EDITORIAL

The human resources for health crisis in Zambia: Deaths, Departures, Demoralising conditions of service and a disinterested Diaspora...

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For over a decade, the health sector in Zambia has given us a glimpse of the nightmare unfolding in the sub-Saharan region, a consequence of not investing in the training of staff to man our hospitals and care for our people. Zambia is facing a human resources for health (HRH) crisis that threatens the attainment of the millennium development goals (MDGs). In our lead article, Miti elucidates the issue of HRH that is neglected and yet critical to combating the health crisis . We add our voice to the numerous voices that have been raised, both local and international, in addressing the imbalances that exist in health care delivery in the developed north and developing south. It does not require a mathematical genius to realise that a Zambian nurse's salary of 110 pounds per month compares poorly to her colleagues working in the United Kingdom and earning over twenty times as much. Yet the donor community has placed a ceiling on how much must go to personal emoluments (PEs). It is paradoxical that these very donors, with the endorsement of our government, have set very ambitious MDGs. What happened to the "Health for all by the year 2000" campaign? Is it not the same international community that are signatories to the Alma-Ata Declaration, which clearly spells out health as a basic human right.[3] There are however indications that there is a change in donor thinking. This is evident in their support of financial and non-financial incentives to keep our doctors in the rural parts of the country.

Needless to say, it is easy to lash out at the donors when some of the problems we are faced with are self-inflicted. At the centre of this unfolding crisis has been our government's policies and attitude towards indigenous health staff. Previous government programmes have undermined the delivery of health in Zambia. Such actions have included the ill-conceived voluntary separation package (VSP) that led to the exodus of many Zambian nurses and the early retirement of resident doctors in 2000 following an industrial dispute. The United Kingdom and Botswana were beneficiaries of the exodus of our nurses and doctors respectively. Suffice it to say, departures and demoralising conditions of service have not been the only factors at play in this nightmare, death has accounted for a large number of health staff lost during this difficult period in our history. As Miti rightly points out, a local factor for the high attrition rates that should not be underplayed is the high mortality and morbidity among health workers from HIV/AIDS related illnesses. It has become increasingly apparent that workplace programs have overlooked hospital workers even though they too are at risk for HIV infection, both from occupational and nonoccupational factors[4]. What is even more of a paradox is that most of our health institutions do not have HIV/AIDS workplace policies whilst other government departments such as Education have had these in place for years. Are we living in a cocoon or denial? Why should the mortality be so high among health workers when antiretroviral drugs (ARVs) have been free for the last five years and we are the prescribers and distributors of these drugs? The consequence of all these factors that have a negative impact on health has been quite evident. We are grappling with an infant mortality rate of 95 per 100,000, maternal mortality rate of 749 per 100,000 and an HIV prevalence of 16% among adults.

Gloomy as this may appear to be, lessons may be learnt from countries like Cuba. This island state now boasts of stunning health achievements with many national health indicators, such as infant mortality rate, comparable to the United States and yet their economy has been struggling for decades. Under a well-structured technical assistance programme, Zambia has benefited from Cuban health personnel who have gone back to their country upon completion. Can't Zambia export its doctors and nurses in an orderly manner so that their foreign earnings are deposited in the Bank of Zambia? For example, three quarters of Egyptian foreign exchange earnings is from the export of its human resource to neighbouring oil-rich countries. The disorderly export of our human resource has led to a failure of our people to invest their earnings in Zambia and in a Diaspora disinterested in their country of birth. If only we could learn from Uganda, which makes a fortune from the foreign earnings reinvested in the country from the hundreds of thousands of Ugandans spread all over the globe.

With conviction as a nation, creative management that seems to finally be in place and strategic engagement of the donor community, attainment of the MDGs may still be a reality. We all have to rise to the challenge.

***References**:*

1. *Miti SK. The human resource crisis in the health sector in Zambia and efforts by the Ministry of Health to address the crisis. Med J Zambia 2007; 34:1: 2-4.*
2. *Ministry of Finance and National Planning (2007) Medium Term Expenditure Framework. Government Printers. Lusaka.*
3. *World Health Organization. Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, Sept 6-12, 1978. WHO, Geneva.*
4. *Karusa K, Ngulube T, Nyumbu M et al. Caring for caregivers: The HIV/AIDS needs of hospital workers in Zambia, Horizons Research Summary 2005. Population Council: Washington DC.*

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The Human Resources Crisis in the Health Sector in Zambia and efforts by The Ministry of Health to address the Crisis

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Introduction

The health sector in Zambia is facing Human Resources for Health crisis. Information from the Human Resources Information Systems in the Ministry shows that the Zambian public health sector is operating at 50% capacity[1]. Causative factors are both exogenous and endogenous. Exogenous factors include austere fiscal measures (HIPC conditionalities) introduced by IMF and World Bank, which restricts the Ministry to recruit beyond the Personal Emoluments (PE) ceilings set by the Ministry of Finance. There is also a growing global labour market for human resources for health in developed countries especially the UK, Australia, New Zealand and the USA. Endogenous factors include poor conditions of service and work environment coupled with low training outputs.

