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Manpower Requirements In Nigeria's Health Sector: The Unmet Need To Maximize Our Gains.

by:

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Definition -What is Health ?

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.
In the context of this definition
Who are the Professionals needed to achieve Health?

- To achieve health we need to invest all that is necessary at environmental and individual levels–
- We need workers whose activities ensure a disease free and enabling environment operating through advocacy and other public health activities.
- We need those who guide us in our health seeking behaviors
- We need those who ensure that we are treated when we are ill
- And those who rehabilitate us if the illness is severe or long standing
- We need workers who administer the health centers, those who document the health events , those who advise the authorities on funding issues ,
- And those who plan for sustainable services.

Justification for The Lecture
Within the context of the WHO definition of health, and the implications we presented, it is evident that the personnel, or manpower component of the health sector is critical for actualization of this holistic definition considering that personnel are critical for actualization of disease management preventive medicine, public (consumer) perspectives, health planning, administration, economics, and research .

In developed countries, socio-economic infrastructure and other components of society that enable health service delivery, research, and training of personnel have been addressed, and for more than a half decade, there are clear definitions not only of the need for all the various health specialties, but also of the roles and responsibilities of staff in those specialties

This generalization cannot be made for the countries of Sub- Saharan Africa exemplified by Nigeria. Here, multiple socio-economic deficiencies have impacted negatively on development of the health sector to an efficient level . Very salient too, are multiple qualitative and

quantitative unmet manpower needs in this sector. In the context of a holistic approach to ensure health for all, personnel or manpower requirements go beyond medical doctors, nurse midwives, pharmacists, and laboratory medical scientists. Many other categories of staff are needed for equally vital roles, from medical records /statistics officers and nutritionists, through physiotherapists, to health economists and health administrators

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The complimentary roles of these other staff can be seen if we consider four different health conditions as illustrative examples.

- Multiple injuries sustained during a road traffic accident
- The recent Ebola virus epidemic in West Africa
- A case of breast cancer.
- The current Lassa Fever outbreak in Nigeria that has resulted in almost a hundred mortalities

Outline of Presentation.

- We will present key words basic to the presentation .
- We will then comment briefly on the evolution of healthcare in Nigeria from traditional medicine to formal scientific medicine, and the current state of Nigeria's health infrastructure .

- Our presentation will next centre on issues of manpower needs for healthcare delivery in the country, current deficiencies , gains made, and the unmet needs for manpower development
- We will then suggest remedies that will result in improvements in the manpower quotient of the health sector, and point out the resultant benefits
- We will end with acknowledgments and a summary.

Key Words For This Presentation

Health ,Nigeria Health Sector, Gains and Limitations ,Health Care Delivery ,Health Care Giver, Health Practitioner, Curative Medicine, Preventive Medicine, Preventive and Social Medicine, Community Medicine, Health Administration, Health Economics, Health Planning, Specialist, Consultant, Federal and State Governments., Non-Governmental Organization , Alternative Medicine, Traditional Medicine, Traditional Birth Attendants, World Health Organization, International Labor Organization, Training , Retraining, Socio Economic Defects, Scientific Medicine

Traditional Medicine in Nigeria- A Brief Resume

Traditional medicine in Nigeria is similar to that found in other African countries and entails a holistic combination of use of indigenous herbs and African spiritual worship , with diviners, traditional midwives, and herbalists as the practitioners. These practitioners are ubiquitous and claim to be able to take deliveries, and cure diverse conditions like high blood pressure, cancers, psychiatric disorders, and venereal diseases.

Belief in illness being derived from spiritual and or social imbalance, diagnoses made by spiritual means, and herbal based oral or topical treatment, are the hallmarks. The principles behind the practice of traditional medicine are at variance with those of the technically and analytically based scientific medicine. Before Colonial presence in Africa, traditional medicine was the dominant means of managing illnesses. In traditional medicine, herbs and other methods used are not subjected to research and public regulation, and education is by verbal transfer to favorites or culturally/ spiritually selected protégées

Empirical training of practitioners, defects in documentation and standardization, practice shrouded in secrecy, ethical breaches, and serious adverse effects of medication are known accompaniments of traditional medicine. Even now in the 21st century, scientific medicine still remains inaccessible to a substantial proportion of the Nigerian populace especially in rural areas because of transport, terrain, and other logistic deficiencies, and traditional medicine remains popular.

Traditional Medicine also gives allowance for the human susceptibility to belief in spiritual/ancestral causation and cure of illnesses.

Origins of Scientific Medical Care in Nigeria

Western medicine was formally introduced into Nigeria in the 1860s, with establishment of the Roman Catholic Mission Sacred Heart Hospital, Abeokuta. The missionaries built a few health centres/hospitals. The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centers in the 1870s. Unlike the missionary facilities, their services were initially for Europeans. Colonial government medical services were later extended to African employees of European concerns and servants of

European workers. The hospital in Jos, for example, was founded in 1912 after the initiation of tin mining activities. Initially, there was a preponderance of mission hospitals especially those run by the Roman Catholic Mission. The missionaries treated everyone , and in addition built schools as a vital component of their evangelism.
Establishment of Scientific Medical Care in Nigeria.

The services in government hospitals and clinics were later extended to native staff and eventually to the general public. More facilities were later built in other areas of the country with the extension of colonial influence. Mainstream Christian (Roman Catholic ,and later Presbyterian and Methodist), mission run hospitals were concentrated in the South- Eastern and Mid- Western parts of the country. By the mid 1950s The Sudan United Mission and Sudan Interior Mission had established some hospitals, in the Middle Belt areas and Islamic North respectively. The two missions operated twenty-five hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in Nigeria until Nigeria gained independence.

