THE HEALTH SECTOR REFORMS AND ITS IMPLICATIONS ON HEALTH CARE DELIVERY SERVICES IN NIGERIA

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ABSTRACT
Healthcare is one of the fundamentals determinants of wellbeing and good governance across the world. Nigeria is among the countries with challenges of an effective healthcare delivery services and because of that, healthcare reform was adopted to ensure that reaching out to the public is effective. This study is an investigation of the healthcare sector reforms introduced in Nigeria to the extent of its successes and / or impact; and the challenges encountered in achieving the target of the reforms. The research used both primary and secondary sources for data collection. The primary sources include in-depth interviews with selected informants in the health sector. The secondary sources consist of books, journals, internet, government documents, and other existing data on the subject matter of the study. The data obtained were discussed and analysed using content analysis and some statistical aids in the process. The research discovered several challenges that impede the healthcare reforms from realising its targets. These include lack of political will, lack of community involvement and transparency. Based on these findings, the study recommends among many others that objective analyses of needs and opportunities aimed at improving health workers' capacities be carried out in order to strengthen the healthcare system in a sustainable manner.

Keywords: Health, Healthcare, Nigeria, Policy, Reform, Services

ABSTRAIT
Les soins de santé sontl'un des determinants fondamentaux du bien-être et de la bonne gouvernance à travers le monde. Le Nigéria fait partie des pays confrontés à des défisen matière de prestation de services de soins de santé efficaces et, pour cette raison, un eréforme des soins de santé a été adoptée pour garanti rl'efficacité de la communication avec le public. Cette étude est une enquête sur les réformes du secteur de la santé introduites au Nigéria dans la mesure de sessuccès et / ou de son impact; et les défis rencontrés pour atteindre l'objectif des réformes. La recherche a utilisé des sources primaires et secondaires pour la collecte de données. Les principales sources comprennent des entretiens approfondis avec des informateurs sélectionnés dans le secteur de la santé. Les sources secondaires sont des livres, des revues, Internet, des documents gouvernementaux et d'autres données existantes sur le sujet de l'étude. Les données obtenues ont étédiscutées et analysées à l'aide d'une analyse de contenu et de quelques aides statistiques dans le processus. La recherche a découvert plusieurs défis qui empêchent les réformes des soins de santé d'atteindrel eurs objectifs. Il s'agit notamment du manque de volonté politique, du manque de participation communautaire et de transparence. Sur la base de ces résultats, l'étude recommande

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entre autres que des analyses objectives des besoins et des opportunités visant à améliorer les capacités des agents de santé soient menées afin de renforcer durablement le système de santé.

Mots-clés: Santé, Santé, Nigéria, Politique, Réforme, Services

INTRODUCTION

In an effort to provide International healthcare standards for her citizens, Nigeria has chosen the Health Sector as one of the areas where reform should be carried out in its Public sector Reform Agenda. Healthcare therefore, becomes one of the cardinal points in the government's Seven-Point Agenda. It is however regrettable to note that the situation of Health Services and by extension the Healthcare Sector in the country cannot meet up the demand for healthcare due to the paralysis and systematic decay of health infrastructure, facilities, equipment and human capital resource (Federal Ministry of Health, 2019).

The reforms in the Health Sector undertaken to revamp it through efficient and effective health care delivery services is yet to achieve that objective (World Health Organisation, 2019). This study is therefore motivated by one question: to what extent have the reforms been able to achieve the desired result in the health sector?

The Concept of the Health Sector Reform

Health Sector Reform in this work is seen as the broad based purposeful and sustainable fundamental change in the function, structure and performance of health systems (i.e. vision, policies, legislation, institutional arrangement, organizations, plans, programmes and projects) in order to deliver efficient, quality, affordable, accessible, effective and equitable health care services to the populace and ultimately improve the health status of the people.

According to Oloreigbe (2006), the key characteristics of a good Health Sector Reform are:

- Structural rather than incremental or evolutionary
- Change in Policy Objectives followed by Institutional Change rather than redefinition of policies alone
- Purposive rather than haphazard change
- Sustained and lengthen rather than one off.
- Political and "top down" process led by national, regional or local government
- Contents is marked by diversity rather than uniformity of measures
- Content is specific to a country and to its health system characteristic.

