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Governance of Public Tertiary Healthcare Institutions in Nigeria

AO Malomo[1], K Aminu[2] and AS Jegede[3]

[1]Department of Neurological Surgery, University College Hospital, Ibadan and Department of Surgery, College of Medicine, University of Ibadan, Ibadan, Nigeria

[2-3] Department of Sociology, Faculty of the Social Sciences, University of Ibadan, Ibadan, Nigeria

Abstract

Introduction: Discourse of the problems plaguing healthcare delivery in Nigeria had failed to trace the root or address them in the context of actual medical practice. Usually, the focus is on the governance of the healthcare system in respect of the role of government and major stakeholders outside the hospital environment.

Approach: We explored the meaning of authority and governance and linked it with the organisation of public tertiary hospitals in Nigeria. Premised on the propositions of the Organisational Theory, the authors critiqued the system of authority and governance in Nigerian tertiary hospitals. We argued that as a colonial bequest, the system of governance of public tertiary hospitals in Nigeria is somewhat adulterated with the traditional pre-colonial form of authority. Likewise, the African culture and philosophy firmly held by the educated elite influence their leadership styles, thus contributing to the lack of accountability in healthcare institutions. Other factors responsible for the flaws in institutional governance were discussed and the way forward was proposed.

Conclusion: Certain leadership traits were identified and a model for effective governance of tertiary health institutions was further suggested, as the existing system of governance needs urgent redress.

Keywords: *Governance, Authority, Healthcare delivery, Tertiary Hospitals, Traditional, Nigeria.*

Abstrait

Introduction: Le discours sur les problèmes qui affligent la prestation des soins de santé au Nigéria n'avait pas réussi à en retracer la racine ou à les aborder dans le contexte de la pratique médicale réelle. Habituellement, l'accent est mis sur la gouvernance du système de santé en ce qui concerne le rôle du gouvernement et des principaux intervenants extérieurs au milieu hospitalier.

Approche: Nous avons exploré la signification de l'autorité et de la gouvernance et l'avons liée à l'organisation des hôpitaux tertiaires publics au Nigeria. Partant des propositions de la théorie organisationnelle, les auteurs ont critiqué le système d'autorité et de gouvernance dans les hôpitaux tertiaires nigérians. Nous avons fait valoir qu'en tant qu'héritage colonial, le système de gouvernance des hôpitaux tertiaires publics au Nigéria est quelque peu falsifié avec la forme d'autorité précoloniale traditionnelle. De même, la culture et la philosophie africaines fermement ancrées par l'élite éduquée influencent leurs styles de leadership, contribuant ainsi au manque de responsabilité des institutions de santé. D'autres facteurs responsables des failles de la gouvernance institutionnelle ont été discutés et la voie à suivre a été proposée.

Conclusion: Certains traits de leadership ont été identifiés et un modèle de gouvernance efficace des établissements de santé tertiaires a été suggéré, car le système de gouvernance existant doit être corrigé de toute urgence.

Correspondence: Prof. Malomo AO, Department of Neurological Surgery, University College Hospital, Ibadan and Department of Surgery, College of Medicine, University of Ibadan, Ibadan, Nigeria

Introduction

Healthcare is on the concurrent list of Nigeria's 1999 constitution and responsibility for its delivery is shared among the three tiers of government. This arrangement is responsible for the decentralisation of the health system [1], resulting in three levels of healthcare delivery – primary, secondary and tertiary. At the apex of health service provision are the tertiary/teaching hospitals. Tertiary hospitals are responsible for training medical professionals, conducting research and providing specialised medical care for the populace [2]. As bureaucratic organisations, public tertiary hospitals in Nigeria are not without flaws and are often criticised by the users [3]. Overall, the Nigerian healthcare system is rated low and grouped among the worst in the world [4]. From all indications, the country is yet to achieve the minimum required health standard and the degree of responsiveness to healthcare needs are rated poorly [5]. Some extant studies on the challenges within the Nigerian healthcare sector have revealed that poor management is a critical issue [6]; hence, healthcare governance or management has remained the focus of many scientific inquiries in recent years.

However, discussions of the problems plaguing healthcare delivery in Nigeria have failed to trace the root of these significant problems or address them in the context of actual medical practice. They often focus on the governance of the healthcare system, vis-à-vis the role of government and major stakeholders outside the hospital environment [7]. Because the system of governance often impacts institutional role performance and, in this case, the national health goals, it is necessary to shift attention to the complex human interaction occurring in tertiary hospitals in the country.

