RESEARCH PAPER

Enhancing Leadership and Governance Competencies to Strengthen Health Systems in Nigeria: Assessment of Organizational Human Resources Development

Accroissement des compétences en leadership et gouvernance pour renforcer les systèmes de santé au Nigeria : évaluation du développement organisationnel des ressources humaines

CHIGOZIE J. UNEKE, PHD
Lecturer/Director, Health Policy & Systems Research Project
Department of Medical Microbiology/Parasitology
Faculty of Clinical Medicine
Ebonyi State University
Abakaliki, Nigeria

ABEL E. EZEOHA, PHD
Lecturer/Researcher, Department of Banking and Finance
Faculty of Management Sciences
Ebonyi State University
Abakaliki, Nigeria

CHINWENDU D. NDUKWE, MBBS
Consultant Community Physician
Department of Community Medicine
Faculty of Clinical Medicine
Ebonyi State University
Abakaliki, Nigeria

PATRICK G. OYIBO, MBBS
Consultant Community Physician
Department of Community Medicine
Faculty of Clinical Medicine
Delta State University
Abraka, Nigeria

FRI DAY ONWE, MSC
Lecturer/Researcher, Department of Sociology/Anthropology
Faculty of Arts
Ebonyi State University
Abakaliki, Nigeria

Abstract

The lack of effective leadership and governance in the health sector has remained a major challenge in Nigeria and contributes to the failure of health systems and poor development of human resources. In this cross-sectional intervention study, leadership and governance competencies of policy makers were enhanced through a training workshop, and an assessment was conducted of organizational activities designed to promote evidence-informed leadership and governance to improve human resources for health (HRH). The training workshop increased the understanding of policy makers with regard to leadership and governance factors that ensure the functionality of health systems and improve human resources development, including policy guidance, intelligence and oversight, collaboration and coalition building, regulation, system design and accountability. Findings indicated that systems for human resources development exist in all participants' organizations, but the functionality of these systems was suboptimal. More systematic and standardized processes are required to improve competencies of leadership and governance for better human resources development in low-income settings.

Résumé

Le manque de leadership et de gouvernance efficaces dans le secteur de la santé demeure un défi de taille au Nigeria et contribue à l'échec des systèmes de santé et au faible développement des ressources humaines. Cette étude transversale sur le terrain s'est penchée sur le renforcement, grâce à un atelier de formation, des compétences de leadership et de gouvernance chez les responsables de politiques ainsi que sur l'évaluation des activités organisationnelles conçues pour favoriser le leadership et la gouvernance fondés sur les données probantes afin d'améliorer les ressources humaines en santé. L'atelier de formation a permis aux responsables de politiques de mieux comprendre les facteurs du leadership et de la gouvernance qui permettent d'assurer la fonctionnalité des systèmes de santé et d'améliorer le développement des ressources humaines, notamment l'orientation des politiques, le renseignement et la surveillance, la mise en place de collaborations et de coalitions, la réglementation, la conception des systèmes et l'obligation de rendre compte. Les résultats indiquent la présence de systèmes pour le développement des ressources humaines dans toutes les organisations des participants, mais leur fonctionnalité reste sous-optimale. Des processus plus systématiques et normalisés sont

nécessaires pour améliorer les compétences de leadership et de gouvernance afin d'assurer un meilleur développement des ressources humaines dans les établissements à faible revenu.

Leadership and governance of health systems, also called stewardship, has been described as the most complex but critical building block of any health system (WHO 2007; Vriesendorp et al. 2010). According to the World Health Organization, leadership and governance are associated with the role of the government in health and its relation to other actors whose activities have an impact on health; this involves overseeing and guiding the whole health system in order to protect the public interest (WHO 2007). Stewardship therefore goes beyond ministries of health playing a leadership role in the health sector (stewardship *in* health) to include focusing on responsibility and tasks for the strategic management of the health system (stewardship *of* health), as well as the intersectoral, socio-political environment within which the health system operates (stewardship *for* health) (WHO 2002).

