

The Nigeria health sector and human resource challenges

C Uneke, A Ogonna, A Ezeoha, P Oyibo, F Onwe, B Ngwu, Innovative Health Research Group

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Abstract

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. 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 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 under served 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.

INTRODUCTION

With disability adjusted life expectancy (DALE) of 38.3 years and the rank of 187 in the World Health Report 2000, the performance of the Nigerian health system is worse than many sub-Saharan countries [1]. There is thus an urgent need to support the health system with adequately trained personnel in order to improve provision of the health services. The poor state of Nigeria's health system is traceable to several factors: organization, stewardship, financing and provision of health services [2]. These have been compounded by other socioeconomic and political factors in the environment. The overall availability, accessibility, quality and utilization of health services decreased significantly or stagnated in the past decade. The proportion of households residing within 10 kilometres 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 [1].

Demographic data are not very reliable in Nigeria. However, 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 [1,2]. 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, has 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, and making the most of their work opportunities.

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-March 2001, out of a total of about 2000 (legally) emigrating African nurses, a trend that is perceived by Nigeria's government as a threat to sustainable health care delivery in Africa's most populous country. About 20,000 health professionals are estimated to emigrate from Africa annually [3]. 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, hundreds of Nigerian-trained doctors continue to migrate annually [4]. For example, in a recent survey 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 midwives or senior community health extension workers (SCHEWs) [1].

Nigeria continues to export health-care professionals to the developed world. Many factors contribute to the brain drain in the 21st century. Some of these factors included the fact that the doctors are trained at a higher level than the facilities they were provided with could deal 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 go back to Nigeria and work [5]. In a recent paper on the brain drain in Nigeria, the World Health Organization outlined these reasons for migration and proposed some solutions, including maintaining minimum standards for local hospitals, increasing salaries, and making incentives for doctors showing willingness to work on underserved diseases [5].

HEALTH WORKER SITUATION IN NIGERIA

Among the many challenges facing the health system in Nigeria, is acute shortage of competent health care providers. 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 and lucrative positions [3,4]. In fact, some of these countries have established recruiting agencies and examination protocols targeting the best and brightest medical minds in Nigeria, prompting the government to require that these agencies register with the Federal Ministry of Health and operate within an established framework [3,6]. Nigeria is a major health-staff-exporting nation, accounting for 347 (recently revised upward to 432) out of a total of 2000 nurses that emigrated out of Africa between April 2000 and March 2001 [7]. This figure appears to be underreported as it fails to take into account the vast number of nurses who migrate abroad under different pretexts. The efflux has resulted to acute shortages in local health facilities and drastically impacted access.

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. While access to medical personnel is readily available in cities, rural dwellers often have to travel considerable distance in order to get treatment. Health workers in under served areas usually have motivational problems at work which may be reflected in a variety of circumstances, but common manifestations include: (i) lack of courtesy to patients; (ii) failure to turn up at work on time and high levels of absenteeism; (iii) poor process quality such as failure to conduct proper patient examinations, and (iv) failure to treat patients in a timely manner [7,8,9].

Doctors and nurses are reluctant to relocate to remote areas and forest locations that offer poor communications with the rest of the country and few amenities for health professionals and their families. Urban areas in Nigeria are more attractive to health care professionals for their comparative social, cultural and professional advantages. Large metropolitan centers in the country offer more opportunities for career and educational advancement, better employment prospects for health professionals and their family (i.e. spouse), easier access to private practice (an important factor in Nigeria because public salaries are relatively low) and lifestyle-related services and amenities, and better access to education opportunities for their children [9]. In addition, the low status often conferred to those working in rural and remote areas further contributes to health professionals' preference for settling in urban areas, where positions are perceived as more prestigious. This has significant consequences on the health of inhabitants of rural areas as unavailability of physicians and nurses within close proximity often leads to delaying and postponing visits to health care facilities until the condition becomes unbearable [9]. Transporting the patient on treacherous roads to urban facilities may take several hours and this may mean the life or death [7].

In Nigeria scarce data on the availability, distribution, and trends in human resources for health (HRH) has been a barrier to effective HRH planning. Nigeria has 13 doctors, 92 nurses/midwives, and 64 community health workers (CHWs) in the public sector per 100,000 population. However, an urban resident has access to 3 times more doctors and twice as many nurses/midwives, compared to a rural resident. Attrition rates are between 1.3% and 2.3%, and are highest among doctors and pharmacists. Rates for doctors and nurses are much higher at the primary level of care than at secondary/tertiary level. Attrition rate in rural

areas is 3 times higher for doctors and 2 times higher for nurses than in urban areas [9].

FACTORS DRIVING HUMAN RESOURCE CHALLENGES IN HEALTH SECTOR IN NIGERIA

The main factors driving this problem have been identified [4,5,7,9] and these include: (i). ?Insufficiently resourced and neglected health systems; (ii). ?Poor human resources planning and management practices and structures; (iii). ?Unsatisfactory working conditions characterized by: heavy workloads; lack of professional autonomy; poor supervision and support; long working hours; unsafe workplaces; inadequate career structures; poor remuneration/unfair pay; poor access to needed supplies, tools and information; and limited or no access to professional development opportunities; (iv). Internal and international migration of health workers.

