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Shortage in Health Workforce: Experiences of Primary Health Care Service Providers in Delta State
Recommendations for Improvement

About CPED Policy Brief

CPED Policy brief series is designed to draw attention of stakeholders to key findings and their implication as a research project is conducted. Actionable recommendations for policy influence and results utilization are also presented.

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Introduction

A major challenge facing the health care delivery system in Delta State as in other parts of Nigeria relates to the acute shortage of professional and competent healthcare providers. The prevalence of inadequate infrastructure for health care and poor compensation packages amongst other factors in the Nigerian health care system have led to the migration of a considerable number of physicians, nurses and other health professionals to other countries particularly developed countries during the last thirty years in search of fulfilling and lucrative positions. Of major importance is the fact that the health manpower that are still in the country are reluctant to relocate to remote rural areas, where communication facilities are poor and where amenities for health professionals and their families are lacking. Shortages in the health workforce are aggravated by the unequal distribution of health workers as a result of economic, social, professional and security factors all of which sustain a steady internal migration of health personnel from rural to urban areas, from the public to the private sector, and out of the health profession itself. Rural and remote employment is usually regarded as having a low status, while urban positions are perceived as more prestigious. Invariably, while access to health personnel may comparatively be readily available in the urban areas, rural inhabitants often have to travel considerable distances in order to obtain basic health services. The unavailability of physicians and nurses in rural areas often leads to a delay in seeking health care until symptoms

BACKGROUND

This policy brief is based on the findings of an on-going research on *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region"*. The project is funded by Canada's *International Development Research Centre (IDRC)*, Ottawa and the *West African Health Organization (WAHO)*. The general objective of the research programme is to contribute to a body of evidence on the strengthening of the health system in Nigeria that can influence the development, modification and implementation of policies on equitable access to health care with specific focus on the primary health care component.

The primary focus of this policy brief therefore is to outline some actions that should be taken to enhance the health workforce in primary health centres located in rural areas of Delta State for the attention of the Delta State government and other providers of primary health care in the state.

METHODOLOGY

Data was collected from all Primary Health Centres in nine Local Government Areas in Delta State using facility audit questionnaires, interviews with health service providers, Community health workers and community stakeholders in the communities where these PHC facilities were surveyed.

Focus group discussions and key informant interviews were held with various stakeholders on their assessment of PHC services in their respective communities.

become unbearable and the disease is advanced. The challenge of the poor distribution of workforce among health institutions located in urban and rural areas, especially in the context of primary health care centres calls for relevant and effective policies to train, recruit and retain personnel in rural areas based on the recent research evidence in Delta State. This policy brief proposes some actions that should be taken to enhance the health workforce in primary health centres located in rural areas of Delta State.

Key Findings on the Distribution of Health Workforce in Primary Health Care Facilities in Delta State and Health Personnel Challenges

The findings of the survey of primary health care facilities in Delta State show that:

- Female employees dominated the employment structure of the primary health centres as over 90 per cent of the primary health staff interviewed were females, except those located near urban centres where males were quite significant. It appeared women were pushed to rural primary health centres in the study areas.

- Only about nine per cent of the staff of the PHCs are medical doctors but most of these are in private primary health centres. Midwives and nurses were the largest category of primary health centres staff followed by auxiliary nurses and community health personnel.

- Less than 50 per cent of the staff in the primary health centres are professionally trained in basic primary health care delivery skills such as IMCI, Maternal and child health, life saving skills, adolescent sexual and reproductive health, HIV/AIDS opportunistic infection treatment, PMTCT of HIV, Family Planning and STI diagnosis and treatment.

- Less than 50 per cent of the primary health care staff were ever involved in outreach primary health care services such as home visitation and follow up, immunization, home service and mobilization of community people. Nearly all staff interviewed reported that they needed assistance with transportation to better visit households and to facilitate the travel of the sick to secondary health facilities during referral.

- Health staff and student nurses during the interviews and focus group discussions indicated that they know that the rural settings in the target LGA are characterized by poor infrastructure, poor health services, limited variety of available housing and few quality educational institutions for their children. When asked whether they had the desire to work in PHCs located in rural communities, they expressed fear of living in communities characterized by lack of basic facilities. According to them rural settings are resource constrained in terms of personnel and equipment. This results in dissatisfaction among nurses due to the unbearable working conditions which result in stress and frustration. It was revealed during the discussions that nurses working in primary health-care settings in the target LGAs were experiencing emotional and physical strain as a result of the shortage of human resources. Furthermore, participating health staff expressed the view that poor communication channels in rural areas limited the flow of information on training opportunities such as workshops and seminars. In addition, they revealed that staff shortages denied them the opportunity to pursue their studies because a replacement was not always available. One of the participants stated as follows:

"...when you stay in rural communities as a health worker, you might end up missing some of the privileges that people in urban areas do enjoy. For example there could be seminars and refresher programmes for staff in your category and while your colleagues in the urban areas are able to attend one may not be aware and furthermore the pressure of work may prevent you from going even if one is aware..."

