NEEDS ASSESSMENT OF THE NIGERIAN HEALTH SECTOR

by

INTERNATIONAL ORGANIZATION FOR MIGRATION, ABUJA, NIGERIA

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<tr>
<td>FGN</td>
<td>Federal Government of Nigeria</td>
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<td>FMLP</td>
<td>Federal Ministry of Labour and Productivity of Nigeria</td>
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<td>GON</td>
<td>Government of Nigeria</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>International Labour Organization</td>
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<td>International Organization for Migration</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MDCN</td>
<td>Medical and Dental Council of Nigeria</td>
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<td>NNVS</td>
<td>Nigerian National Volunteer Service</td>
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<td>NEEDS</td>
<td>National Economic Empowerment and Development Strategy</td>
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<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NNVS</td>
<td>Nigeria National Volunteer Service</td>
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<td>NPopC</td>
<td>Nigerian Population Commission</td>
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<tr>
<td>NUC</td>
<td>National Universities Commission</td>
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<td>O.A.U.</td>
<td>Obafemi Awolowo University</td>
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Executive Summary

The current needs assessment was aimed at identifying the skills gap in Nigeria’s health sector. The outcome of this process is to provide government with the necessary information on the existing skills gaps in order to support Nigeria National Volunteer Service (NNVS) to develop their outreach capacity to identify the Nigerians who are willing to contribute their competencies and skills towards national development in health. The process of encouraging skills and knowledge flow from the diaspora to the country of origin for national development, otherwise called brain gain, is in recognition of the presence of relevant skills and competencies in the diaspora that could be harnessed for national development alongside remittances sent by her nationals.

The needs assessment research design employed a mixed method of data collection consisting of a comprehensive desk review of relevant health statistics, published and unpublished documentation and in-depth interviews with senior management of tertiary health institutions and professional regulatory bodies of the country’s health sector.

The result of the needs assessment indicate serious gaps in Nigeria’s health infrastructure and human resources for health which, because of the complex institutional framework managing the health sector in Nigeria present visibility challenges. One of the reasons why Nigeria’s human resources for health (HRH) crisis does not appear so glaring is the insistence from many quarters on quoting of figures which indicate that Nigeria has one of the largest stocks of human resources for health (HRH) in Africa, comparable only to Egypt and South Africa. The needs assessment shows that Nigeria’s current stock of practising physicians (30,232 doctors by 31st December, 2013) is only about 35% of the officially quoted numbers from a database whose content has never been updated since 1963. As a corollary, the density of HRH is much lower than often officially acknowledged. With 0.17 doctors to 1000 population, Nigeria’s physician density is actually among the lowest in Africa and compares very unfavourably with emerging countries like South Africa (5.5), Tunisia (11.9), Algeria (12.1), Brazil (17.2), Mexico (28.9); and developed countries, such as Greece (60.4), Austria (47.5) and Italy (42.4). Nigeria has less than one-tenth of the required number of doctors to meet its needs.

It is well known and acknowledged that Nigeria’s human resources for health are geographically mal-distributed in favour of urban areas and Southern Nigeria. Push-pull factors such as overall level of development, quality of health infrastructure, number and workload of health workers, salaries and intangibles, influence the decisions of health workers to leave or to stay. Apart from these, the current state of insecurity in some states in Northern Nigeria is contributing to their inability to attract medical doctors to their health facilities.

Decentralization of the Nigerian health sector allows each state and local government the freedom to hire its own health practitioners. Having the freedom, but alas, not the budget, to pay decent salaries to their doctors has led to several positions not being filled at these levels of health service delivery, even in the face of growing number of unemployed doctors who are consequently forced out of the country in search of jobs.

Every year, up to 1000 of Nigeria’s freshly trained medical graduates are not being
absorbed for internship and are literally being forced out of the system due to lack of medical human resource planning and management. Each year about 700 Nigerian doctors emigrate to Europe (mostly the UK), North America, Australia, West Indies and South Africa in search of better working conditions.

Senior health management officials interviewed identified specific areas for profitable diaspora collaboration which include the following emerging specialised fields:

- nuclear medicine,
- oncology,
- radiotherapy,
- molecular biology,
- end of life care and
- emergency medicine
- mental health.

Nigerian tertiary health care institutions are eager to collaborate with diasporans in these areas but not under any conditions. They, as professionals want a partnership of co-learning that is based on a realistic and sustainable agenda which must add value to the existing knowledge and experience. They are faced with daily challenges of decaying and inadequate health infrastructure and the absence of basic amenities like electricity, often taken for granted in other countries. Diaspora collaboration based on simple importation of skills alone is unfortunately not sufficient. It should also involve improvement of the infrastructure such as provision of major equipment and investment in electricity generation. The equipment must be rugged, tropicalised and skills of technicians be developed to service the equipment. In the absence of these conditions, collaboration would be another meaningless exercise.

The crisis in Nigeria’s human resources for health is not static and can only worsen unless urgent remedies are applied. Our study has shown that a two-pronged approach is needed. In the search for members of the diaspora with relevant skills to fill the identified gaps, it is imperative to tackle the burning issues in the country’s human resource planning and management listed above. The main recommendations flowing from the analysis are firstly to officially acknowledge that there is a crisis in the Nigeria’s human resources for health and tackle the issues behind the mal-distribution of human resources for health.
I Background

With the number of Nigerians living abroad steadily increasing to an estimated 3.4 million in 2012, there is new awareness of their potential for the country’s development. In effect, remittances from Nigerians currently in the Diaspora have been estimated by the World Bank to be over $21 billion (N3.28 trillion) for the 2013 fiscal year¹. This is three times higher than the $7 billion that Nigeria received in Foreign Direct Investment in 2012 and is over 70% of its Gross Fixed Capital Formation (GFCF)².

IOM Nigeria is implementing a project funded by the European Union aimed at promoting better management of migration in Nigeria. The overall objective of the project is to enhance the capacity of Government to manage migration in order to maximize its development potential. With diaspora mobilization being a key component of the project, IOM is providing technical support to the Nigeria National Volunteer Service (NNVS) to strengthen its capacity to fulfil its mandate of mobilizing the Nigerian Diaspora for national development. This will enable the NNVS to engage and mobilize diaspora for development through diaspora investment schemes and temporary return of highly qualified diaspora members. In addition, IOM is supporting NNVS to develop an online portal which will provide a system for registration of Nigerians in the diaspora to enable NNVS secure substantial information on socio-demographic characteristics, geographic location and professional profiles as well as gauge their willingness to invest in Nigeria. While registration is intended to create a data base of all Nigerians in the diaspora, the mapping targets Nigerians in the health and education sectors in 3 pilot countries: United Kingdom, South Africa and the USA.

To complement the outcome of the mapping exercise, IOM is conducting the current needs assessment to identify the skills gap in Nigeria’s health sector. The outcome of this process will, provide the Government of Nigeria with the necessary information on the existing skills gap, in order to support NNVS to develop their outreach capacity to identify Nigerians who are willing to contribute their competencies and skills towards national development in the health sector. The process of encouraging skills and knowledge flow from the diaspora to country of origin for national development, otherwise called brain gain, is in recognition of the presence of relevant skills and competencies in the diaspora that could be harnessed for national development alongside remittances sent by nationals.

1.1 Objectives

The purpose of this needs assessment is to identify skills and competency gaps in the health sector and provide government with recommendations on how the gaps can be addressed. The information gathered will assist the government to establish a matching system to mobilize diaspora for national development through a pilot scheme to encourage temporary or permanent return of highly skilled diaspora members particularly in the health sector.

² Dan Steinbock, 2013, www.economonitor.com
1.2 Specific activities performed

Specific activities performed in the course of the assessment included:

- Development of the assessment tool and work plan for the needs assessment exercise.
- Visit to stakeholders implementing similar programmes like diaspora Health Professionals Desk and Joint Health Committee, the National Universities Commission, Fed Ministry of Health Diaspora Focal Person
- Briefing and debriefing meetings with IOM throughout the period of the consultancy.

1.3 Methodology

Combined methodologies were employed to achieve the objectives of the needs assessment. These included a comprehensive desk review of relevant needs assessment documents and implementation frameworks, group discussions and one-on-one interviews (both semi-structured and in-depth interviews) etc.

1.1.1 Desk review

This assignment was guided by a rigorous literature review of research and assessment reports on Human Resources for Health (HRH), not only in Nigeria but in comparative developing countries like Ghana and South Africa. Apart from the Federal Government, various development partners including the EU, IOM, African Development Bank have conducted studies or engaged stakeholders in reflection around migration and HRH. This review leveraged on information from research studies and government documents to determine Nigeria’s HRH capacities, needs and goals. In some instances, where sufficient data is available, relevant calculations were made to arrive at the current situation of HRH. We based our information on the number, composition and qualifications of personnel in the health sector on a rigorous review of literature on HRH as well as in-depth interviews with the core professional regulatory body; the Medical and Dental Council of Nigeria.

This review and questionnaire explored the following issues:

1. Description of Nigeria’s health indicators
2. Description of the Health system
3. What are the sources of information on Nigeria’s HRH?
4. Assessment of each source and selection of the most accurate information on current HRH
5. Health workforce production table
6. Gaps identified:
   - The unequal distribution of HRH between states, especially between Southern and Northern Nigeria states
   - The unequal HRH distribution between urban and rural areas of Nigeria
   - Factors related to the attrition of HRH.
   - The training and growth rate of HRH in Nigeria.
   - Policies and responses proposed and/or implemented to achieve the goals of the Health Policy
- Shortage of internship positions for doctors, dentists, pharmacist and medical laboratory scientists.
- Shortage of positions for residency (postgraduate training) for doctors and dentists.

