**NATIONAL HRH POLICY 2006**

WHO (2006) defines Human Resources for Health as “those who promote and preserve health as well as those who diagnose and treat diseases.

Human resources are the heartbeat of health service delivery. This is evidenced by the fact that health worker numbers and quality are positively associated with immunization coverage, increased outreach of primary care, and infant, child and maternal survival.

Factors often cited by health professionals especially from the public sector for migrating or leaving their professions include:

I. Poor conditions of service and demoralizing work environments, non availability of relevant equipment and logistics, and lack of incentives for hard work,

II. Unclear career pathways and sometimes absence of, or inadequate career counseling facilities thus making staff take career decisions that may not meet their aspirations.

III. Delays in promotion, poor placement after training and inadequate opportunities for professional advancement.

IV. Many African countries have civil service rules that make health professionals feel that management positions are more rewarding and prestigious than progressing along the health professional lines.

V. Inadequate HR planning at the various levels and this is compounded by the non-availability of reliable, complete and up to date information on staff for decisions making.

VI. Staff distribution in many developing countries is skewed towards urban areas because the development agenda of governments do not create platforms for equitable distribution of social amenities.

VII. In Nigeria, mal-distribution between states is fuelled largely by variations in hiring arrangements as health professionals move from one locations to the other. Hiring arrangements in some states do not favour non-indigenes.

VIII. Mobilisation, allocation, and utilisation of health resources are fragmented among different players. In the Nigerian context, activities of private sector health providers are poorly coordinated. This affects staff development and utilization.

IX. There are no standards to guide staffing and their utilization for both the private and public sector. Whilst worker productivity in the public health sector is very low, many private sector health practices on the other hand suffer from poor work quality because of commercial pressures.

The figures presented in Table 2.1 are for some health professional categories registered by Nigeria’s professional medical/health regulatory bodies as in 2006. They include health workers in both the private and public health sectors, and, very likely, health professionals who are not practising in the country or may not be practising health care at all.

## **Table 2.1. Number of some Categories of Health Workers in Nigeria 2006**

|  |  |  |
| --- | --- | --- |
| **Staff Type** | **Number of Staff** | **No. of Staff/100,000 population** |
| Doctors | 39,210 | 30 |
| Nurses | 124,629 | 100 |
| Midwives | 88796 | 68 |
| Dentists | 2,773 | 2 |
| Pharmacists | 12,072 | 11 |
| Medical Lab. Scientists | 12,860 | 12 |
| Community Health Practitioners | 117,568 | 19 |
| Physiotherapists | 769 | 0.62 |
| Radiographers | 519 | 0.42 |
| Health Record Officers | 820 | 0.66 |
| Environmental Health Officers | 3441 | 3 |

**2.2 Staff Training**

There are 20 fully and 3 partially accredited medical schools spread throughout the country; about 5 additional ones have been proposed. About 33 states in the federation have approved nursing training schools, with some states having as many as 5. Some states do not have any midwifery training instituteon

Some states are better endowed with institutions that train various categories of health professionals than others. The less endowed states such as Jigawa and Gombe are disadvantaged in attracting adequate numbers of critically needed health professionals. Considering the large capital outlay required in setting up and operationalising training institutions, the short term solution should not be replication of programmes in all states. There is need for every state to regularly assess its critical human resources for health requirements, and rationalization of the use of existing training institutions, with provision of adequate resources to enable them cater for clearly defined needs of clusters of states.

Government is the main financier of health training all over the country.

In recent times, newly graduated doctors, pharmacists, physiotherapists, and medical laboratory scientists do not readily get accredited facilities to enable them do their internship. Some have to wait for as long as two years before they can get placement. In the heat of the frustration some are noted to have abandoned their professions altogether and looked for something else to do.