Whether or not the Health Sector Reform in Nigeria possesses the above listed characteristic is contestable due to the disjointed and more often contradictory Health Policy followed by haphazard reform processes and procedures as could be seen later in this work.

In order to have a comprehensive Reform Policy, the Nigerian Government as noted earlier encapsulated in the 7-Point Agenda, the Health Sector as one of the priority areas of focus. This is because of the importance of health and healthcare to the economic and socio-political development of any nation. It is a popular saying that the wealth of any nation can be measured by the health status of its citizens, in true confirmation of the popular adage which affirms that "Health is Wealth" (Federal Ministry of Health, 2007).

It has thus been recognized that health for the citizenry has become one of the drivers of rapid economic development. Together with education, they are the most important sectors where public attention is focused in order to ensure greater human development. For sustainable development in healthcare, it is generally agreed that there should be improved funding as well as improved infrastructures. The Health Sector Reforms in Nigeria have underscored government's

resolve to make a clean departure from the past. Some of these reforms include the National Health Insurance Scheme (NHIS); the intensified crusade against HIV/AIDS, Malaria and Tuberculosis pandemics; the focus on primary and preventive healthcare; and the restructuring of tertiary healthcare delivery institutions (Federal Ministry of Health, 2007).

The Vision touches every aspect of Nigerian's life according to the reform document of the Federal Ministry of Health (2004) and covers the following areas: households, communities, government, and healthcare. While the Households are expected to be informed and empowered to sustain their health needs with appropriate help from the government, have productive and defined roles and the ability to promote healthy lifestyles and eradicate cultural inhibitions and harmful practices; the Communities are expected to receive unhindered access to healthcare needs; as the healthcare system strengthen and promote community goals. In this context, Government becomes people-centered, accessible and accountable and is responsive to the health needs of the people. Government therefore, set up a realistic agenda and achieves its goals through effective partnerships with households and communities. The Healthcare system becomes a), community driven and responsive to the needs of the people, b), deliver high quality, integrated, comprehensive and continuous services, c). accessible, affordable, available, acceptable and optimally funded, d), supported by robust public-private partnerships at all levels, and e), driven by a pro-poor financing system.

The vision of the reformed healthcare can therefore be summarized as being people-centered; which encourages the participation of all stakeholders, and aimed at developing quality services at affordable prices. This beside empowering all citizens to know and use their rights and responsibilities for better health; and thus creates sustainable partnerships with all sectors.

Reasons for the Health Sector Reforms

The healthcare sector reforms were motivated by a number of reasons. As outlined in the Reform Document (2004), Nigeria was ranked 187th among the 191 UN member states by the World Health Organization (WHO) in 2000. Nigeria was ahead only of the Democratic Republic of Congo, the Central African Republic, Myanmar and Sierra Leone.

a) There is no existing National Health Act that describes the National Health Service delivery system, and defines the health function of each of the three tiers of government and the roles and responsibilities of all stakeholders.
b) Resource allocation was inefficient and unbalanced between the three levels of care (Federal, State and LGA).
c) Nigeria has one of the lowest national health budgets in Africa. The country spends approximately US$4.00 per capita on health, versus US$14, which is the global minimum recommended by WHO for developing countries.
d) The quality of health services and facilities was, and is still very low. Service facilities at all levels are dilapidated, under-funded, and poorly equipped with equipment. The referral system is largely nonfunctional.
e) Consumers are dissatisfied with the quality of health care available. Because they are generally uninformed and unaware of their rights and responsibilities, they are unable to either demand their rights or act on their own obligations for maintaining good health.
f) Fake, substandard, adulterated and unregistered drugs are norm in the market. Supplies of safe affordable essential drugs and other consumables are erratic at best.
g) Human Resource management is very poor leading to inefficient and poor service delivery.
h) The weak service delivery system is unable to deliver a minimum package of quality health care including routine immunization, emergency obstetric care, prevention and

management of communicable diseases and infections especially Malaria, Tuberculosis and HIV/AIDS.

i) There is minimal relationship between the Public and Private Health sectors.
j) There is poor coordination and collaboration among donor and development partners.