World War I had a strong detrimental effect on medical services in Nigeria because a sizeable proportion of the few available medical personnel, both European and African were drafted to serve in the war fronts in Europe . After the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established.
Initially, Nigerian physicians, even if trained in Europe, were generally prohibited from practicing in government hospitals unless they were serving African patients. This practice led to protests and to frequent involvement by doctors and other medical personnel in the nationalist movements of the period.

By 1960, there were 118 mission hospitals, compared with 101 government hospitals. In general there was a preponderance of health facilities for maternal and child care in line with established medical trends . At the attainment of Nigerian independence, a noticeable defect was the location of few hospitals in the rural areas where approximately 80 percent of the population resided. The misdistribution of physicians was even more marked because few trained doctors who had a choice wanted to live and work in rural areas.

Some doctors were forced to work in rural areas as a requirement for gaining experience and promotion. Later doctors were constrained to serve in rural areas as part of their required service in the National Youth Service Corps, established in 1973. Few, however, remained in remote areas beyond their required term.

With the formation of states and later local governments, ownership of health establishments was divided among federal, state, and local governments. Private clinics/hospitals started evolving and grew in number from the 1970s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds). 3,023 owned by state governments (47 percent of hospital beds); 6,331 owned by local governments (11 percent of hospital beds); and 1,436 privately owned establishments (providing 14 percent of hospital beds).

Nigeria has always faced problems of geographic /regional distribution of medical facilities and health personnel with the South initially faring better than the north, and urban areas faring better than rural ones within the same geographical region . For example, in 1980 there were an estimated 2,600 people per physician in Lagos State, compared with 38,000 per physician in the much more rural Ondo State.

Whereas approximately 60% to 70 % of the population of most states live in rural regions, only 42 percent of hospitals were located in those areas. The mal-distribution of physicians and other health workers was and up till now is even more marked because few trained health professionals would opt to live and work in our welfare hostile rural areas given the choice .

The Role of The Christian Missionaries in Healthcare Manpower Development

The Christian missionaries 'health sector capacity building in Nigeria did not stop at setting up health facilities. They also played a prominent role in promotion of health manpower by providing expatriate medical and other health staff, sponsoring undergraduate and postgraduate medical education, often in Europe, for many of the first generation of Nigerian doctors and pharmacists. They provided local training for indigenous nurses, paramedical , and auxiliary staff . In addition, education of many Nigerians in their primary and secondary schools

helped lay the groundwork for a wider distribution and acceptance of modern medical care.

During World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to much of the Nigerian population. A ten-year health development plan was announced in 1946. The University of Ibadan was founded in 1948; it included the country's first full faculty of medicine and university hospital, still known as University College Hospital. A number of nursing schools were established, as were two schools of pharmacy. By 1960 there were 65 government nursing or midwifery diploma training schools.

The 1946 health plan established the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions. The plan also budgeted funds and facilities for hospitals and clinics concentrated in the main cities with neglect of the rural areas. There were initially very few health practitioners consisting of missionaries, British Government doctors and nurse midwives on secondment or some other special posting. Nigerian doctors trained either in the Yaba School of Medicine, or Britain, other practitioners – nurses, pharmacists, and laboratory technologists also benefitted from expatriate sponsored training. A good proportion of the indigenous non-doctor staffs were locally trained auxiliaries. The senior staffs were transferred from one hospital to another across the country - for example from General Hospital, Degema or Port Harcourt, to that in Sokoto.

Deficiencies in Manpower Requirements

The colonial and missionary establishments concentrated on training of doctors, nurses, pharmacists, and laboratory technologists (scientists) in descending order of preference.

Very noticeable was the absence of provision for other healthcare professionals including health administrators. This defect still persists up to date. Another defect was a total absence of planning for the geographical distribution of health facilities and staff to man the facilities. Noticeable too in the establishment of health services by both Federal and State governments in Nigeria was the provision of physical structures for the health facility far ahead of planning for efficient staffing and staff manpower, and glossing over the manpower

requirements for management of the facility.

The typical sequence in establishing a health facility was, and till now is a politically motivated announcement of the intention to start a facility, followed by budgeting/ sourcing for funds since a commitment had been made , awarding the contract for the physical structure, and when it was completed, posting a few reluctant and inadequately oriented staff to commence health services there. Provisions for housing and other components of onsite staff welfare were generally neglected. Staff consequently reported intermittently for duty because of difficult terrain and transport challenges, and offered epileptic services.
Governments on occasion reacted by employment of expatriate staff from India, other Asia countries, and Cuba and a few other countries as advisers, health practitioners/ consultants, or managers in these facilities. It is generally not clear if these expatriate staff /advisers are conversant with the disease pattern and other specific health needs of our country. These defects have resulted in an inability to manage primary healthcare issues. They are also reflected in the unacceptable mortality and morbidity patterns seen in maternal and child health, and vaccine preventable infectious diseases.

Qualitative and Quantitative Defects in Basic Staff Training.
The Christian missionaries, and The British colonial governments who started the Nigerian Health Sector apparently concentrated on provision for training of medical doctors and few nurse midwives because of limited funds, and they deemed these staff to be core health staff. To provide complimentary staff, they trained auxiliary nurses, pharmacy, laboratory technology, and radiography staff, and workers to keep patient records . These cadres of auxiliary staff are still present today and function in the health sector. Because of inadequate numbers of qualified health personnel in developing countries, The World Health Organization, Governments, and Non Governmental Organizations have approved the fact of their existence, training, and function; and so we have a variety of auxiliary staff who fill the personnel gaps in the health sector in developing countries. These auxiliary staff are able to perform basic functions in several health specialties but their background defects in secondary education and basic sciences training implies that they are unable to understand the implications of pathophysiology of disease and scientific issues related to patient management, recovery, and rehabilitation.

It makes sense to think that inadequate funds underlie the apparent neglect of the need to train other health professionals since the entry requirements for undergraduate degree admission in pharmacy, optometry, physiotherapy, radiography, laboratory science and a few other courses which are science based (physics, chemistry, biology and mathematics) with English are virtually the same as those for medicine.