The lack of effective leadership and governance (stewardship) in the health sector has remained a major challenge in most low- to middle-income countries (LMICs), including Nigeria, and this has contributed in no small measure to the failure of these countries' health systems. Nigeria's Federal Ministry of Health has observed that the lack of performance of the country's health system is attributable to the weakness in the leadership/stewardship role of government in health (FMOH 2004). The Federal Ministry of Health has identified up to eight constraints that impede the stewardship role of government in Nigeria's health sector: (a) poor definition of the roles and responsibilities of key actors; (b) lack of the requisite enabling management and stewardship tools, such as relevant policies, an operational health sector strategic development framework and so on; (c) the challenges of fostering intersectoral collaboration with other arms of government and the wider society; (d) poor dissemination and enforcement of health policy implementation; (e) absence of legal and constitutional backing for some major policy thrusts; (f) the fact that current policies do not include the definitive roles and responsibilities of the private sector; (g) the generally depressed state of evidence-based budget and plan management practices; and (h) inadequate funding of the health sector (FMOH 2004).

Because stewardship of the health system is principally a government responsibility, to discharge it requires an inclusive, well thought out policy vision that recognizes and assigns roles to all principal players, uses a realistic resource scenario and focuses on achieving systemic goals (WHO 2000). Among the most vital and indispensable principal players in the health system of any country are the health workers. Human resources for health (HRH) have been described as the cornerstone and drivers of health systems and must be adequate if the health millennium development goals are to be achieved (WHO 2000). The WHO has noted that overall, there is a strong positive correlation between health workforce density, service coverage, health systems performance and health outcomes (WHO 2007).

Through its National Health Workforce, Leadership and Stewardship Capacity initiative, the WHO supports member states to strengthen their leadership capacity in the process of developing, implementing, monitoring and evaluating HRH policies, plans, norms and standards (WHO 2009). This initiative is very timely in the case of Nigeria, as in other LMICs, because among other expectations, strong and effective leadership and governance actions are principally needed to manage dynamic labour markets that address entry into and exits from the health workforce, and to improve the distribution and performance of existing HRH in LMICs. Several reports have indicated that the leadership competencies to manage health systems effectively (including HRH) are essentially lacking among those charged with the responsibility – i.e., ministries of health in LMICs (Ovberedjo 2007; WHO 2002; Vriesendorp et al. 2010).

In LMICs, including Nigeria, there is a dire need for the development of leadership competencies in the health sector to enable the principal actors to manage and lead better so that teams, units and organizations can fully use and continuously develop their potential to transform human and financial resources and other inputs into improved services and, ultimately, improved health outcomes. This study therefore had two overriding objectives. The first was to strengthen the leadership and governance competencies of policy makers and stakeholders in the Nigerian health sector to improve both HRH and broader health system performance. The second was to assess organizational human resources development operations with the intent to provide scientific information that will promote evidence-informed leadership and governance activities in HRH.

Methods

The intervention strategy and evidentiary basis for its development

LEADERSHIP AND GOVERNANCE TRAINING WORKSHOP

A one-day leadership and governance training workshop was held in August 2010 in Abakaliki, the capital of Ebonyi State in southeastern Nigeria. The theme of the workshop was *Leadership, Governance and Management: Critical Competencies for Health Systems Strengthening*. The goals of the workshop were (a) to enhance the leadership and management capacity of the participants for strengthening the Nigerian health system and (b) to conduct a staff and organizational appraisal/performance assessment of HRH development as perceived by policy makers and other stakeholders.

Health policy makers and other major stakeholders in policy making were invited to the workshop. These included directors, project and program managers, and heads of departments in the State Ministry of Health. Others included hospital administrators, chief executive officers of civil society groups including non-governmental organizations, leaders of national health-based associations and health directors/managers in uniform services. In Nigeria, these individuals are described as the key actors in the health policy making process (Uneke et al. 2010; FMOH 2004). The invitation letters were sent to these individuals about two weeks prior to the date of the workshop.

