) respondents were purposively selected among federal and state-level (FCT) accountability actors, with the aim of appraising their different roles in health system governance. However, only twelve (12) key informant interviews were conducted with key actively serving staffs from: the National Assembly (NASS), Federal Ministry of Health (FMOH), Budget Office of the Federation (BOF), National Health Insurance Scheme (NHIS), Medical and Dental Council of Nigeria (MDCN), Independent Corrupt Practices and Other Related Offence Commission (ICPC), civil society organizations (CSOs), media, private health care provider (HCP), and with health consumers. The twelve (12) respondents interviewed comprised of 8 men and 4 women. Formal correspondence (letter of introduction) were dispatched to all respondents followed by verbal information through phone calls.

The author developed and reviewed the interview guide with AHBN staff and adapted it to suit the different accountability actors. The interviews sought to elicit respondents' views on six focus areas identified to be important towards achieving the study objectives: (i) their understanding of accountability and its different perspectives; (ii) associated accountability linkages; (iii) mechanisms or strategies in place to ensure accountability; (iv) the effectiveness of the mechanisms and strategies; (v) existing accountability gaps; (v) barriers and the challenges; and (vi) recommendations on how accountability could be improved.

A verbal consent was sought from all the respondents, who were also informed that participation was voluntary, and that information collected would be treated as anonymous. Interviews were audio recorded and transcribed, while the transcripts were edited for grammatical errors. Thematic approach was used to extract information and analyze data.

2.3 Limitation

All the twelve (12) interviews conducted incorporated the views of only one person from each of the selected accountability actors (institutions) and the report relies on the opinions and experiences of a limited number of respondents identified as having sufficient knowledge and information on the role of the institution in health system governance. However, the views/responses of the respondent may not necessarily be representative of the overall perception of accountability issues in the organization. It is possible that the results would have been substantially different if a different set of informants had been interviewed. Therefore, the results should be interpreted with caution.

Other limitations include the inability of the authors to conduct key informant interview due to bureaucratic bottlenecks, despite repeated efforts over a three-week period with representative of the OAuGF, development partners and public healthcare provider.

3.0 RESULTS AND DISCUSSION

3.1 Accountability in Context

There are different types of accountability actors and relationships connected to each other in networks of control, oversight, cooperation, partnership, and reporting. It is therefore important to have clear understanding of the concept of accountability, the actors that have the power, authority, and right to ask for answers and explanations, to engage with the accountable parties in discussion of those answers and explanations, and to impose and enforce sanctions.

All twelve (12) respondents found it challenging to provide an all-encompassing qualitative description about two core elements of accountability which are answerability and sanction, indicating general lack of clear understanding of the concept amongst accountability actors in the health system. Common description of accountability by the respondents include: *"faithful stewardship of the resources given to someone to achieve set results and goals (Private HCP)", "proper management of resources for health (CSO)", "being entrusted with some resources to achieve results, and the person needs to be accountable for these resources (NHIS)" and "achieving value for money (BOF)", "ensure oversight and that funds are spent according to specification (NASS-H)"*. Other perspectives include *"ensure there are no duplication of services (NASS-H)"* and *"how various governance bodies and structures playing their role of resource mobilization, resource allocation, resource utilization and monitoring in terms of discharging their responsibilities (NASS-S)"*.

The diversity in the description of the terminology suggests a considerable variation in the understanding of the concept. Therefore, accountability should not be presumed to mean the same thing to everybody. It could mean different things to different people, and care should be taken to make assumptions about people's perception when they discuss the subject of accountability. However, there was good comprehension and awareness among all the respondents of their role as accountability actors and linkages with other players.

From the array of responses, it is clear, that the spotlight of current public financial management system mostly demands accountability for expenditure to ensure that monies received were not mismanaged, not accountability for performance to ensure that monies released delivered the benefit that is expected. It does not appear that public servants are held accountable for the results that monies were budgeted and released for.

The effectiveness of an accountability system depends on the relative mandate/power of a particular actor to demand information and impose sanction on one hand, and the corresponding connection to supply information and respond to sanction. Good examples include the NASS with constitutional mandate for budgetary oversight of health MDAs and unlimited power to demand information on budget implementation but lacking the power to impose sanction by itself; the MDCN as regulatory institution with legal mandate to regulate professional practice having power to demand information from medical and dental professionals and impose sanctions when necessary; and the NHIS as a key accountability actor

in the nation's health insurance industry with legal mandate for regulating health insurance and the power to demand information from HMOs and the HCPs and impose sanctions.

All the respondents have good understanding and are aware of what constitute accountability gaps in the health system. These comprise different forms of infringement, infractions, contraventions or violations in financial management and underperformance in programme or project implementation. Others include deficiency in delivery of health services such as poor quality of care, non-compliance with professional ethics, standards and code of conduct, medical abuses and frauds.