Nigeria's Budget in 1966 was 92 Million Pounds.

But one must face the realities of ensuring efficient health care delivery. Even though the functions of the doctors and nurses are very important in managing the patient's illness, the functions of the other health professionals from medical records officers, through clinical psychologists and health educators, to medical rehabilitation officers and home visitors are necessary adjuncts without which efficient treatment, complete recovery and rehabilitation will be impossible.

The few university faculties and the professional councils of most of the other health professionals also designed undergraduate and fellowship training programs often with sub-optimal clinical input. The absence of sufficient numbers of these staff have resulted in logistic bottlenecks in the flow of service delivery in hospitals, unnecessary delays, and marked frustration for both patients and healthcare givers alike. Staff deficiencies in clinical issues have often led to misinterpretation of laboratory results, and unwarranted statements that leave the patients and public confused recently too , with the introduction into health service delivery of physical sciences models, computerized and automated equipment, and protocols using mathematical models , it is imperative that all health staff need continuous updates if they are to keep abreast of recent developments in theory and use of equipment in their respective fields.

Qualitative and Quantitative Defects in Retraining, and Orientation of Staff.

Federal and State governments, international NGOs, and other foreign sponsors yearly commit considerable funds to training programs, but there is no central coordinated appraisal of needs at individual service levels, nor is there sufficient collaboration between the sponsors to maximize the beneficiaries' needs for sponsorship. Beyond managing patients disease conditions, issues surrounding hospital

administration, preventive medicine and other aspects of public health, planning for efficient sustainable health services (including health financing, and economics) have all suffered considerable neglect over the years, with a vicious cycle being created in which the end result is inadequate numbers of personnel in these specialties to give service and conduct basic and post basic training of staff. The situation is compounded by poor/inappropriate funding, deficiencies in planning, and disparities in employment of staff in our health institutions. There are several institutions in which there are redundant non- contributory staff employed for various reasons, and a noticeable deficiency in quality and number of staff needed for efficient service delivery.

The Classic Medical Training Model in The University of Ibadan. (UI)

During the initial undergraduate medical training for six years at The UI, students admitted with Ordinary level credits were taught advanced level physics, chemistry, and zoology for the first one year (Preliminary Year) to replicate the Higher School advanced level requirements for the five year direct entry program. The University of Lagos adopted a similar program .

Later both University of Nigeria, Nsukka, and the University of Ife (now The Obafemi Awolowo University, Ile -Ife) included a variety of student friendly social science courses during the Preliminary year.

Holistic Healthcare Educational Programs as Conceived and Taught by UI from the Mid 1970s.

The University of Ibadan and the UCH later expanded the number of health related departments for undergraduate, postgraduate, and fellowship training programs. The scope of their various curricula was modified to include many aspects of preventive and social medicine, nursing/midwifery, nutrition, health education, health economics, and sociology in relation to health service delivery. Development of faculty programs emphasizing a multidisciplinary holistic approach to medicine has multiple advantages including increased international recognition, and provision of a sound educational base for service delivery, undergraduate and postgraduate training, and research. It also facilities collaborative research and obtaining international research grants.

It is unfortunate that most other Nigerian Universities especially the newest one have been unable to replicate this model in their Colleges of Health Sciences. Constraints to universal establishment of this desirable model in other Nigerian universities include lack of funding and competition by other institutional demands. Another constraint centers on conservative attitudes with resistance to changing global educational and professional trends. This has led to a vicious cycle in which most of the tertiary health training institutions – Colleges of Medicine, teaching hospitals, and research institutes remain grossly deficient with respect to number and quality of personnel and other indices of capacity building.

Health Infrastructure in Nigeria.

The Federal Government has the role of funding and coordinating/ supervising the affairs of tertiary healthcare, university teaching hospitals, federal medical centers , and research institutes. State governments fund and manage secondary healthcare the various general hospitals .

Primary healthcare is largely managed by local governments with focus on primary health centers and dispensaries, which are regulated by the federal government through the National Primary Healthcare Development Agency. Average total expenditure on healthcare as a percentage of the country's gross domestic product averages 4% to 5% . There are also a few missionary hospitals, and many private

clinics hospitals operating at different levels of specialization.

The Ideal Manpower Situation for Nigeria's Health Sector .
Manpower requirements for the health sector have already been well defined by the World Health Organization (WHO), and in developed countries the optimal socio-economic infrastructure and presence of national health insurance has promoted the establishment of well defined roles for all cadres of healthcare workers with stringent guiding professional rules and regulations. Platforms for litigations, and sanctions are available to address erring staff. Very noticeable too are the well defined roles for health administrators, health planning and health economics. A minimum of 75% of the health services including basic and post basic training, and research is provided by the private sector. Federal and State governments' roles are limited to enacting of enabling laws/ regulations, supervision of few key establishments, maintaining the databases, taxation, coordination of all activities through the National Institutes of Health and The Centres for Disease Control and Prevention, maintenance of sanctions, and collaborating with WHO and other international bodies.

Managing The Need for Medical Specialists in Nigeria .
Initially, expatriate mission and government general medical practitioners, and their few available Nigerian counterparts were adequate for maintenance of health services. The need for specialists arose with the expansion of health services, and challenges in managing complications of disease. The need for lecturers with establishment of medical schools, and public health specialists also arose. Local residency training was started in the University College Hospital, Ibadan by The Royal Colleges of Physicians and Surgeons. Some Nigerian doctors became specialists by travelling to The UK to take the examinations after completing their undergraduate training in Ibadan, and with their respective postgraduate qualifications were appoint able as consultants.

The Defunct Master of Medicine (M Med) Program.
Later attempts to establish the Master of Medicine (MMed) degree were not successful and the advent of the West African and National Postgraduate Medical Colleges led to suspension of any further attempts to start university based medical residency programs.