Faces of the crisis

The crisis can be depicted from three broad perspectives namely, recruitment, attrition, and distribution. These three factors have an interrelational effect on the human resources for health crisis facing the sector. The following is an illustration of how the three factors interplay and impact on the human resources situation in the health sector:

Recruitment

To start with, the training institutions have a **low capacity** to produce enough graduates to meet the demand for health workers in the sector. The production and training of health workers has not kept pace with health sector needs, both in quantitative and qualitative terms, especially to address the increasing burden of disease as a result of HIV/AIDS and to cater for evolving and expanding health worker roles and new forms of service provision. The under-funding of health training institutions, poor training and accommodation facilities, inadequate equipment and materials, and the lack of training staff have resulted in high attrition rates from pre-service training, fewer graduates and deterioration in the overall quality of outputs. This has resulted in fewer numbers of graduates to be recruited into the system.

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Restrictions on recruitment to maintain the PE to GDP ratio are another factor that has severely affected the number of health workers in the sector. Macroeconomic policies, driven by multilateral partners' conditionalities, are impacting on the ability of the health sector to increase its spending on Human Resources for Health. Restrictions are mostly on the civil service budget, which has led to constraints on health worker recruitment and salaries. In the case of the health sector in Zambia, there is the need to conform to the PRSP targets that the Government has agreed to for the level of spending on public servant personal emoluments (PEs), which is currently set at 8.04 % of PE to GDP ratio[2, 3]. The national PE/GDP ratio in 2004 was 7.49% and the MoH budget for PEs was K234 billion, which represents a PE/GDP ratio for the health sector of 0.9163%. The PE/GDP ratio for 2005 was 0.7676% [4].

Due to piecemeal restructuring, the Ministry of health only had an approved establishment for 93 staff at the Ministry headquarters. There was no establishment to which the rest of the 23,000 plus health workers could be placed. This made recruitment of health workers difficult, as there were no vacancies against which they could be recruited. Related to the problem of lack of an establishment was the emphasis on recruitment of non-core health workers such as accountants and data management specialist which was primarily driven by the health reform program, which gave more weight to systems development, and less on service delivery. For instance out of the 23,000 health workers on the Ministry of Health payroll in 2005, 11,000 or 48% were support staff [5, 6].

Attrition

There are many reasons given for health worker attrition in Zambia. Evidence suggests that a substantial number of Zambian health workers are migrating to other countries, attracted by better conditions of service and career development opportunities. Other causes of attrition include death mostly due to HIV/AIDS, the early statutory retirement age at 55 years when health workers are still productive, resignations and dismissals. At larger institutions the workload for the remaining staff increases when an individual leaves. At a health centre where the individual is the last remaining health professional, the loss of one person can have much more dramatic effects.

Distribution

The problem with staffing shortages goes beyond numbers and the overall headcount. There are severe staffing imbalances in terms of numbers, skills mix and geographical distribution. Numerical imbalances are a result of staffing shortages, high population/staff ratios, and pay and workplace conditions. Poor training quality, inadequate training facilities, shortages of trainers, staff absences and the mismatch between skills and health sector needs cause skill mix imbalances.

Distributional imbalances are as a result of urban-rural disparity, weak posting procedures, personal preferences and socio-economic considerations. Imbalances are also as a result of the use of essential cadres e.g. medical specialists and senior nurses for managerial functions. There is some evidence to suggest that the total number of doctors in-post may actually be lower than the reported figure as some are in managerial/administrative positions.

Analysis by province shows a skewed staff distribution in favour of urban areas, e.g. Lusaka has a doctor population ratio of 1:6247, which compares very well with the WHO standard of 1:5000 compared to Northern Province with a ratio of 1:65,763.[2]

Impact of the crisis on health service delivery

The shortage of human resources has been a major constraint in the Ministry's efforts to scale up its health programs. This has contributed to lack of improvement in overall health status as the crisis entails that Zambia cannot guarantee the provision of the basic health care package.
It is evident that the shortage of human resources and the increasing attrition of staff are major obstacles to improved service delivery in Zambia. There are only just over 600 doctors working in the public sector and there are severe shortages of nurses and other key staff[2]
Planned interventions are not being implemented simply because there is not enough staff or suitably trained staff in the health facilities to provide the services. For instance, unqualified health workers are currently running about one third of the rural health centres. This has greatly compromised the quality of health services delivered. Unless concerted efforts are made to address the crisis immediately, the MDG targets will not be attained.

Current intiative to address the crisis

Current initiatives to address the crisis are being done at the district level, at national level and through bilateral co-operation with Co-operating Partners supporting the sector.