3.2 Accountability and Stewardship

Stewardship and accountability are intricately connected. The obligations of stewardship include steering good governance, enhancing the quantity and quality of connections between stakeholders and partners, providing a traction to enhance accountability, and facilitating a culture of strong accountability. The World Health Organization (WHO) includes stewardship among the four major functions of health systems, along with financing, resource generation, and service delivery. [(16)]

According to WHO, stewardship in the health system describes how government actors take responsibility for fulfilling health system functions, assure equity, and coordinate interaction with government and stakeholders. [(17)]

The Federal Ministry of Health (FMOH) has the responsibility of exercising stewardship role in the health system. [(14) (15)] The roles played by the FMOH and its agencies in the health system governance emanates from the National Health Act (NHAct) 2014. The NHAct established the framework for the regulation, management and development of a national health system. It also set standards for rendering health services and other related matters through a chain of actors consisting of the Minister of Health and the heads/CEOs of health MDAs to take effective administrative and programmatic decisions that will improve the country's health and provide an accounting of the FMOH and its agencies resource utilization, activities, and achievements; investigate and remedy deficiencies and problems.

As part of its stewardship role, the FMOH supervises health MDAs and tertiary health institutions to ensure they achieve agreed-upon performance targets with respect to outputs and results of programmes implemented including health service delivery and involving quality assurance and compliance with professional ethics and code of conduct, standards, and procedures. However, despite the presence of the NHAct and other policy documents, there are considerable challenges to the FMOH's efforts in the discharge of its stewardship roles. One respondent observed that there are about "*eighteen provisions in the NHAct of which only BHCPF is being partially implemented, indicating significant challenges with the stewardship role of the Ministry (FMOH)*". Of great concern is the non-implementation of Certificate of Standard and Emergency Medical Services. The respondent also identified different factors and challenges militating against effective stewardship and accountability in the FMOH and health system in general. These include lack of clear understanding and awareness about the NHAct by health leaders, managers, professionals and the citizens in general. Other challenges include inadequate resources, absence of positive policy environment, structures and processes that would enhance implementation of the NHAct. As a result of weak stewardship, the FMOH has fallen short in supervision and monitoring of health MDAs and health institutions and many of them are failing to achieve performance targets with respect to outputs and results of programmes. There are also significant challenges in monitoring and evaluation of programmes, particularly in areas of performance management, data stewardship and

management practices including utilization, ensuring equity and quality of service, improving health outcomes, effective collaboration and coordination of partners and stakeholders.

Some respondents identified gaps in the role of the FMOH in the human resource for health management including *"non-compliance for approved quota in training institutions and maldistribution of professionals with respect to the three tiers of the health system (Private Provider, MDCN, FMOH)".* Emphasis was particularly laid on the issue of *"lack of or non-existence of performance management mechanisms that lay emphasis on productivity to ensure that MDAs earn their allocations and professional earn their salaries (Private Provider, ICPC)*" and *"lack of leadership and management development programme for health professionals to ensure that health leaders and managers have required leadership and management skills (FMOH, Private Provider)".*

One respondent observed that *"the appointment of the CEO of health agencies without the input of the FMOH deprives the Hon. Minister of Health and the FMOH the power to exercise effective supervision over the agencies and the appointees, thus, constituting a serious impediment to accountability in the health system (FMOH)".* This is in "*contravention of the laws establishing the health MDAs (FMOH)*".

3.3 Existing Accountability Mechanisms, Gaps and Challenges in the Health System.

Enhancing accountability in health systems through various mechanisms is increasingly emphasized as crucial for improving the nature and quality of health service delivery worldwide and particularly in developing countries. [3] According to the different respondents, there exist diverse accountability mechanisms in the health system, and various gaps and challenges which constitute significant drawback to healthcare delivery.

Identified mechanisms include use of standard protocols and guidelines for public expenditure management and procurement, regular financial reporting of expenditures and budget performance, financial and performance audit of MDAs, monitoring of financial transactions through digital platform, establishment of anti-corruption agents in the MDAs, making investigation reports public and prosecution, reporting cases of accountability gaps or incidents directly to accountability actors through different platforms such as dedicated phone lines, emails, social media, department, enrolment/contact centre, website with clear contacts of state offices. Other mechanisms include *"system review in the health MDAs, and approach based on the power vested on the commission to instruct and advice any MDA on its corruption-prone processes and to supervise the review of such processes. This has helped in reducing over bloated personnel cost*, *use of ethics and compliant scorecard (ICPC)"*, *"guidelines and SOPs for accreditation of HMOs, HCPs (NHIS)", "invoking the Freedom of Information Act and Civic engagement (CSO)".*

All the respondents agree that the mechanisms and processes for addressing accountability in the health system are not remarkably effective and efficient.