### 1.1.2 In-depth interviews

In-depth interviews were conducted with senior management of the Obafemi Awolowo University Teaching Hospital Complex as well as the Obafemi Awolowo School of Health Sciences, Ile-Ife and with senior management of the Medical and Dental Council of Nigeria, Abuja.

### 1.4 Review of the ongoing mapping exercise in the UK, the USA and South Africa

The current assessment is meant to complement the ongoing mapping exercises being conducted by IOM in the UK, USA and in South Africa. The mapping exercise is to identify diaspora Nigerians in the health sector, resident in these countries and ascertain their willingness to contribute their skills to Nigeria’s development in various ways. If the results of the mapping exercise become available in the course of our assessment they will be reviewed so as to identify areas where profitable matches can be envisaged between Nigerians in the Diaspora with needed skills and those willing to make them available for national development, and the health facilities in Nigeria that lacks these scarce skills.

### 1.5 List of persons interviewed for the assignment

In order to identify skills and competency gap in the health sector and provide government with recommendations on how the gap can be addressed, various stakeholders were contacted and interviewed. A list is provided below:

**IOM Nigeria**
- Ms. Lily Sanya, Programme Officer, Data and Policy
- Mr. Tarsoo Ade, Diaspora Mobilization Officer

**Tertiary Health Institutions**
- Prof. Adesegun Fatusi, Provost, Obafemi Awolowo School of Health Sciences
- Dr. Olabanji, Chairman, Medical Advisory Committee (CMAC), Obafemi Awolowo University Teaching Hospital Complex
- Mrs. Christiana Bose Akintunde, Administrative Officer 1, Clinical Services and Training

**Medical professional regulatory bodies**
- Medical and Dental Council of Nigeria, Dr. Udugbai Ilevbare, HoD, Planning Research and Statistics

**Federal Ministry of Health, Human Resources for Health Programme**
- Dr. Olutunji Labiran, former Assistant Director and lead author of AHW0, WHO and the European Union, 2008 Human Resources for Health Country Profile, Nigeria.
Medical practitioners
   - Dr. Hestia Idiodi Thomas, Lagos University Teaching Hospital
   - Dr. Emmanuel Adegbe, Abuja

It was not possible to interview the Nigerian National Volunteer Service, nor the Nursing and Midwifery Council but secondary data was collected in these areas for the report.
2 Appraising the Number, Composition and Qualification of Nigeria’s Human Resources for Health

The World Health Organization reports that the world does not have sufficient health personnel, estimating that about 4 million health workers are needed to fill the gap in global Human Resources of Health. The number of health workers per thousand population in 2006 was estimated at 2.9/1000 in Africa; 5.8/1000 in Southeast Asia; 14.9/1000 in the Americas (North and South) and 40.3/1000 in Europe\(^3\), showing a clear relationship between level of development/poverty and human resources for Health. However, most African countries that have a high disease burden continue to face severe shortages of health workers. A major global challenge is the retention of health workers in remote and rural areas, not only in poorer countries, but practically everywhere. Thus, an understanding of push-pull factors such as quality of health infrastructure, number and workload of health workers, salaries and intangibles, that influence the decisions of health workers to leave or to stay, and the strategies effective for retention, is imperative\(^4\).

Nigeria’s HRH is in crisis although this is not often publicly acknowledged. There is a dearth in the quality, quantity and mix of health care workers with a skewed distribution towards urban and southern population, alongside the existence of multiple categories of health care providers from orthodox to traditional\(^5\). The planning and management of HRH still poses a major challenge to health development in the country as evidenced by the absence of a human resource plan, especially at lower levels of health care and a disconcerting absence of coordination, alignment and harmonization of HRH needs at all levels of government. In addition, the dearth of skills, high attrition rates, and problems with the HRH mix, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are contributing to inequitable access to health care services to the disadvantage of lower levels of care, rural areas and the northern parts of the country.

2.1 Description of Nigeria’s Health Indicators

According to the National Strategic Health Development plan 2009-2015, “...the health indicators in Nigeria have remained below country targets and internationally set benchmarks including the MDGs, which have recorded very slow progress over the years. The health status indicators for Nigeria are among the worst in the world. Life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3 years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on the health and survival of Nigerians, remaining the leading causes of morbidity and mortality. Nigeria has an estimated population of 175 million inhabitants, which constitutes 2% of the world population; however, the country accounts for only 14% of


\(^4\) Shrikant I. Bangdiwala, Sharon Fonn, Osegbeaghe Okoye, Stephen Tollman, Workforce Resources for Health in Developing Countries, Public Health Reviews, 2010, Vol. 32, No 1

global maternal deaths (WHO, 2012). The maternal mortality ratio of 840 maternal deaths per 100,000 live births in 2010 is unacceptably high.

Nigeria has the highest number of HIV infected persons in the African continent and the fourth highest TB burden in the world. Non communicable diseases are increasingly becoming public health problems, especially among the affluent urban population. Currently, under five mortality rate is estimated at 128 for every 1,000 live births (Nigeria Demographic and Health Survey preliminary report, NPC, 2013), an improvement from 2008 according to the same report. According to the 2013 DHS report, only about 61% of women who recently had a live birth sought antenatal care from a skilled provider while 36% had their recent baby at a health facility. Uptake of immunization for children in Nigeria is also low as only 25% of children are fully immunized at age one. This has not improved from the 23% reported in the 2008 NDHS and is still very low compared to neighbouring countries like Ghana where in 2008, 79% of children aged 12-23 months were fully immunized (GDHS 2008).

Wide regional variations exist in health indicators across the zones. Infant and child mortality in the North West and North East zones of the country are in general twice the rate in the southern zones while the maternal mortality in the North West and North East is over 6 times the rate recorded in the South West Zone. There are also wide variations in these rates across regions, socio-economic strata and rural-urban residence. These indicators do not converge towards achieving the MDGs in Nigeria.

### 2.2 Increasing Outbound Medical tourism by Nigerians

Nigeria allocated 4.5% and 3.5% of the total GDP to health in 2009 and 2010 respectively. Although health allocation was increased to 5% in 2012, it is still way below the 11% of GDP recommended by WHO and like most allocations, it is badly managed and is nothing near what is necessary to clear the backlog in healthcare investment carried over through the years. The ruined state of the nation’s healthcare sector, resulting from lack of medical equipment, epileptic power supply, and inadequate medical personnel has led to a general loss of confidence in this sector. Over the past decade, while the rest of the population continues to die of preventable diseases like malaria, diarrhoea, cardio-vascular diseases, top government officials with life threatening ailments or not, travel abroad for health care paid for by government ministries. Other wealthy Nigerians pay their medical trips from private funds while a small minority is sponsored by organisations and philanthropists. The most frequently visited countries by Nigerian medical tourists are the USA, UK, Germany, Switzerland, and more recently, India. India is currently the choice destination for medical care by many Nigerians mainly because its healthcare is comparatively the most affordable. The most frequent treatments sought by Nigerians in these countries are alternative medicine, corrective, and transformative surgeries. It is estimated that at least 3,000 Nigerians travel to India monthly for medical treatment and spend up to 20% of Nigeria’s total annual budgetary allocation for health care.

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6 available at http://www.measuredhs.com/publications/publication-pr41-preliminary-reports.cfm


8 Kaduna State was spending over N1.2 billion on medical care overseas for officials. See http://allafrica.com/stories/200909100110.html

2.3 The Country’s Health System

According to the Core Welfare Indicator Questionnaire (CWIQ) survey conducted by the National Bureau of Statistics (NBS 2004\textsuperscript{10}), 50.9% of the population has access to modern health care but only 9.6% of them utilize this service, mostly because it is of inadequate quality. Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other with no collaboration. Both the private and public sectors provide orthodox health care services in the country while traditional medicine is small scale and private. The private sector owns 38% of these facilities and provides 60% of orthodox health care in the country.

The country’s orthodox health system exists at three levels: the Primary, Secondary and Tertiary, with Primary health care as its cornerstone. In 2005, the Federal Ministry of Health (FMOH) estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. The Federal Ministry of Health oversees the national health delivery system through its eight Departments, five Agencies/Research Institutes, 20 Teaching Hospitals, 23 Federal Medical Centres, 14 Specialist Hospitals/Centres, 14 Health Professional Regulatory Bodies, and 17 Health Professional Training Institutions. Under the three-tier health care system, Primary Health Care which provides essential/preventive care is the responsibility of Local Government Authorities (LGAs). The Secondary Health Care (SHC) subsystem is funded by the 37 State governments and the Tertiary Health Care (THC) is funded by the Federal Ministry of Health to provide higher level of care with appropriate facilities to back up as referral hospitals. Due to the inefficiencies of the Primary Health Care system, the referral system is not operational and both secondary and tertiary institutions are burdened down with providing basic health care. While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services.

The Private Out-Of-Pocket- Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated $10 per capita expenditure on health\textsuperscript{11}, thereby limiting equitable access to quality health care. As a result of Nigeria’s underinvestment in health, many international agencies, donors and NGOs are working in the health sector to try to improve indicators. Some form of coordination exists through regular partner forum meetings organized by the Federal Ministry of Health and chaired by the Minister of Health, but except for the Interagency Coordinating Committee for polio eradication, or the committee on tuberculosis, formal inter-sectoral collaboration for health development and coordination is yet to be developed.