The Seven Strategic Pillars of the Health Sector Reforms

The seven pillars of the Health Sector Reform were identified by the reformists to include:

a). Defining the stewardship roles of the three tiers of Government; b), Strengthening the National Service delivery system and its management; c).Reducing the disease burden due to priority health problems; d), Ensuring adequate health resources are available and better management systems are in place; e), Improving access to quality health services; f), Enhancing consumers' awareness and community involvement in health; g), Promoting effective partnership and coordination.

Implementation Framework f the Health Sector Reforms

The key mechanisms through which the Federal Ministry of Health plans to address the Health Sector Reforms are included in the National Health Act. The key issues under consideration in the National Health Act are grouped into various areas, such as:

a) Responsibility and Eligibility for Health and Health Services where there should be:
i), a clear delineation of roles and responsibilities of Federal, State and LGAs at the different level of health services; ii), the participation of private health facilities in the provision of health services based on actual local needs to encourage equitable spread of services, and, iii) identification of eligibility criteria for payment exemption for health services in public health establishments to safeguard the interest of the poor in the communities.

The Act also identifies the rights and duties of the users and health care personnel, such as:

i), Health worker or health establishment must not refuse to provide emergency treatment to anyone; ii) Users' rights to informed consent and full information including cost, range of diagnostic procedures and treatment options, benefits, risks and implications to user; iii) User's rights to informed choice in a language and manner the user understands, and iv), Full recognition of the rights of the health care provider.

National Service Delivery System

The Act also contains the National Service Delivery System at the three tiers of government including the village health communities and inclusive of private health care and specifically it spelt out the functions of:

1. The Federal, State Governments and LGAs in providing health services.
2. The National Council on Health as an Advisory body to the Federal Government.
3. A new National Consultative Health Forum and National Hospital Services Agency.
4. The National Primary Health Care Development Agency, and the National Primary Health Care Development Fund.
5. Regulation of the establishment of health facilities at all levels, through the issuance of a certificate of needs and standards.

The National Health Promotion Policy

The Reforms are back up with a policy frame work (Health Promotion Policy,2005), which provides for:

1. Stewardship role of the Ministry of Health in National Health Promotion Policy
2. Broadening the narrow focus on health education in Nigeria to take into account current understandings of Health Promotion and Consumer rights
3. Action to improve quantity and quality of Health Promotion at community, LGA, State, national and international levels.
4. Action to promote the rights and responsibilities of consumers.
5. Enhancing the quantity and quality of Health Promotion in key settings including community, schools, health facility and workplace.
6. Mobilize the potential of the mass media for Health Promotion.
7. Strengthening inter-sectoral collaboration for Health Promotion.
8. Partnership between public and private sectors, NGOs and civil society.
9. Capacity building in Health Promotion at all levels including channeling of resources both (human and financial) and training of personnel.
10. Strengthening of current health education services so that they can play a key role in the coordination, support, training and dissemination of guidelines of good practice and networking in Health Promotion.
11. Strengthening research, monitoring and evaluation of Health Promotion.
12. Resource mobilization.

METHOD OF DATA COLLECTION AND ANALYSIS

The research used both primary and secondary sources of data. The primary source included in-depth interview with stakeholders in the health sector. A total number of sixteen (16) informants were chosen for the interview. Three (3) of the informants were senior officials in the Federal Ministry of Health Abuja. Three (3) informants were selected from the management of the Teaching Hospital and Federal Medical Centres in selected States in Northeastern Nigeria and one (1) in National Hospital Abuja due to accessibility and affordability. Four (4) academicians were interviewed from the health-related courses and healthcare administration experts. Three (3) informants were chosen from civil societies that were operating in the health sector, and two (2) from selected from the public policy analysts. The criteria used for their selection were based on accessibility to the researcher, their possession of quality data and information and feasibility as well as confidentiality. The interview was conducted using semi-structured questions designed in a questionnaire separately for each of the category among the informants.

The secondary sources used for the study consisted of reports and official documents from the government on the issues of health sector reform made available to the researcher by the authorities concerned. Others included books, journals, internet sources and existing data on the subject matter of study.

The data obtained were grouped and presented in the discussion section for analysis and interpretation using content analysis. Statistical aids were also used such as charts for illustration.

DISCUSSION AND FINDINGS

In this section, the data gathered are presented and analysed to derived the findings. The interpretation and discussions of the findings are carried out to enhanced suggestions, and recommendations.