Local Post Graduate Training Colleges – Their Fact

The National and West African Postgraduate Medical Colleges were founded in the 1960s but started formal training of residents several years later through two sections – Colleges of Physicians and Surgeons respectively. The West African Colleges have affiliation with the examining board of the Francophone Postgraduate programs. The residency programs of both National and West African Postgraduate Medical Colleges formerly had some degree of reciprocity with the respective Royal Colleges in The UK , but have recently lost this reciprocity because of alleged deficiencies in the standard of training of the local colleges.

The West African College of Physicians

This college was formally inaugurated in Lagos, Nigeria, on 23rd October 1976. It is one of the two Colleges of the West African Post-graduate Medical College (WAPMC), the largest specialized agency of the West African Health Community (WAHC). The WAHC has recently changed into the West African Health Organization (WAHO) to accommodate other West African countries with its headquarters at Bobo-DiouLasso, Burkina Faso

The West African College of Surgeons

The College was founded in 1960 following a casual discussion between Victor Anomah Ngu a Cameroonian professor of Surgery and a British surgeon Dr. Charles Bowesman on the need for an association of Surgeons in practice in West Africa. In 1973, the association metamorphosed into the College and in 1975 the college was inaugurated as a constituent college of the West African Postgraduate Medical College (WAPMC) - a specialized agency for the West African Health Community. It has sixteen member nations.

The National Postgraduate Medical College of Nigeria

The National Postgraduate Medical College of Nigeria was established in1979 as a parastatal of the Nigeria Federal Government Ministry of Health with the mandate to train medical specialists capable of providing world-class service delivery, training, and research. In conjunction with The West African Colleges, The National College is the apex of postgraduate medical education in Nigeria.

Collaboration Between The Postgraduate Training Colleges

Nigeria is the main sponsor of the West African Colleges, and by virtue of its population has the largest number of both trainers and resident doctors taking the exams. There is currently maximum collaboration between the National and West African Colleges to maximize all efforts and reduce operating costs. The establishment of these colleges has resulted in improvements in the available medical manpower for service delivery, training, and research in the west African sub-Region

Unfortunately a good number of the specialists find themselves constrained to leave the sub - region to other countries all over the world in search of better working conditions and actualization of their professional/academic goals .

Benefits of Local undergraduate and Post Graduate Training in the Health Sector.

The benefits of local training of both undergraduate and post graduate training of medical officers and other health specialty staff are

- Allowance for training of increased numbers of staff.
- Familiarity of both trainers and trainees with the local disease pattern and health sector challenges,
- Retention of trained staff and products to work in the country,
- Saving of funds especially foreign exchange,
- Promoting the capacity of the country to train health personnel for local and international needs.
- Promotion of basic and advanced cutting edge research in the country.
- Attraction of research grants to the country.
- Development of medical science and technology in the country.
- Promotion of service delivery and access of the public to quality health services.
- Reduction of the tendency for Nigerian individuals to migrate to and settle in the Diaspora with loss of our local culture and heritage
- The proliferation of medical Schools, combined with the activities of the local postgraduate medical colleges has not only been beneficial for sustaining health services in the country, but has also served as a very critical intervention for manpower development in the Nigerian health sector, and indeed those of other countries in the West African Sub-Region.
- Local Colleges of Medicine and their affiliated teaching hospitals

have served as the pivots for development of undergraduate, postgraduate, and professional fellowship training programs for nursing, radiography, medical laboratory science, physiotherapy, medical records, and a few other health related courses.

- Currently, more than 95% of health workers in Nigeria received both undergraduate/diploma, and postgraduate/post diploma/fellowship training locally.
- The local training in an estimated 15 % of resident doctors are supplemented by some form of experience in centers of excellence outside the country , while about 25% to 75% have to do postings outside the hospital of their residency depending on their specialty, and the requirements of the respective faculty.

Issue of Continuing Professional/Academic Development

On acquisition of the postgraduate fellowship (for doctors), and professional diplomas/fellowships for other professionals, the onus for further training, sub-specialization, retraining, and ensuring updates in the profession lies solely with the candidate . There is perennial limitation in funding by the government, and often issues of continuing education and professional activities are glossed over during appraisals /promotion . A good percentage of staff are therefore contented with continued service while neglecting continued professional /academic development.

Limitations of Local undergraduate and Post Graduate Training in the health sector

Our universities, hospitals, and other health institutions are currently suboptimal compared to institutions in developed countries with respect to capacity for quality service delivery, training and research
Local training promotes inbreeding and a false sense of achievement

- The international rating of our graduates and institutions will remain low with local training
- Locally acquired certificates and fellowships may not gain wide international acceptance

The Overseas (Year Abroad) Training

In the early 1970s, the defunct Federal Military Government conceived a medical manpower enabling program in which resident doctors at the senior registrar level spent one year in pre-arranged approved centers abroad to improve their clinical, and research skills while at the same

time acquiring exposure to international standards appropriate for their specialty. The program which lasted about ten years was very beneficial in that the trainees and their mentors were able to harmonize The Overseas (Year Abroad) Training with local healthcare delivery needs . Unfortunately the program was latter stopped for unclear reasons. (? lack of funds). Its products are currently at the apex of Nigerian medical service delivery, undergraduate and postgraduate medical education, and research. A few recipients of the year abroad training deviated from the program's objectives to do foreign fellowship examinations, and some were subsequently employed there or in Middle East Countries. A variant of the Year Abroad (The Double Sponsorship Program) evolved years later and still exists in some faculties up till date.

The Role of The National Youth Service Corps Year in Health Service Delivery

A health related objective of the National Youth Service Corps (NYSC) year was to provide basic health services (by young graduate doctors, nurses, pharmacists, radiographers, optometrists, and other staff) in rural areas in all the states.

