Addressing the shortage of female health workers

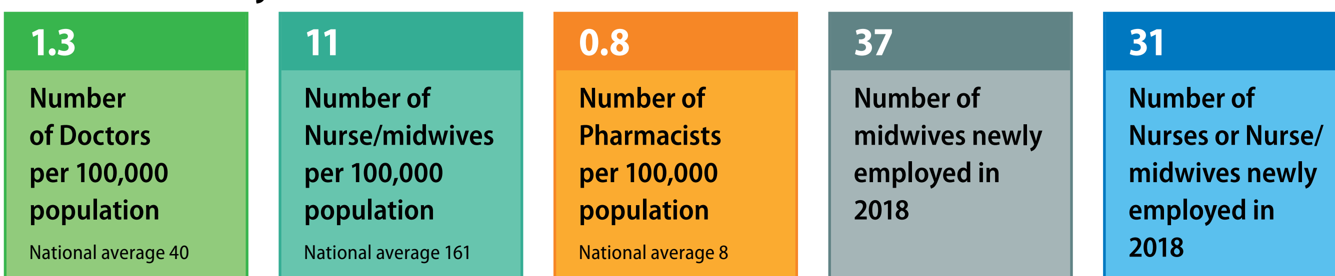
Yobe State:
Urgent action is needed now to increase the number of skilled health workers

Yobe must urgently produce more than 15,700 skilled health workers

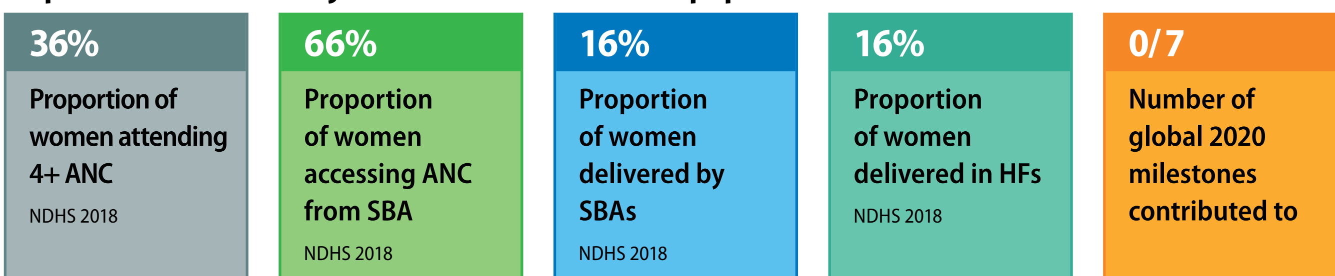
Yobe State in numbers

Background

Current availability of skilled health workers

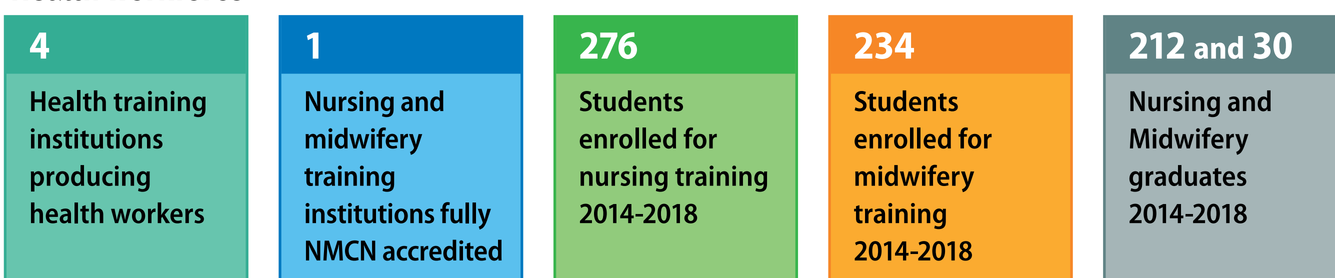


Impact of Yobe health system on the health of the populationn



Health workforce distribution

Health workforce



Immediate and urgent attention is needed to increase skilled health worker production in the state

Summary

Yobe State must produce at least **15 times more skilled health workers** than currently available in the State.