\textsuperscript{10} http://www.nigerianstat.gov.ng/nada/index.php/catalog/30
2.4 Health Policies

The Revised National Health Policy represents the collective will of the people and government of Nigeria to provide a comprehensive health care system that is based on primary health care. It describes goals, structure and strategic policy direction for health care delivery system in Nigeria. It further describes the roles and responsibilities of the three tiers of government without neglecting the non-state actors. Its long term goal is to provide the entire population with adequate access to not only primary health care but also to secondary and tertiary services through a well functioning referral system.

The National Strategic Health Development Plan (NSHDP) 2009-2015 approved by the Federal Executive Council in December 2010, gives a roadmap for improvement of the country’s health and health systems. The Health Plan is the reference for the health sector Medium Term Sector Strategy (MTSS) and annual operational plans and budgets at all levels. The eight priority areas of the Strategic Health Development Plan are as follows:

1. Leadership and Governance
2. Health Service Delivery
3. Human Resources for Health
4. Financing for Health
5. Health Management Information Systems
6. Partnership for Health
7. Community Participation and Ownership
8. Research for Health

Below we shall focus on Human Resources for Health

2.5 Nigeria’s Human Resources for Health Crisis.

Nigeria’s overall health system performance was ranked 187th position amongst 191 member States by the World Health Organization (WHO) in 2000. The National Strategic Health Development Plan recognised the HRH crisis and states that “There is a dearth in the quality, quantity and mix of health care workers with a skewed distribution towards urban and southern population, alongside the existence of multiple categories of health care providers from orthodox to traditional”. The planning and management of HRH still poses a major challenge to health development in the country as evidenced by the absence of a human resource plan, especially at lower levels, lack of coordination, alignment and harmonization of HRH needs at all levels of government. In addition, dearth of skills, problems with HRH mix, poor motivation, differential conditions of service, remuneration and work environment. Negative attitude to work, high attrition rates and poor supervision are added challenges, some of which contribute to inequitable distribution to the disadvantage of lower levels of care, rural areas and northern parts of the country. Also, entry qualifications and the ceilings placed on enrolment to schools of

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midwifery and nursing by their regulating body are limitations to addressing the very critical HRH challenges in some parts of the country. In addition the country is confronted with lack of emergency preparedness to respond to epidemics.

2.6 Sources of information on Nigeria’s Human Resources for Health

Nigeria has a formal health information system (HIS) that is meant to be nationwide in its coverage however, until 2004 it was incapable of providing usable data. It was redesigned in 2004 to be able to track the progress made in the implementation of the MDGs but it is still unable to provide usable information on health because of the following challenges:\(^{14}\):

- Finance
- Shortage of staff
- Shortage of materials
- Inadequate coordination of data flow
- Complexity & overlap of data collection instruments
- Lack of feedback to peripheral levels
- Huge backlog of unprocessed data

Unlike most other Health Management Information Systems, it provides no information on Nigeria’s Human Resources for Health.

The absence of an efficient data base for Nigeria’s health workforce has no doubt created a visible disconnection between the number and mix of health workers and the country’s needs on the one hand and on the other, available health facilities. This in turn blinds the country to the reality of glaring gaps in health resources. To this end the Federal Ministry of Health in collaboration with the World Health Organization and the United States government commenced the establishment of the National Human Resources for Health Information System (NHRHIS) in 2010. The system is expected to amongst other things capture new graduates from different health institutions annually and to also present summary statistics based on a number of human resources for health indicators which will present Nigeria’s Human Resources health status in relation to local and international benchmarks. No data has yet been produced by the NHRHIS\(^ {15}\).

2.7 Nigeria’s reported stock of Human Resources for Health

There were 52,408 Nigerian Doctors on the medical register as at December 2007 making Nigeria a country with one of the largest stocks of human resources for health (HRH) in Africa, comparable only to Egypt and South Africa according to most sources in Nigeria\(^ {16}\). At first glance, and assuming this figure to be correct, the country would appear to have

\(^{14}\) Abubakar A. A, Health Management Information System in Nigeria (undated), www2.pitt.edu%2F~super7%2F43011-44001%2F43561.pptx&ei=iB3AUX2FQPAlIAfRgYGQgQdsugy=AFqQCNFnxJUsxJUJ1- PBBWU3QTwvef/sQaxg2=RDgqWDSf97oaepEKHQbvm=+v.58187178.d.ZG4&cad=rja. accessed on 29/12/2013

\(^{15}\) http://www.ntanews24.tv/News/Africa/2013/May/MAY7/Human%20Resources%20For%20Health%20Info%20System.html

more than enough health personnel, but this is not so.

First of all, HRH should always be considered with respect to the number of people to whom the health resources are addressed. Nigeria’s population is over three times that of South Africa, therefore its HRH should be three times that of South Africa for a meaningful comparison to be made of both countries. Secondly, Nigeria’s figures for HRH stock are highly unrealistic because there has been neither any serious attempt to update the records since 1960 nor to remove from the register any professional who has died, retired, emigrated, or who has never practised the medical profession.

Consequently, like in most HRH crisis countries, shortages of health professionals are being decried all over Nigeria outside of the South West. The Minister of Health has for the first time agreed with the World Health Organization (WHO) at a recent conference on Human Resources for Health that Nigeria is one of the 36 African countries experiencing a shortage of medical doctors, nurses and midwives. It would seem then that in spite of the large stock announced, Nigeria has densities of nurses, midwives and doctors that are far too low to effectively deliver essential health services. Although in recent years, migration to foreign countries may have declined, the primary challenge for Nigeria remains inadequate production and inequitable distribution of health workers.

Let us revert to the often cited figures of Nigeria’s HRH stock and examine them critically. There were 39,210 Nigerian Doctors on the medical register in 2005. The number grew to 52,408 in December 2007 and 55,376 in 2008. However only 14,000 (27% of the reported stock) of doctors had paid the annual practising licensing fee for the year 2007. The same applies to all other medical professions and no register has ever been updated to take into account the number of deaths, retirement, migration or any form of exit. Does this mean that Nigerian medical practitioners are mostly unlicensed or that the database is populated by numerous “ghost” workers who are no longer practising because they have either retired, emigrated, died or have never practised? Table 1 below shows the total number of health workers in Nigeria and in South Africa for 2005. Even if the Nigerian figure of 39,210 physicians were to be correct, and we shall show in a little while that it is not, the stock should be seen against the backdrop of the total population size that these doctors are meant to serve. In 2005, South Africa’s 34,829 doctors catered for 45 million people whereas their 39,210 Nigerian colleagues were faced by a daunting population of over 136 million people, three times the workload of the South African health workers (see last row of Table 3). Brought to the same denominator, we see in Table 2 that there are 0.3 physicians to 1000 persons in Nigeria compared to 0.77 to 1000 in South Africa.

---

Table 1: Total number of health workers in Nigeria and South Africa, 2005

<table>
<thead>
<tr>
<th>Categories of HRH</th>
<th>Nigeria Number 2005*</th>
<th>South Africa Number 2005**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>39 210</td>
<td>34 829</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>213425</td>
<td>184 459</td>
</tr>
<tr>
<td>Dentists and technicians</td>
<td>2113</td>
<td>5 995</td>
</tr>
<tr>
<td>Pharmacists and technicians</td>
<td>12072</td>
<td>12 521</td>
</tr>
<tr>
<td>Environ, and public health</td>
<td>3441</td>
<td>2 529</td>
</tr>
<tr>
<td>Laboratory technicians</td>
<td>-</td>
<td>1 968</td>
</tr>
<tr>
<td>Other health workers (physiotherapist, Occupational therapist, Speech therapist, Optometrist)</td>
<td>2246</td>
<td>40 526</td>
</tr>
<tr>
<td>Community health</td>
<td>19268</td>
<td>9 160</td>
</tr>
<tr>
<td>Management and support</td>
<td>820</td>
<td>28 005</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>253,385</strong></td>
<td><strong>319 992</strong></td>
</tr>
</tbody>
</table>

Total Population in the country                          136,032,236          45,214,001


Table 2: Total health worker density per 1000 population in Nigeria, South Africa and Africa, 2005

<table>
<thead>
<tr>
<th>Categories of HRH</th>
<th>Nigeria 2005* Density per 1000 population</th>
<th>South Africa 2005 Density per 1000 population**</th>
<th>Africa 2005 Density per 1000 population**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>0.29</td>
<td>0.77</td>
<td>0.22</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>1.57</td>
<td>4.08</td>
<td>1.17</td>
</tr>
<tr>
<td>Dentists and technicians</td>
<td>0.02</td>
<td>0.13</td>
<td>0.04</td>
</tr>
<tr>
<td>Pharmacists and technicians</td>
<td>0.01</td>
<td>0.28</td>
<td>0.06</td>
</tr>
<tr>
<td>Environ, and public health</td>
<td>0.03</td>
<td>0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>Laboratory technicians</td>
<td>0.01</td>
<td>0.04</td>
<td>0.06</td>
</tr>
<tr>
<td>Other health workers (physiotherapist, Occupational therapist, Speech therapist, Optometrist)</td>
<td>0.02</td>
<td>0.90</td>
<td>0.17</td>
</tr>
<tr>
<td>Community health</td>
<td>0.14</td>
<td>0.20</td>
<td>0.45</td>
</tr>
<tr>
<td>Management and support</td>
<td>0.01</td>
<td>0.62</td>
<td>0.41</td>
</tr>
<tr>
<td><strong>Country’s population</strong></td>
<td><strong>136,032,236</strong></td>
<td><strong>45,214,001</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.1</strong></td>
<td><strong>7.08</strong></td>
<td><strong>2.63</strong></td>
</tr>
</tbody>
</table>

Table 2 also shows the density of nurses and midwives per 1000 population in both countries compared to the rest of Africa in 2005. Again we observe that for the same number of potential patients, South Africa has double the number of nurses in Nigeria. With Nigeria’s 2.1 health workers per 1000 population, compared to South Africa’s 7.08, we can begin to see that in spite of its impressive stock of health personnel, Nigeria does not have sufficient medical staff for its health needs (see Fig.1).