These Corps members were to work in primary health centers and small general hospitals, and accompany public health workers in mobile clinics to do community based primary healthcare distribution projects.

Actualizing the national healthcare objectives of the NYSC year has not been easy. Inadequate numbers of healthcare graduates, preference for postings to urban and other conducive areas, inadequate planning and preparation for the corps members welfare and service delivery, difficult terrain , security issues, and sub-optimal remuneration, have all been factors militating against maximizing the health related benefits of the NYSC posting. To compound matters now, there is insecurity in a sizeable proportion of the areas in the country where the corps members' health services would have been needed, and no one wants to be posted there

Issues of Cohesion, or The Lack of it among the Tiers of Health Service Delivery

The original conception of healthcare in Nigeria assumed that institutions at the various levels of care will be interdependent and collaborate with each other. This same assumption was also entertained for Federal, State and private hospitals with teaching

hospitals, specialist hospitals, and research centres at the apex of healthcare under guidance of the Federal Ministry of Health. Unfortunately, this much needed cohesion and collaboration has not been achieved , and currently each group apparently operates independent of the other.

Training of Allied Professionals in The Health Sector

Most of the allied health professionals have established diploma, undergraduate, postgraduate, and professional training programs. Currently, university undergraduate degree programs are the gold standard of basic training . This can be supplemented with professional fellowship training. Pharmacy and Nursing have West African College fellowships programs. Pharmacy, laboratory science, radiology, and physiotherapy all now have university based professional doctorate degree programs

The Recent Proliferation of Medical Schools and Teaching Hospitals, and Faculties of Related Health Specialties

The last two decades has witnessed a proliferation of universities and inevitably, establishment of medical schools and teaching hospitals, and faculties of related health specialties. With ownership by federal government, state governments, religious missions, and private entrepreneur groups. Most of the initial effort has been concentrating on establishing medical schools . Issues of substandard funding, accreditation difficulties, staff deficiencies, and over intake of students are topical Most of these ventures have left the respective health profession regulating council busy trying to enforce standards .

Regulation of Best Practices and Ethics in Nigeria's Health Sector.

The Medical and Dental Council of Nigeria (MDCN) is empowered to address ethical issues and regulation of professional standards (including reduction of quackery and malpractice) among medical doctors and dental surgeons. There are similar Councils for the pharmacists, laboratory scientists, nurse midwives , radiographers, etcetera. Their respective disciplinary panels have the status of a high court of the Federal Government, and convicted professionals can seek legal redress at the level of The Federal Court of Appeal.

Unfortunately the presence of these councils has not been able to facilitate reduction of inter disciplinary discord in the health sector.

Geographic inequality and Inadequate Coverage of The Sub-Urban and Rural Areas

Access of the public to health facilities in any region in Nigeria is influenced by different local and regional factors including geographical location, terrain difficulties, public confidence in the type and quality of services offered, and hospital bills. Also, the Nigerian Ministry of health usually spends about 70% of its budget on urban facilities where only approximately 30% of the population resides.

Interdisciplinary Discord in The Health Sector

Interdisciplinary discord in the health sector is a recent and very unfortunate occurrence . The causes of this discord are multiple , with a background conception of allied health practitioners being equal to medical doctors from perspective of academic background, training, and professional usefulness; and therefore demanding equal remunerations and administrative positions. This situation persists despite The Hippocratic Oath taken by all health professionals emphasizing their total commitment to safeguard life above all other inclinations, and explicit guiding statements by both WHO and the International Labor Organization on roles and responsibilities of different cadres these health workers. The government has not been able to resolve the differences , and the results have been contentions, accusations and counter accusations , litigations, and strikes that have paralyzed the health sector.

The Scramble for Administrative and Political Positions

This phenomenon has been insidious and on face value justified by a need to have qualified and experienced professional in administrative positions to assist in moving the health and other public sectors forward. But on critical appraisal, it has resulted in loss of the vital services offered by many of these staff . To compound matters, these positions are associated with attractive conditions of service and are enticing prospects for the beneficiaries who were already eager to escape from professional frustration, inability to achieve their goals, and poor remuneration /other welfare packages general for all civil servants in the country. This contrasts with the situation in developed countries where professionals are valued by the society, actualize their professional and academic ambitions, and earn reasonable incomes from these endeavors.

Inadequacies of The Organized, and Unorganized Private Health Sector

Ideally, up to 75% of health service delivery should be driven by the private health sector. But currently, private health hospital/clinics in the main are often small, and run on part time basis by government employed health staff for the sole purpose of augmenting their poor salaries. These private health institutions charge medical bills that a substantial percentage of the public cannot afford, and unfortunately a proper working public health insurance has not been established in Nigeria They therefore lack capacity to provide a critical level of healthcare delivery for the public. But they are useful in providing healthcare delivery for those who are financially stable, and in their availability during the ever present strikes by government workers.

Manpower Challenges Related to Inadequacies of The Organized, and Unorganized Private Health Sector

Many private hospitals are defective qualitatively and quantitatively with respect to qualified and experienced health manpower. They use staff from government and other private hospitals on adjunct or part time basis. This implies that twenty four hour patient management may not be assured most of the time.

Attrition Related to sub- optimal implementation of Governing Edicts, and other defects in Legislation

On paper, there are well spelt out regulations, edicts, and ethical requirements for best practices with stipulations for sanctions, but empowerment of these edicts by both professional bodies and governments has largely not been very effective. This has resulted in widespread observed breaches of ethics and best practices. Fortunately, the public is increasingly aware of their rights and there are now occasional audits and cases of litigation.

Tertiary Level HealthCare Challenges

Actualization of efficient health service delivery, basic and post basic training, and research in Nigerian tertiary institutions is limited by lack of funding, qualitative and quantitative manpower defects, lack of appropriate/viable equipment, staff indiscipline, inter professional discord, health workers strikes, and inefficiencies in supervision at the level Federal and State Ministries of Health.