- The focus group discussion participants and the respondents of key informant interviews pointed out that the health workers in PHCs in rural areas are experiencing major difficulties in the delivery of their services due to serious shortages of personnel. They pointed out that in some PHCs health care is managed on a daily basis by a single qualified professional nurse. This contributes to excessively heavy workloads and the poor performance of such

staff, which tend to tarnish their reputation in the eyes of the stakeholders in the communities. A key informant participant who is a PHC staff noted that:

"We are terribly understaffed, we work very hard, and most of the time one is totally exhausted. When one nurse is on maternity leave or sick leave, there is no replacement we have to cover her part of the work. This is tough. "

- The participants who are PHC staff pointed out that they had to cope with infrastructural constraints, including lack of basic necessities such as accommodation, communication systems, water and electricity. They reported that some of them do feel frustrated about the shortage of water which they consider basic and should be made available in the PHCs so that they can effectively deliver their services to the community members. They emphasized that it was difficult to perform any task without electricity and that health services came to a standstill without light. Some of the participating PHC staff reported that maternity cases were sometimes attended to using candlelight and that could hamper the delivery of quality care. To cut and suture episiotomies using candlelight may lead to complications that could be harmful to patients. One of the participants stated as follows:

"…….As I am talking right now we have not had water for the past three weeks; patients assist by bringing water with small buckets. Families are expected to bring water along when they bring a woman in labour. The problem has not been attended to despite repeated requests. The toilets are a big health hazard when we are without water. In this situation how are we be expected to teach the community about a safe water supply and usage"?

Another stated …
"We stay three to four days without water in the clinic, yet we are supposed to wash hands between patient examinations."

Some of the focus group participants also mentioned the inadequate supplies of drugs as a constraint to caring for clients. According to them, the supply of drugs did not cover the number of clients most PHC facilities. The supplies tend to be exhausted before the next order was due. This situation puts further pressure on health staff who are viewed by stakeholders and users as not providing adequate care to them.

Policy Recommendations

While production of health workers has greatly expanded in recent years, this has not led to any improvement in the availability of health personnel in rural primary health centres in Delta State. The problems of imbalances in the distribution of these health personnel persist, with certain local government areas in the state remaining at a disadvantage. There is an urgent need to adopt sustained and innovative actions to address the state's current health-workforce problems in primary health centres located in rural communities of the state. Some actionable proposals are presented in the following section:

- Improve the retention and distribution of the health workforce in rural PHCs by improving working conditions and financial (and non-financial) incentives, such as free days, study or maternity leave and better social dialogue.
- Develop and strengthen rural health service coverage by equipping the semi-skilled health workforce to maintain rural health centres.
- Formulation of hardship or rural posting pay policy for health workers in rural/underserved areas;
- Train and increase the use of lay community health workers.
- Development of an overtime policy for their health-care workers. This would supplement the professional nurses' salaries and assist with filling the gap in available human resources.

Conclusion

Achieving community participation in health service delivery in resource-limited but a high disease burden setting as it is in the rural areas of Delta State is not a simple task. In many parts of the rural areas of the state the perception of the general population is often that of a grossly inefficient formal health sector that has simply failed to deliver. Additionally, community members may seek remuneration for participation in health service delivery, a stance that is not often sustainable in poorly resourced rural communities as it is in Delta State. Furthermore, health service personnel may not be willing to involve laypersons in the execution of health programmes, an act that they may view as a dilution of their own expertise. The onus is on health planners to devise appropriate and context-specific ways in which to achieve sustainability by keeping lay people motivated in community participation in health programmes while at the same time keeping in mind the limitations of cost-containment. The rationale for proposing participatory community-based interventions in Delta State is based on the fact that many maternal and neonatal deaths occur at home, and could potentially be avoided by changes in antenatal and newborn care practice and better understanding of health problems.

ABOUT CPED

The *Centre for Population and Environmental Development (CPED) is* an independent, non-partisan, non-profit and non-governmental organization dedicated to promoting sustainable development and reducing poverty and inequality through policy oriented research and active engagement on development issues. CPED started as an action research group based in the University of Benin, Benin City, Nigeria in 1985. The action research group was concerned with applied research on sustainable development and poverty reduction challenges facing Nigeria. The research group also believed that communication, outreach and intervention programs, which can demonstrate the relevance and effectiveness of research findings and recommendations for policy and poverty reduction, especially at the grassroots level, must be key components of its action research. In order to translate its activities more widely, the Benin Social Science Research Group was transformed into an independent research and action Centre in 1998. It was formally registered in Nigeria as such by the *Corporate Affairs Commission* in 1999.

The establishment of CPED was influenced by three major developments. In the first place, the economic crisis of the 1980s that affected African countries including Nigeria led to poor funding of higher education, the emigration of academics to advanced countries which affected negatively, the quality of research on national development issues emanating from the universities which are the main institutions with the structures and capacity to carry out research and promote discourse on socio-economic development. Secondly, the critical linkage between an independent research or think tank organisation and an outreach program that translates the findings into policy and at the same time test the applicability and effectiveness of the recommendations emanating from research findings has been lacking. Finally, an independent institution that is focusing on a holistic approach to sustainable development and poverty reduction in terms of research, communications and outreach activities is needed in Nigeria. CPED recognises that the core functions of new knowledge creation (research) and the application of knowledge for development (communication and outreach) are key challenges facing sustainable development and poverty reduction in Nigeria where little attention has been paid to the use of knowledge generated in academic institutions. Thus, CPED was created as a way of widening national and regional policy and development debate, provide learning and research opportunities and give visibility to action programmes relating to sustainable development and poverty reduction in different parts of Nigeria and beyond.

The vision is to be a key non-state actor in the promotion of grassroots development in the areas of population and environment in Africa. **The overall mission** is to promote action-based research programs, carry out communication to policy makers and undertake outreach/intervention programmes on population and environmental development in Africa

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