

## Optimizing Human Resources for Health Towards Universal Health Coverage: Promising Policy Thrusts

### Background

Nigeria's health system performance is sub-optimal and the country's health indices do not reflect its income status. The infant mortality rate is as high as 69 deaths per 1,000 live births, and the under-5 mortality rate is 107 deaths per 1,000 live births, higher than the Sub-Saharan African average of 49 deaths per 1,000 live births and 71 deaths per 1,000 live births respectively.<sup>1</sup> The disease burden in Nigeria has been exacerbated by limited access to basic health care services, posing a significant barrier to achieving health policy goals. The low skilled birth attendants rate exemplifies the below-par health access, as only half of births are assisted by skilled health workers, and only a third of children aged 12-24 months are fully immunized.<sup>2</sup> One of the factors responsible for the sub-optimal health system performance is the Human Resources for Health (HRH) constraints characterized by low density, inequitably distributed, sub-optimally motivated, and under-supervised health workforce. The gap in the health workforce density in Nigeria is coupled with the inability to optimize the available human resources for health. This constitutes a barrier to strengthening the healthcare system and the quest to put the country on the universal health coverage (UHC) trajectory.

Several government policies are geared toward addressing gaps in HRH outcomes, such as low workforce density, inequitable distribution of HRH, inadequate skill mix, and

suboptimal workforce performance. Some of the policies include Primary Health Care Under One Roof (PHCOUR) which involves migration of management of primary health Care (PHC) staff from LGAs to the State Primary Health Care Boards (SPHCB), Primary Health Care HRH strategic plan, exit replacement policy, task shifting policy, linking of HRH database to payroll, and recruitment and retention strategies. Other policies include the Basic Health Care Provision Fund (BHCPF), Midwives Service Scheme (MSS), Community Health Influencers Promoters Service (CHIPS) program, etc. Though these policies exist in many states, their implementation levels vary widely across the states. Some development partners have also supported promising HRH interventions. One is the World Health Organization's support to the Federal Ministry of Health on the Human Resource Information System. The Bill and Melinda Gates Foundation (BMGF) also developed a 10-year PHC HRH Strategic Plan for its supported states. To expand its HRH interventions in Nigeria, the BMGF engaged the Development Governance International (DGI) Consult to develop an HRH Strategy for its Nigeria Country Office.

As part of the process of developing the HRH Strategy, DGI Consult conducted HRH situation analysis in ten states – Bauchi, Borno, Gombe, Lagos, Kaduna, Kano, Nasarawa, Niger, Sokoto, and Yobe, to identify gaps and best practices in human resource governance,

<sup>1</sup> World Bank Open Data (2022). Accessed at: <https://data.worldbank.org/indicator/SP.DYN.IMRT.IN>, <https://data.worldbank.org/indicator/SH.DYN.NMRT>, <https://data.worldbank.org/indicator/SH.DYN.MORT>

<sup>2</sup> Nigeria Demographic and Health Survey, 2018

optimization, outcomes, etc. This led to the identification of policies and practices being implemented in the states towards optimizing the health workforce to achieve health system goals. This policy brief describes some HRH policies and optimization-enabling practices implemented in some states and the key results of these on the HRH landscape.

### Approach

The HRH situation analysis used mixed (quantitative and qualitative) methods to generate evidence on the gaps in HRH governance, financing, and political economy; HRH management and regulation; HRH optimization; and service delivery. The major activities conducted include (a) entry meetings to introduce the project to key stakeholders; (b) development of an HRH optimization framework to examine the HRH landscape; (c) development of data collection tools in line with the components of the theoretical framework; (d) literature review; (e) key informant interviews; (f) stakeholder workshops to obtain additional information;



Figure 1: Stakeholders Workshop on Human Resources for Health Optimization- Kaduna State

(g) rapid facility assessment to have an objective insight into the current level of HRH