Current Benefits and Limitations of sponsored staff training and re-training programs

All categories of health workers on occasion are sponsored to academic and professional programs. The institution and indeed the trained worker should benefit from these programs if a platform is set up to step down the gained experience to other staff and commence service delivery of the new techniques. Several new services and specialty /sub Specialty units have arisen from such programs.

Issues Related to Training of Sub-Specialists

On face value, both doctors, and their colleagues in other allied health professions are committed to having a core of well trained and certified sub specialists. But the prevailing sub-optimal state of the health sector, funding difficulties, and logistic problems negate actualization of this noble dream. Doctors, allied health professionals, and on occasion health administrators should be trained at the same time to form a complete enabled team. The current trend has been to train doctors and one or two nurses/ laboratory scientists for the project, and neglecting the mandatory minimal requirements needed to offer the subspecialty service.

Security Issues

Security is a fundamental requirement for human existence. The past few years have witnessed repeated episodes of assault, kidnappings, assassination, armed robbery, and other acts of violence directed against health workers and their families especially medical doctors. This episodes have resulted in several deaths and physical disability. The Nigeria security authorities have apparently been powerless in relation to either preventing these acts of violence, or apprehending the culprits

The Attrition of Industrial Action (Strikes) in The Health Sector

Strikes and other forms of industrial action are common even though unwelcome occurrences in the Nigerian Health Sector. The reasons for these industrial actions range from unresolved industrial disputes over issues of pay and welfare packages, through protests against alleged disparities in the remuneration of different professional groups to the recent phenomenon of strikes as a protest against kidnapping and other acts of violence against professional colleagues. Whatever the reason(s) for these industrial actions, they result in paralysis of health

services for varying ,and often significant periods of time, neglect of service delivery to the vulnerable low income segment of the public who cannot afford the expensive bills of the private clinics, avoidable mortalities and morbidities especially those associated with pregnancy and child health, loss of continuity in health service delivery, training and research, and artifacts in interpreting health data.

In the University of Port Harcourt Teaching Hospital for example, in 2014 strikes resulted in epileptic hospital services for only 56% of the year, there were only 1089 deliveries. Trainee staff (resident doctors, other hospital staff) and candidates from elsewhere suffered from suspension of training activities, irregularities in data collection, suspension of projects, and inability to meet timelines in their respective academic goals. The hospital lost accreditation in some medical postgraduate training faculties. Undergraduate , postgraduate and fellowship programs of different health professional groups had to be rescheduled with resultant elongation of the timelines for the training programs

The effect of these strikes on the public are worthy of mention. Rescheduling of investigations, treatment regimens, surgical operations, and post –operative rehabilitation implies continuous high levels of public frustration and eventually loss of confidence in government health services. Those who can afford the expensive bills of the private clinic abandon government hospitals. The less privileged low income earners are constrained to borrow money to patronize private clinics. Neglected and unheard, many suffer and die in silence .Auxiliary health staff, native /naturopathic healers, and TBAs are too happy to fill in the gaps left by striking scientific medicine professionals

The Medical Outreach Phenomenon

Medical outreach programs are recent phenomena which evolved about a decade ago . In these programs sponsored by local and internationally based benevolent individuals and organizations, groups of health workers headed by doctors offer rural populations community based treatment of medical conditions for short periods of time generally not more than two weeks. This measure has its usefulness but is inadequate since it covers only a small proportion of each year. It has also been noticed to create an unwholesome situation in which the beneficiaries are constrained to wait for variable periods of time without any medical care between one outreach program and the next .

Special Concerns Related to Research

Even outside academic communities, there is a worldwide tendency to document and give meaningful statistical interpretation of events. Nigerian health workers are enthusiastic about research activities .But they are limited by insufficient funding to do multidisciplinary collaborative cutting edge research, absence of optimal research enabling facilities like equipment, consumables, and basic and anti plagiarism databases, peculiarities of our local disease patterns, and other public health issues like illnesses compounded by alternative medicine treatment.

Manpower Challenges and Inefficiency in the Regulation of Pharmaceuticals

A 1989 legislation listed essential drugs. The regulation was also meant to limit the manufacture and import of fake or sub-standard drugs and to curtail false advertising. This list of essential drugs has undergone recent amendments.

Drug quality is primarily controlled by the National Agency for Food and Drug Administration and Control (NAFDAC). The NAFDAC is generally apathetic towards constituting scientific think tanks under the medical research institutes to conduct clinical trials that would ascertain the suitability of locally manufactured pharmaceuticals and those imported from elsewhere. The country is apparently contented with accepting The USA Food and Drug Administration (FDA) as the gold standard and having units here collaborate with drug trials conceived in other countries. The clinical trials that introduced Artemesinin based anti-malarial treatment were conducted in five African countries excluding Nigeria

Several major regulatory failures have produced international scandals: The year 1993 recorded more than 100 adulterated paracetamol syrup related child mortalities in Oyo and Benue State, the end result was the death of 100 children. A year later, batches of the offending drug containing poisonous ethylene glycol, the major cause of the deaths, were still being sold over the counter.

In 1996, about 11 children died, and up to a hundred suffered severe morbidity from contamination during the Kano Pfizer experimental trial of the drug trovafloxacin. Between 2008 and 2009, a contaminated teething medication caused mortality in over 80 children.

More health staff including those trained in food and pharmaceutical

administration and control are needed to monitor the activities of Nigerian private entrepreneurs who import generic brands of drugs from Asian countries.