The Facts about Health Status in Nigeria

The fact about state of the Nigeria's health indicates a worrisome situation. For instance, on May 24, 2004, the National Population Council (NPC) released the latest data from the Nigerian Demographic Health Survey (NDHS 2003, quoted in FMOH 2004). It is seen as the most accurate measure of the nation's state of health since 1990. Although the data raised more questions than answer, it provides a resounding wake-up call for immediate and comprehensive action. This is graphically presented in table 1

Figure 1 (about here) shows that Infant Mortality rate in Nigeria is 100 deaths/1000 and under 5 Mortality Rate is 201/1000 whereas the other chart shows that 38% of children in Nigeria are stunted and 29% of children under 5 are underweight (NDHS, 2003 adapted from FMOH 2004). Comparatively, the current statistics indicated that not much changed has been recorded since 2004 even with the introduction of the reforms as indicated in table two below.

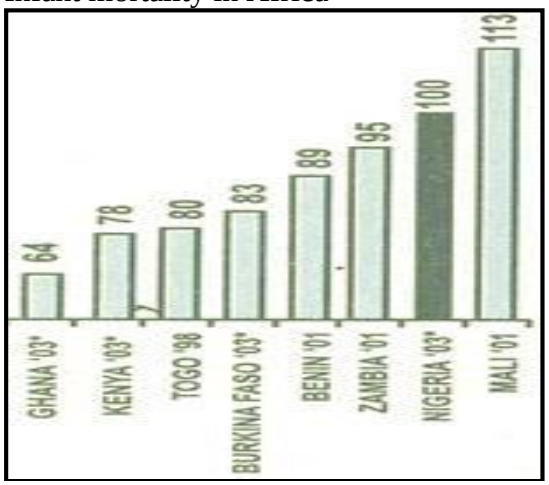
Table 1: State of Health in Nigeria 2004

Infant and Child Mortality Rate	
Infant Death There are averages of 100 infant deaths for every 1000 live births (10%).	Child Death For every 1000 children born, 201 (or one out of every five) children died before they were five years old (20%).
Child Health	
Only 13%of children aged 12 to 23 months have received the recommended course of immunizations.	23% of children have received no immunization at all.
Maternal Health	
60% of women received antenatal care at least once from a trained health care provider.	
Two out of every three births happen at home.	
17% of women have no assistance during delivery and 26% are assisted by an untrained person.	

Source: Federal Ministry of Health 2004.

A Comparative Indicators of Health Status in Nigeria and other African Countries

Infant mortality in Africa



Nutritional Status of children

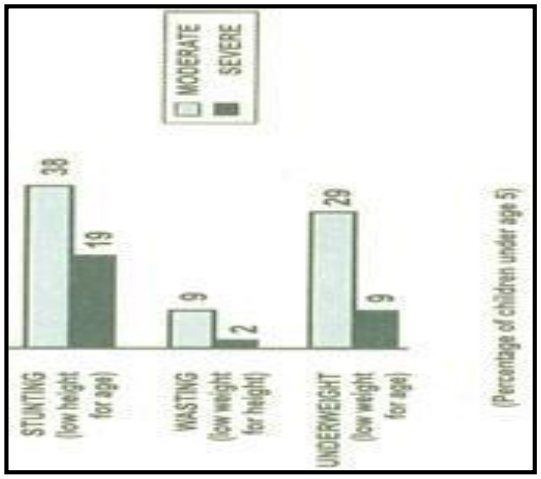


Fig.1: Comparison of Infant mortality rate and nutritional status of children in Africa.