Bureaucrats, Authority and Healthcare Governance

In a complex organisation, governance and authority work in synchrony to develop and promote the system's goals. Governance requires that individuals holding a position of authority make the right decisions, perform their roles effectively and handle every situation professionally, despite the difficulties and imponderables they may encounter. Recent investigations of health sector governance reported poor-quality service and community-dissatisfaction as the major symptoms of both failed governance and leadership in healthcare delivery [8]. The leadership skills of bureaucrats are also strongly associated with the quality of care, utilisation of healthcare services and health outcomes. An empirical study in Nigeria equally identified some leadership gaps in a healthcare setting [9].

These snags are more perceptible in the sophistication of bureaucrats about governance matters and their utility of the position of authority. The sophistication of the decision-makers varies. While some are well-versed and skilled in governance, others are unskilled and can barely coordinate activities effectively or solve problems. These variations in the skills and knowledge of governance have considerable import on role performance, problem identification and problem-solving, hence, the profound connection between hospital governance and quality of care. This necessitates prioritising authority and governance of healthcare institutions in scientific inquiries in order to enhance good healthcare delivery.

Organisational Structure of Public Tertiary Hospitals

University teaching hospitals, federal medical centres, national orthopaedic hospitals, the National ENT Centre, National Eye Centre and psychiatric hospitals constitute the public tertiary hospitals in Nigeria. The structure of tertiary hospitals is complex and we must take into cognizance the peculiarity of the hospital environment where various groups- administrators, academics, and professionals converge. Each of these groups constitutes an organisation and has stable patterns of relationships (formal and informal). They are productively connected and work towards identical goals.

In teaching hospitals, the academics are members of the teaching staff and are attached to various academic units chaired by Heads of Department (HODs). The administrative division is characterised by hierarchy as seen in the general civil service with vertical ranks and lines of authority. The medical professionals have authority based on certified expertise, seniority and professional ethical differences, regardless of academic grade or civil service hierarchical locus. One of the unique features of tertiary hospitals is that an employee may belong to two or more groups simultaneously; another is the complexity of the lines of authority and decision-making. For instance, these hospitals are governed by, at least, four kinds of authority: the bureaucratic, the professional, the collegiate, as well as the traditional form of authority. These are briefly discussed next.

- The first is the bureaucratic or hierarchical authority, the civil service kind of authority (typical Weberian authority). It is a superior-subordinate kind of authority where ranks exist and an individual obeys the order of those above her/him without questioning. This authority is justified based on a position that presupposes experience, judgement and capability.

- The second is the professional form of authority, which is not based on hierarchical position or seniority as found in the civil service but is rather based on certified expertise and seniority. Here, the professionals who are specialised in an area of medicine would be deferred to by other professionals who are non-experts in that area or those in the same area but who are less experienced. This form of authority is justified based on expertise and deference. Professional authority is halfway between hierarchical and collegiate authority. Orders are obeyed here because life is at stake while authority is respected because the individual possesses superior insight, judgement and skill. Although the free questioning that exists in the university does exist among professionals, for practical purposes, the judgement of the most senior among the certified experts in a field is usually deferred to among doctors.
- The third is the collegiate authority. In a teaching hospital, the collegiate form of authority operates within the university system. The collegiate authority involves mutual respect and authority does not exist in précis; everything is questioned and must be justified unlike what obtains in hierarchical authority. Free questioning exists as superiors may be questioned based on the activities expected.
- The last is traditional authority which is based on respect for age and social status. Its inherent justification lies in culture and tradition. Traditional authority is obeyed without question, as would be expected in ages and settings where risks to life and limbs are high during regular daily activities.

The co-existence of these forms of authority may have implications for hospital governance and service delivery in departments and wards. That is, the convergence of these forms of authority within the tertiary hospital structure makes the social context of its operation quite complex. Studies have associated the complexity of the social organisation in tertiary hospitals with some of the challenges in healthcare delivery [10]. For example, the complexity may impair interpersonal relationships among healthcare professionals.

The existing system of healthcare service governance in Nigeria is best understood through the lens of the Organisational Theory. Indeed, the Open Systems Perspective of an organisation is perfectly suitable for the subsisting discourse in this article. According to this perspective, no organisation is insulated from the external influences of its social and cultural environments. It further notes that the interaction of subsystems and actors in any organisation is not mutually exclusive of the culture in the environment. Therefore, this theoretical orientation shall drive the appraisal of the governance of public tertiary healthcare institutions in Nigeria.

