

The current crisis in human resources for health in Africa

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Overview

The current crisis in human resources for health in Africa has reached a serious level in many countries. A complex set of reasons has contributed to this problem, some exogenous, such as the severe economic measures introduced by structural adjustment, which often result in cutbacks in the number of health workers while some endogenous reasons, including misdirected human resource and training policies, weak institutions, and inappropriate structures [1].

Dimensions of the human resource crisis:

The number of trained healthcare workers in Africa has always been inadequate, but in recent years, many countries have experienced serious shortages of almost all cadres due to economic and financial difficulties and incomplete civil service reform [1]. In general, the health personnel to population ratios in Africa have been low and have always lagged behind the rest of the world. The WHO World Health Report 2006 identified 57 countries facing a critical health workforce crisis. Each of these countries has less than 23 health workers (doctors, nurses, midwives) per 10 000 people – the minimum necessary to achieve an 80% coverage rate for deliveries by skilled birth attendants or for measles immunization [2]. Sub-Saharan Africa (SSA) faces the greatest challenges. It has 11% of the world's population and carries 25% of the global disease burden, and it has only 3% of the global health workforce and accounts for less than 1% of health expenditures worldwide [2]. The total workforce of doctors, nurses and midwives in African is estimated at 590,198 with an estimated shortage of 817,992 and required percentage increase of 139, which is highest compared to other parts of the world - see Table 1.

The provider-to-population ratios persistently remains high with most countries having one doctor per

10,000 or more of the population [3]. Many countries do not meet WHO's "Health for All" standard of one doctor per 5,000. Even those that do have enough doctors, geographic maldistribution is so severe that there may be a 1:500 ratio in the city (e.g. Nairobi) while remote Turkana District suffers from a 1:160,000 ratio [Support for Analysis and Research in Africa, SARA 2003].

The immediate causes of the crisis appear to be due to poor economic growth and successive fiscal difficulties. On the one hand, the ability of African governments to attract, retain, and maintain the morale of professional health workers is reduced by budgetary stringency, as treasuries are unable to upgrade salaries and working conditions, especially of skilled staff. On the other hand, because medical and nursing training in Africa is mostly government-provided or financed, governments' capacity to train health workers has also been severely limited due to fiscal crises. This dual pressure on the production and maintenance of health workers has created shortages in key cadres such as doctors, clinical officers, medical assistants, nurses, midwives, and laboratory technologists/technicians [1].

Even though the immediate determinant of the HR crisis

Table 1. Estimated critical shortages of doctors, nurses, and midwives by WHO region

WHO Region	Number of countries		How many <5 have marked fingers		
	In countries with shortages	With shortages	Total workforce	Estimated shortage	Percentage increase required
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
South-east Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,560	119
World	192	57	3,355,728	2,358,470	70

WHO April 2006. Available at www.who.int/nhr/2006/media_centre/WHR06_slides_en.pdf

is budgetary, the underlying causes can be traced to policies toward public-sector employment that African countries have adopted since independence. Generally, African governments stretched the size of the civil service faster than their economies grew. Employment growth has been favored over income growth in the public sector, driving down the real wages of civil servants. Consequently, the total number of health workforce in most African countries is actually quite large, but most of the workers are unskilled or lowly trained [1]. Additionally, trained health manpower tends to migrate to the developed countries where they can get better opportunities and earnings.

Production of health workforce has not kept pace with need, especially with the ever-increasing burden of disease brought about by HIV/AIDS and resurgent epidemics. Pre-service training of health workforce in many African countries is funded through their ministries of health. Insufficient funding for the training of medical, nursing, and allied professions results in both low numbers of graduates and poor quality of graduates. HIV/AIDS and resurgent epidemics have increased the burden of disease in Africa, relative to the rest of the world, thus raising the need to produce more trained health workers [1].

Many health workers are ill-motivated since they are inadequately paid, inadequately equipped, infrequently supervised and informed, and have limited career opportunities within the civil service, thus some search for better future both locally and abroad.

Many medical, technical, and managerial positions in health programs and facilities are now unoccupied and scarce medical personnel are often misused for management tasks [1].

Donor resources dedicated for training and HR development, though large, have been poorly coordinated and have not addressed the underlying cause of poor staff motivation [1].

Opportunities and risks to ease the human resource crisis:

Adopt a systems approach in establishing HR problems, improve the HR information base, and conduct a human resource inventory and planning exercise which, in themselves, can be instructive to MOHs [1].

To break the cycle of high standards–limited entrants–few workers, it is essential that workforce supply restrictions be properly adjusted through professional substitution,

redefinition of functions, reforms in the staffing standards, and refocusing of pre-service training [1].

To make performance scores really significant, adopt a decentralized responsibility of hiring and payment of staff, such that local managers should have the authority to employ, deploy, promote, discipline, and fire health staff [1].

Clarify the definition of staff responsibilities and performance, and keep them informed of changes and inspired.

Gradually shift towards results-oriented performance management. Inadequate performance of health staff should be corrected through appropriate training and coaching so that they could achieve their own individual results. And appropriate incentives and/or recognition or any other sort of motivation should be provided for excellence in performance.

Conclusion

Frontline health workers are essential to promoting sustainable community health systems and mobilizing for medical emergencies. Many individuals, families and communities are central in promoting health though they are neither paid nor specialized. In low-income communities, informal, traditional, and community health workers are essential, supplemented by associate professionals. They provide links to other cadres through referral systems, and they take the lead in health system innovation [4].

References

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