The training workshop began with a 55-minute lecture delivered by a member of the study team. The content of the lecture included nine central themes: (a) leadership and governance factors that ensure functionality of the health systems, (b) impact of weak leadership and governance, (c) policy options and implementation strategies for addressing leadership and governance problems, (d) accountability of the key actors in the health system to the beneficiaries, (e) leading/managing to strengthen the health system, (f) leadership and management strategies to improve health outcomes, (g) promoting good governance in public and private health organizations, (h) dimensions of governance in the health sector and (i) issues pertaining to improved health system performance.

The lecture was followed by an interactive session with the participants and involved comments, contributions, discussions, questions and answers. The workshop lasted five hours.

STAFF AND ORGANIZATIONAL APPRAISAL AND PERFORMANCE ASSESSMENT QUESTIONNAIRE

Components of human resources development were assessed through a pre-tested, structured questionnaire that included human resources management capacity, human resources planning, personnel policy and practice, human resources data, and performance management and training. The questionnaire was designed to evaluate human resources management in terms of recruitment policies, performance assessments and staff appraisals. The questionnaire developed was based on the assessment tools described by Management Sciences for Health (MSH 2009a) and Huddart (2005).

Ethical considerations

This study was approved by the Senate Committee on Research (SCR) of Ebonyi State University in Abakaliki, Nigeria and by the Ebonyi State Ministry of Health in Abakaliki. Both approvals were granted on the basis that participation in the study would be voluntary following informed consent, that participants' anonymity would be maintained and that every finding would be treated with utmost confidentiality and only for the purpose of the study. These directives were strictly followed.

Data analysis

Basic analyses of the data collected via the questionnaires were conducted, including the methods of median, mean and range developed by Johnson and Lavis (2009).

Results

Up to 120 individuals who fulfilled the target participant inclusion criteria (i.e., health sector policy makers and stakeholders) were invited to the leadership training workshop. Of this number, 86 (72%) attended and participated in the workshop. The demographic/official designation attributes of the target participants are shown in Table 1.

TABLE 1. Demographic/official designation attributes of the participants of a leadership and governance training workshop in Ebonyi State, Nigeria

Participant Attributes	No. (%) of Participants
1. Gender	
Male	45 (57.7)
Female	33 (42.3)
Total	78
2. Age	
25–34	11 (14.1)
35–44	36 (46.2)
≥45	31 (39.7)
Total	78
3. Marital Status	
Single	13 (17.3)
Married	59 (78.7)
Separated/Divorced	3 (4.0)
Total	75
4. Type of Organization	
Ministry of Health	43 (53.8)
Non-governmental organization	8 (10.0)
Health-based association	21 (26.3)
Uniform services	8 (10.0)
Total	80
5. Official Designation	
Director/President/Chairman	18 (25.0)
Manager/Head of department/Superintendent	31 (43.1)
Program officer/Project secretary/Executive member	23 (31.9)
Total	72
6. Years of Experience in Current Designation (in years)	
<3	26 (33.3)
3–5	26 (33.3)
5–10	19 (24.4)
>10	7 (9.0)
Total	78
7. Level of Organization's Function	
Primary	33 (45.2)
Secondary	23 (31.5)
Tertiary	17 (23.3)
Total	73
8. Country Level of Operation	
Federal	7 (9.2)
State	39 (51.3)
Local government area	30 (39.5)
Total	76
9. Highest Academic Qualification	
Diploma	15 (19.2)
Bachelor	45 (57.7)
Master's	18 (23.1)
Doctorate	–
Total	78

Table 2 (*http://www.longwoods.com/content/22749*) summarizes the results of the staff and organizational appraisal/performance assessment questionnaire.

The assessment of components of *human resources management capacity* indicated that funds allocated for human resources budgets and staff in most of the organizations are very limited and that management staff have limited experience.

