The lack of human resources for health in Africa is a conspicuous crisis that has deteriorated throughout the years. Regardless of the extensive global acknowledgement from many member states of the severity and urgency of health worker shortage in Africa, very slight progress has been accomplished to improve the health workforce in African nations labelled as the “human resources for health (HRH) crisis countries”. The ongoing problem has been brewing since the 1970’s, developing after the adoption of the Declaration of Alma-Ata in 1978 during the International Conference on Primary Health Care, held in Kazakhstan. The Declaration of Alma-Ata emphasized the criticalness of all governments and health organizations, including the World Health Organisation (WHO), as well as health workers and society to promote and provide for the health of the growing population. Being the first international proclamation to highlight the significance of primary health care, with it came a lot of support and hope for a better future. Nevertheless, according to the WHO, as of 2011, there are 57 HRH crisis countries, 37 of which are in Sub-Saharan Africa.

The typical justification for the shortage in human resources for health is often limited to poor inadequate resources. This is exacerbated by a pool of political and financial problems that discourage an investment in hiring well educated and trained health workers, as well as medical and other health-related resources. In spite of the pressing need for more health workers for over three decades in African nations, national HRH support schemes remain under-financed, under-developed, uncoordinated and small-scale. This in turn, ultimately leads to them not being carried out and the crisis continues to grow. The human resources for health crisis in African nations has been aggravated due to multiple factors, including political instability in the region and unsatisfactory and deprived health systems. These health facilities are characterized by poor working conditions which in so doing, lead to the limited number of health workers to decrease further. This is because they choose to migrate to More Economically Developed Countries (MEDCs) in search for better job opportunities.
To illustrate the scale of this demanding issue and to put it into perspective, in 1970, 33 out of 41 African countries had a medical doctor ratio below one physician per 10,000 people. Excluding South Africa at the time, no African country had a physician density above 2.0 per every 10,000 people. Thus being unable to function effectively with efficiency and remaining severely understaffed, many HRH crisis countries have sought new ways to address the problem. Several African nations have implemented new forms of work rotations, often referred to as “task-shifting”. In this new scheme, less skilled healthcare workers cover and complete tasks that higher skilled health workers would typically carry out. The problem stems from how policies are made, how leaders are recognizing the issue, how the WHO and foreign benefactors support the cause, the need to improve human resources for health in African nations, and how development schemes are prioritized in these countries, without much consideration to the importance of health care first.

**Definition of Key Terms**

**Human Resource for Health (HRH)**

Anyone who is involved in the healthcare system such as but not limited to physicians, nurses, social healthcare workers and midwives. The human resource for health department deals with matters like development of the healthcare system, management, information and research and more. More recently, the subject of HRH has been critical in the development and growth of many nations and awareness has increased regarding the issue, making it prominent on the global health agenda.

**HRH Crisis Countries**

The WHO roughly calculated a shortage of about 4.3 million healthcare workers including physicians, nurses and midwives worldwide. This scarcity is most serious in 57 of the poorest countries in the world, especially those in sub-Saharan Africa. An HRH crisis country is a country which falls below the required threshold of 2.28 qualified healthcare workers per 1000 people, according to the WHO. Of the 57 HRH crisis countries in the world, 37 are in Africa.

**Declaration of Alma-Ata**

Announced in 1978 during the International Conference on Primary Health Care, which took place in Alma-Ata, Kazakhstan, USSR. This Declaration stated that governments, organisations and citizens likewise need to work cooperatively to develop sufficient and of high standard healthcare systems globally, in order to provide for the growing population and ensure the health of people. The Declaration of Alma-Ata is the first international declaration to emphasize the importance of public health, especially in Less Economically Developed Countries (LEDCs) such as those in Africa, and called upon nations to implement primary health care in their countries.
Physician density

It is the number of physicians relative to the size of the population, given per 1000 people. In simpler terms, it is the doctor to patient ratio. According to the WHO, statistics proved that more than 45% of their member states have less than 1 physician per 1000 people in their countries. Africa combined has around 0.2 doctors for every 1000 people. As stated in a WHO report in 2013, sub-Saharan Africa lacks an approximate number 1.8 million health workers. This is due to the emigration of the qualified health professionals from African countries to MEDCs in search of better job opportunities and a safer environment, which is a process referred to as “brain drain”.

Task-shifting

Task shifting is a form of work where tasks are given to less specialized healthcare workers, from highly specialized workers where it is suitable in order to strengthen the efficiency of the work and share the workload to provide better healthcare services. It was prominent during the HIV/AIDS epidemic in Africa as task-shifting was used to increase the health workforce rapidly to meet the demands of the patients and services needed to be provided.