Figure 1: Density of health workers in Nigeria and South Africa in 2005 (un-corrected)

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Nurses and midwives</th>
<th>Community Health</th>
<th>Management and support</th>
<th>Other health workers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>0.29</td>
<td>1.57</td>
<td>0.14</td>
<td>0.01</td>
<td>0.09</td>
<td>2.1</td>
</tr>
<tr>
<td>South Africa</td>
<td>0.77</td>
<td>4.08</td>
<td>0.2</td>
<td>0.62</td>
<td>1.41</td>
<td>7.08</td>
</tr>
</tbody>
</table>

2.8 Inaccuracies in the Published Human Resources for Health Figures

Nigeria’s published figures of HRH and the implied density situation could be very misleading when taken at face value. We have earlier cast doubts on the country’s published figures of HRH as unrealistic, it is therefore important to discuss this. The country’s HMIS does not provide information on HRH thus we have to depend on professional bodies and training institutions for information on stock. No census has ever been taken on the current population of practising health workers. There is also no serious attempt to enforce payment of licensing fees for practitioners.

Table 3 shows the total number of health workers in Nigeria in the year 2008 and 2009. At
first appraisal, Nigeria looks well endowed with 0.37 physicians per 1000 population in the year 2008, compared to Ghana’s 0.11\(^{19}\) and one wonders why Nigeria’s health indicators are so much worse than Ghana’s. One plausible explanation well supported by literature about the decaying health infrastructure in Nigeria is the argument that a high number of physicians can do nothing without basic resources like electricity, water, medicines etc.

However, although this is an uncomfortable reality in Nigeria, it is not a sufficient explanation for the disconnect. The other clue to the puzzle is that Nigeria’s HRH size and its implied density, is actually overestimated, simply because it is based only on entries into the profession since 1963\(^{20}\) and Nigeria’s HRH stock has never been updated to weed out any duplications\(^{21}\), retirements, deaths, emigration or any form of exit from the medical profession\(^{22}\). It is clearly not a stock but an accumulation of various entries into the medical profession from the numerous training institutions in the country, with no idea of current status, i.e. whether these qualified persons are still practising or not. Continuing to quote these figures in official reports on Nigeria’s stock of HRH is misleading.

Table 3: Total number of Health Workers and those in good standing in Nigeria, 2008-2009

<table>
<thead>
<tr>
<th>Categories of HRH</th>
<th>Nigeria Number of Health Workers 2008</th>
<th>Nigeria Density of Health Workers per 1000 population 2008</th>
<th>Nigeria Number of Health workers in good standing 2009</th>
<th>Nigeria Number of health workers in good standing 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>55 376</td>
<td>0.37</td>
<td>59 136</td>
<td>20 998</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>224 943</td>
<td>1.49</td>
<td>230 941</td>
<td>N/A</td>
</tr>
<tr>
<td>Dentists and technicians</td>
<td>3 781</td>
<td>0.02</td>
<td>2 464</td>
<td>1 257</td>
</tr>
<tr>
<td>Pharmacists and technicians</td>
<td>18 682</td>
<td>0.12</td>
<td>14 353</td>
<td>6 713</td>
</tr>
<tr>
<td>Environ, and public health</td>
<td>4 280</td>
<td>0.03</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Laboratory technicians</td>
<td>22 683</td>
<td>0.15</td>
<td>14 887</td>
<td>8 966</td>
</tr>
<tr>
<td>Other health workers (physiotherapist, Occupational therapist,</td>
<td>2 313</td>
<td>0.02</td>
<td>5 029</td>
<td>1 929</td>
</tr>
<tr>
<td>Speech therapist, Optometrist)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td>19 268</td>
<td>0.13</td>
<td>40 491</td>
<td>N/A</td>
</tr>
<tr>
<td>Management and support</td>
<td>nd</td>
<td>nd</td>
<td>49 53</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>351 326</td>
<td>2.32</td>
<td>1.38</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Population</td>
<td>149 662 370</td>
<td>154 502 749</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


\(^{20}\) Interview with Dr. Olatunji Labiru, author of AHWO, WHO and the European Union, 2008 Human Resources for Health Country Profile, Nigeria.

\(^{21}\) Any physician who is qualified in one cadre and then receives a higher-level qualification for another cadre is registered in both.

\(^{22}\) Federal Republic of Nigeria, 2013, Nigeria Health Workforce profile as of December 2012, draft report. P.16
2.9 Nigeria has less than One-tenth of its Required Number of Doctors

The published figures of Nigeria’s “stock” of HRH are therefore inflated, but by how much is yet to be correctly determined. Table 3 gives an indication from figures published by the Ministry of Health showing the number of Nigeria’s Health Professionals considered to be “in good standing” with their professional regulating bodies. In order to legally practise medicine in Nigeria, all medical doctors must register and obtain a licence from the Medical and Dental Council. This licence must be renewed annually upon submission of proof of accumulation of at least 20 credit units from Accredited Continuing Professional Development (CPD) providers. The licence is valid from 1st January to 31st December.

Out of 58,325 doctors in the stock in the year 2009, only 20,531 (35%) were considered to be legally practising the medical profession. This brings the density of physicians actually practising under licence to 0.14 per 1000 population, close to half of the overall African average of 0.22 per 1000. South Africa has 5.5 times more practising physicians per 1000 population than Nigeria. Unfortunately, we have no figures for nurses and midwives in good standing, but it would seem that the overestimation of stock is evident in most of the medical profession. Note that the World Health Organisation recommends 2.3 doctors, nurses and midwives per 1000 population as a minimum threshold for health worker density. It could therefore be said that Nigeria has less than one-tenth of the required number of doctors to meet its needs.

Only one serious study of Nigeria’s net HRH situation exist. It is entitled, “A Situation Assessment of Human Resources in the Public Health Sector in Nigeria”, a systematic random sample survey of health facilities at the primary, secondary and tertiary levels. Based on the actual staffing situation of surveyed facilities, the study estimated that in 2005 the public sector in Nigeria had about 17,800 doctors, 122,000 nurses and midwives, and 86,600 community-level health staff (CHOs/CHEWs). This translated to 0.13 doctors, 0.92 nurses and midwives, 0.10 pharmacists, and 0.64 CHOs/CHEWs in the public sector per 1000 population. Generally, it is estimated that about 75% of health professionals practising in Nigeria are employed by the public sector. Based on this assumption, we can therefore estimate that there were in total 22,250 practising physicians (public and private sector combined) in Nigeria in the year 2005; a little above one half of the number officially registered are consistently quoted. This then brings the density of physicians per 1000 population to 0.15 instead of 0.3 reported by WHO in the year 2005 (see Table 1).

By December 2011, Nigeria had 28,370 medical doctors legally practising in the country, according to the 2012 Health Workforce Profile report. This constitutes a density of 0.17 physicians to 1000 population. The Medical and Dental Council of Nigeria in a recent interview reported that by 31st December 2013, there were 30,323 medical doctors in good standing in its log books out of over 85,000 registered. This again constitutes a

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23 Which we understand to mean people who actually exist and have renewed their annual practising license
density of 0.17 doctors to 1000 population in Nigeria.

The results of this study point to the following facts:

1. Nigeria’s current stock of practising physicians is about 35% of the officially quoted numbers because the data have never been updated since 1963.

2. As a corollary, the density of HRH is much lower than it is often acknowledged. With 0.17 doctors to 1000 population, Nigeria’s physician density is actually among the lowest in the continent and compares very unfavourably with Brazil (17.2), Mexico (28.9), Algeria (12.1), Tunisia (11.9), Libya (19.0); and developed countries, such as Greece (60.4), Austria (47.5), and Italy (42.4).

3. In 2005 South Africa had over 5.5 times the density of Nigeria’s physicians, and the rest of Africa had over twice the density of Nigeria’s doctors. The situation has hardly improved in recent times.
3 The Current Situation of the Nigerian Health Sector

As stated earlier, Nigeria has less than one-tenth of the required number of doctors to meet its needs by WHO standards. Apart from overestimating the actual size of its HRH and therefore not taking the necessary steps to deploy an adequate number and mix of health professionals, the Nigerian health sector is characterized by mal-distribution of health work force and poor coordination amongst key players, lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing and a weak health infrastructure, according to Babatunde Oshotimehin, Minister of Health\textsuperscript{27}. There exists an uncomfortable mix of under-utilization and over-utilization of the skills of health professionals depending on the geographic location and professional category/sub-category involved\textsuperscript{28}. One assessment reported that the density of persons per public sector doctor in southern Nigeria was about a quarter of that of Northern Nigeria\textsuperscript{29}.