With distribution heavily skewed towards urban areas and production rates extremely low, the health workforce-to- population ratio is **far below the national average.**

To significantly reduce maternal and children under-5 deaths, meet the health needs of their fellow citizens, and global targets to achieve universal health coverage, **Yobe policy makers must commit** to the production of an adequate number of well-motivated, equitably distributed, frontline health workers.

As a matter of urgency, we recommend that Yobe State addresses the following key recommendations:

Key recommendations

Education

- Scale-up training and recruitment of community midwives.
- Increase the number of enrolled students at Health Training Institutions given current resources by aligning tutor-to-student ratios with standards used in other countries.

Finance

- Provide adequate funding for the State Ministry of Health to expand pre-service training capacity and increase production of health workers to meet demand for health services in Yobe State.
- Direct government investments to increasing the production of skilled birth attendants (physicians, nurses, and midwives) to expand access to essential health services towards achieving UHC.

Policy

- Review the incentive package to ensure frontline health workers are retained especially in rural Yobe.
- Increase the term of service for all health workers and tutors by instating the federal retirement exemption that is now allowed for college professors.
- Review terms and conditions for health workers who are non-Yobe indigenes to become more attractive.
- Institute a robust HRH data management system in Yobe state.

The challenge

A WHO paper[1], providing guidance on the workforce required to meet the Sustainable Development Goals (SDGs) and health needs for Universal Health Coverage (UHC) signposts the need to go beyond the focus on the right number of Skilled Birth Attendants and to focus rather on Skilled Health Workers (from 2.31 SBAs to 4.45 SHWs per 1000 population)[2]. In Yobe there is only 0.38 skilled health workers for every 1000 population.

Yobe State - Key Facts

Background and situation in 2018

Population (projected from 2006) **3,528,762**[3]

Annual Population growth rate **3.5%**

Total number of workers in state health sector **7,848**

Total number of health workerswith some skill **3,168**

Total number of skilled health workers available **1,326**

Total number of skilled health workers needed to deliver on UHC/SDG **15,703**

Number of midwives newly employed in 2018 **37**

Number of nurses or Nurse/Midwives newly employed in 2018 **31**

Number of Health Training Institutions producing health workers **4**

Number of Nursing and Midwifery Institutions with full accreditation **1**

Source: Human Resource for Health Policy Brief for Borno state Report. W4H 2019.

A finalised HRH plan with government investment is now needed urgently

The health workforce in Yobe is far below the national average as shown in Table 1.

Currently 1,326 skilled health workers are available in the Yobe health system. But Yobe must produce more than 15,703 skilled health workers to provide care for its current population of 3,528,762.

Yobe State is commended for having had a Human Resources for Health (HRH) Policy in place since 2014. The HRH desk in the Ministry of Health has been created but lacks the resources to carry out its basic functions. A finalised HRH strategic plan is a key next step as is government investment to provide a budget for HRH. These steps will support ownership and sustainability of HRH systems.

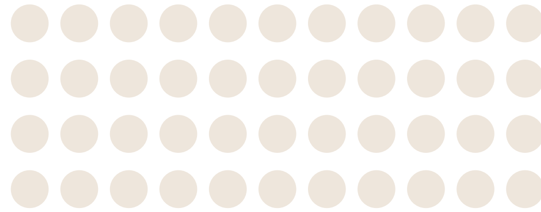
The education and partnership functions of the HRH system are strong with WHO and the UK aid-funded Women for Health programme providing support to the state. However, policy implementation, leadership and financing are much weaker as the government has not demonstrated strong political will and this is compounded by ongoing conflict between armed opposition groups. Reliable and regular HRH data is limited and impacts on policy makers who lack the availability of evidence to make informed HRH decisions.