Appraisal of Authority and Governance in Nigeria Tertiary Hospitals

Positions of bureaucrats in tertiary hospitals are positions of influence and responsibility for decision-making. By implication, these positions are consequential, i.e., the decision-makers should be blamed for any bad outcome in governance and ultimately, service delivery. However, merely a small percentage of authors and stakeholders pay attention to the managerial problems in public hospitals because, when things fail in the society (especially government institutions), we presume that the government is responsible since it is responsible for ensuring quality healthcare delivery. Collectively, we readily blame the government without considering exceptions where bureaucrats in positions of authority should be blamed. Moreover, the unpredictability of human behaviour and the fact that the government will certainly not run health facilities directly justifies the inevitability of appraising the governance and authority of Nigeria's tertiary health facilities. Hence, some factors competing with institutional authority and ideal governance in Nigerian tertiary healthcare facilities are highlighted. These factors explain some of the inefficiencies and the poor utilisation of orthodox medicine in the country.

- African Culture
- Heterogeneity of Personnel
- Insider-outsider Threat
- A Pot-pourri of Traditional Leadership Style and Formal Authority
- Professional Authority and Unwritten Comradery
- Western Socialisation Tainted with African Ideology
- Faulty Professional Socialisation
- Changing Philosophy and Culture

African Culture: Culture determines human behaviour in all dimensions. African culture, in particular, glorifies leaders, who as either kings or priests or both or the equivalents of these, are regarded as representatives of the gods [11], as evident in popular cultural practices and traditions. The perception of leaders as agents or representatives of the gods entails a 'lord-subject' or sometimes 'master-slave' relationship. In comparison, authority in Western culture (since the French and other revolutions), from which scientific learnings and endeavours reach Africans, is different from that of

Africa thus, affecting the system of governance in our institutions [12]. Here, most employees in formal institutions are ignorant of the Western philosophy behind the institutional rules and systems of governance since they were inherited from a different culture. The rules operational in Western societies originated from their histories of revolutions and befit their acceptable interactions and are grounded in their philosophy, ecology and sociology. Unfortunately, Africans have retained and adopted (and translated) these rules (and not necessarily the attendant principles, theories, or philosophies) as well as our primordial customs and traditions [13]. Thus, the current governance systems and institutions are dissimilar to the colonial legacy.

For instance, the practical leadership model currently operational in most formal organisations is essentially a defective application of the divine leadership inherent in the authority of traditional rulers or kings. In African culture, it is believed that the position of authority is divine [11]. However this notion is misconceived and misinterpreted by leaders while the people are oblivion of their oppression and suppression. Translating this to the teaching hospital environment, each section of the hospital has lords; these lords transform into supreme lords who have emulated the misconception of the kings and colonial masters. The leader has an empire (unit/department) where he is 'god'. In the ensuing interaction, the traditional leadership culture breeds fear in the subordinates, thus contributing to the lack of accountability in our social institutions.

***Heterogeneity of Personnel*:** The tertiary hospitals, as a typical formal organisation, comprises individuals or workers with diverse social backgrounds, values, customs and traditions, since training, inductions and institutional influences have not fully transformed these into any singular modes. These differences among healthcare professionals may constitute problems to social interaction in tertiary hospitals and may also affect their perception of work and perception of others. Therefore, the heterogeneity of actors in tertiary health facilities impacts the responsiveness of health institutions, health system performance and, of course, the quality of care.

Insider-outsider Threat: Another factor that may affect institutional authority is what can be called 'societal myth'. By societal myth, we imply the myth which operates within every individual in the society. This can be likened to what obtains in the hypothetical 'state of nature' where, according to Hobbes, there is constant fear [14]. Based on this societal myth, every group in contemporary societies has two kinds of threat- *the internal threat* and *external threat.* Internal threat is that emanating from within the group while external threat comes from outside the group [15]. However, the threat which is emphasised in each society varies. In the Western world, the myth over-focuses on internal threat [everyone may use his power, like in the state of nature, where "life was solitary, poor, nasty, brutish and short…" [14], while they appear to take external threats for granted. Conversely, Africans are more concerned about external threats; they assume that the internal threat does not exist, forgetting that the real enemies may be within the group. Therefore, the 'non-us' are treated as less than us amongst us whereas 'our' post-colonial leaders are seemingly worshipped; authority and advantages are worshipped rather than being examined and check-mated ceaselessly.

