POLICY *Brief*

CPED *Policy Brief Series No. 2, 2014*

Enhancing the Distribution *and* Performance of Primary Health Care Work Force In Nigeria: *The Case of Delta State*

POLICY BRIEF PAPER BY CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT, CPED

This Policy Brief is supported by the T***hink Tank Initiative Programme initiated*** and managed by the ***International Development and Research Centre (IDRC)***

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Centre for Population and Environmental Development, CPED

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© Centre for Population and Environmental Development (CPED)
BS-1 and SM-2 Ugbowo Shopping Complex,
Ugbowo Housing Estate
P.O. Box 10085, Ugbowo Post Office
Benin City, Nigeria
Website: www.cpedng.org | E-mail: agonoks@yahoo.com
Tel: 07055195964, 08080472801

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First produced in 2014

Series Editor:

Professor Andrew G. Onokerhoraye
Executive Director, CPED, Benin City

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PREFACE

This policy brief is the first in the series of communication to policy and decision makers on the on-going research project of the *Centre for Population and Environmental Development (CPED)* titled *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region" funded by IDRC and WAHO.*

The policy brief series is designed to draw attention to key findings and their policy implications as the project is being executed. This edition which focuses on health manpower challenges is based mainly on the outcome of the qualitative survey in which key stakeholders participated in the research process through key informant interviews and focus group discussions.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy paper. We also appreciate the corporation of the Delta State Government and other stakeholders within and outside Delta State in collaborating with CPED in the execution of the on-going research project so far.

Andrew G. Onokerhoraye
Editor

BACKGROUND

The importance of health workforce to the effective functioning of health care systems is widely recognized in health care planning and provision. Shortages of health workers constitute a significant barrier to achieving health-related Millennium Development Goals (MDGs) and expanding health interventions in remote rural communities in a country such as Nigeria. Although some components of the MDGs were formulated to promote basic health care delivery, there are some clear limitations in the MDG framework which obviously impact on the realization of MDGs. The targets and indicators set for the health components of the MDGs focus mainly on increasing the coverage of certain priority health services and on improving health outcomes, but did not pay adequate attention to the health system actions required to attain the specified objectives. Of major importance is the fact the importance of the health workforce in the achievement of the various objectives of the MDGs was underplayed. Human resources in health system are defined as the stock of all individuals engaged in promotion, protection or improvement of the health of the population. Also referred to as health work-force, they cater to both private and public sectors of the health delivery system in addition to dealing with disease prevention, health promotion, public health interventions, management and support services.

A major challenge facing the Nigerian health system 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. In fact it has been stated that the vast proportion of Nigeria's

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health manpower production in her various educational institutions during the last thirty years have migrated to other countries. 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 that all 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.

The inequitable spatial distribution of healthcare workforce in Nigeria is compounded by a concentration of key health professionals in urban areas. 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 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 research evidence in different parts of Nigeria. Such evidence based policies should emanate from action and participatory research in which key stakeholders in the primary health care system participate in the analysis of the problem and the articulation of relevant remedies and policies.

This policy brief is based on the findings of an on-going research

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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 and modification and implementation of policies on equitable access to health care with specific focus on the primary health care component. This policy brief presents the findings of the qualitative surveys of primary health centres and the localities in which they are located across nine target Local Government Areas (LGAs) in Delta State entailing key informant interviews and focus group discussions with key stakeholders and groups. This policy brief is therefore based on the views of the stakeholders and the actions and policy recommendations they suggested to improve health workforce in primary health care centres in different parts of Delta State. The final reports of the project will integrate all the recommended actions and policies.

Ethical Considerations

Approval and permission to conduct the study was granted by the Delta State Government of Nigeria through the State Ministry of Health Research. The research protocol entailing the research methodology and the survey instruments were approved by the Delta State Ministry of Health's Ethical Review Committee. For each participant interviewed, informed consent was obtained. Similarly focus group discussion participants also gave their consent before being asked to participate in the discussions. The project research team informed the participants regarding the purpose, methods and procedure of the study. The participants made an informed choice to take part in the study, and did so freely and voluntarily. They were asked to sign or thumb print on a form to indicate that they had

given their informed consent to be interviewed or participate in any discussion and were informed that they could refuse to answer any question or discontinue their participation at any time. The privacy of the participants was respected throughout the surveys and all information collected has been kept strictly confidential. The participants' anonymity was ensured by substituting their names with numbers or codes. Participants were treated fairly and any unclear information was clarified for them during the study.