Table 1 Comparison:

Strength of Yobe health workforce versus the National Average

Doctors

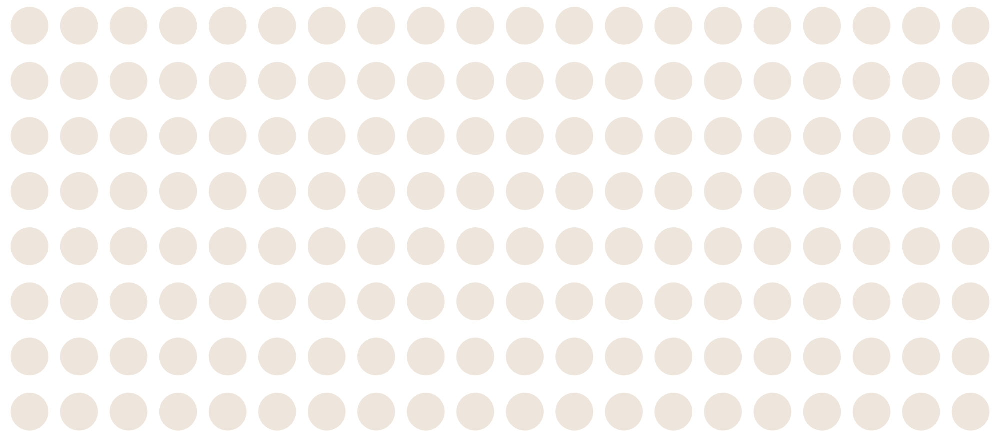
National Average per 100,000 population **40**



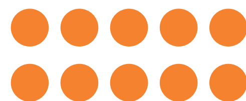
Yobe State per 100,000 population **1.29**

Nurses or Midwives

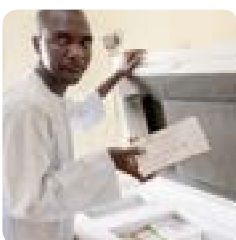
National Average per 100,000 population[4] **161**



Yobe State per 100,000 population **10.84**



Pharmacists



National Average per 100,000 population[5] **8**

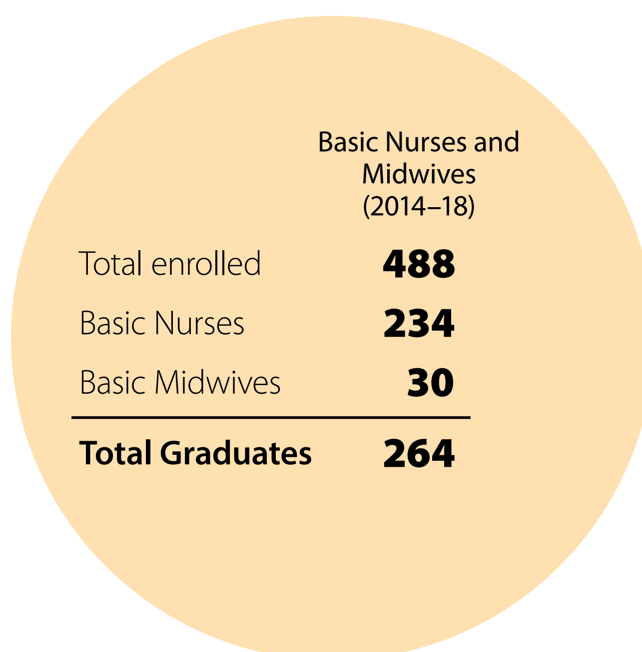
Yobe State per 100,000 population **.76**

Distribution of the health workforce is inequitable, skewed toward urban areas. Only one LGA (Potiskum) has health workers across the four categories of Community Health Officer, Nurses, Midwives and Medical Officers. Of note is the fact that four of the LGAs only have one category of health worker and in very limited numbers. (Fune: 1 CHO; Karasuwa: 1 Midwife; Gulani: 4 Midwives; Yusufari: 3 Midwives) and only two LGAs (Gujba and Potiskum) have one medical officer each. Most doctors, nurses, midwives and pharmacists are based in secondary and tertiary health facilities in the state capital and some of the LGA headquarters.