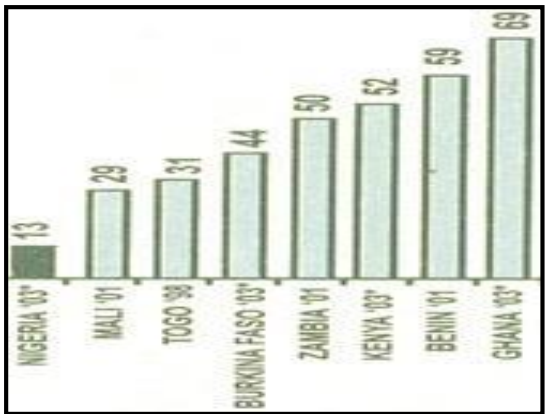
Table 2: State of Health in Nigeria 2019

Infant and Child Mortality Rate	
Infant Death There are averages of 69.8 infant deaths for every 1000 live births (8.23%).	**Child Death** 2,300 children died daily. This is equivalent to 15 Boeing 737-300 series airplanes fully loaded with 145 children five years and below crashing every day killing all the passengers on board.
Child Health	
Overall, 57.2 % of children aged 12 to 23 months had received the third dose of DPT/Penta as at 2019.	17% of children have received no immunization at all according to survey in 2018.
Maternal Health 9.2 million women got pregnant annually in Nigeria with 60% of women received antenatal care at least once from a trained health care provider. Maternal death of 1 in every 13 as compared to 1 in 31 for other Sub-Saharan African countries. Estimated annual maternal death of 40, 000 accounting for 14% of the total global death. One Nigerian woman dies every 1 minutes which is equitable to 109 daily.	

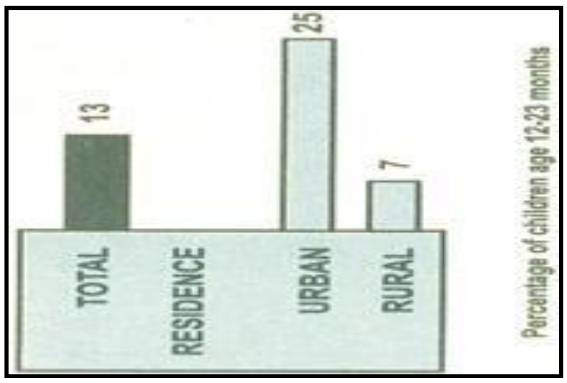
Source: Federal Ministry of Health 2019.

A Comparison of Vaccination Coverage in Some Selected States of Africa and Nigeria

Full vaccination coverage in Africa

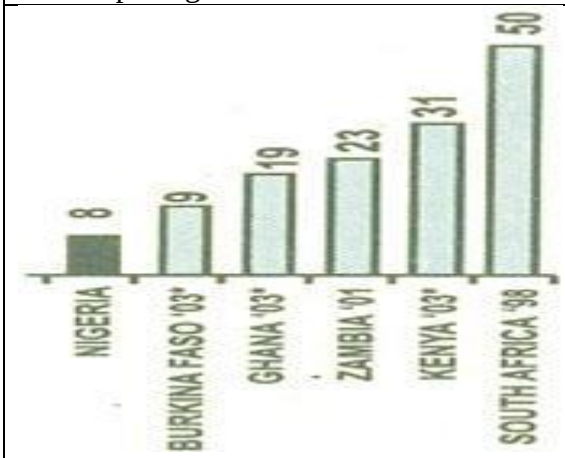
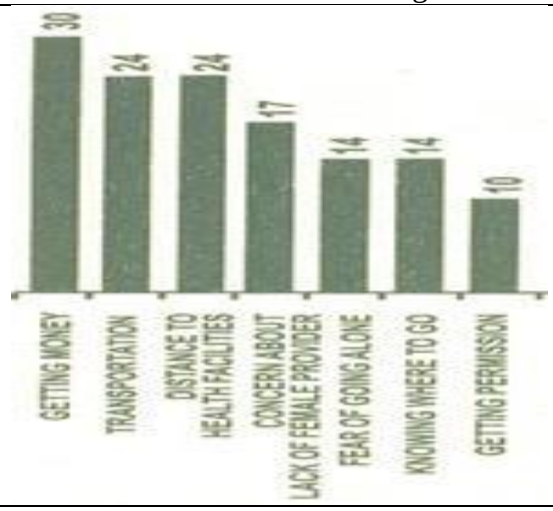


Full vaccination coverage according to residence



Source: Federal Ministry of Health 2004.

Child Spacing and Barriers to Health Access in Nigeria

Child Spacing Use of Modern Methods	Barriers to Health Access in Nigeria
	

Source: Federal Ministry of Health 2004.