Financial accountability in the health system bequeaths the responsibility to enhance financial integrity and performance of public institutions on actors such as the Budget Office of the Federation, OAuGF, and the ICPC. The purpose of financial accountability is to promote prudent use of resources based on statutory provisions using a variety of approaches such as financial guidelines, regular audits, monitoring and evaluation, structured reporting system and performance surveys.

Available report indicates that state of budget transparency around the country is deplorable. [18] One respondent highlighted the existence of in-built mechanisms designed to ensure accountability and transparency in budgeting process and affirmed that *"our process is a lot more transparent than you can find across the public service, we issue circulars, and we publish them on the website for everyone to see and allow engagement with any sector of interest (BOF)"*. The budgets for the ministries are not produced by the budget office. The in-built mechanisms includes the reqirement that MDAs submit their budget through GIFMIS while the budget office aggregates them and engages in bilateral discussion with the ministries, giving them room to come and discuss their submissions. Public consultations on the aggregated budgets are also done, declaring, transparently and openly, estimated revenues from various sources such as oil, taxes, custom duties etc.

However, he agreed that despite the presence of such mechanisms, deficits in financial accountability in the health system is still prevalent. The respondent expressed some concern that *"many projects are not based on needs and sometimes fraught with frauds and wastes, and cited example of "buying Prado Jeep and Hilux Pickup for CEOs instead of buying ambulances (BOF)"*. There was far-reaching discussion around the country's health financing key performance indicators which have remained suboptimal. [19] [20] [21] The respondent acknowledged that Nigeria has fallen short of achieving global and Africa health financing indicators, including health budget allocation over the past five years which has remained below 5% relative to the benchmark of 15% of Government's total budget. However, the respondent stated that *"financial constraints (poor revenue, competing needs and inadequate resouces) are responsible for the inability of the government to meet Abuja benchmark and the erratic releases of funds (BOF)"* but cited lack of absorptive capacity of some government MDAs in the health system as a significant accountability issue. Examples include cases of *"unspent capital allocation mopped up from many MDAs annually"* and *"un-accessed funds under the BHCPF (BOF)"*. So far, the federal government has approved over NGN166 billion for spending since 2018 as follows: NGN55 billion in 2018, NGN51 billion in 2019, NGN25 billion in 2020, and NGN35 billion in 2021. [22]. However, most of the funds have remained un-accessed due to unwillingness or inability of the states to provide counterpart fund which is a condition to accessing the fund.

The Office of the Auditor-General of the Federation (OAuGF) is a critical actor in financial accountability in Nigeria. It derives its mandate from the 1999 Constitution of the Federal Republic of Nigeria, as amended (Sections 85 and 86), and is empowered to undertake audits of all income and expenditure of the Federal Government of Nigeria. Financial audits are an important tool to enforce compliance and accountability as well as identify gaps in understanding and practices. The OAuGF routinely conducts audit of the FMOH and its departments and agencies and submit its report to the National Assembly. While it has unrestrained capacity to demand information, it cannot impose sanctions. However, NASS has power to act on the report of the OAuGF.

The authors were unable to conduct an interview at the OAuGF due to beaucratic bottlenecks. The officer delegated for the interview responded by saying "*Sir, I am not authorized to speak on the topic. You may refer to AGF Annual report on the subject matter (OAuGF)"*. However, some other key informants identified occurrences of many forms of contraventions/violations of financial guidelines and procedures, and exceptions in procurement management and programme operational areas in many health MDAs. Highlighted frequently cited audit incidents include irregularities in payment/expenditures, irregularities in contract award, execution and payments, failure in remittance of revenue and circumvention of procurement process. The 2018 report of the OAuGF contained many of such incidents and concerns about value for money in the execution/implementation of programmes and activities. [23]

The ICPC is another critical accountability actor and significant player in the country's effort to improve accountability in the health system. The ICPC has the mandate to investigate allegations of corrupt practices and in appropriate cases, prosecute the offenders. [24] One respondent identified "*systemic dysfunction; inadvertent breaches of regulations; ignorance of proper procedures; and sometimes, willful violation of laid down rules of doing government business by public officials (ICPC)"* as common accountability gaps. Laying credence to the above submission, available reports on the Primary Health Care Development Project[25] and NASS Constituency Project [26] have uncovered accountability gaps in the delivery of procured items at the project sites such a case of three units of ambulances and large consignment of sets of top-grade equipment found in a state of disuse and deterioration.