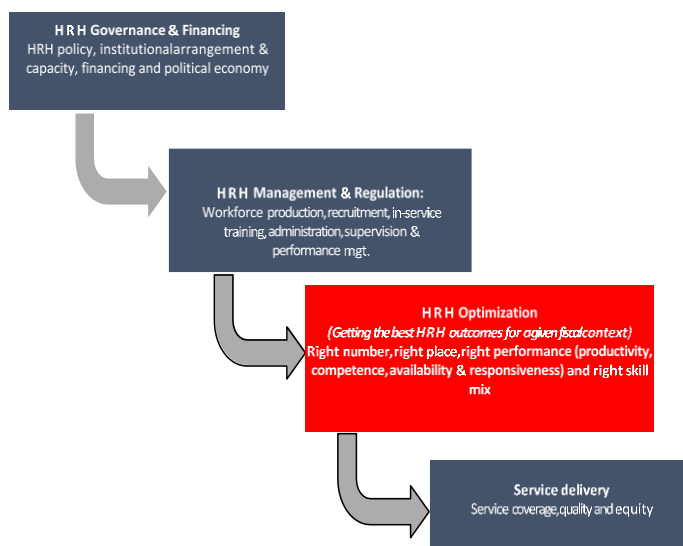
optimization in the states; and (h) validation workshops to verify the data collected and seek stakeholders' input in the findings.



Figure 2: Stakeholders Validation Workshop on Human Resources for Health Interventions - Kano

The HRH optimization framework considers all drivers of optimal HRH performance. It combines assessment and governance elements to create a comprehensive HRH optimization model. The framework integrates elements from the international HRH Action Framework,<sup>3</sup> WHO HRH Assessment Guidelines<sup>4</sup> and the WHO health system governance action plan for UHC.<sup>5</sup>

Figure 3: HRH Optimization Framework



<sup>3</sup> CapacityPlus. Global Health Workforce Alliance. 2024. HRH Action Framework: A Comprehensive Approach for Addressing Health Workforce Issues. Available from: [www.capacityplus.org](http://www.capacityplus.org)

<sup>4</sup> World Health Organization. 2004. A guide to rapid assessment of human resources for health. Geneva, World Health Organization.

<sup>5</sup> World Health organization. 2014. Department of Health Systems Governance and Financing. Health Systems Governance for Universal Health Coverage.

## **HRH Optimization Policies in Practice**

HRH optimization is getting the best HRH management outcomes within a given fiscal context. The desirable HRH outcomes include having the right number of health workers in the right places, in the right skill mix and with the right performance.

The situation analysis compiled the HRH optimization-enabling practices implemented in the states and their impacts. The policies and practices that were being implemented in some of the states to improve HRH outcomes are described below.

### **1. Exit Replacement Policy**

The high attrition of the health workers, one of the HRH challenges identified across the states, has led to a shortage of the affected cadres of staff, especially the frontline health workers, which has implications for health service delivery. In addition to its implication for service delivery, the delay in replacing exited health workers constitutes a significant source of wastage in the health sector as wages and salaries of these erstwhile workers still find their way out of government coffers. Standing order on exit replacement is a policy geared towards removing workforce replacement bottlenecks that aims to promptly fill HRH gaps to cushion the effect of attrition on service delivery and minimise wastage.

The standing order on exit replacement in the health sector was issued by the Governor of Lagos State in the year 2020 to remove bureaucratic bottlenecks that impede the replacement of exited health workers. The Lagos State Primary Health Care Board and Lagos State Health Service Commission have the approval to immediately replace health workers who exited the workforce for one

reason or another, and this is being practised quarterly or as the need arises. The standing order on exit replacement has led to a relatively stable trend in the number of healthcare workers despite the high attrition of healthcare workers experienced in the state.

Across the states assessed, only Lagos State had a robust plan to replace exited health workers.