Methodology

A qualitative, descriptive and exploratory research design was used to examine a variety of issues relating to primary health care delivery and utilization in the sampled target local government areas including the health workforce situation. The population of the qualitative survey comprised health professionals of various categories working in primary health centres, student nurses in nursing schools, community leaders in localities where primary health centres are located, users of primary health services, women, especially those of child bearing age. The respondents and participants were selected randomly from the communities and from the staff of the primary health centres located in them. The participants selected from the primary health centres included nurses, midwives who had worked in the primary health-care setting for more than one year. Key informant interviews entailed collecting data by means of unstructured questionnaires which lasted between 60 and 120 minutes each, using the direct contact approach. The unstructured interviews were carried out more like normal conversation, but with a purpose. During the interviews probing questions were asked in order to elicit more information from the participants and show participants that the researcher was interested in their experiences. The interviews were recorded by means of a tape recorder to prevent loss of data, and transcripts were made of the recordings. The researcher team made appointments with the

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participants and interviewed them while they were off duty at the clinics where they worked, or at their homes. Focus Group Discussions (FGDs) with randomly selected community leaders and other stakeholders including primary health staff were conducted in the nine target local government areas. The discussions with respect to health workforce covered health staff experiences, attitudes towards working in rural areas and suggestions about potential interventions to improve health worker distribution in primary health centres. Discussions lasted between one and two hours, and were digitally recorded, supplemented by note taking.

FGD recordings and field notes were reviewed for clarity, transcribed, uploaded into the qualitative analysis software and subjected to content analysis. This involved development of a coding "tree" or thematic framework. A draft coding tree was developed from the FGD topic guide and refined using themes emerging from transcripts. Information under each code was then compiled and tabulated to obtain a clearer picture of the issues arising from the data, and to compare views across different groups of participants.

Views represented in the findings as presented in this policy brief are from a small randomly selected sample of key stakeholder, health workers and users of primary health services. This may limit the generalization of study findings as expected in qualitative research methodology. Despite this limitation, the sample was selected scientifically hence they can be viewed as representing the true population of primary care health workers and the users of their services in Delta State.

Findings of the Qualitative Survey

In terms of personnel key informant respondents and participants in focus group discussions agreed that most PHC services in the target LGAs are staffed mainly by community health workers and

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nurses/midwives. They pointed out that there are remarkable differences between public and private providers in their LGAs in that private providers are generally better staffed by nurses, midwives, and doctors compared with public PHCs. Thus private primary health centres are better staffed than those owned by the public sector. The outcome of the discussions during focus group meetings and during key informant interviews indicate that participants on the demand and supply side agreed that there is persistent health personnel shortage in primary health centres in the target local government areas, especially in those established by the various levels of government. There was also agreement among the participants that PHCs located in urban centres are better staffed than those in rural areas and that this applies to PHCs owned by private and public agencies. Participants noted that a typical PHC in the urban area do have as many as thrice that staff in the PHC located in rural areas. In addition PHC in urban centres have a full complement of staff of various professional background including nurses, doctors and pharmacists compared with those in rural communities which do not regularly have the services of doctors. It against this background of inadequate staff in PHCs located in rural areas that participants presented their views on the various challenges facing health workforce in PHCs in the target LGAs. These views are presented as follows.

Perception of Rural Life in the Target LGAs: Participants in the qualitative surveys view rural areas to be those which are generally remote and characterized by poor infrastructure (bad roads, limited transport services, no electricity, poor mobile phone network, and low water supply), poor health services, limited variety of available housing and hardly any recreational facilities. They pointed out that government policies and programmes over the years in Nigeria have not paid adequate attention to the challenges facing rural communities. The participants pointed out that inhabitants of rural communities are generally disadvantaged in

the development programmes of the country and this explains the absence of basic social and infrastructure services. This perception and the reality of rural life in the target LGAs have implications for the posting and retention of health workforce in PHCs located in such areas. On the other hand, urban areas are perceived by the key informant respondents and focus group participants to be more accessible with stronger infrastructure, better health services and educational institutions, and a variety of recreational facilities. Some of the health staff, who are married, commented that they often get separated from their children when they are posted to rural communities, as their children are schooling in urban areas away from them because rural schools are generally of substandard quality both in terms of quality teachers and teaching facilities. One of the focus group participants stated as follows:

"...you know our country, Nigeria, how things are despite over fifty years of independence and the implementation of various development plans, infrastructure is still bad, if you take me to a remote area, there is no accessibility, there is no infrastructure, and there are no roads, it rains one is stranded in this community because of bad roads. This makes it difficult for me to rush to see my family in the urban area in case of emergency. How can I be happy working here? ...."

Desire to Work in PHCs in Rural Communities: 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 have 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..."*

Challenges of Working in PHCs in Rural Communities: 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 have to cope with infrastructural constraints, including lack of basic necessities such as accommodation, communication

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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.