The respondent also identified some other challenges which constitute constraints to accountability in many health MDAs described as "*problem of integrity in the system (ICPC)*". They include *"late submission of AuGF Report which may sometimes make imposition of sanction overdue as events may have been overtaken, attitude of the Budget Office on inadequate overhead allocation and the non-regular allowances in health institutions which are not captured by IPPIS"*. These occurrences is alleged to *"encourage MDAs to spend personnel cost on overheads such as diesel, cleaning services (ICPC)"*. There is also the issue of the financial system which *"allows for multiple payrolls/salaries" and "partial loyalty of in-house anti-corruption agents in the MDAs who are afraid of the persecution by the management (ICPC)"*.

Performance accountability encompasses demonstrating and accounting for performance in the light of expected and agreed-upon performance targets, with respect to programme outputs and results of public agencies and programmes. Available reports indicate the country's sub-optimal performance in achieving national and international health targets on key health indicators. Coverage of key Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services including childhood immunization, family planning, antenatal care and delivery services are low. For example: only 23% of children aged 12-23 months received all vaccinations, while contraceptive prevalence rate is at 17% [10]. [11] In a similar manner, there are significant challenges in the distribution of health facilities and human resources. These resources are inequitably distributed between tiers of service delivery in relation to the distribution of disease burden; and between rural and urban areas, across regions (north versus south) and among states. Some of the respondents acknowledge that the health system in Nigeria has *"fallen short of meeting the national and international health goals citing the inability to achieve health MDGs, and currently the SDGs and poor health outcomes (FBO, CSO and the Media)"*.

On professional accountability, one respondent identified "*non-compliance with professional ethics, standards and code of conduct, medical abuses, frauds and wastes as common deficits in healthcare delivery and cited that a number of health professionals have been sanctioned by regulatory institutions for offences that are related to professional misconduct, medical negligence and malpractice (MDCN)"*. There are also significant concerns about *"quality of care and patients' rights which are frequently not guaranteed in many health facilities and unsatisfactory patients experience and satisfaction (Health MDCN, Consumers, CSO and Media)"* This corroborates available reports on provider accountability deficits and its impact on medical practice and health outcomes. [27] [28]

One respondent posited that MDCN as a regulator is *"encumbered in discharge of its responsibilities by persistent long absence of Board following dissolution by the government whichs often result in delay in adjudication of pending disciplinary cases (MDCN)"* . The MDCN Act is currently under review to strengthen the Council's role in regulation of medical and dental practice and mitigate existing challenges.

However, the council is accountable to the executive and the legislature through mechanisms such as quarterly or annual budget performance monitoring/budget implementation report, financial audits and submission of activity reports to the FMOH and the NASS.

In order to enhance provider accountability, one respondent asserted that, in their facility, they engage in full disclosure of bill to HMOs and patients, pre-vetting of claims before submission to HMOs, electronic bill preparation and payment, regular capacity building for all staff including medico-legal training, upholding patients' rights and use of grievances redressal system for addressing grievances by health consumers. However, there was no display of patients' bill of rights in the healthcare facility and exit interview of some health consumersin the health facility indicate lack of awareness of the patients' bill of rights.

One respondent (an enrollee) under NHIS said *"he is not educated about NHIS business processes concerning benefit package and his rights under the scheme (Health Consumer)"*. One respondent, affirmed that "*change of HCP by enrollees and non-remittance of provider payment are available sanctions that can be imposed on erring providers (NHIS)*" Other challenges identified include slow grievance redressal and justice system which was said to be cumbersome with an expensive judicial process as well as the lack of awareness on the right to report grievances. Also cited, was poor communication of laws and policies along with the lack of national strategy for addressing grievances in healthcare. It was observed that private facilities were more responsive to the author's request for an interview than public facilities due to administrative bottlenecks.

Some respondents disclosed that there is *"lack/inadequate awareness about provider accountability and existing mechanisms such as grieviances redressal, and patients' bill of rights. And that existing mechanisms are not effective and efficient and constitute impediment to patient's satisfaction. However, the mechanisms were said to be more efficient in private healthcare facilities(NGO, Media and Health Consumer)"*.

*A*nother sore area is the human resources for health (HRH). Nigeria has one of the largest stocks of human resources for health (HRH) in Africa but, like the other 57 HRH crisis countries, has densities of nurses, midwives and doctors that are still too low to effectively deliver essential health services (1.95 per 1,000) [(29)]. Also, available workforce is reported to be limited by poor commitment, conflict of interest, low capacity and absenteeism resulting in low productivity, particularly in public health institutions. [(30).] One respondent identified HRH challenges to include *"poor work culture, top heavy bureaucracy in the delivery of health care services and lack of framework to analyze and distribute health workers, particularly in public hospitals (Private HCP)"*

To address low productivity and ensure value for salaries earned by health professionals and consultants, the respondent suggested *"regular supervision and monitoring of health professionals, setting performance target and ensuring regular performance measurement and review)"* and *"instituting disciplinary measures and sanctions for erring staff (Private HCP)"* a practice he opined is more common in private than public facility.