|  |  |
| --- | --- |
| **Table 2.2** | |
| S/N | States | | | Medical | | Nursing | | Midwifery | | Pharmacy | CHEWS |
| 1 | Abia | | | 1 | | 3 | | 3 | | 0 | 1 |
| 2 | Adamawa | | | 0 | | 1 | | 1 | | 0 | 1 |
| 3 | Akwa Ibom | | | 0 | | 3 | | 4 | | 1 | 2 |
| 4 | Anambra | | | 2\*\* | | 4 | | 4 | | 1 | 1 |
| 5 | Bauchi | | | 0 | | 1 | | 1 | | 0 | 1 |
| 6 | Bayelsa | | | 0 | | 1 | | 0 | | 0 | 1 |
| 7 | Benue | | | 0 | | 2 | | 2 | | 0 | 4 |
| 8 | Borno | | | 1 | | 2 | | 1 | | 0 | 2 |
| 9 | C/ River | | | 1 | | 5 | | 3 | | 1 | 2 |
| 10 | Delta | | | 0 | | 2 | | 2 | | 0 | 1 |
| 11 | Ebonyi | | | 1 | | 1 | | 1 | | 0 | 1 |
| 12 | Edo | | | 2\*\* | | 2 | | 2 | | 1 | 1 |
| 13 | Ekiti | | | 0 | | 1 | | 1 | | 0 | 1 |
| 14 | Enugu | | | 1 | | 3 | | 3 | | 1 | 4 |
| 15 | F.C.T | | | 0 | | 1 | | 1 | | 0 | 0 |
| 16 | Gombe | | | 0 | | 1 | | 1 | | 0 | 1 |
| 17 | Imo | | | 1\*\* | | 5 | | 3 | | 0 | 2 |
| 18 | Jigawa | | | 0 | | 1 | | 0 | | 0 | 1 |
| 19 | Kaduna | | | 1 | | 4 | | 4 | | 1 | 4 |
| 20 | Kano | | | 1 | | 1 | | 1 | | 0 | 2 |
| 21 | Katsina | | | 0 | | 1 | | 1 | | 0 | 3 |
| 22 | Kebbi | | | 0 | | 1 | | 1 | | 0 | 1 |
| 23 | Kogi | | | 0 | | 1 | | 2 | | 0 | 1 |
| 24 | Kwara | | | 1 | | 1 | | 1 | | 0 | 2 |
| 25 | Lagos | | | 2 | | 3 | | 3 | | 1 | 2 |
| 26 | Nasarawa | | | 0 | | 0 | | 1 | | 0 | 2 |
| 27 | Niger | | | 0 | | 1 | | 1 | | 0 | 2 |
| 28 | Ogun | | | 1 | | 3 | | 2 | | 1 | 1 |
| 29 | Ondo | | | 0 | | 1 | | 1 | | 0 | 1 |
| 30 | Osun | | | 2 | | 5 | | 4 | | 1 | 2 |
| 31 | Oyo | | | 2 | | 4 | | 5 | | 1 | 2 |
| 32 | Plateau | | | 1 | | 2 | | 2 | | 1 | 3 |
| 33 | River | | | 1 | | 1 | | 1 | | 0 | 1 |
| 34 | Sokoto | | | 1 | | 2 | | 1 | | 0 | 2 |
| 35 | Taraba | | | 0 | | 1 | | 0 | | 0 | 1 |
| 36 | Yobe | | | 0 | | 1 | | 0 | | 0 | 1 |
| 37 | Zamfara | | | 0 | | 1 | | 0 | | 0 | 1 |
| **Total** | | **23** | **69** | | **62** | | **9** | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **S/N** | **State** | | **Population** | | **Doctors** | **Dentists** | | **Nurses** | **Mid-wives** | | **Med- Lab.**  **Scientists** | **Pharmacist** |
| 1 | Abia | | 2,963,275 | | 527 | NA | | 1123 | NA | | 185 | 238 |
| 2 | Adamawa | | 3,254,227 | | 89 | NA | | 882 | NA | | 9 | 116 |
| 3 | Akwa Ibom | | 3,730,227 | | 321 | NA | | 6528 | NA | | 122 | 142 |
| 4 | Anambra | | 4,329,820 | | 669 | 6 | | 1395 | 240 | | 239 | 342 |
| 5 | Bauchi | | 4,431,424 | | 110 | 5 | | 200 | 330 | | 7 | 73 |
| 6 | | Bayelsa | | 1,737,020 | | | 6 | | |

Records available in most states lump doctors and dentists together, as well as nurses and midwives. It does not bring out clearly the distribution and availability of some very essential cadres. In some states midwifery training is a requirement for employment into the public sector for all registered nurses. It is however difficult to differentiate between nurses who have had additional professional training in midwifery and are practicing as such from those who are still engaged in general nursing. There are very low numbers of some members of the medical care team such as radiographers and medical laboratory scientists in some states. The discontinuation of the diploma in radiography programme and the subsequent closure of schools are likely to worsen the situation if intakes into the degree programmes are not increased.

There is evidence of rural/urban disparities in the distribution of health staff. Some states are better endowed with health professionals than others. Some states are however noted for having rules and regulations that unfairly discriminate even against essential and critically needed health professionals that are not indigenes.

Processes and procedures for recruitment of health professionals tend to be cumbersome in many states. Remuneration packages for health professionals vary a great deal between federal and states and also among states. The result is that health professionals tend to gravitate into federal facilities and states where better remunerations are offered. Private providers (except faith based ones) mainly operate in urban settings where income levels are generally high and clients are perceived to have the ability to pay for services rendered. Resultantly there is poor access to qualified and competent health professionals for people living in rural and deprived areas that bear a greater portion of the disease burden.

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