In terms of *human resources planning*, the findings indicated that most organizations have a mission and goals but these are not formally linked to planning. Furthermore, in organizations that have an annual human resources plan, most of the respondents indicated that the plan is not always based on the organizational goals.

With regard to *personnel policy and practice*, the mean ratings mostly ranged above the midpoint, while the median rating was mostly at 3 for the following components:

- job classification system;
- compensation and benefits system;
- recruitment, hiring, transfer and promotion;
- orientation program;
- policy manual;
- termination and grievance procedures;
- relationship with unions; and
- labour law compliance.

The median rating indicates that most of the organizations had a personnel policy and practice system, although the system's functionality may not be optimal. Most of the organizations also had a job classification system; a compensation/benefits system understood by all employees and used in a consistent manner; a recruitment, hiring, transfer and promotion system based on established criteria; formal procedures for termination and grievance based on performance standards; and a formal relationship with unions in which management addresses human resources issues.

The assessment of *human resources data* for such components as staffing and computerization shows low median and mean ratings, suggesting that most of the organizations collect employee data but have difficulty updating this information on a regular basis. The finding also indicates that computers are in place in most organizations but resources to develop data management systems are lacking. However, with respect to personnel files, higher mean and median ratings indicate that most of the organizations maintain current personnel files for all employees.

In terms of *performance management*, the mean rating of such components as job descriptions, staff supervision work, work planning and performance review were generally high, while the median rating was 3. This rating suggests that in most of the organizations all staff have job descriptions, there are established lines of authority and there is a formal system in which supervisors are required to develop work plans, yet in most cases the supervisor's role and function are poorly understood and thus little supervision actually takes place.

Staff *training* showed a marginally high mean rating while the median was 3, indicating that in most of the organizations training is linked to staff and organizational needs. However, in other areas, such as management/leadership development and links to external pre-service

training, mean ratings are marginally low with the median at 2. This implies that most of the organizations do not regularly develop management capacity and there is only a loose relationship with pre-service training institutions.

Discussion

In Nigeria, as in many LMICs, there is an increased desire and willingness among policy makers and major stakeholders in the health sector to improve skills and understanding of the strategies that can enhance the transparency, governance and efficiency of the health system (Uneke et al. 2010). The attendance rate of 72% at the training workshop in the present study clearly demonstrates the participants' willingness to engage in efforts designed to enhance their performance in the health sector. However, the view of capacity building has shifted from high-profile training opportunities for individuals to the development of institutional capacities (Milèn 2001). A number of previous reports have noted that improving policy makers' understanding of the topics covered in this study's training workshop will enhance their leadership and governance competencies in the running of efficient health systems (Vriesendorp et al. 2010; Islam 2007; WHO 2000, 2007).

Findings from this study clearly indicate that although most organizations have a human resources management system, the system's functionality is far from optimal. The majority of participants noted that funds for developing human resources within their organization were limited and also that current human resources management staff have limited experience. Furthermore, although organizations have a stated mission and goals, these are not formally linked to human resources planning. The low level of funding for HRH development identified by our participants could be a major factor in the dearth of experience among management staff and the lack of consistent programs to enhance management capacity. Other reports indicate that inadequate funding for human resources development is a common problem in the health sector of most LMICs, particularly in Africa and Asia (Adano 2006; Asante and Hall 2010). Adano (2006), for instance, has observed that ministries of health in sub-Saharan Africa tend to channel considerable resources into large national health programs for HIV/AIDS, tuberculosis, malaria and other health crises, but the equally alarming crisis in HRH lacks both the funds and the dedicated champions of the higher-profile issues.

Participants in this study noted that most of the organizations have a personnel policy and practice system (including job classification; compensation and benefits; recruitment, hiring, transfer and promotion; and formal procedures for termination/grievance and relationship with unions). However, they described these systems as limited in functionality and operating below optimal levels. This was also the case with employee data collection: participants acknowledged serious challenges in maintaining up-to-date data and lack of resources to enhance data management. Problems with functionality, data maintenance and inadequate resources have been reported in many other LMICs (MSH 2009b,c). It seems likely that the failure of health systems in LMICs, including Nigeria, may result from inadequate attention to HRH development by the leadership of the health sector.