There are many categories of development partners offering different types of Development Assistance for Health (DAH) in Nigeria including the multilateral, bilateral organisations and international NGOs in support of the government, technically and financially. However, the effectiveness and sustainability of DAH interventions in Nigeria have not been well studied.

The authors were also unable to conduct an interview with a development partner due to beaucratic bottlenecks. However, one respondent identified poor accountability as an impediment to flow of DAH into the country citing *"unwillingness of many donors to contribute to basket fund including the BHCPF (BOF)"*. Aide Memoire (AM) is an instrument used by development partners to ensure accountability in the use of donor funds. An example is the Aide Memoire signed between GAVI and the Government of Nigeria, establishing the terms and procedures for management of immunization services support and health system strengthening approved by the GAVI Board, which listed conditions to be fulfilled. The instrument states that *"failure to comply with the terms of the AM may result in the suspension of the funding as set out in GAVI Terms and Conditions. (BOF)"* The AM also provides that Nigeria "*will take responsibility for replenishing GAVI cost support lost due to bank insolvency, fraud and unforeseen event. (BOF)*" The Global Fund also has similar provision for its grants.

It was on the premise of the foregoing, that two international development partners demanded for refund of monies said to be lost due to weaknesses in the country's accountability mechanisms. [31] [32]

Ironically, no mechanism was identified through which the government held development partners like WHO and UNICEF accountable for the budgeted funds remitted for special procurement of vaccines, family planning commodities, anti-malarial medicines and Ready to Use Therapeutic Food (RUTF). One respondent posited that the *"federal budget office is satisfied with the procurement processes of these partners (BOF)"*, hence does not require additional mechanism for holding them accountable.

The OAuGF has statutory responsibility to audit all public funds spent to ensure value for money. It is therefore important to examine financial and performance accountability mechanisms for the government funds remitted to the development partners for such procurement.

In the health system, political accountability flows from the FMOH and its agencies to the NASS, and through NASS to the citizenry. Therefore, NASS is a critical accountability actor, with strong power and capacity to demand for information, and the possibility of imposing sanction. It exercises political accountability through three mechanisms: (1) budget approval and ensuring that the budget is in the best interest of people - health needs and demand; (2) oversight function which enthrones fiscal discipline, enforces efficiency and cost effectiveness in budget implementation and ensures that organisations and government officials are held accountable; and (3) collaborate with CSOs to encourage independent monitoring system for effective monitoring of project implementation. [10] The oversight activities leverage on the constitutionally mandated power of investigation under Sections 88 and 89 of the Constitution to expose corruption, inefficiency, and waste in the conduct of government business. As a political accountability actor, the NASS ensures that government acts in accordance with agreed-upon standards of probity, ethics, integrity, and professional responsibility and ensuring that public officials are held responsible for their actions and held liable for actions that go against established rules and principles. To ensure effective oversight function, the NASS regularly receive progress reports on budget implementation, i.e. the amount released against what was budgeted and its achievement.

Two respondents disclosed that NASS have mechanisms to hold MDAs accountable but do not impose sanctions. Mechanisms identified include *"oversight functions and public hearing through which NASS can expose infractions and corrupt practices and make recommendations to restraining agencies such as ICPC, EFCC through the Presidency (NASS-House & Senate)*". Others include the *"Public Complaint Committee through which citizens can lodge complaints and the Public Accounts Committee which receive the Auditor-General's Report from the Presidency and sends report back to the Presidency (NASS-House & Senate)*" who then takes the final decision.

The respondents confirmed that the mechanisms are *"not very effective and regular as sometimes, there are inevitable political dimensions to decision making and it is the Presidency that has the final say on whether restraining agencies will sanction or not*". *((NASS-House & Senate)* They also identified challenges to include inadequate financing of oversight functions, lack of clear understanding of the different levels of healthcare and their roles and responsibilities by the legislatures. This sometimes *"lead to purchasing items that are not useful in a healthcare center during the implementation of the constituency projects (NASS-House & Senate)*". Considerable concerns about the effectiveness of the oversight function in political accountability due to incidence of legislative oversight abuse in Nigeria has also been reported. [(33) (34)]

CSOs and the media are critical health sector accountability actors. Their focus is basically on interest aggregation and advocacy They are also critical for providing information on health policies, regulations, and responsibilities so that citizens can become knowledgeable consumers of health services. They often collaborate in generating and disseminating information necessary for citizens to hold public health officials and agencies accountable. [(35) (36)] However, some respondents cited *"inadequate information and awareness in the media and public domain about provider accountability as a significant challenge (CSO and the Media)".* And that "*the effectiveness of the media is limited by non-compliance by many MDAs with the FOI law, consequently CSOs and media are frequently denied access to vital information that can be used to hold public officers accountable."(Media).*