Apart from the problems identified above that mostly boarders on maternal and child health care, other health problems on HIV/AIDS and malaria have become Africa's greatest health challenge in contemporary times. Statistics have indicated that about 40 million people are estimated to be living with HIV/AIDS across the world. Out of this figure, about 2 million are children. In 2005 alone, about 2.8 million people died of HIV/AIDS. In Africa, about 30 million people are infected with the virus, out of which 3 million are children. Africa's prevalence rate has generally hovered around 6%, and about 2 million deaths were recorded in 2005 (WHO, 2005) as cited in Bankole 2008). In 2018, the statistics revealed that about 36.9 million individuals were living with HIV/AIDS globally and 212 million malaria cases and 429, 000 deaths were recorded (WHO, 2019).

In Nigeria, it is estimated that 3.4 million people were living with the HIV/AIDS in 2005, with women and girls accounting for 50%. This number was estimated to increase to between 3.7 and

4.3 million in 2008. Further estimates equally indicate that between 3 and 4 million Nigerians will die of Aids-related causes in 2008. (Bankole,2005).

It has been established that AIDS mostly afflicts the population within the most productive age-bracket of 20-35years. Mother-to-child transmission has been on the increase. Families are losing their breadwinners. Schools are losing teachers and students. The effect of HIV/AIDS and malaria on productivity and social life is, therefore, quite obvious. And even when recent statistics by the National Agency for the Control of AIDS (NACA) have given hope of a reduced prevalent rate, there is much more to worry in Nigeria. Such worries would have to do with funding, care, support and discrimination. Responses thrown up by these and other new challenges in the health sector must be well targeted through legislations that would complement government policies as pointed out in the reform programme implementation strategy (Federal Ministry of Health, 2019).

It was assumed that by 2010, Nigeria would have an effective and affordable health delivery system that meets the needs of empowered populace through the integration of relevant services by all stakeholders and sustained partnership with all sectors of the society. From the data assessed so far, it is not likely that even by 2020 Nigeria would realize the dream of having effective health institution. The data presented above were to enable the convenience of comparison between the time of the reforms, the implementation and the outcome to allow for the determination of the successes and challenges. The current data are provided in table 3 below.

Table 3: Some Selected Health Indicators in Nigeria 2019

S/no.	Indicator	Percentage
1.	Vaccination coverage in Nigeria 2019: BCG, DTP, Pol3, MCV1 & Hepb3	65%
2.	Child Spacing usage by different methods	43.8%
3.	National HIV prevalence	1.45
4.	Malaria incidence (110 million clinically diagnosed annually)	50%
5.	Malaria deaths incidence (estimated death 100, 700 per annum)	0.054%

Source: World Health Organisation (2019) retrieved from www.who.org

Why the Health Sector Reform Cannot Achieve its Desired Objectives of Improving the Health Care Services in Nigeria

The Nigeria's health system is in a poor state and this is traceable to several factors especially the gross under-funding of the health sector and shortage of skilled medical personnel at the primary health care level. The contradiction is that Nigeria is one of the several major health-staff-exporting countries in Africa. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of fulfilling job and lucrative positions. Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. Health workers in underserved areas usually have motivational problems at work which may be reflected in a variety of circumstances, but common manifestations include: lack of courtesy to patients; failure to turn up at work on time and high levels of absenteeism; poor process quality such as failure to conduct proper patient examinations and; failure to treat patients in a timely manner. These challenges can be addressed by increased funding of the health sector and the introduction of multiple incentives to health workers to make working in unattractive areas more appealing (Federal Ministry of Health, 2019).

According to Uneke et al (2008), with disability adjusted life expectancy (DALE) of 38.3 years and the rank of 187 as reported in the World Health Report (2000), the performance of the Nigerian health system is worse than many sub-Saharan countries. There is thus an urgent need to

support the health system with adequately trained personnel in order to improve provision of the health services. They further stated that the poor state of Nigeria's health system is traceable to several factors: organization, stewardship, financing and provision of health services. These have been compounded by other socioeconomic and political factors in the environment. This therefore means that the overall availability, accessibility, quality and utilization of health services decreased significantly or stagnated in the past decade. For instance, the WHO Country Cooperation Strategy (2002-2007) report reveals that the proportion of households residing within 10 Kilometers of a health centre, clinic or hospital is 88% in the southwest, 87% in the southeast, 82% in the central, 73% in the northeast and 67% in the northwest regions (WHO, 2019).