In an exploratory study involving Ethiopia, Kenya, Tanzania and Uganda, significant gaps were found in the six major functions of HRH management, including personnel policy, performance management, training, data systems, strategy development, and general leadership and management (MSH 2009b). Interestingly, the participants in the present study observed that personnel files in most of their organizations are maintained and kept up to date, a finding borne out by other reports from African countries (O'Neil and Paydos 2008; QHP-MHGHS 2005; MSH 2009b). This finding was not unexpected because in most LMICs the process is done manually and therefore does not require highly technical expertise as in a computerized personnel filing system.

Findings from this study indicated that in most of the organizations, all personnel have job descriptions and there are established lines of authority, but supervision is poor and the role and function of supervisors are not well understood. Reporting on the implementation of South Africa's new community health worker policies, Lehmann and Matwa (2008) observed that almost no direct on-the-job supervision was taking place among community health workers and, consequently, accountability to superior officers was very limited. The multi-country African study cited above (MSH 2009b) noted that performance management in the health sector involves having appropriate job descriptions, a staff supervision system and a formal performance planning and appraisal process. That study reported that up to 70% of respondents acknowledged that staff supervision was poor and that they needed additional training to carry out these functions (MSH 2009b), highlighting the importance of training in HRH management.

Although most of the organizations in the present study linked their training to staff and organizational needs, unfortunately such training was not regularly done. This is a major challenge with HRH development in LMICs. Management Sciences for Health (2009b) reported that a considerable majority of the health managers surveyed in Ethiopia, Kenya, Tanzania and Uganda expressed the need for additional skills related to personnel policy, including HRH planning, more training to improve their capacity for using data systems and more training on HRH development strategies. These findings underscore the need for health organizations to routinely staff HRH professionals and take advantage of their guidance in human resources development and management. A more recent report indicates that without the guidance of a HRH professional, managers do not develop adequate management skills, a shortfall that can reduce their effectiveness (MSH 2009c).

Rowe and colleagues (2005) have suggested that HRH are effective only if the system in which they function is able to (a) educate sufficient numbers of adequately trained and appropriate health workers, (b) provide sufficient financing for their salaries, supplies and transportation, (c) effectively motivate them and manage their administrative, information, logistics and supply needs, (d) establish appropriate physical infrastructure and delivery models and (e) provide safe working conditions. According to the WHO (2007), in any country a "well-performing" health workforce is one that is available, competent, responsive and productive. The findings of this assessment have identified the areas of the HRH management systems to be strengthened in LMICs.

Conclusion

The outcomes of the staff and organizational appraisal and performance assessment conducted in this study suggest that HRH development operations in Nigeria are sub-optimal, as in other LMICs. The evidence from this study and the prevailing literature cited clearly indicate that effective leadership and governance mechanisms are an indispensable requirement for improved performance of the health systems and development of HRH in LMICs. The World Bank (2004) has advocated for the initiation of a new public sector leadership and management philosophy that calls for responsibilities to be delegated to local areas, with specific tasks and decision-making at the local level, a focus on performance (outputs and outcomes) and incentives for good performance.

Workshops similar to the one used in this study can be employed by LMICs to sensitize and strengthen the leadership competence of the health sector to manage HRH challenges effectively. Because the management of HRH is an organization's leadership and governance function involving the effective management of people to achieve health goals, it should be carried out in a systematic manner using established, standardized processes by dedicated staff trained in HRH management.

Good management policies, systems and leadership practices can be powerful agents of change. Only a leadership and governance structure with the requisite competency can achieve these goals in the health sector.

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Correspondence may be directed to: Dr. C.J. Uneke, Department of Medical Microbiology/ Parasitology, Faculty of Clinical Medicine, Ebonyi State University, PMB 053 Abakaliki, Nigeria; tel.: 234-08038928597; e-mail: unekecj@yahoo.com.