Some respondents identified different mechanisms used by CSOs and the media to mobilize the citizens and hold government agencies accountable in Nigeria. This includes advocacy to political leaders, policy makers and health managers and presenting evidence to the government and relevant stakeholders, civil education activities and public campaign using IEC and radio/TV programmes and mobilizing the public towards greater understanding of the clients' rights, tracking of expenditure and measuring indicators that focus on fiscal responsibility. Of great significance is leading and mobilizing citizens for campaigns seeking reforms such as the role played by the Health Sector Reform Coalition (HSRC) in the passage and eventual assent to the NHAct, 2014 during which CSOs and the media exerted enormous pressure on the government. Other mechanisms identified include involvement in programme development and implementation processes, supporting capacity building of the legislature and the use of litigation to enforce greater accountability. [(37) (38)]

One respondent observed that the effectiveness of CSOs in promoting accountability in the health system is weak because of the *"inability of the FMOH to engage, organize and build capacity of CSOs in implementing accountability mechanisms and interventions". (CSO)* While ICPC has successfully organized CSOs into a National Ant-Corruption Committee (NACC) to enhance its work, there is no evidence of existence of such platform in the FMOH to help hold health MDAs accountable, and check cases of abuses, frauds and wastes in the health system.

Though CSOs are typically accountable to funders and boards of management (upstream), and the host country via compliance to relevant legislation (horizontally), and to beneficiary communities and other local entities (downstream), one respondent admitted that compliance in this regard has not been effective.

4.0 RECOMMENDATIONS

A number of recommendations were proffered for promoting accountability in various aspects of the health system by the key informants during the interview. The recommendations are discussed under the following categories:

1. **Sustained High Level Advocacy and Sensitization on Accountability and Transparency in the Health System-**

Over the years, most health system advocacy programmes on health financing have focused on soliciting for more and more money for health, with little emphasis on value for money. Some respondents pointed out that despite increased investment in health, particularly, in the implementation of the international health goals such as the MDGs, and currently the SDGs, the country has continued to fall short in achieving development goals. Consequently, the stakeholders want performance measures so that they can hold government accountable, a development that reflects citizen demands for evidence of programme and organisational effectiveness and improvement in services delivery. -Performance measurement of programme outputs and outcomes will provide important, if not vital, information on current programme status and how much progress is being made toward important programme goals. [39]

Hence, there is need for high-level targeted advocacy for a paradigm shift from current demand for accountability on expenditures (financial reporting) to performance measurement (and monitoring), focusing on results and outcomes (non-financial reporting). Performance measures will provide reliable and valid information on performance/delivery of services and enable stakeholders to hold those in government accountable. High level advocacy should be targeted at the political leaders, policy makers, health leaders and managers, legislatures, CSOs and media at all levels.

Virtually, all the respondents demonstrated lack of sufficient understanding of accountability as a subject matter and inadequate information on some types of accountability mechanisms such as patients' rights and grievances redressal system. -Hence, the need for public enlightenment campaign on different types of accountability mechanisms in the health system using different IEC strategies including media advocacy and intervention by the National Orientation Agency.

One respondent suggested that sustained advocacy and sensitization efforts should be targeted at promoting and achieving efficiency in resource utilization as some MDAs have not shown sufficient capacity to utilize or spend all the money that has been allocated in the past. The respondent also suggested timely release of appropriated funds to the MDAs to ensure effective implementation of their annual budget as delayed releases or sometimes non-releases of funds remain a considerable challenge confronting many MDAs in their operations making it difficult to demand for accountability as at when due.

It was also recommended that "*increased resource allocation may need to be considered for overhead costs particularly in health institutions and some MDAs, where overhead costs are observed to be grossly underfunded*". So also, is the need to examine the challenges posed by "*non – regular allowances which are funded through over bloated personnel cost, an area that still constitute significant accountability challenge currently been investigated*".

2. Strengthening the Use of Digital Technology to promote Accountability and Transparency-

Expansion and strengthening the use of ICT innovation was identified as a veritable intervention with unlimited potential for promotion and institutionalization of accountability in the health system. Four respondents representing the Federal Budget Office, ICPC, NHIS and a healthcare provider acknowledged the progress in combating frauds and wastes in many sectors through the introduction of new government policies in the public financial management system such as Treasury Single Account (TSA), Integrated Payroll and Personnel Information System (IPPIS), Government Information Financial Management Information System (GIFMIS), Bank Verification Number (BVN), among others. Two of the respondents disclosed that implementation of TSA and IPPIS/BVN is saving the country billions of naira every month and had facilitated the elimination of ghost workers in various MDAs. Also, one of them confirmed that Nigeria had joined the Open Government Partnership (OGP), an international multi-stakeholder initiative focused on improving transparency, accountability, citizen participation and responsiveness to citizens through technology and innovation. Other areas where efforts should be expedited in the use of digital technology include through: e-NHIS to improve business processes such as enrollment of clients, accreditation of providers, provider payment, complaints management; Electronic Medical Records (EMR) to improve efficiency of healthcare facilities.