### **2. Health Workforce Cadre Conversion**

One of the HRH management issues revealed by the HRH situation analysis is the suboptimal capacity to use HRH data for decision-making. This was grossly lacking because, for many states, partners have supported the development of their state health workforce registry, but the data have not been regularly updated. Some states have gone back to using manual and electronic databases managed by the State Ministries of Health (SMoH) and State Primary Health Care Development Agencies (SPHCDA). In 2021, the National Primary Health Care Development Agency (NPHCDA), in collaboration with the SPHCDA and the SMoH, conducted an extensive human resource for health preliminary assessment that established several gaps in the health workforce across the states. One of the issues identified is excess health workers in the non-clinical cadres (environmental health officers, environmental technicians, health information technicians, medical record officers, etc.) despite the shortage of health workers in the clinical cadres.

One of the states where data were successfully used for decision-making is Sokoto State, which adopted a health worker cadre conversion policy to respond to the surplus of non-clinical staff. The policy aims to convert

non-clinical staff to clinical staff through appropriate education to fill the clinical workforce gaps. Through the policy, the state trained Community Health Extension Workers (CHEWs) who were willing and qualified to become nurses in the State, which helped to fill the gaps in nurses/midwives. The state's branch of the Nursing and Midwifery Council of Nigeria secured approval for 440 slots for the conversion of non-clinical cadre of staff to nurses/midwives, and the Community Health Practitioner Registration Board of Nigeria approved 150 slots to address the shortage. The environmental health officers, environmental technicians, health information technicians, medical record officers and other non-clinical staff were converted to nurses, midwives and CHEWs through Community Nursing, Community Midwifery, and CHEW training programs. This data-driven initiative currently being implemented, has addressed critical HRH gaps in the state.

### **3. Task Shifting and Task Sharing Policy**

The Task Shifting and Task Sharing (TSTS) Policy promotes the rational redistribution of tasks among existing health workforce cadres alongside expanded training and retention programs. This allows a health system to maximize the existing workforce, ease service delivery bottlenecks, and expand the workforce. The implementation of the TSTS policy also led to the review of the pre-service and in-service training curriculum for different cadres of health workers, particularly the CHEWs, who are now being trained on expanded life-saving skills and broader maternal and child health services, which provides them good leverage to manage basic Reproductive, Maternal, Newborn, Child and

Adolescent Health + Nutrition (RMNCAH+N) clinical services.

In Nasarawa state, the TSTS policy was domesticated in 2018, and about 500 CHEWs were trained in Modified Life-Saving Skills to bridge the shortage of frontline health workers at the PHC level. The Implementation of the TSTS policy in the state correlates with an increase in the number of deliveries at the PHCs. This is evidenced by the increase in the percentage of delivery by a skilled provider from 48.5% in 2016 to 55.5% in 2021, surpassing the national average of 50.7%.<sup>6</sup> Also, during the same period, the percentage of women who received antenatal services from a skilled provider increased from 67.9% in 2016 and 72.0% in 2021. Implementing the Task Shifting and Task Sharing policy is associated with some improvements in the state's maternal and child health indicators. For instance, the under-five mortality rate reduced from 121 per 1000 live births in 2016 to 65 per 1000 live births in 2021.<sup>7</sup>

### **4. Biometric Attendance and Tracking Technology**

Absenteeism, especially in rural primary healthcare centres, has long been a challenge, often linked to inadequate rural retention strategies such as insufficient rural allowances and housing for healthcare workers. Insecurity is also a major factor that contributes to absenteeism in some parts of the country. Gombe State has set a replicable example by deploying biometric attendance tracking technology (BATT) in five Local Government Areas (LGAs) to address the persistent issue of absenteeism among health workers. Health workers in these LGAs are required to register their attendance via fingerprint scanners daily, and failure to meet attendance

<sup>6</sup> Multiple Indicator Cluster Survey, 2021

<sup>7</sup> Multiple Indicator Cluster Survey, 2021

requirements without proper authorization results in the withholding of salary. This system is directly linked to the state treasury and ensures accountability by only releasing withheld salaries after clearance by relevant health authorities. Unlike other states that still rely on traditional methods such as facility rosters and community feedback, the introduction of the biometric system in Gombe State has created a more efficient and transparent mechanism for tracking attendance.