In the context of a tertiary hospital, while there are several problems within the healthcare sector, the professionals may at one level, underestimate the problems created for others by their own group's behaviours and at another level, may inappropriately or disproportionately blame 'external' or 'extra-organisational' agencies for their problems. Since they are likely to underestimate internal threats, they often blame their problems mainly on the government (external threat), for instance. However, if they took the fear of internal threat seriously, every authority, advantage and power would be watched seriously and made to adopt accountable, open and inclusive modes of operation. This implies that people place substantial trust in leadership; they trust authority, power and advantages. So, what they tend to have in practice is usually an abusive lord-subject relationship which is inimical to development, because when you worship advantages, authority, power and privileges, those in leadership positions tend to act irresponsibly and unwittingly.

A Pot-pourri of Traditional Leadership Style and Formal Authority: In most formal organisations in Nigeria, what obtains is the combination of the traditional style of leadership and the bureaucratic or formal authority. The same is equally true in the governance of healthcare institutions. The two are oftentimes diluted in the hospital environment where, without special training, managers and administrators may not be aware of entering or crossing the boundaries of hierarchical, collegiate, professional (and traditional) leadership/authority. Administrators in public tertiary hospital settings may have inappropriate expectations or behaviours, or even make inappropriate or invalid pronouncements, and, in some cases, 'policies'.

Professional Authority and Unwritten Comradery: This is one of the factors which, when unrecognised and unaddressed, could be competing with healthy justified institutional authority in Nigeria. The hospital is a melting pot of professionals and each professional group or association is formed more to protect its members from external threats. Every profession has its ethos and ethics guiding the conduct of its members while the general principles and ethos of every medical and allied profession are understandably not identical. Similarly, the social organisation, including authority modes, within each profession differs from what obtains among other professional groups within the hospital and, if unappreciated and unaddressed, can depress the quality of healthcare services.

For instance, if members of a particular group are allegiant to the head of their group in the hospital due to this unwritten comradery, teamwork in their department or unit of deployment can develop fault-lines. Some personnel can rationalise the failure to comply with authority in their place of deployment by pleading professional guidance or regulation as the reason for non-compliance. Thus, it is safe to say that in several ways, inappropriate or abusive tapping into unwritten comradery can indeed act as an undetected or ignored source of dysfunction and disruption. This might conceivably contribute to the irritation, blame game, unhealthy rivalry, and power tussles that have been witnessed in Nigeria's health sector over time [16]. This often creates barriers within the hospital structure because the established lines of authority, communication and expected patterns of interaction may be disrupted and treated with disdain or hostility from the personnel.

A Bigger and More Fundamental Issue

Western Socialisation Tainted with African Ideology: As colonial legacies, Western education and Western medical practice are alien to Africa. Thus, there is no synchrony between Western education and African culture and philosophy which are firmly held by the educated elite. Unlike in an ideal formal organisation, the authority relationship in our tertiary hospitals, even in administrative functions, is a mixture of traditional and bureaucratic forms of authority. Hence, the interaction of actors within the system is influenced by external forces. This dissonance between the practice models and socialisation is because formal education is foreign and has never been authentically integrated into our traditional system nor has it been interrogated and well examined. It was almost like an impalement upon and not an embedment within the African psyche. What resulted from this imposition, according to Diop is:

> *...novel hybridized cultures in the form of African tradition and European modernity. This invariably led to the schizoid personality of the African: on the one hand modernizing but on the other hand culturally beholden to tradition. (Diop, 2012: 227)*

Formal education in Africa was not designed to produce intellectuals but to produce human functional elements for the colonial masters [17]: agencies, who can read, write and work but not necessarily think, discern, judge and determine. Hence, the potential effectiveness and the advantages of western education and medical practice in our society and culture are disparaged by the mixture of an ill-integrated Western value system with African philosophy. For instance, Africans believe that *juju* works but popular science contradicts this. So, Africans in the context of Western spheres of work have learned to live with a split soul. Similarly, personnel in formal organisations are influenced by extra-organisational factors. They ostensibly follow the formal administrative rules, whereas the extra-organisational factors, which are seemingly not fundamental to the work, affect official role performance. It cannot be overemphasised that this situation affects every institution, including the health sector.

Faulty Professional Socialisation: The scientific and professional training may be defective in the humanities just as technical, moral and cultural competencies can vary. Similarly, being a brilliant or highly qualified academic or professional does not translate to being a good administrator, manager or even leader. Furthermore, unlike in fully traditional or fully Western settings, professional and social maturity may not correspond; intellectual and emotional competencies can vary. The interpersonal relationship of a highly qualified individual might be infantile because the system of learning is not comprehensive in its content, methods, and evaluation. People may only accrue knowledge and technical skills without overall personal development. Being highly qualified in a core area, in these situations, does not equate to administrative capability and understanding of governance; the administrative skills may be primordial and infantile. Sadly, these discrepancies affect all other social and psychological realities which affect tertiary health institutions.