Action at the District Level

Some District level managers have made local initiatives to address the crisis using locally available resources. Action at ***District Level*** includes:

- Provision of staff transport for health centres in remote areas through purchase of motor bikes.
- Group performance incentive schemes such as performance related allowances for meeting some targets such as immunisation coverage.
- Top-up salaries for staff in remote areas to attract staff to serve in health centres that are hard to reach and in the least developed areas.
- Renovation of staff accommodation and the provision of safe water through sinking boreholes.
- Electrification of health centres and staff houses using solar in remote areas.

Action at National Level

Through the national budgetary allocations to the Ministry of Health, the Ministry of Finance has during the last two years increased its overall allocation to health, and also made some deliberate budget allocations earmarked at addressing the Human Resources for Health crisis. For instance there has been:

- An increase in government budget to the health sector from 9% in 2004 to 12% in 2005. In 2007, the overall Government budget allocation to the health sector increased from USD$130 million in 2006 to USD$205 million, an increase of about 36%.[5]
- An allocation of US$9.4 million to the Ministry above the sector PE budget for recruitment and retention of 1,800 employees
- An allocation of about USD$1 million for the Car Loan Scheme for medical doctors in the 2006 budget.

Support from Cooperating Partners

Co-operating Partners have been very instrumental in introducing targeted interventions aimed at addressing the crisis. This has been done through the following interventions:

- The Zambia Health Workers' Retention Scheme for medical doctors in rural areas with support from the Royal Netherlands Government. The scheme pays a rural hardship allowance of Euros 360 for category D districts or Euros 310 per month for category C districts; a one off Euros 3000 housing rehabilitation grant; access to loan equivalent to

90% of the value of the 3 year contract which is equivalent toEuros 10,044 for category C districts or Euros 11,664 category D districts towards the purchase of vehicle or house mortgage; and end-of-contract incentive equivalent to Euros 2790 or Euros 3240 for category C or D districts respectively.

- Recruitment of 9 Provincial Clinical Care Specialists with support from USAID.
- Renovation & construction of houses for medical staff in Luapula Province with support from USAID
- Institutional & scholarship support for the training of Zambia Enrolled Nurses and Midwives in North Western Province with support from UNFPA which bonds the trainees to serve in the North Western Province for a minimum of two years upon graduation.
- WHO salary supplementation for lecturers at the School of Medicine, University of Zambia.
- SIDA support for training of nursing tutors, curriculum review & general strengthening of nurse training institutions.

Establishing Placement Links with the UK National Health Service

Recently, the Ministry of Health has been engaged in discussion with the UK Government through the Tropical Health and Education Trust to enter into a strategic alliance where health workers from the UK National Health Service and medical universities will engage in a placement program at health facilities in Zambia. The NHS and UK University staff will engage in the following activities for a limited duration through this program:

- Training in teaching, research, administrative support, management and leadership.
- Teaching clinical and other skills to doctors, nurses, paramedics, and undergraduates.
- Service planning and design.
- Some targeted support through equipment and learning materials.

The Ministry of Health and the Tropical Health and Education Trust in the UK will run the placement program through a Health Link program, which will be co-ordinated.

Country level solutions to address the crisis

The Ministry of Health has realized that all the above initiatives were implemented in a fragmented manner hence the need for a co-ordinated and holistic approach to resolving the crisis. In addition, the extent of the crisis prompted the President of the Republic of Zambia to demand for a comprehensive plan to address the crisis. This demonstrates commitment at the highest political level.

In response to the presidential directive and realizing the need to provide a strategic framework within which a more coherent response to the crisis can be implemented, the Ministry of Health developed a Human Resources for Health (HRH) Strategic Plan 2006 – 2010[2]. The HRH Strategic plan will provide an implementation framework for all efforts towards resolving the Human Resources crisis in Zambia.

The HRH Strategic Plan will serve as an entry point for all Government and Co-operating Partner support for HRH. The plan has been costed at USD313m for the first three years. The Ministry of Health is using the plan as a tool to mobilise resources for HRH. There are commitments from the EU, CIDA, Sida, USAID and DGIS to contribute towards the implementation of the plan. In 2007, a total of USD$15 million has been allocated from the Co-operating Partners to a common funding pool called the Human Resources for Health Basket fund[3].

Challenges to implement the HRH strategic plan

Zambia now faces the challenge of mobilizing enough resources to implement the HRH Strategic Plan. Furthermore the Ministry of Health must convince all donors supporting the sector response to address the crisis to shift from pilots and project mode of supporting HRH to an integrated and holistic sector wide approach support to HRH.

References

1. *MoH (2005) Ministry of Health Human Resources Information System (Unpublished).*
2. *MoH (2006) Human Resources for Health Strategic Plan (Unpublished).*
3. *MoH (2007) Ministry of Health Action Plan (Unpublished).*
4. *Ministry of Finance and National Planning (2005) Medium Term Expenditure Framework. Government Printers. Lusaka.*
5. *Ministry of Finance and National Planning (2007) Medium Term Expenditure Framework. Government Printers. Lusaka.*
6. *Public Service Management Division (2005) Public Management and Expenditure Control (Unpublished).*