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RESEARCH PAPER

Enhancing Leadership and Governance Competencies to Strengthen Health Systems in Nigeria: Assessment of Organizational Human Resources Development

Accroissement des compétences en leadership et gouvernance pour renforcer les systèmes de santé au Nigeria : évaluation du développement organisationnel des ressources humaines

CHIGOZIE J. UNEKE ET AL.

TABLE 2. Staff and organizational appraisal/performance assessment of human resources development in the health sector in Ebonyi State, Nigeria

Human Resources Management Capacity				
HR Budget (N=68)**	***Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no budget.	There is limited money available to fund HR.	Budget is allocated for HR but is irregular.	Money for HR staff and related activities is a permanent budget item.
	Mean (2.2) Median (2) Range (1–4)			
HR Staff (N=78)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There are no staff for HR functions.	There are HRM staff but they have limited experience.	There are trained HRM staff but only at a level to maintain basic procedures.	There are experienced HRM staff who maintain HR functions.
	Mean (2.2) Median (2) Range (1–4)			
Human Resources Planning				
Organizational Mission & Goals (N=75)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No formal mission statement or organizational goals exist.	Mission/goals exist but are not formally linked to HR planning.	Mission/goals linked to annual HRD planning.	Mission/goals linked to annual HR planning.
	Mean (2.4) Median (2) Range (1–4)			
HR Planning (N=74)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No annual HR plan exists.	Annual HR plan exists, but is not based on organizational goals.	Annual HR plan exists based on organizational goals but not evaluated for effectiveness.	Annual HR plan based on organizational goals exists. It is implemented and evaluated.
	Mean (2.3) Median (2) Range (1–4)			

Personnel Policy and Practice				
Job Classification System (N=77)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No formal system exists to classify jobs.	There is some attempt to classify jobs, but it is uneven and incomplete.	A job classification system exists, but it is not used as a basis for other HRM functions.	A job classification system exists and is used in a formal manner for other HR planning.
	Mean (3.2) Median (3) Range (2–4)			
Compensation & Benefits System (N=74)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No formal system exists for determining the salary scale.	A formal system exists, but it is not used in a routine manner.	A formal system exists, is understood by all employees and is used in a consistent manner.	A formal system exists and is used consistently. It is also used to determine salary upgrades and merit awards.
	Mean (2.7) Median (3) Range (1–4)			
Recruitment, Hiring, Transfer & Promotion (N=73)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No formal process exists for recruiting, hiring, transfer and promotion.	There are systems for hiring, etc. but they are not followed.	There are formal systems, based on established criteria, but they are not used consistently.	There are formal systems, monitored and used in all hiring, transfer and promotion decisions.
	Mean (2.8) Median (3) Range (1–4)			
Orientation Program (N=72)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no formal orientation program for new employees.	There is a program, but it is not implemented on a regular basis.	Orientation is offered in a routine manner, but does not emphasize the mission, goals and performance standards.	Orientation is offered to all new employees and emphasizes the mission, goals and performance standards expected.
	Mean (2.3) Median (2) Range (1–4)			
Policy Manual (Organizational chart, work hours, policy, discipline, grievances, benefits, travel, etc.) (N=75)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No policy manual exists.	Policy manual does exist, but it is out of date.	A current policy manual does exist but it is not available to all employees.	An upgraded policy manual does exist and is available to all employees.
	Mean (2.6) Median (3) Range (1–4)			
Termination & Grievance Procedures (N=72)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No formal procedures exist.	Formal procedures exist, but are not related to performance standards.	Formal procedures based on performance standards exist, but are not followed in a consistent manner.	Formal procedures based on performance standards are known to all employees and are used consistently.
	Mean (2.9) Median (3) Range (1–4)			
Relationship with Unions (N=74)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no link between HRM, management and the union/s.	Links exist between HRM, management and union, but roles are not clear.	Management involves HR union issues, but on an irregular basis.	Management, HRM and the union work together to resolve issues and prevent problems.
	Mean (2.5) Median (3) Range (1–4)			