Changing Philosophy and Culture: At a time in first-generation tertiary hospitals in Nigeria, the philosophy of governance, the spring of institutional goals and national resources were linked then

leadership in various arms and levels of governance was linked. Although available expertise in our health institutions has since sky-rocketed, effectiveness and efficiency have, however reduced because of the gaps between the thinkers and controllers in society; core skills have outstripped emotional, intrapersonal, interpersonal, social, political and economic capabilities. The ability to tap into and influence policies and resources have equally waned. Unless leaders in various sectors are influential in overall governance through learning, competence, and influence, resource allocations will remain inappropriate and the sectors will be avoidably incapacitated through fund and influence shortages.

Moreover, the type of authority in healthcare institutions has not changed much compared to what was inherited from the colonialists, although the world that dictates other aspects of our national life has since moved on. Much of our orientations, philosophies, values and social ethics have lagged behind. In a global village and network, such gaps are likely to create frustrations, alarm and dysfunction. Such concerns need to be addressed in training new professionals and leaders in the sector.

The Way Forward

For effective governance of public tertiary healthcare institutions in Nigeria, prospective administrators must possess certain leadership qualities. They must be insightful, flexible; and their character must be self-transcending. For effective governance, prospective administrators must be people who want the total good, servants of the whole who are happy only when the whole is happy; in other words, people with the holistic-organic perspective required to treat the hospital like a human body.

The flexibility of the leader is quite important since the whole system is, flexible, anyone occupying leadership position must be open and accommodating, especially, since activities in tertiary healthcare institutions cut across professional borders. But this quality does not have to be exclusive to only those occupying the overall leadership position. The same applies to minimum supervisory positions among professionals in the health sector. Furthermore, before assuming office, prospective administrators should have special training in administration through which they can gain insight, conviction and persuasion. Through the training, they can equally acquire the ability to re-orientate themselves in terms of being critical and, simultaneously, accommodating. Once they have insight, their attitude, emotions and behaviour would be more productive, productive in the sense that they become self-transcendent, changing from who they are considered to be to what the whole system is becoming. They would then start seeking to enhance the image of the institution.

The model of governance we recommend is a form of rational authority, which is why the word 'insight' is very important here. The university collegiate system should be adapted to the extant system of governance of public tertiary hospitals without disrupting it, that is, flexibility should be allowed to make it accommodating and reflective. In this model, decisions should be made based on the best evidence and to enhance the ultimate good of the system. Hence, those in charge of hospital governance must have the quality of self-transcendence. This means they must embody the overall good and purpose while their goodness and badness become that of the system as a whole, because they donot hold office for themselves but for the whole institution. Therefore, they should be truthful and love the truth because these are the only elements that can make them efficient, flourishing and fulfilled in their position.

The administrators must dissolve themselves into the universal good of the institution and must be flexible and open to reasoning, for example, by seeking opinions from colleagues and subordinates so that decisions are made based on reasoning and evidence, and not personal wishes. The opportunity to question authority must also be provided while the system also fosters a climate of intellectual engagement. Moreover, running tertiary hospitals with just titular authority, without the necessary intellectual engagement, has failed us. So, if governance becomes flexible and evidence-based and is controlled by insightful leaders who are self-transcendent (irrespective of their profession), it would be the best for teaching hospitals. It is, therefore, noteworthy that effective governance of public tertiary hospitals could be achieved by any professional with the necessary skills, because running a hospital does not necessarily have to be by a medical doctor or any other health professional. As seen in other climes, managers who are not medical doctors have been trained and have successfully governed healthcare institutions.

Conclusion

The tertiary health care institution is a complex organisation. As a sector and as part of our larger society, it has various gaps in its governance as already discussed. As it is, the authority patterns, the institutional goals and individual interests are seemingly unsynchronised while the system is somewhat closed. However, if the identified gaps are gradually and formally addressed, the sector will get back its old glories. Fortunately, these gaps are not associated with science and technology. Rather, filling them will

first involve *being aware of them and then appropriating modern and post-modern gains from the Humanities*. The authors proposed a model that can be adopted in this environment while certain leadership traits for effective governance of health institutions were equally identified. With such qualities, all components of the institution and the society, in general, are expected to benefit, immensely.

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