The continual drain of health workers from Nigeria, combined with decades of harsh economic policies, has led to chronically under-funded health systems. Health workers are paid meager salaries (for instance the purchasing power of a Nigerian doctor is 25% lower than that of a doctor even in eastern Europe) and they work in insecure areas and have heavy workloads, but lack the most basic resources, including insufficient drugs or medical equipment; they have little chance of career advancement [9]. Doctors complain of 'brain waste', and seek better opportunities for professional development in countries with better medical infrastructure [4]. Furthermore, scores of Nigerian doctors currently overseas are willing to return to Nigeria provided appropriate employment opportunities are available. Unfortunately, not only are such opportunities very scarce, there is growing unemployment among registered doctors in Nigeria [4]. Furthermore, there is little enthusiasm by locally based senior medical staff to create openings for overseas-based doctors. Also, accreditation processes tend to be based on the principle of reciprocity, thus disadvantaging overseas-based doctors willing to return [10]. In Nigeria the main source of increase in health workforce comes from new graduates (83% of total new incoming staff); 60% of new graduate doctors but only 25% of new graduate nurses/midwives entered public sector; new graduate nurses accounted for only 1% increase in the number of public sector nurses [9].

WAY FORWARD

Adequate human resources for health (HRH) are a key requirement for reaching health goals. Quality data and

accurate projection of future HRH requirements are needed to inform the health policy planning process. In Nigeria, as in many countries in the region, scarce data on the availability, distribution, and trends in HRH has been a barrier to effective HRH planning [9]. Stilwell et al. [11] and Dovlo [12] have provided a succinct account of factors influencing migration of health workers from developing countries, and how to manage the complex issues. Some of the recommendations can be adopted to address the human resource challenges in the health sector in Nigeria. The types of interventions could include (i). Reforms in medical education which stipulates a special allocation of student admission quota to candidates from rural areas into State University Medical School and sitting of other Tertiary Institutions of Health Sciences in the rural areas; (ii). Provision of housing for health workers in under-served areas; (iii). In-service training and career development opportunities; (iv). Subsidy for school fees and transportation for in-service training; (v). Hardship pay for rural/underserved areas; (vi). Utilization of unemployed and retired health workers: – expanded hiring and contracting; (vii). Scaling up and adjusting skills mix of pre-service training; (viii). Rural recruitment and training; (ix). Use of community health workers and new cadre of health workers.

Since human resources for health is influenced by incentives, it can be seen as an interrelated system involving staff with a complex mix of skills and motivations. Hence it is obvious that effects of salaries and benefits aimed at one group of professionals will reverberate through the entire system. Therefore because policy makers need to know if specific incentives will reinforce health system goals or upset a delicate balance, this situation would create an excellent opportunity for findings to be used in making appropriate decisions [12]. Incentives are relevant to the issue of health worker mobility. A number of 'push' and 'pull' factors affect movements of health personnel. Available information indicates that financial incentive is an option to aid recruitment and retention in under serviced areas [13,14]. Multiple incentives to make working in unattractive areas more appealing have been proposed with variable success [15]. More generous benefits, such as health insurance and vacation time, are the most commonly used incentives. Other benefits may include tuition reimbursement, flexible work hours, bonuses based on experience or length of commitment, study and recreation leaves, employment opportunities for doctor's spouses, better accommodation facilities and improvements in educational institutions for doctor's children [15,16].

In conclusion, efforts to strengthen health worker motivation must protect, promote and build upon the professional ethos of medical doctors and nurses. This entails appreciating their professionalism and addressing health workers' professional goals such as recognition, career development and further qualification. It is important for the government to develop the work environment so that health workers are enabled to meet personal and organizational goals. This requires strengthening health workers' self-efficacy by offering training and supervision, but also by ensuring the availability of essential means, materials and supplies as well as equipment and the provision of adequate working conditions that enable them to carry out their work appropriately and effectively [17]. Governance and leadership in health must now be expressed as tangible actions that result in senior managers and policy-makers valuing and respecting health workers. New career and incentives systems must be developed, along with better social and technical support for health workers [12]. These recommendations would help to address the human resource challenges in the health sector in Nigeria and other developing countries of similar setting.

CORRESPONDENCE TO

CJ 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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Author Information

CJ Uneke, M.Sc.

Department of Medical Microbiology/Parasitology, Ebonyi State University

A. Ogbonna, M.Pharm.

Department of Pharmaceutical Sciences, Federal Medical Centre

A. Ezeoha, Ph.D.

Department of Banking and Finance, Ebonyi State University

PG Oyibo, MBBS

Dept of Community Health, Ebonyi State University Teaching Hospital

F. Onwe, M.Sc.

Department of Sociology/Anthropology, Ebonyi State University

BAF Ngwu, MBBS

Department of Medical Microbiology/Parasitology, Ebonyi State University

Innovative Health Research Group

College of Health Sciences, Ebonyi State University