3.1 Skewed Distribution of the Health Work force

Apart from South Western Nigeria which alone accounts for 43.9% of the medical doctors and the majority of the other health workers, there is a general shortage of HRH in the rest of the country as can be seen in Table 5 below. The North East zone is the hardest hit by shortages in HRH followed by the North West. Table 4 shows that the North East, with 14% of Nigeria’s population has only 4% of its doctors, whereas the South West, home to 20% of the population is blessed with 43.9% of the doctors. The North West, more populous than the South West and with a higher disease burden, has only one fifth of its doctors. Most of the country’s medical doctors are concentrated in the tertiary and secondary health facilities located in urban areas. There the pay is very attractive and the conditions of work are way better than in the rural areas where infrastructure development has halted since the late eighties.

\textsuperscript{27} May 2009, http://www.healthresearchweb.org/br/nigeria/policies
\textsuperscript{28} WHO, 2004, WHO Country Health Profile: Nigeria p.12
\textsuperscript{29} WHO, 2000 WHO Country Profile, Nigeria
Table 4: Regional distribution of Nigeria’s health workers in percentages

<table>
<thead>
<tr>
<th>Categories of HRH</th>
<th>Total un-updated stock*</th>
<th>North Central Percentage</th>
<th>North East Percentage</th>
<th>North West Percentage</th>
<th>South East Percentage</th>
<th>South South Percentage</th>
<th>South West, Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>52 408</td>
<td>9.73</td>
<td>4.06</td>
<td>8.59</td>
<td>19.59</td>
<td>14.37</td>
<td>43.9</td>
</tr>
<tr>
<td>Nurses</td>
<td>128 918</td>
<td>16.40</td>
<td>11.65</td>
<td>13.52</td>
<td>15.29</td>
<td>27.75</td>
<td>15.35</td>
</tr>
<tr>
<td>Radiographers</td>
<td>840</td>
<td>14.30</td>
<td>3.66</td>
<td>5.97</td>
<td>1500</td>
<td>18.30</td>
<td>43.00</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>13 199</td>
<td>19.94</td>
<td>3.80</td>
<td>7.79</td>
<td>11.74</td>
<td>12.39</td>
<td>44.00</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1 473</td>
<td>10.08</td>
<td>2.73</td>
<td>8.32</td>
<td>8.58</td>
<td>7.93</td>
<td>62.00</td>
</tr>
<tr>
<td>Medical Laboratory Scientists</td>
<td>12 703</td>
<td>6.82</td>
<td>1.72</td>
<td>3.6</td>
<td>35.26</td>
<td>23.89</td>
<td>62.00</td>
</tr>
<tr>
<td>Environment and public health workers</td>
<td>4 280</td>
<td>9.39</td>
<td>11.27</td>
<td>18.94</td>
<td>12.36</td>
<td>15.69</td>
<td>32.08</td>
</tr>
<tr>
<td>Health Records officers</td>
<td>1 187</td>
<td>13.34</td>
<td>4.85</td>
<td>11.6</td>
<td>14.64</td>
<td>29.90</td>
<td>26.00</td>
</tr>
<tr>
<td>Dental Technologists</td>
<td>505</td>
<td>14.08</td>
<td>5.92</td>
<td>5.92</td>
<td>12.96</td>
<td>16.62</td>
<td>44.50</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>5 483</td>
<td>7.17</td>
<td>9.12</td>
<td>18.00</td>
<td>8.58</td>
<td>11.80</td>
<td>46.00</td>
</tr>
<tr>
<td>Percentage of Nigeria’s population</td>
<td>100</td>
<td>14</td>
<td>14</td>
<td>26</td>
<td>12</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: AHWO, WHO and the European Union, 2008, p.23

* Note that the actual number of practitioners is around 35% of this but the geographical distribution is probably correct.

Figure 2 shows the density of medical doctors in some states, highlighting the terrible disadvantage of the northern states in the area of human resources for health. Lagos state and the FCT have 10 -15 times the number of doctors in ten Northern Nigeria states including Zamfara, Kebbi, Jigawa, Bauchi and Niger.
3.2 **Difficult Working Conditions of Nigerian Medical Professionals**

Nigerian medical professionals are confronted on a daily basis with:

1. Decaying and inadequate infrastructure especially lack of basic amenities like water and electricity at the health facility. Some labour rooms in rural areas are filthy for lack of water to assure minimum hygiene. One university teaching hospital visited, reported that the electricity from the national grid is unreliable; the renal units, ICU, laboratory, theatre, casualty, etc. operate on diesel generators 24 hours a day running up a bill of about 5 Million Naira (30,675 USD) of diesel to power the generators producing electricity. They have been forced to
generate some of this money locally from their patients after the Federal Government slashed the health sector allocation in 2013.

2. Nigeria’s health facilities are not expanding to cope with expansion of personnel being trained. In southern Nigeria, there are now specialists in every department of tertiary institutions but there are often no equipment for them to work with, especially, there are no electricity to run the few available equipment. There are also not enough spaces to admit patients in the hospitals.

3. Lack of basic working materials and resources like soap, disinfectant and medicines,

4. Insufficient specialist medical personnel leading to a backbreaking workload for most health practitioners especially those in rural health facilities,

5. Inadequate referral services coupled with the fact that many patients wait until they are at a critical state of health before visiting health facilities, which are often ill equipped for that level of care

6. Frustration from patients and their families whose expectations of quality care cannot be met because of the above listed challenges

7. Gender issues: midwives’ and nurses have backbreaking professional workload (including night work) which leaves them less time and energy to fulfil their family obligations thereby putting some of them in a position where they have to choose between their careers and family obligations, something that is peculiar to women.

8. Increasing insecurity in some states like Borno, Yobe, Adamawa, Plateau and Benue

9. Lack of professional advancement for southern medical professionals working in Northern Nigeria.

It is believed that these are some of the factors responsible for the demotivation and high level of attrition in some branches of the profession\textsuperscript{30}. Staff attrition rates, measuring the number of those leaving the health service are highest for doctors and pharmaceutical staff. HRH attrition rates in rural areas are generally higher than in urban areas.

3.3 Remuneration Discrepancies between Tertiary, Secondary and Primary Sectors

Interviews with senior management of tertiary health services indicate that beyond the aforementioned challenges, there are also the issues of remuneration and the enormous discrepancy between the tertiary; Federal Government supported university teaching hospitals and the secondary and primary health facilities supported by state and local governments. Health care has been placed in the concurrent legislative list, meaning that every state and LGA can contribute to its own health cost. As long as it is above the minimum wage of N18,000 per month (about 110 USD) state governments are now free to decide what they want to pay medical doctors but then, the latter also have the freedom to move to better paying positions in urban areas or in the richer states. Consequently,

\textsuperscript{30} Omolubi E and Akinyemi A., 2013, Influencing Midwife Retention Strategies for the Nigeria Subsidy Reinvestment Empowerment Program (SURE-P), World Bank, unpublished report
many states and Local Government Areas are understaffed in HRH because they cannot or are unwilling to pay the highly attractive negotiated wages for doctors. The Chief Consultant at the Teaching Hospital (Federal Government establishment) earns twice what his colleagues would earn at state level (except for Cross River, Akwa--ibom, Delta and Rivers State). Local Government Areas pay poorly and no longer employ doctors because they claim that they can no longer afford the Consolidated Medical Salary Scale (CONMESS) agreed upon.

3.4 Emigration of Nigerian Medical Professionals

Since the year 2009, Nigeria has been losing an average of 700 doctors annually to Europe, America, Australia and South Africa. It has been reported that 864 doctors migrated abroad from Nigeria in the year 2012. In the year 2013, 699 doctors requested for letters of good standing out of whom the highest number (243) went to the United Kingdom, 147 went to Canada, 81 went to South Africa, 71 to Australia and 47 emigrated to the United States. The peak of 3,500 emigrations of Nigerian doctors was recorded in 2007.

Doctors are not the only health professionals emigrating: nurses and midwives left the country in droves, with emigration peaking at over 5000 departures annually between the year 2002 and 2005, when Nigeria lost more nurses than it produced. The massive brain drain, dropped gradually to about 1000 annually in the year 2011.

Table 5 Nigerian doctors intending to emigrate by country of destination and date

<table>
<thead>
<tr>
<th>Country</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>979</td>
<td>1236</td>
<td>1,236</td>
</tr>
<tr>
<td>Ireland</td>
<td>714</td>
<td>851</td>
<td>851</td>
</tr>
<tr>
<td>U.S.A</td>
<td>122</td>
<td>189</td>
<td>189</td>
</tr>
<tr>
<td>Denmark</td>
<td>9</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Israel</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>South Africa</td>
<td>-</td>
<td>-</td>
<td>538</td>
</tr>
<tr>
<td>West Indies</td>
<td>304</td>
<td>384</td>
<td>384</td>
</tr>
<tr>
<td>Canada</td>
<td>136</td>
<td>176</td>
<td>176</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Singapore</td>
<td>6</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Australia</td>
<td>49</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Germany</td>
<td>7</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Poland</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Italy</td>
<td>2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Guyana</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>New Zealand</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Nepal</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Ghana</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Russia</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Libya</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Ukraine</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Liberia</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>2341</td>
<td>2985</td>
<td>3,567</td>
</tr>
</tbody>
</table>

Source: AHWO, WHO and the European Union, 2008 p.31

Discussions with stakeholders indicate that although the situation with regard to emigration of health personnel has improved with the recent upgrading of the salaries and allowances, Nigerian doctors and nurses continue to be attracted by the better salaries and working conditions in the developed and emerging countries. These include satisfactory work conditions for their spouse, good quality schools for their children and amenities for the family. The push factors towards overseas work are the same that discourage urban physicians from taking up appointments in rural areas and in some of the very rural states of northern Nigeria: absence of electricity, water, basic supplies, inadequate medical equipment. lack of a conducive environment for the family such as absence of good schools and social amenities.