3. Full Implementation of the Provisions of the National Health Act-

The NHAct 2014 provides a framework for the regulation, development and management of a health system and sets standards for rendering health services in Nigeria. The law has clearly outlined a number of provisions covering various areas of the health system, whose implementation would help strengthen the system, ensure effectiveness and efficiency in healthcare delivery and improve equity and guarantee better health for the citizens. One respondent lamented that some years after the enactment of the law, many provisions have remained largely unimplemented due to several challenges, principally, lack of positive policy environment and budget provision for its implementation, and general lack of awareness of the NHAct.

Since accountability in the health system flows from the stewardship role of the FMOH, the Ministry should establish an advisory group consisting of academics, specialists from other multilateral agencies (particularly WB), and specialists from interested bilateral agencies to advice on implementation of the NHAct, particularly, the necessary mechanisms for creation of positive policy environment, broad based sensitization and awareness creation, collaboration with the legislature and relevant stakeholders to ensure required funds are appropriated for its full implementation and performance monitoring.

4. Capacity Building on Health Governance to Strengthen Leadership and Management, and Performance Monitoring and Measurement

Strong leadership and sound management requires that leaders and managers can provide good governance in the health sector – carrying out a wide range of steering and rulemaking related functions

as well as contribute to reducing inefficiency, waste and corruption and getting better value for money as they seek to achieve national health policy objectives.

With between 20% and 40% of health resources wasted through various forms of inefficiency and wastage, ministries of health are coming under increasing pressure to improve accountability in the health sector.[40] Therefore, policy makers, health leaders and managers can be empowered to act as accountability actors, creating culture of accountability in health MDAs and healthcare organizations, and ensuring that programme implementers and health professionals are equally empowered to be accountable for their actions.

5. Strengthening of Existing Accountability Mechanisms-

While many respondents agree that there are different types of accountability mechanisms existing in the health system, they stressed that in many cases, the mechanisms are ineffective and inefficient and responsible for various accountability incidents and gaps. Commonly cited weak mechanisms include Patients' Bill of Rights which is frequently not upheld, Grievances Redressal System for resolution of patient's complaints which is slow, Freedom of Information (FOI) Act which is often violated and AuGF Audit Report which often become overdue.

Therefore, efforts should be made to identify and strengthen accountability mechanisms that are ineffective, inefficient, and non-responsive.

6. Enforcement of Sanctions-

Sanctions are a key tool for safeguarding established standards and values. However, for the tool to achieve its full potential, proper determination and enforcement of sanctions is fundamental. Enforcement of various types of sanctions is delegated to relevant accountability actors who are responsible for imposition of prescribed sanctions. The respondents identified different types of sanctions which can be enforced. Examples include: MDCN may suspend or withdraw practice license of medical and dental practitioners, the courts may impose fine, seize properties or funds, and the NHIS may de-accredit healthcare providers or HMOs. Effective accountability requires that both conditions of answerability and sanctions are fulfilled.

Therefore, accountability actors should ensure that relevant sanctions are diligently enforced to serve as deterrent to future offenders.

7. Strategic Approach to Promoting Accountability and Transparency in the Health System-

Strategic approach may be required to ensure institutionalization and sustainability of accountability and transparency initiatives. Though the BHCPF has an accountability framework, the health system does not have a comprehensive strategy and framework for accountability. It is suggested that to deepen accountability in the health system, development of a National Strategy and Accountability Framework for the Health System may be considered.

5.0 CONCLUSION

The health system in Nigeria is characterized by various mechanisms aimed at promoting accountability. However, most of the mechanisms are ineffective and inefficient due to several gaps and challenges which constitute significant drawback to the performance of the health system and healthcare delivery. Therefore, for the government to make significant progress in achieving national and international health goals including the UHC, strong accountability should be a central focus of health system improvement efforts. Accordingly, priority attention should be given to strengthening mechanisms, processes and practices that emphasize value for money and mitigate general inefficiency in financial and programme management and ensure effective implementation of health interventions.

Proffered recommendations for promoting accountability in the health system includes sustained high level advocacy and sensitization on accountability and transparency in the health system; strengthening the use of digital technology to promote accountability and transparency; full implementation of the provisions of the national health act; capacity building on health governance to strengthen leadership and management; strengthening of existing accountability mechanisms; enforcement of sanctions; strategic approach to promoting accountability and transparency in the health system.