Production of frontline health workers in the state is so slow that it will not be possible for the state to meet the skilled health worker requirement to deliver on SDG3 and UHC.

Fig 1: Production of Basic Nurses and Midwives in Yobe State

An already poor situation is likely to worsen with a growing population and such low production



Add an increasing population and attrition from existing staff (retirement, resignation, migration and death) to the slow enrolment/graduation rates and the rate of production is extremely low compared to requirements and needs. Production of medical officers and pharmacists is expected to be even worse although there is no current data to illustrate this.

For Yobe State to catch up to the rate of production needed by 2030, the rate of enrolment and production of nurses and midwives will have to increase by a factor of x 14.7 annually from the baseline figures presented in Fig 1.

Even if all four Health Training Institutions in Yobe State were fully accredited and production at full capacity, the institutions would not be able to produce the numbers of skilled health workers needed.

Impacts

The single most important factor to significantly reduce maternal and under-5 mortality in Yobe state is an adequate number of well-motivated, equitably distributed, frontline health workers.

Less than 17% of women hace access to a skilled birth attendant at delivery

Yobe State's current Maternal Mortality Ratio (MMR) is estimated to be more than 1,000 deaths per 100,000 live births, which is significantly higher than the SDG targets (70 per 100,000 live births). The Yobe Infant Mortality Rate (IMR) is 90 deaths per 1,000 live births, which is 7.5 times the SDG target of 12, and the Under-5 Mortality Rate (U5MR) is 152 deaths per 1,000 live births, which is 6 times the SD target of 25[6].

This shows that Yobe state and other states like it are making it difficult for Nigeria to be on track to reach the health related SDG targets.

Addressing barriers to the availability and retention of health workers

Too many barriers are limiting the number of health workers available, strong policy changes are needed

Several barriers limit the availability and retention of the health workforce in Yobe State. These factors need to be addressed if we are to make progress towards global and state ambitions by 2030. They include: inadequate incentives; unwillingness of deployed Midwifery Service Scheme midwives to work in Yobe; inadequate funding and release; delay in completing employment processes; unfavourable policies such as employment of non-indigenes only on a contract basis and posting health workers outside their LGA of origin; interference with deployment /postings; lack of adequate number of midwives for employment; health worker attrition- remuneration gaps; and insecurity and conflict in the state and surrounding areas.

A strong policy on attracting, recruiting and retaining skilled health workers with incentive packages will start to reverse the trend. Table 2 outlines the enabling factors highlighted by WHO for motivating and retaining health workers.

1. Global Strategy on Human Resources for Health (Workforce) 2030, WHO
2. ibid
3. https://www.citypopulation.de/php/nigeria-admin.php?adm1id=NGA008
4. https://www.who.int/workforcealliance/countries/Nigeria_En.pdf
5. https://allafrica.com/stories/201309040940.html
6. Demographic and Health Survey (DHS) Nigeria 2018

Table 2 Enabling factors: Motivation and retention of Health workforce (WHO)

Source: Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention: Global Policy Recommendations. Carmen Dolea, World Health Organization. 2010.

Education	■ Target admission policies to enrol rural female students. ■ Locate health training schools in rural areas. ■ Expose female students of various health disciplines to rural community experiences and clinical rotations. ■ Design continuing education accessible to rural health workers to support their retention.
Policy	■ Introduce and regulate enhanced scopes of practice in rural areas. ■ Introduce different cadres of health workers with appropriate training and regulation for rural practice e.g. Community Midwife, Community Health Extension Worker. ■ Ensure compulsory service requirements in rural areas plus appropriate support and incentives. ■ Provide scholarships and other education subsidies with enforceable agreements of return of service in rural areas.
Finance	■ Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc., sufficient to outweigh the opportunity costs (as perceived by health workers) associated with working in rural areas to improve rural retention.
Infrastructure	■ Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecom, schools, etc.). ■ Provide a safe working environment with support systems.

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