According to the Demographic Health Survey (DHS 2003 as quoted in Uneke et al (2008), there is evidence that the key health indicators have either stagnated or worsened. Life expectancy dropped from 53.8 years for females and 52.6 years for males in 1991 to 48.2 years for females and 46.8 years for males in 2000. The infant mortality rate (IMR) rose from 87.2 per 1,000 live births in 1990 to 105 in 1999. About 52% of under-five deaths are associated with malnutrition. The maternal mortality rate (MMR) of 800 per 100,000 live births is one of the highest in the world. This could be attributed to the gross under-funding of the health sector and shortage of skilled medical personnel at the primary health care level. The impact of chronic under-funding, together with high levels of emigration and the worsening impact of the AIDS pandemic, have led to a rapidly mobile health workforce ready to seek better opportunities elsewhere. But healthcare professionals also move from rural areas to the cities and from the public to the private sector, seeking to optimize the quality of life for themselves and their families.

The above assertion was supported by the then supervising Minister of Health (2009), Dr. H. M. Lawan in his press briefing thus “it is noteworthy that most of our health expenditures are yet to translate into level of much desired improvements in health of the populace due to the continuous weak state of our health system especially at the State and Local Government levels and health being on the concurrent list of the Constitution”.

It is therefore important to note that when examining global health care systems, it is both useful and important to explore the impact of human resources on Health Sector Reform. Commenting on the importance of Human Resource Management in Health Sector Reform, Uneke et al (2008) stated that while the specific health care reform process varies by country, some trends can be identified. Three of the main trends include efficiency, equity and quality objectives. Various human resources initiatives have been employed in an attempt to increase efficiency. Outsourcing of services has been used to convert fixed labour expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts and internal contracting are also examples of measures employed.

As was reflected in this work, many human resources initiatives for Health Sector Reform also include attempts to increase equity or fairness. However, the strategies aimed at promoting equity in relation to needs require more systematic planning of health services. Some of these strategies should include among other things, the introduction of financial protection mechanisms, the targeting of specific needs and groups, and re-deployment services. One of the goals of human resource professionals should be to use the above and other measures to increase equity.

According to Uneke et al (2008), human resources in Health Sector Reform also seek to improve the quality of services and patients' satisfaction. Health care quality is generally defined in two ways: technical quality and socio-cultural quality. The technical quality refers to the impact that the health services available can have on the health conditions of a population. Socio-cultural quality measures the degree of acceptability of services and the ability to satisfy patients'

expectations. Thus, this means that professionals in this field are faced with many obstacles in their attempt to deliver high-quality health care to citizens. Some of these constraints include budgets, lack of congruence between different stakeholders' values, absenteeism rates, high rates of turnover and low morale of health personnel.

It is therefore believed that better use of the spectrum of health care providers and better coordination of patient services through interdisciplinary teamwork which is achieved through good human resource management is an important component of Health Sector Reform. This is because since health care is ultimately delivered by people, effective human resources management will play a vital role in the success of Health Sector Reform.

According to Raufu (2002), Nigeria is one of the several major health-staff-exporting countries in Africa. For example, 432 nurses legally emigrated to work in Britain between April 2001-March 2002, compared with 347 between April 2000 and March 2001, out of a total of about 2000 (legally) emigrating African nurses. This trend is perceived by Nigerian Government as a threat to sustainable health care delivery in Africa's most populous country. Also, about 20,000 health professionals are estimated to emigrate from Africa annually. Data on Nigerian doctors legally migrating overseas are scarce and unreliable, largely because most wealthy 'destination' nations like Australia currently make it virtually impossible for overseas-trained doctors to migrate to their countries primarily on the basis of medical skills. Nevertheless, according to Raufu (2002), hundreds of Nigerian-trained doctors continue to migrate annually. Also, it was revealed in a recent survey that only 41.9% of primary health facilities provide antenatal and delivery services and 57.73% of such health facilities work without any midwife. Furthermore, 18.03% of such facilities operate without either junior community health extension workers (JCHEWs) or senior community health extension workers (SCHEWs).