Labour Law Compliance (N=74)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no review of HR policies to ensure compliance with local and/or national labour law.	There is some effort to review labour law, but it is not done on a regular basis.	A review of the labour law is done regularly as a formal part of the HR function, but policy is not always adjusted to ensure compliance.	HR policy and practice are adjusted as needed to be in compliance with the local and/or national labour law.
	Mean (2.1) Median (2) Range (1–4)			
Human Resources Data				
Employee Data (Number, where deployed, skill level, gender, cadre, year of hire, etc.) (N=77)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	None of these data are collected on any kind of systematic basis.	Most of these data are collected, but not maintained or kept up to date.	All of these data are available and up to date, but data are not formally used in HR planning or forecasting.	All of this data are available and up to date. Systems are in place. Data are formally used in HR planning and forecasting.
	Mean (2.2) Median (2) Range (1–4)			
Computerization of Data (N=56)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There are no computers or data systems available.	There are computers in place, but no resources to develop systems for data management.	Computers and data management systems are available, but HR information is not produced regularly.	Computers and data management systems are in place and data files are up to date. HR information is regularly produced.
	Mean (2.4) Median (2) Range (1–4)			
Personnel Files (N=72)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No individual employee records exist.	Limited employee personnel files are maintained but not regularly updated.	Personnel files for all employees are maintained and kept up to date.	Updated personnel files for all employees exist, as well as policies for appropriate use.
	Mean (3.1) Median (3) Range (1–4)			
Performance Management				
Job Descriptions (N=75)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	No job descriptions are developed.	Some staff have job descriptions, but they are not always up to date.	All staff have job descriptions, but they are not all complete or up to date.	Complete job descriptions exist for every employee and are kept up to date.
	Mean (3.1) Median (3) Range (1–4)			
Staff Supervision (N=73)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no clear system of supervision.	Lines of authority are unclear.	There are established lines of authority, but the supervisor's role and function are not understood.	Supervisors understand their roles and lines of authority and meet regularly with their employees.
	Mean (3.0) Median (3) Range (1–4)			

Work Planning & Performance Review (N=76)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no work planning and performance review system in place.	A work planning and performance review system is in place, but it is informal.	There is a formal system and supervisors are required to develop work plans.	Supervisors and employees develop work plans jointly and performance reviews are conducted on a regular basis.
	Mean (2.8) Median (2) Range (1–4)			
Training				
Staff Training (N=79)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no staff training plan.	Training is offered on an ad hoc basis, but is not based on a formal process of assessing staff needs.	Training is a formal component of the organization and is linked to staff and organizational needs, but it is not available for all staff.	Training is a valued part of the organization and opportunities are developed for staff based on staff and organizational needs.
	Mean (2.6) Median (3) Range (1–4)			
Management & Leadership Development (N=77)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no policy regarding developing strong management capacity.	There is an emphasis on developing management capacity but it is not done on a regular basis.	The organization makes an effort to develop managers through training, but participation is selective.	A plan for management and leadership development is in place and there is an opportunity for everyone based on performance criteria.
	Mean (2.3) Median (2) Range (1–4)			
Links to External Pre-Service Training (N=80)	**Rating 1**	**Rating 2**	**Rating 3**	**Rating 4**
	There is no formal link with pre-service training institutions.	There is a loose relationship between the organization and pre-service training institutions.	The organization and pre-service training institutions work together to ensure curricula are based on skills.	The organization and pre-service training institutions also offer regular inservice training for staff.
	Mean (2.2) Median (2) Range (1–4)			

HR=human resources, HRM=human resources management, HRD=human resources development

* The values represent Likert rating of 1–4 points. In terms of analysis, mean and median values ranging from 1.00–2.49 points are considered low, whereas values ranging from 2.50–4.00 points are considered high.

** N=number of respondents