President’s Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR is a United States government initiative established to provide support and to resolve the global HIV/AIDS epidemic. It was first established by the United States’ President, George W. Bush, in 2003 and since supplied $80 billion in funding for HIV/AIDS treatment, prevention, and research. This great investment made it the biggest international health program dedicated to a single disease in history. In its latest review in 2018, PEPFAR is said to have saved 17 million people in Sub-saharan Africa.

Background Information

To understand why this is a pressing issue, we need to understand how it came to be and the consequences it led to. There are several factors contributing to why there is a shortage in human resources for health in Africa.

Declaration of Alma-Ata

The Alma-Ata Declaration was announced in September of 1978, during the International Conference on Primary Health Care, held in Alma-Ata, USSR, now known as Almaty, Kazakhstan. Co-sponsored by the WHO, the Declaration stressed the “the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people”.

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the people of the world."\(^1\) It was the first ever international declaration that acknowledged and highlighted the importance of primary healthcare and called upon governments to provide for their countries’ citizens. It defines health as “a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity” and stated that acquiring health is a fundamental right to all of the world’s population. The member states which ratified the Declaration saw it as an initial step towards the social goal of achieving health for all by the year 2000. Regardless of the failure to achieve that goal, the Declaration of Alma-Ata still acts as a guideline for international healthcare, with which Africa is included. The Declaration plays an important part in improving human resources for health in African nations as it emphasizes the importance of well-being and health workers in achieving a fit population and improving the standard of living by improving medical care.

**Growing population.**

One of the leading causes of this crisis is the growing population of Africa. The population of Sub-Saharan African is growing at a profound speed with a population growth of 2.7% each year. While also having the world’s biggest disease load, Africa has the smallest ratio of physician to population, which is expected to worsen according to the work of IntraHealth International and WHO. This is due to the inadequate working conditions in hospitals, the lack of equipment and the unsafe environment, which pushes doctors away from practicing in African nations. Not only that, but severely limited opportunities for people in Africa to attend medical schools and get the necessary qualification hinders the chances of increasing the number of health workers to balance out the ratio as well. The WHO and IntraHealth International’s recent work proved that the health workers shortage will increase from a current 12 million to 18 million in the next decade, and since Africa has the largest shortage, it will be affected the most by this. This is due to the ageing workforce, where workers choose to retire early or seek other, better paying opportunities to sustain themselves, all while there is a lack in the number of young people entering health-related professions.

**Immigration to MEDCs**

Another problem that Africa faces is the large-scale migration of its healthcare workers to MEDCs and industrialized countries in search of better living standard and better salaries, all of which cannot be provided easily in Africa. Physicians are pulled towards the promise of a better life, and pushed away from the challenging working conditions that became a stock characteristic of Africa. These challenges drive hundreds of health workers away each year leaving Africa with scarce human resources. This is not just a matter of intercontinental immigration, but migration is also evident within African nations themselves, where there are imbalances in the workforce between rural and urban cities. While Africa is experiencing a yearly growth in its urban population, the growth rate is currently 4.1% compared to a

\(^1\) [http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf](http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf)
global rate of 2.0%. With 63% of the total Sub-Saharan population residing in rural areas, a bigger portion of the population lacks the simple necessities needed for healthcare and so the problem continues to arise. Urbanised cities attract more healthcare workers due to the relatively high income, the more advanced instruments, the better working conditions and job security as well as a chance for career development. While this is extremely beneficial in the way that it results in the physician density to increase, and considering how generally urban cities are more populous, thereby more people are attended to due to the increase of workers in such areas. Nevertheless, this greatly affects the rural areas. The flow of healthcare workers from rural areas to urbanized cities results in a great reduction in the care offered to the people who cannot afford to move to more developed areas. This leaves rural areas neglected and in turn, they suffer the most. There is a great lack of human resources for health in rural cities due to the lack of transport, adequate housing and availability of medical equipment which all limit the physician and the nurses’ ability to provide care for these populations. As a result, African nations are short of 2.4 million doctors and nurses.

**Political conflict and instability in the region**

Armed conflict in the region is also another powerful reason underlying the loss of human resources for health. In places of conflict as well as post-conflict reconstruction, well-educated healthcare workers are essential to provide medical attention to vulnerable groups that may have been displaced or injured during the trouble. Nonetheless, in various conflict-affected African nations, years or often decades of conflict resulted in an increased shortage of the few trained physicians and nurses. This is because of the lack of safety provided with being in these conflict-stricken countries, and the constant feeling of insecure stability; thereby healthcare providers flee to safer countries, which are often MEDCs, in search of a more peaceful lifestyle.