In spite of all the above, Nigeria continues to export health-care professionals to the developed world. Many factors contribute to the brain drain. Some of these factors include the fact that the doctors are trained at a higher level than the facilities they were provided with, and that in Nigeria they typically earn about 25 per cent of what they would earn working in North America, Europe, or the Middle East. Another factor is little incentive for doctors who have relocated to come back to Nigeria and work. In a recent paper on the brain drain in Nigeria, the World Health Organization outlined some reasons for migration and proposed some solutions. These include maintaining minimum standards for local hospitals, increasing salaries, and making incentives for doctors showing willingness to work on underserved diseases. These are problems that the reform did not discuss in details and is having a negative impact on the health services in Nigeria. A clear testimony of these facts could further be buttressed by the Communiqué issued out at the end of the 53rd meeting of the National Council on Health held at Asaba, Delta State on the 11th – 16th March 2010. Among other health problems, the Council identified the following:

1. That Nigeria still maintains a high maternal mortality ratio at over 545 maternal deaths per 100,000 live births (NDHS, 2008), making the attainment of MDG target of three-quarters reduction uncertain.
2. That 350,000 new cases of cancer were diagnosed annually in Nigeria and if unchecked, this incidence was estimated to reach 500,000 new cases by 2020 and that the resulting high case fatality was related to the fact that over 80% cancer patients present in Hospitals are at the advanced stages of the disease.
3. That NHIS is a veritable tool for addressing two of the MDG health related goals and that under the NHIS Formal Sector Programme, over 4 million federal civil servants and their

dependants nationwide, were accessing health services but the council noted that only Cross River and Bauchi States had formally logged on to the NHIS Programme.

4. Nigeria is still one of the 4 polio endemic countries in the world and all the three serotypes of Wild Polio Virus (WPV) were in circulation.
5. With regard to malaria, the Council noted that malaria remained a major public health priority in the country and that at the end of 2010, it represents a terminal period of launching rollback malaria initiative supported by WHO and other partners.

The above facts on the Nigerian health system clearly revealed enormous problems account for the yearning implementation gap in Health Care in Nigeria. The Federal Ministry of Health (2009) realizing the implementation gap was quick to point out that government and stakeholders must act urgently to close the implementation gap in Health Promotion and suggested the following:

1. Strengthening leadership and workforces.
2. Mainstream Health Promotion.
3. Empower communities and individuals.
4. Enhance participatory process.
5. Build and apply knowledge.

Be that as it may, the problems are still far from being solved. This is because the above suggestions are still either not implemented or poorly implemented as the gaps are still widening without any hope in the near future that it will finally be closed.

CONCLUSION AND RECOMMENDATIONS

In order to deliver the desired result, the Health Sector Reform Programme requires complete reorganization. Since the HSRP recognizes that the enactment of appropriate legislation with emphasis on the roles and obligations of the three tiers of government can clarify the relationship and structural design of the system, the health reform programmes should be reorganized to involve all state-holders. For instance, one of the HSRP strategic objectives is the strengthening of the Nigeria health system and its management, for this to be achieved, certain actions must be taken: actions to redefine the essential public health functions, roles and responsibilities of FMOH, its parastatals and other agencies; institutional design in response to roles and responsibilities; review of laws and setting up various national health institutions to align with the National Policy on Health and refurbishing tertiary health institutions and standardizing equipment. To achieve these reforms, the following recommendations of actions should be taken in order to improve the Health Sector Reform for better performance:

1. Reforming/restructuring of health services approaches through objective analyses of needs and opportunities, and aimed at improving health workers' capacities in order to strengthen the healthcare system in a sustainable manner
2. Enthronement and institutionalization of evidence-based healthcare activities at all levels
3. Regular evaluation and review of our health sector policies and practices, experience and innovations, within and between institutions, professions and professionals.
4. Better training and firm national policies that would manage our so-called brain drain, i.e. sincere and realistic strategies for dealing with migration of health staff to developed countries.
5. A broadly-based popular movement for the health sector, which crosses all sections of our society and which draws on our history, our mythology, our traditional values and the collective consciousness of our society.

6. Improvement in the funding of the Health Sector.
7. Review of the NHIS operational guidelines especially as it affects patient's access to health.
8. Upgrading of health care equipment, facilities and general infrastructure.
9. Enhancing and improving the Primary Health Care services.

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