Figure 3: Emigration of Nigerian medical doctors to foreign countries


Figure 4: Emigration of Nigerian nurses and midwives to foreign countries

Source: Federal Republic of Nigeria, 2013, Nigeria Health Workforce profile as of December 2012,
3.5 Addressing Specific Shortages in Human Resources for Health

In addressing the shortages in skilled birth attendance and in improving maternal and child health, the deployment and strengthening of midwifery services have been advocated (World Bank, 1993; WHO, 2004; SAFE, 2003). The Midwife Service Scheme (MSS), initiated in the year 2009, hired, trained and deployed midwives to primary health centres in needy communities. One lesson learned from the MSS was the high attrition rate among midwives, even among the newly deployed. Consequently, SURE-P MCH programme planned to recruit, train, and deploy 2,000 Midwives and 1,000 Community Health Extension Workers (CHEWs) throughout the states of the Federation with priority given to the areas in most need. In addition it will support capacity building of 12,000 Village Health Workers already employed in primary health centres nationwide.

3.6 Health Workforce Production: How do We Absorb Medical Graduates?

The major sources of incoming staff in the public health sector are new graduates (83% of total new incoming staff in 2005). They represent an increase of about 3% of manpower in the public sector. Nigeria’s medical training institutions produced about 2,000 doctors, 5,500 nurses, and 800 pharmacists per year in 2002/2003 (FMOH, 2003). With the current 17 accredited medical schools and 20 University Teaching Hospitals to train Doctors, 69 Schools of Nursing and Midwifery, and 45 Schools of Health Technology to train Community Health Workers, Nigeria would appear to be able to produce sufficient numbers of human resources for the delivery of its health services. However, this is only true in the major cities and southern Nigeria where HRH is concentrated, or outside Nigeria’s borders.

3.7 Grossly Inadequate Number of Training Facilities in Northern Nigeria

Table 6 below shows that two thirds (222) of the 339 health training schools are located in southern Nigeria, with the North East being the most disadvantaged region. The contribution of new graduates to the existing number of staff varies among staff categories; from 7.7% for doctors to only 1% for nurses/midwives. It is estimated that about 1,200 new medical graduates (who have completed their National Youth Service Corp assignment) were recruited into the public sector in the year 2005, which indicates that about 60% of newly qualified doctors started their career in the public sector\footnote{Chankova, Slavea, Ha Nguyen, David Chipanta, Gilbert Kombe, Ali Onoja, and Kayode Ogungbemi. September 2006}.
Table 6: Number of Health Training Schools by geopolitical zone in 2008

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Total</th>
<th>S/East zone</th>
<th>S/South zone</th>
<th>S/West zone</th>
<th>N/Central zone</th>
<th>N/East zone</th>
<th>N/West zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acc. Med. Sch</td>
<td>26</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>App. Sch. of Nursing</td>
<td>76</td>
<td>19</td>
<td>18</td>
<td>20</td>
<td>10</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>App. Sch. of Midwifery</td>
<td>77</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>10</td>
<td>6</td>
<td>10</td>
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<tr>
<td>Med Lab. Sch</td>
<td>12</td>
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<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rehab. Therapist</td>
<td>06</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sch. Of Radiogr</td>
<td>05</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sch. of Pharm</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sch. of Pharm Tech</td>
<td>19</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Sch. Of Record Off</td>
<td>40</td>
<td>3</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>CHO's Sch</td>
<td>13</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td>CHEWs Sch</td>
<td>43</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Dental technician</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental therapy</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Optometry</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>339</td>
<td>68</td>
<td>73</td>
<td>81</td>
<td>45</td>
<td>26</td>
<td>46</td>
</tr>
</tbody>
</table>


3.8 Medical Internship in Nigeria: Penury in the Land of Plenty

Nigeria’s human resource planning for health is at an embryonic state and this has dire consequences for the management of human resources for health. The National Human Resources for Health Strategic Plan (2007) reported that both the Federal and most State Ministries of Health do not have structures and capacities to facilitate the development and implementation of integrated HRH plans. Very few State Ministries of Health have evidence of routinely planning for human resources for health. Staff management responsibilities and functions are centralized in offices such as the Head of Civil Service, the Civil Service Commission, or Health/Hospital Management Boards. Intakes into health training institutions are not influenced by evidence-based predetermined staff requirements. Consequently, many of the health training institutions over-produce some cadres of staff who do not readily find employment within the state yet are not employed by other states where needs exist. At the same time, there is gross under-production of other cadres who are critically needed in the states.33

Currently, the country is producing doctors that are not getting absorbed due to systemic inconsistencies in human resource planning. In the year 2013 for example, 3537 medical doctors graduated from training institutions and were awarded provisional registration certificate/practicing licence by the Medical and Dental Council to become houseman. However, there are currently only 2658 spaces available in the country’s medical training facilities; teaching hospitals (1696), Federal Medical Centres (144), General, Specialist and Military hospitals (687) and private mission hospitals (131). There is therefore a whopping figure of 879 or 25% of recently graduated medical doctors who cannot complete their training because they have no place to undertake their compulsory housemanship. That is not all: more than half of the available spaces for housemanship in the state and private

---

mission hospitals (no housemanship in the primary health care facilities) are not filled because no young doctor will accept the miserable wages and work conditions they offer. In order to redress the imbalance between North and South, the Medical and Dental Council has limited the number of spaces for housemen in Southern Nigeria and increased the number in the North. In recent years, more positions for physicians have been created but apparently, freshly trained doctors (mostly from Southern Nigeria) are reluctant to go to the north. They would rather wait for up to two years for a posting or leave the country. Evidently, those who go abroad for housemanship often do not return.

Therefore, we can safely conclude that every year, up to 1000 of Nigeria’s freshly trained medical graduates are not being absorbed and are literally being forced out of the system for lack of medical human resource planning. According to the provost of the OAU College of Health Sciences, “the question is not how many medical professionals we are producing, but what facilities do we have to absorb them?” In a recent National Universities Commission board meeting, human resource planning was evoked and thus health systems operatives are asking how many health personnel are actually needed and where?
4 International Cooperation in the Health Sector

International cooperation in the health sector is assessed at the level of the Federal Ministry of Health and the professional licensing authorities as well as in Nigeria’s tertiary institutions. In 2013, the Federal Ministry of Health at a conference in Recife, Brazil and in collaboration with its partners made commitments to improve Human Resource for Health, reiterating the President’s pronouncements on Diaspora partnership. These commitments included activities to be carried out through its agencies and other stakeholders to improve Human Resource for Health towards achieving improved healthcare services for Nigerian citizens. This is also expected to reverse medical tourism and encourage health professionals in Diaspora to come back home to contribute to the healthcare sector. Apart from medical missions, health professionals in the Diaspora are encouraged to visit the country for educational missions and also invest in the ailing health sector under the principles of Public Private Partnership. In the University Teaching Hospitals, diaspora relations are less structured.

4.1 Federal Ministry of Health’s Diaspora Desk

The government has particularly requested Diaspora engagement in three areas: capacity building and exchange, leveraging diaspora networks overseas, and coaching and mentoring of medical students and young Faculty. The Federal Ministry of Health facilitates the activities of the Heath professionals in Diaspora, particularly by trying to structure foreign health missions in Nigeria and supervising their activities during their stay. Foreign health missions have become more frequent in recent times especially as quality medical care becomes less accessible to the country’s poor and rural dwellers. ASA-USA, the Anambra State Association of USA, started annual medical missions of two week duration in the state 12 years ago, treating mainly vision problems, diabetics and hypertension. They estimate that within the period, the medical team has visited 90 out of the 178 communities in the state and had attended to over 900,000 people.

However, some of the issues are being raised by foreign health missions. They include:

1. Lack of structured documentation and data collection of mission activities, its quality and feedback from patients or community.
2. Lack of continuity of care due to poor collaboration with local healthcare colleagues for follow-up or management of complicated cases.
3. Inadequate management of complications and misadventures following surgical procedures after the teams have returned to their resident countries.
4. Lack of robust evidence of the value of short term missions to the overall health of the

34 http://nappsa.org/
35 http://www.who.int/workforcealliance/forum/2013/3gf_finaldeclaration/en/
36 I owe a special gratitude to Mrs. Ogbaudu P.A for her comments on an earlier draft of this section
people prompting some to question the cost-effectiveness or cost-benefits of the vast majority of missions.

5. Disregard for the code of medical ethics in Nigeria advertising, research, abrupt discontinuity of care and lack of maintenance of confidentiality.

6. Medical missions are often unable to provide the full-spectrum of care required for complex medical conditions.

7. Lack of co-ordination - invitation of foreign teams by States and LGA are not communicated to the FMoH.

8. Lack of monitoring, evaluation and research on the activities and outcomes of medical missions.

9. Use of missions as tools for political campaigns to the detriment of quality healthcare delivery.

10. Supply of equipment - some items become “burdens” rather than “benefits” because they are obsolete and are not accompanied by user manuals.

11. Few short-term medical teams keep records of the patients they have seen and the medications that they have distributed. Medications, if not properly labeled with accurate dose regimen may cause problems if a patient desires follow-up care.