The biometric attendance system has produced significant achievements within a short period, including cost savings and better workforce management. Over 600 million naira was saved in just 15 months due to a reduction in absenteeism, and the discovery of 23% of healthcare workers involved in unauthorized training with pay. The system has also drastically reduced attempts to falsify attendance and improved adherence to leave protocols. Additionally, Gombe has been able to prioritize incentives for high-performing workers, further motivating health staff. With continued implementation, the state anticipates saving up to 1 billion naira monthly, making this biometric system an innovative and replicable solution for reducing absenteeism and enhancing accountability in the health sector.

### **5. Proper Political Economy Navigation**

Political Economy Analysis (PEA) is crucial in understanding how power dynamics and stakeholder interests influence the design and implementation of HRH policies.

The favourable political economy in Kaduna State played a pivotal role in advancing staff redistribution and implementing the PHCUOR policy. The strong collaboration among the state health MDAs, the Executive Governor,

the State House of Assembly, and other key actors fostered a conducive environment for HRH reforms. The then Executive Governor, Mallam Nasir El-Rufai, gave an executive order to implement the staff redistribution plan and fully implement the PHCUOR policy. The initial resistance from some stakeholders in the state necessitated the executive order. The Governor's executive order facilitated the redistribution of healthcare staff to address capacity gaps and the full implementation of the PHCUOR policy. This move, backed by multi-sectoral support, demonstrated how political leadership can mitigate resistance and drive HRH reforms effectively.

The support from the governor and other high-level stakeholders significantly reduced the challenges associated with staff redistribution. The redistribution initiative addressed the capacity gaps across healthcare facilities and empowered the workforce through skill development. As a result, there was an improvement in the state's health system's ability to deliver essential services at the primary healthcare level, underscoring the importance of leveraging political commitment to implement far-reaching HRH policies.

### **6. Incentivizing Rural Posting**

The rural posting allowance is a strategy that is used to reduce health workers' attrition, absenteeism, and rural-urban migration of health workers. In Yobe State, the rural posting allowance initiative was introduced to address the inequitable distribution of health workers, especially in rural and hard-to-reach areas, where the staff shortage was most critical. Health workers in urban LGAs had been disproportionately favoured, leaving rural communities underserved and experiencing poorer health outcomes. To encourage the redistribution of health personnel, the state

government commenced the payment of rural posting allowance, 20% of health workers' basic salary, which is paid in addition to their salary.

The rural posting allowance gained further importance during the peak of insurgency in Yobe State when health worker attrition rates were alarmingly high. As a deliberate response, the state government doubled the rural posting allowance for workers stationed in rural areas, significantly boosting retention in these critical zones. In addition to the financial incentives, the government offered non-financial benefits, including fully furnished housing, opportunities for pilgrimage, and in-service training for employees who had served for at least two years. This comprehensive package of incentives was instrumental in curbing the attrition of health workers, stabilizing the workforce in rural areas, and ensuring that essential healthcare services continued despite the challenges of the insurgency.

## Conclusion

As fiscal constraint poses a major barrier to achieving recommended health workforce density in Low-and Middle-Income Countries (LMICs), optimizing HRH becomes an essential component of workforce strategy towards achieving UHC and improving overall health outcomes. The HRH challenges, including workforce shortages, skewed distribution, and underutilization, continue to hamper the LMICs' progress towards UHC. However, promising HRH policy interventions like the exit replacement policy, cadre conversion, the use of data for decision-making, the provision of rural posting incentives, the task-shifting and task-sharing policy, and the use of biometric attendance technology have been

implemented in some states in Nigeria with notable results.

To further optimize HRH and achieve health system goals, it is imperative to scale and replicate these policies elsewhere while fostering a culture of data-driven decision-making and continuous HRH capacity building. Through sustained political commitment, inter-sectoral collaboration, and the alignment of HRH policies with local needs, LMICs can significantly strengthen their health workforce, improve health access, and move closer to achieving UHC. These policy thrusts will benefit from impact evaluation to generate more profound evidence of their effectiveness, establish causality and learn lessons for necessary policy modification.