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7.0 ANNEXES

Annex 1: Table Showing Accountability Types, Health System Focus and the Purposes

Type of Accountability	Health System Focus	Purposes of Accountability
Financial	Cost accounting/budgeting for: -Personnel -Operations -Pharmaceuticals/supplies Definition of basic Benefits packages Contract oversight	• Financial control and management. • Compliance with prescribed input and procedural standards; cost control; resource efficiency measures; elimination of waste, fraud and corruption. • Procedural compliance.
Performance	Health system performance accountability focuses on results - intended goods, services and benefits for citizens such as: • Quality of care, • Service provider behavior • Patients' satisfaction • Regulation of professional bodies and practices • Contracting out of services etc	• Assurance and improvement/learning • Adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and vales; and quality of care standards and audits. • Benchmarking, standard settings, quality management, operations research, monitoring and evaluation(M&E)
Political/Democratic	Political/democratic accountability enhances the legitimacy of government in the eyes of citizens. • Service delivery equity/fairness transparency • Responsiveness to citizens • Service user trust • Dispute resolution	• Control and assurance. • Control relates to use of taxpayer funds, addressing market dynamics and distribution of services (disadvantaged populations). • Assurance focuses on principal-agent dynamics for oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values.
Social	It involves constructive engagement between citizens and government.	• Check the conduct and performance of public officials, politicians, and service providers. • Ensures public resources are used judiciously to deliver services, improve community welfare, and protect people's rights.

Annex 2: Table Showing Accountability Actors and Linkages

Type of Accountability	Name of Actor	Mandate/Role in Accountability	Capacity to Demand Information	Capacity to Impose Sanction	Linkages	Capacity to Supply Information	Capacity to Respond to Sanction
Financial	FMOH	Financial and Programme oversight over budget and programmes of Health Departments and Agencies	+++	+	Health Departments and Agencies such as NHIS, NPHCDA, Public Healthcare Facilities	###	###
	Budget Office of the Federation (BOF)	The BOF oversee the budget preparation including allocating resources in accordance with government priorities, implementation, and monitoring of budget and promoting efficient delivery of services.	+++	+	Health MDAs	###	---
	ICPC	Examine the practices, systems and procedures of public bodies to ensure that they are not vulnerable to corruption, and investigate complaints from members of the public on allegations of corrupt practices and in appropriate cases, prosecute the offenders.	+++	+++	Health MDAs	###	###
	OAuGF	Review whether public money was spent or not for the approved purpose and with due regard to efficiency, economy and effectiveness.	+++	???	Health MDAsi	###	???
	International Donors (WHO)	Provide development assistance for health	+++	+++	Ministry of Budget and National Planning, Health MDAs	###	###

Type of Accountability	Name of Actor	Mandate/Role in Accountability	Capacity to Demand Information	Capacity to Impose Sanction	Linkages	Capacity to Supply Information	Capacity to Respond to Sanction
	Regulatory Agencies (MDCN)	Regulation of professional practice and standards	+++	+++	Public Healthcare Facilities, and the NASS	###	###
	NHIS	Regulation and control of health Insurance in Nigeria (services, HMOs/providers and payments)	+++	+++	HMOs, Health Care Providers, Health Consumers (Clients), and the NASS	###	###
	Health Consumers (Clients)	Users of health services	+++	+	NHIS, HMOs, Health Care Providers	###	#
Professional / Provider (Service Delivery)	Regulatory Agencies MDCN	Regulation of professional practice and standards	+++	+++	Public & Private Healthcare Facilities and Health Professionals, and the NASS	###	###
Political or Democratic	NASS	Approves the national budget, ensuring that the budget is citizen-centered and hold government and government functionaries accountable through oversight function which enthrones fiscal discipline, enforces efficiency and cost effectiveness in budget implementation.	+++	+++	Health MDAs and Government Officials	###	###
Social	CSOs (HERFON)	Mobilizing citizens and local organisations to check abuses of the state and poor government practices	+++	+	Health MDAs and Government Officials, and the NASS	###	#
	Media	Mobilizing citizens and local organisations to check abuses of the state and poor government practices	+++	+	Health MDAs and Government Officials, and the NASS	###	#

The above table illustrates both information demand/ supply and sanctions on a single table.

Codes:

Capacity to demand information or impose sanctions: *Weak + Medium ++ Strong +++*

Capacity to supply information or respond to sanctions: *Weak #* Medium ## Strong ###

Annex 3: Table showing Areas of Focus/Thematic Issues used to extract information and analyse data

S/N	Area of Focus
1	**Understanding** of accountability and its different perspectives
2	Associated **accountability linkages**
3	**Mechanisms or strategies** in place to ensure accountability
4	E**ffectiveness** of the mechanisms and strategies
5	Existing **accountability gaps**, **barriers** and the **challenges**
6	**Recommendations** on how accountability could be improved.