Health Insurance in Nigeria

Historically some limited form of health insurance can be said to have been present in Nigeria since independence in that government and private establishments were and are still committed to paying bills for workers treatment when they were ill. In May 1999, the Nigerian government introduced the National Health Insurance Scheme which encompasses government employees , the organized private sector, and the informal sector . The scheme also covers children under five, permanently disabled persons, and prison inmates. In 2004, the Federal Government under President Obasanjo expanded the scheme to include administration by agents (Health Management Organizations - HMOs) in the private sector. The current level of the scheme is still unsatisfactory for various logistic reasons

Health Insurance in Nigeria- Are there any benefits for healthcare professionals ?

Currently because of defects in the establishment of the National Insurance Scheme which was conspicuous in not mentioning health workers' remuneration, HMO activities would appear to be geared only towards maximizing their financial gains at the expense of the healthcare workers , the patronizing public, government, and private health hospitals. Several health workers in the bid to improve their earnings from the insurance scheme have been constrained to join HMOs, or establish their own organization.

Issues of Public /Private Partnership

Public /Private Partnership (PPP) is of proven benefit in development and maintenance of the health sector in developing countries. Unfortunately there are currently few PPP ventures involving established multinational organizations and a currently a preponderance of private individual entrepreneurs from the unorganized private sector. This has caused resistance of health professionals to PPP ventures in health institutions, and friction between health professionals and their respective establishments.

The Brain Drain 1 -Emigration of healthcare Workers to the Diaspora

Retaining health care professionals is an important objective of any healthcare delivery system. Migration of health care personnel outside a country is a topical issue that gives cause for concern. In the last three decades, developing countries have suffered from migration of qualified and experienced health professionals to developing countries in Europe and North America.. The principal reasons for this unwelcome development are the apparent benefits of better pay, realization of professional /academic goals, and improved quality of life in those countries. A reasonable percentage of all cadres of health professionals migrating abroad benefited from government funds for education, and personnel time and effort during their training in the various institutions here, Their migration has resulted in patriotism identity crisis, loss of Nigerian funds invested in health care education, and health professional shortages.
Retaining these trained professionals has been identified as an urgent goal

The Brain Drain 2. Is the gap left by health workers given Political /Administrative Appointments Justified?

On occasion, health workers of administrative grade and union leaders are given federal, state administrative or political appointments, and a few leave the service in search of private or political enterprise. On face value it is easy to argue that many of them are highly knowledgeable/skilled and their temporary or permanent exit will create a vacuum in the service.

A critical appraisal of the situation brings out the following facts:

Life is dynamic and all individuals should feel free to pursue their respective goals provided they are within the tenets of professional regulations and the law. With their wealth of experience they will contribute positively to politics and government. They are empowered to contribute to and head committees related to health, and automatically become advocates for the health sector

The Brain Drain 3 . When should health workers retire/disengage from the service ?

With our dire need for health workers, are we justified in

retiring/disengaging qualified, experienced and internationally exposed staff who are still active and very productive on the grounds that they are up to retirement age ?

Which staff are preferable ?

Overage/retired but efficient staff who not only improve the international rating of the institution but can also groom younger staff ?

Or younger staff who come late to work, contribute minimally, and seek every excuse to absent themselves from work ?

Summary of The Current Situation in The Health Sector - Our Gains in Manpower Development

From humble beginnings set up by the Christian missionaries and British Colonial Government, Nigeria has been able to accumulate a core of educationally knowledgeable and professionally competent health workers most of whom were locally trained. These health professionals have sustained the service delivery, training and research components of the country's health sector. The training activities have also provided healthcare manpower for the developing countries (North America, United Kingdom, and Europe) . The proliferation of academic and professional health training institutions have ensured that we have health professionals and specialists to manage complicated clinical cases and public health issues. The background for actualization of international standards in health service delivery , training, and research is already present needing only logistic refinements to actualize our goals A good number of our locally trained health professionals , all Nigerian born, are employed in international centers of excellence in the Diaspora, but are still affiliated to their relatives, associates and their country Nigeria. Many Nigerian health professionals are currently serving in administrative and political positions and can act as advocates for progress in the health sector especially manpower development.

How then do we Maximize Our Gains, and Reduce Our Limitations?

We can maximize our present gains by first advocating for reduction of the country's current socioeconomic deficiencies. This goal will facilitate enabling activities which will correct the deficiencies that prevent health professionals from achieving their respective academic and professional goals .

The Way Forward - Suggested Remedies

A composite appraisal of the current manpower situation in the country should be undertaken. This move will provide data to enable short and long term planning . The total number of professional groups that are necessary for efficient function of the Nigerian Health Sector should be itemized and the unmet qualitative and quantitative deficiencies with respect to orientation, training, and re-training of these staff carried out. Advocacy for establishing the required faculties and other institutions for academic and professional training for all categories of health workers should be undertaken with governments. Attempts should be made to compile a composite list of Nigerian health workers in the Diaspora to enable incorporating them into capacity building in the health sector even if it is done on adjunct basis.

Advocacy should be undertaken for improved funding of the health sector, improved security in the country, improved social amenities including establishment of health institutions in the rural area , and sponsorship of deserving health workers for training, retraining and other capacity building activities.

Other potential interventions needing advocacy are including health workers in the already established Tertiary Education Fund (TETFUND) and Petroleum Development Trust Fund (PDTF) sponsorship programs, and establishment of special funds for improving capacity in the health sector especially in relation to staff welfare and academic/professional development .

The Federal Ministry of health should reorganize the health sector with respect to established ILO and WHO models for health workers (including welfare packages) which are already operative in developed countries. Orientation seminars for all categories of health workers should be carried out to create a forum for resolving inter professional discord promoting issues, academic assemblies resembling university senates should be set up in tertiary health institutions to include all senior staff of administrative grade. Well defined regulations and edicts should be put in place for managing the health sector especially tertiary institutions. Finite practicable time limits should be assigned to duration of headship of all health institutions, and within institutions for all departments.