As a result of some of the issues raised by the increasing number of foreign medical missions, the FMoH has developed Standards and Guidelines for the conduct of Medical/Health Missions in Nigeria in collaboration with its stakeholders. The guideline is expected to ease some of the challenges faced by health professionals in the Diaspora and the communities where they work. A study of the guidelines confirms the basic nature of the document. It mentions seven requirements including notification of intending mission, obtaining clearance from the Medical and Dental Council, certification of imported drugs and equipment as well as an end of mission report. While the Diaspora desk facilitates the obtaining of official permits and documents, it is not clear what other support or follow-up is provided to these foreign missions. It would seem that once they have obtained the requisite temporary license to practice during their visit to Nigeria, health missions are usually left on their own until they leave.

The FMOH resuscitated its Public Private Partnership Unit while its Diaspora Desk has signed a number of MOUs with registered associations of health professionals in the diaspora. Technical Committees help to drive the action point of the different MOUs. The Diaspora groups rotate chairmanship of the different committees.

The MoU with the Nigerian Association of Pharmacists and Pharmaceutical Scientists in the Americas (NAPPSA) identifies the following areas of cooperation:

2. Pharmaceutical Research & Basic BioMedical Science Research.
3. Pharmaceutical & Pharmacy Service Delivery and Skills Transfer
4. Quality Assurance (QA) and QA knowledge Transfer.
5. Technology Transfer for Pharmaceutical Manufacturing – i.e. production, testing, packaging, control, release, storage and distribution.
6. Investments – Public Private Partnerships (PPP) and Private Investments.
7. Improving conditions to make Nigeria a Desirable Destination for Clinical Trials, including the establishment of Centers of Excellence for Clinical Trials.

38 see annex to this report
8. Improving availability of key Pharmaceutical Materials by completion of the petrochemical industry and other policy initiatives.
9. Licensure Reciprocity for Nigerian Pharmacists in the Americas to facilitate opportunity to practice in Nigeria.
10. Capacity building of pharmacists in the provision of drugs and provision information services.
11. Training on logistics/supply chain management of pharmaceuticals and health commodities.

NAPPSA has been championing the cause for the inauguration of a governing board of the Pharmacists Council of Nigeria (PCN), stating that “the long absence of a duly constituted Board has hindered progress in Nigeria’s pursuit of the MDG Goals.”

The MoU signed with the Association of Nigerian Physicians in the Americas (ANPA), Medical Association of Nigerian Specialists in Great Britain (MANSAG), National Association of Nigerian Nurses in North America (NANNA), Nigeria Nurses Charitable Association in the UK and Canadian Association of Nigerian Physicians and Dentists (CANPAD) identifies the following areas of cooperation:
- Research
- Skills and expertise transfer
- Training and Capacity building
- Investment
- Public private partnership.

ANPA has recently developed a template for the Nigerian Undergraduate Medical and Dental Curriculum

### 4.2 MDCN Arrangements with Nigerians in the Diaspora

When asked if they have collaborative arrangements with Nigerians in the Diaspora, the Medical and Dental Council answered in the affirmative, indicating a good relationship with Nigerians in the US and UK. These diasporans regularly come for medical missions which require limited registration to practise. There is a Diaspora Desk at the FMoH which coordinates these activities and works with the Council to ensure that there are no bureaucratic bottlenecks. All states and LGAs are directed to the Council for necessary assistance to support humanitarian activities taking place in their communities.

### 4.3 Tertiary health sector collaborations with the Diaspora

Discussions with the Medical and Dental Council of Nigeria indicate that they do collaborate with both foreign national regulatory bodies and the main international sister regulatory body: the International Association of Medical Regulatory Authorities, IAMBRA.

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They work together to track practitioners all over the world to ensure that anyone charged with unethical practice is denounced. If a foreign medical personnel comes to Nigeria, the Council first and foremost verifies his/her status with the medical council in their country before giving them a licence to practise. The licence may be renewed the next year after he/she has paid the annual fees, demonstrated current knowledge and practice, and is confirmed as having no pending case of unethical practice.

The university teaching hospitals and secondary health sectors are yet to have a structured system of foreign collaboration but they are moving towards that direction albeit on an ad hoc basis. Most of these collaborations are with partners in the USA in the areas of nephrology, ophthalmology and general surgery. One of the university teaching hospitals currently runs a project dealing with cancer of the rectum which involves the lead person coming from the USA to operate with the local team thereby transferring skills. There is also the SMILE train and other collaborative groups on cleft palate. There are some initiatives like the “Ife Advances in medical and dental practice programme” recently set up, targeting the Obafemi Awolowo medical school Alumni. Four Alumni of the university, usually visit from UK, USA and Canada for emergency medicine and other projects. The college initiated this and recognises its importance but the programme is costly to run. They are currently discussing with a US professor who wants to collaborate with Nigerians in pathology. Collaboration in the area of sleep medicine is being discussed with an alumnus. An MoU is usually drawn up for such collaborations. This allows the local institution to provide basic infrastructure and technical staff for such initiative while it is the responsibility of the expert to bring in his/her equipment as the hospital cannot singlehandedly execute the project.

4.4 Areas of Special Interest in Diaspora Collaboration

Putting it bluntly, one respondent opined that Southern Nigeria actually has too many medical doctors in the basic professional qualifications. While recognising that this was not the case for the rest of the country, he added that Northern Nigeria must create a conducive environment in terms of comparative wages and infrastructure to attract medical doctors from other parts of the country in a free job market. For several years now, doctors in Southern Nigeria who have completed their theoretical training, have to wait for up to two years to get a position as house officers for their compulsory residency practice. Some of them who do not find positions in Nigeria either go overseas or return to medical school to retake their final exams and sometimes undertake speciality training.40

Nigeria lacks specialists in many areas. Currently, there are only 600 paediatricians to care for over 40 million children, compared to the United Kingdom where there are over 5,000 for 20 million children. There are less than 200 pathologists, about 15 oncologists; 10 neurosurgeons and no podiatrist. This situation leads to endless waiting of patients and overworked specialists41.

Nigeria needs diaspora collaboration in the following emerging specialised fields:

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40 There seems to be inadequate information on the available places for residency in the North or an unwillingness by Southerners to go there for various reasons including low pay and insecurity.

1. nuclear medicine,
2. oncology,
3. radiotherapy,
4. molecular biology,
5. end of life care,
6. emergency medicine
7. mental health.

4.5 Conditions for Successful Collaboration with the Diaspora

Diasporans collaboration with locals either temporarily or permanently will be helpful but it requires careful thought and planning, says a provost interviewed. He warned that some people who have been away may have narrow perspectives on the current situation of the health care system as some alumni who visited the country are usually amazed at the relatively high level of infrastructure in some tertiary hospitals. However, they tend to be shocked by the erratic electricity and absence of basic equipment and supplies to smoothly run a health facility. Diaspora collaboration must be anchored on a realistic agenda based on joint understanding of what the local needs are. Nigerian tertiary institutions, where the collaboration would be most meaningful, have a fairly well developed system which is bugged down mainly by lack of electricity and basic supplies. Nigerians therefore want a diaspora partnership of co-learning based on a realistic and sustainable agenda which must add value to the current knowledge and experience.

Diaspora expertise is unfortunately not enough to make up for Nigerian government’s prolonged underinvestment in health care infrastructure and planning. Diaspora collaboration will be more meaningful after major investment in health equipment and electricity generation for hospitals as well as the creation of a conducive incentivised environment for health professionals to want to take up appointments in Northern Nigeria. Nigerian doctors are available and waiting to take up appointments under good conditions. They are also enthusiastic about collaboration with their diaspora colleagues, but under good conditions. The problem is that the current environment is not conducive in most of the areas where there are shortages in human resources for health. To confirm this, a strike action has started from July 1st, 2014, which is threatening to paralyse all Federal and state hospitals in Nigeria.
5 Conclusions and Recommendations

The current needs assessment was aimed at identifying the skills gap in Nigeria’s health sector. The outcome of this process is to provide government with the necessary information on the existing skills gap in order to support NNVS to develop their outreach capacity to identify Nigerians who are willing to contribute their competencies and skills towards national development in health care. The process of encouraging skills and knowledge flow from the diaspora to the country of origin for national development, otherwise called brain gain, is in recognition of the presence of relevant skills and competencies in the diaspora that could be harnessed for national development alongside remittances sent by her nationals. The areas identified by respondents for profitable diaspora collaboration include the following emerging specialised fields:

1. nuclear medicine,
2. oncology
3. radiotherapy,
4. molecular biology,
5. end of life care,
6. emergency medicine
7. mental health.

Nigerian tertiary institutions are eager to collaborate with diasporans in these areas but not under any condition. They, as professionals, want a partnership of co-learning based on a realistic, sustainable agenda which must add value to the current knowledge and experience. They are faced with daily challenges of decaying and inadequate health infrastructure and the absence of basic amenities like electricity, often taken for granted in other countries. Diaspora collaboration with simple importation of skills is unfortunately not sufficient. It should also involve a process of joint assessment of need and consensus on how to fill the identified needs. Where equipment is imported, it must be rugged, tropicalised and the skills of technicians developed to service the equipment. In the absence of these conditions, collaboration would be another meaningless exercise.