Emotional Pressure of Health Workforce in PHCs in Rural Communities: Key informant respondents and focus group participants, especially PHC staff, expressed emotions such as anger, sadness, fear and suffering. They also indicated that in certain instances they felt frustrated and hopeless. They said that working 24-hour shifts was strenuous, especially because patients do not understand the

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situation under which they work. They pointed out that lack of time due to inadequate staffing precludes quality patient care. Most of the focus group participants including community-based stakeholders and users of PHC services agreed that lack of rural human resources can impose an additional burden on nurses, thus contributing to anger, sadness, suffering and frustration, which lead to high staff turnover. Due to the shortage of staff nurses, they sacrificed and worked long hours, which contributed to fatigue, stress and burnout.

A lack of adequate staffing and organisational resources is obviously one of the most common characteristics of nurses working in PHCs located in rural areas. Some participants added that patients expect the best treatment, no matter what the staffing situation is. In some primary health-care facilities the number of professional nurses employed remained the same despite the increase in the use of their services. One participant who is a health worker noted as follows:

"......the shortage of staff is our greatest challenge, a challenge that required us to use all our knowledge and various skills. At rural primary health-care facilities, the few staff managed large numbers of patients every day. We have to assess, plan, implement and evaluate treatments, as well as conduct home visits..."

Welfare Challenge Facing Health Workforce in PHCs in Rural Communities: The major issue that emerged from this theme was the separation of health staff in rural PHCs from their families. Participants who rendered services in rural PHCs were concerned that they could not be with their children. Participants felt that their children needed their mothers' guidance, as well as assistance with school work and other reassurance. Without their mothers' presence, children's progress at school often declined as their father may not have the required time to assist the children in their homework. Participants pointed out that health workers in rural PHCs would be encouraged to remain in rural areas, if managerial structures recognised that they

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had roles and responsibilities, such as child care and housework, apart from their waged work. They emphasized that flexible scheduling not only meets patients' needs, but also attracts health staff who cannot work traditional nursing shifts. They noted that separation from families for long periods of time could negatively affect nurses' marriages and their relationships with their children. The kinds of feelings expressed by the participants were often suppressed as a result of the culture of the work environment. Professional nurses had to be responsible and display an accurate image of the profession and the life of the patient had to be their first consideration. Yet there are fundamental dissatisfactions with the condition under which health workers work in rural areas and could seize any opportunity available to abandon rural localities for urban centres.

Participants' Recommendations for the Attention of Policy Makers and other Stakeholders

In the context of this participatory action research, the participants in the focus group discussions and key informant interviews were asked to suggest ways in which the prevailing health workforce situation of PHCs can be improved for the attention of key stakeholders and policy makers in Delta State and at the national level. A synthesis of the recommendations proposed by the participants and respondents is as follows:

- Efforts must be undertaken in Delta State in particular and other parts of Nigeria in general to limit the impact of the health worker shortage on its health system by giving considerable attention to the recruitment of staff for PHCs, especially those located in rural areas.
- Presently low health staff production, particularly of nurses, has to be substantially accelerated to catch up with growing demands and attrition.
- 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.

- Improve the performance and productivity of existing staff by increasing opportunities for life-long training and improving career development prospects.
- Develop and strengthen rural health service coverage by equipping the semi-skilled health workforce to maintain rural health centres.
- The government needs to invest not only in its health workers but in its facilities, by ensuring regular medical supplies, upgrading facilities and improving working conditions in rural and poorer areas.
- Provision of housing for health workers in under-served areas;
- In-service training and career development opportunities for health workers;
- Formulation of hardship pay policy for health workers in rural/underserved areas;
- Articulation of a programme on the utilization of unemployed and retired health workers through expanded hiring and contracting;
- Increased use of new cadre of 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.
- A rural housing programme should be put in place so that rural houses should be built in target communities in order to accommodate professional nurses with families.
- A solar system should be installed at all facilities to

- supplement the electricity supply during power cuts.

Conclusion

Availability of health workforce in PHCs located in rural areas, especially remote communities is dependent on the effective policies and interventions that influence the decision of health workers to stay or leave those areas. In the context of the situation in Delta State and indeed other parts of Nigeria, appropriate recruitment and retention strategies, sound policy support, adequate fund allocation, staff motivation, creating job satisfaction, better infrastructural support and efficient supervision and monitoring could reduce health workforce imbalances. To deliver available, accessible, affordable, equitable integrated preventive promotive and curative health services, the health workforce needs to be adequately trained and motivated. These are the recommendations made by the stakeholders as outlined above and should be taken into consideration by policy makers.

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