Meaningful PPP arrangements with the organized private sector should be introduced in ownership and management of selected

health institutions. Well defined PPP management of residency programs should also be commenced. Emphasis should placed on performance not attendance. Properly defined ratios of clinical/technical staff to administrative staff should be introduced.

Establishment of National Institutes of Health and Centers for Disease Control and Prevention should be a priority. Development of staff programs using USA models and in line with ILO and WHO recommendations should be started . Retention of experienced staff who are productive should be recommended. Creation of a situation in which productive staff in areas of need can serve in multiple institutions on an adjunct or consultancy basis should also be commenced . Government should create well defined pyramidal structures in health service delivery with tertiary institutions at the apex, and the Federal/ State Ministries offering supervisory roles, and defining levels of collaboration between different levels of health care delivery.

All health institutions should use the ILO and WHO recommendations to define staff employment requirements, and organograms for professional activities /roles, and remuneration packages.

Addressing the perennial defects in funding of the health sector is of top priority. When sponsoring staff for programs, their institutions should ensure that facilities are made available for the trained /retrained staff to commence work on return to their institutions.

A Futuristic Projection .

It is unlikely that our country will remain in this situation of suboptimal indices of healthcare delivery. Once the socio-economic background has been laid for correction of most of the basic defects in the health sector, over a period of time most of these defects will be corrected. We look forward to the near future in which there will be minimal deficiencies in the number of all cadres of well trained healthcare workers with all respecting their well defined roles in health care delivery, training, and research, and collaborating with each other to ensure holistic health for all Nigeria.

The prevailing situation then will be proper funding of the health sector, proper training and certification of health workers in line with international standards, and their adherence to professional ethics and inter- professional collaboration. Then too, our private health sector will be well organized and operating at levels consistent with what obtains in developed countries.

Mass drift of health workers to developed countries will be reduced to a minimum because working standards, training and research opportunities, and rates of remuneration in Nigeria will be acceptable.

The consuming public will no longer be constrained to seek medical care elsewhere. Strikes and contention between different cadres of health workers will be reduced to a minimum, and industrial/workplace harmony will be increased .

The roles and responsibilities of different cadres of health workers will be better defined, workers within each profession will have optimum welfare packages and workers will be able to actualize their respective professional/academic dreams.

The consuming public will have more access to efficient and affordable healthcare , and the need to travel out of the country will be reduced with savings in our much needed foreign reserve.

Similarly, the current drift of healthcare professional to other countries will be reduced and Nigeria may approach the level where it attracts professionals from other countries seeking improved professional, and welfare opportunities here.

What is Most Crucial in Solving The Manpower Needs in The Nigeria Health Sector

We hope that ultimately, socio-economic development with increased levels of public formal education, individual and public empowerment, and access to human rights to addresses inconsistencies in the system will provide the answer. The Unmet need to maximize our gains in manpower development in the health sector will then be addressed gradually with time.

NMA Recently Faulted the 2016 Budgetary Allocation to Health

The Nigerian Medical Association (NMA) recently faulted the 3.6% 2016 budgetary allocation to the health sector and the absence in the budget proposal of the N60bn (equivalent of at least one per cent of the Consolidated Revenue Fund) envisaged to accrue as the Basic Health Provision fund as enshrined in the National Health Act of 2014.

Summary

Nigeria has a core of well trained health professionals in many specialties. Most of them are locally trained and have been able to sustain service delivery, training, and research activities. However,

socioeconomic deficiencies reflected in challenges in funding, staff welfare, infrastructure, and artifacts created by insecurity, strikes, inter professional discord have prevented the staff from realizing their academic and professional goals . Advocacy for correction of the country's socioeconomic deficiencies will pave the way for correction of the qualitative and quantitative manpower challenges in the health sector.

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My medical and nursing colleagues in The Department of O&G, UNIPORT/UPTH made very useful contribution to the content of this lecture and have always been very supportive in all my academic and clinical ventures.

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Finally to The Almighty God be The Glory for His Mercies and Grace that enabled us survive 2015.

An Afterthought.

As we look forward to the future in which most of our health professionals working in Nigeria can actualize their professional dreams, a future in which all indices of healthcare delivery, training, and research in Nigeria will be at par with those found in developed countries, and health workers in different specialties will work together in harmony in an industrial strike and kidnapping free Nigerian environment,

We remind ourselves that from humble beginnings the pioneers in the Nigeria health sector made substantial gains in service delivery, manpower development, and research. They worked tirelessly, did not

go on strike, and managed all challenges resulting from inter-professional differences such that discord was virtually unknown of.
Prof Nimi Briggs and C T John as first and second head of the Obstetrics & Gynaecology Department, UNIPORT/UPTH respectively shared the single available office with five other consultants and the chief nursing officer in charge of the department for eleven years. They focused on the terminal objectives of improved service delivery, manpower development, and research. The results of their efforts in manpower development are obvious today

We Should Continue to Hope for of Socio-Economic Advancement

Socio-economic development and advocacy will enable improved funding and most of the suggested remedies in the health sector. Money does not buy happiness but pays the rent and enables the candidate's transport and other logistics to search for it.
But We as health practitioners should not be discouraged by current funding difficulties and other deterrents. We Should Emulate the Asians (especially India and China) who are moving forward despite nature's challenges.
Families and communities in Asia now pool their financial resources together to train deserving young relatives in The USA , UK, and Europe. They also collectively set up family or community health institutions (health management organizations, hospitals, drug companies, and non-governmental health organizations) .We are witnesses to their efforts . Sick individuals worldwide, even from The USA and Europe now travel to India for medical treatment.

Nigerians are Equally Capable . After All, We Built Abuja, Our Magnificent Capital

We must rise to the occasion, and ensure that we make our maximum input each day.

Last Words

I wish to end by saying:
Thank You all for a Hitch – Free Transition from 2015 to 2016 and God Bless You For Listening.

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