While working on the issue of diaspora collaboration, grave problems of human resource planning and management plaguing the country were revealed. They can be summarised as follows:

1. Nigeria’s current stock of practising physicians is about 35% of the officially quoted numbers because the data have never been updated since 1963
2. As a corollary, the density of HRH is much lower than often officially acknowledged. With 0.17 doctors to 1000 population, Nigeria’s physician density is actually among the lowest in the continent and compares very unfavourably with Tunisia (11.9), Algeria (12.1), Libya (19.0), Brazil (17.2), Mexico (28.9); and developed countries, such as Greece (60.4), Austria (47.5) and Italy (42.4).
3. In 2005, South Africa had over 5.5 times the density of Nigeria’s physicians, and the rest of Africa had over twice the density of Nigeria’s doctors. The situation has hardly improved in recent times.
4. It is well known and acknowledged that Nigeria’s human resources for health are geographically mal-distributed in favour of urban areas and Southern Nigeria but there seems to be no political will to tackle the problem by providing infrastructure and creating a conducive work environment to encourage medical doctors to take up appointments in poorly serviced states or rural areas. Merely giving the state and Local Government Authorities the freedom but not the budget to improve the payment packages of their doctors has led to several positions not being filled in these levels of health service delivery, even in the face of a sufficient number of unemployed doctors who are consequently forced out of the country in search of jobs.

5. Apart from the low wages, the current state of insecurity in some states in Northern Nigeria is contributing to their inability to attract medical doctors to their health facilities.

6. Every year, up to 1000 of Nigeria’s freshly trained medical graduates are not being absorbed for internship and are literally forced out of the system due to lack of medical human resource planning.

7. Every year, about 700 Nigerian doctors emigrate to Europe (UK), North America, Australia, West Indies and South Africa in search of jobs.

The following recommendations flow from the analysis:

1. The crisis in Nigeria’s human resources for health requires urgent government attention
2. Acknowledge that Diaspora collaboration can be meaningful only after improved health infrastructure (at least regular electricity!)
3. Tackle the issues behind the mal-distribution of human resources for health
4. Provide serious incentives to make rural areas and Northern Nigeria attractive to medical personnel
5. There is need for greater coordination around the various diaspora initiatives

A two-pronged approach is urgently needed in the Nigerian health sector. In the search for members of the diaspora with the relevant skills to fill the identified gaps, it is imperative to tackle the burning issues identified in the country’s human resource planning and management.


Annexes

Table A1: Number of Health Professionals in Nigeria in 2009

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total</th>
<th>In good standing</th>
<th>Female</th>
<th>Male</th>
<th>Public</th>
<th>Private</th>
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<tbody>
<tr>
<td>Doctors (Nigerian)</td>
<td>58,325</td>
<td>20,531</td>
<td>7,883</td>
<td>12,648</td>
<td>14,371</td>
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</tr>
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<td>Doctors (Alien)</td>
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<td>467</td>
<td>321</td>
<td>146</td>
<td>402</td>
<td>55</td>
</tr>
<tr>
<td>Dentists (Nigerian)</td>
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<td>1,239</td>
<td>350</td>
<td>889</td>
<td>480</td>
<td>759</td>
</tr>
<tr>
<td>Dentists (Alien)</td>
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<td>18</td>
<td>14</td>
<td>4</td>
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</tr>
<tr>
<td>Pharmacists</td>
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<td>Midwives</td>
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<td>24,808</td>
<td>15,735</td>
<td>38,666</td>
<td>879</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1,974</td>
<td>Na</td>
<td>775</td>
<td>1113</td>
<td>1129</td>
<td>161</td>
</tr>
<tr>
<td>Health Record Officers</td>
<td>4,953</td>
<td>Na</td>
<td>2236</td>
<td>2717</td>
<td>2654</td>
<td>1368</td>
</tr>
</tbody>
</table>


REQUIREMENTS FOR MEDICAL/HEALTH MISSIONS IN NIGERIA

The Federal Ministry of Health in a bid to achieve effective and efficient medical/health missions in the country has developed basic requirements for medical/health missions in Nigeria. It is therefore imperative that all individual, groups or corporate organizations to be adhered to these requirements as stated below.

Notification of Intending Mission

Individual, groups or corporate organizations intending to provide medical or health services to Nigeria must notify the Diaspora Unit of the FMoH of their intention three months before the planned mission. This is necessary:

1. To give the FMoH enough time to effectively coordinate all ministries, departments and agencies such as MDCN, Nursing and Midwifery Council of Nigeria, Pharmacy Council of Nigeria, NAFDAC that are involved in facilitating medical missions
2. To enhance proper recording and data generation of medical missions as well as on the activities of the health professionals from the Diaspora
3. To allow the Diaspora Unit enough time to verify the relevance of the medical mission to the host community
4. To allow FMoH confirm from the host State/community of their preparedness for the medical mission.

**Obtaining Clearance for Foreign Medical/Health Missions**

obtaining clearance for Foreign Medical/Health Missions, All applications to the Diaspora Unit must contain the following information:

- Name and address of host health institution, LGA and State to be visited
- Type of mission – state whether medical, surgical or both, local or foreign
- Duration of the mission with inclusive dates
- Name and specialty of lead professional for the mission
- Specific requirements - for instance, all doctors are expected to produce (a) Evidence of being registered in country of origin and being in active practice, (b) A current letter of Good Standing from a regulatory body and (c) Submission of duly completed temporary registration and practicing License application forms” (see appendix R1 for full details)
  A copy each of the Practicing License and Specialty Certificates of each physician, surgeon, nurse or health professional in the mission shall be submitted together with the application
- Application letter with the necessary documents should be received by the Diaspora Unit of FMoH at least three months prior to the expected date of commencement of the mission
- Name(s) and specialties of mission team members (if known)
- Written consent from the sponsoring host organization (LGA or NGO) or community (State, Local Government Area or Health facility) certifying the need and type of mission to be conducted. This shall be the responsibility of the Diaspora Unit and/or Mission Lead.

**Feasibility study**

Feasibility study must be undertaken to clearly identify the aims of the mission and the risks associated with it, the consequences of such risks and what steps to take to mitigate them.

**Human Resources**

- Foreign health professionals must demonstrate a valid license to practice in their country of residence in order to obtain limited registration to practice in Nigeria. Under no circumstances shall a foreign physician and/or related health professional practice their profession without a Special Temporary Permit from the MDCN or relevant Nigerian regulatory body.
  - Nigerians doctors intending to conduct medical/health mission in Nigeria must be fully licensed with the MDCN. Please note:
  - Nigerians holding Nigerian passports will be given full registration by the MDCN and must have also obtained license for the current year of practice Nigerians holding foreign passports will be granted limited registration to practice for the period of the mission.
  - Each member of a foreign medical/health team must submit the following documents (in English translation) when applying for temporary license to practice during the duration of the mission: Valid/current license from country of
Evidence of specialist qualification, for example, board certification. Four passport photographs (taken within one year) signed on the reverse.

Drugs

All Drugs to be imported intending missions must meet the following requirements: List of items together with quantity and the expiration dates for the drugs and medicines (not less than 6 months shelf life upon arrival in the country). Flight details to facilitate clearance at the ports. Deed of donation authenticated at the country of origin. Deed of acceptance from the host hospital (community) in line with the drug donation policy. An electronic copy shall be received 60 days and urgent arrangements shall be completed 28 days before the expected date of commencement of the medical/health mission. Drugs and medicines to be used or donated should be on the government’s approved essential drugs list. Application must be submitted two months before the date of mission to facilitate clearance from FMoH and other relevant agencies. The FMoH shall facilitate the issuance of clearance through the Department of Food and Drugs Services (FDS) and NAFDAC for the drugs, health products and medical equipment.

Where the imported drug is not on the essential drug list, a request with appropriate documentation must be made to NAFDAC for special dispensation for importation of the limited quantity required for the mission. The medical mission group and host organization/community should ensure that a report of the outcome of the mission is forwarded to relevant authorities so that steps can be taken to address any issues as a result of the mission.

Equipment

a) All equipment to be imported must be certified to be functional by a hospital engineer in the base country and not older than 5 years from date of manufacturer in line with policy on equipment donations in Nigeria.

b) If equipment is for donation, this should be specified and adherence to the policy on the donation of medical equipment (Guidelines for Donation of Medicines and Healthcare Equipment in Nigeria) should be complied with.

c) If equipment is to be left behind, it should be accompanied with accessories, user manuals and a suitably qualified and licensed local technician must be trained on basic maintenance during the mission. Also, contact for purchase of accessories and parts must be provided at the end of the mission.

End of Mission Activities

• An End of Mission Report shall be submitted by the head of the medical/health mission to the Diaspora Unit of the FMOH within four weeks of completion of the mission.

• All records and audio-visual documents must be submitted in triplicate unless submitted in electronic format.

• All materials submitted to Diaspora Unit shall be the property of the Nigerian Government and may not be used for advertisement, solicitation or medical publication without the written and expressed approval of the FMoH.
• Exit interview - The report shall contain the results of an exit interview conducted by the mission team of the following: Sample of beneficiaries or patients Local organisers/Local Government/State Government to determine ways of improving future missions from the community/perspective.

• The post mission report should contain the following minimum basic information:

The location of the community (beneficiary). The State\LGA. The categories of personnel with their attendant qualifications and expertise. Collaborating agencies such as health centers, medical clinics local government agencies and departments. Numbers, age and gender of cases seen. The major categories of diseases, ailments treated. List of medicines distributed and surgical interventions done. No of trainees (of training missions). The plan of care including endorsements to the necessary health facilities (follow-up, further evaluation and management). Morbidities and mortalities if any.

• The End of Mission Report and recommendations must contain provider information including:

- Duration of mission
- Logistics
- Main outcomes
- Challenges
- Quality improvement strategy
- Next steps.

g. Nigerian host organizations must report the outcome of their post mission survey to the Diaspora Unit of the FMoH.

Source: FMoH