Likewise, with the political instability in the region, politicians in African nations face a mountain of social demands from the public, ranging from food security including agriculture, improving transport and infrastructure, education and health. However, health seems to be getting the least attention as only a few African countries, namely Botswana, Burkina Faso, Mali, Niger, Rwanda and Zambia have succeeded in meeting the Abuja Declaration of 2001, which stated that all governments should invest 15% of their revenue in health. This is evident throughout Africa since the development in healthcare is minimal, as health ministers fail to value health. Moreover, the lack of investment in healthcare systems is also due to the lack of resources for it. Governments are aware of the lack of human resources for health in their nations and so they avoid funding the healthcare system as improving health is not just a matter of money, but also of the country’s social stability and quality of life.

**Epidemics and disease outbreaks**
Furthermore, Africa is home to many epidemics. The malaria outbreak, the Ebola outbreak and the AIDS epidemic all affected Africa greatly. The 2014-2016 Ebola outbreak in West Africa resulted in the loss of 11,325 people, with 28,600 cases reported after two and a half years from its inception. Likewise with the malaria outbreak, the estimated number of deaths is around 435,000 in 2017 according to the WHO, and Africa is home to 92% of malaria cases and 93% of malaria deaths.

**HIV and the AIDS epidemic**

In addition to these general causes, the AIDS epidemic in African nations led to the rapid increase in the needs of the African population, accelerating the HRH crisis and giving way to new methods such as task-shifting to become more prominent. Africa houses 11% of the world’s population, however, it holds 60% of the number of people with HIV/AIDS. The defective healthcare system and services are also overwhelmed by the AIDS epidemic. With the American President’s Emergency Plan for AIDS Relief (PEPFAR) coming into effect again in 2008, an international goal was set aiming to train 140,000 new health workers in a matter of 5 years with the financial aid of PEPFAR funds. This was a first step towards an effective solution to improve the human resources for health in African nations. However, as disease-control programs are made a priority, most new and trained healthcare workers are provided with work by these programs that national healthcare is put aside and it results in a lack of physicians to practice on regular citizens. Subsequently, hospitals and medical centres have to find a way to divide the scarce number of physicians to manage the heavy workload, and that is usually done by a concept known as substitution, where tasks are assigned between different cadres regardless of what their jobs entail to support the workload. This system has been used previously and is commonly in response to emergency needs, mostly in understaffed rural medical centres.

**HRH crisis countries**

The World Health Organization (WHO) set a goal of one physician per 5000 people in 1978. This affected physicians themselves as well, as some countries implemented a strategy in which healthcare professionals have to complete a compulsory period of time serving under-developed areas. Later on, in 2006, the WHO announced a minimum of 2.28 qualified health workers per 1000 people. It was clarified that if a country falls below that recommended threshold, WHO will declare it an HRH crisis country. The basis for this target is, it is the minimum level of medical care and assistance that 80% of pregnant women need to have sufficient antenatal and postnatal services from a physician, nurse or midwife. Out of the 46 countries in Sub-saharan Africa, 37 of them are labelled as HRH crisis countries.

The lack of human resources for health in African nations is impairing the development of the quality of life in Africa, access to life-saving medical requirements such as childhood immunization and vaccinations, safe and hygienic delivery services for pregnant women, as well as access to treatment for HIV/AIDS, malaria and tuberculosis. The WHO’s 2006 report on World Health approximated that more
than 4 million healthcare providers are needed to close the gap between MEDCs and LEDCs when it
comes to human resources for health, and of those 4 million, 1.5 million are needed just for Africa.

Major Countries and Organizations Involved

World Health Organisation (WHO)

The WHO is an agency of the United Nations that is dedicated to promoting international public
health. It is part of the UNs Development Group. The WHO was established in 1948, on the 7th of April
with the aim of improving primary healthcare, access to human and physical resources for health in
addition to financing and training a new health workforce. The organization’s current priority is to provide
service for people with HIV/AIDS, Ebola. Malaria and tuberculosis, all of which are very prevalent in
Africa.

Nevertheless, after the 2014-2016 Ebola outbreak in West Africa, WHO was greatly criticized for
its lack of adequate and sufficient financing and staffing in the region. Likewise, a WHO report on Ebola
stated that the already poor and deprived healthcare system and health workers are undermined by the
underfunding of the health systems, but also the WHO. The WHO’s role in countries and supporting
public health has declined greatly due to budget cuts which they have been facing. This left the WHO
more of an advisor for the African governments, depending on their funding and financial status.

Still, WHO is in charge of the mission of the Health Systems and Services Cluster. This project is
meant to aid and assist member states to build adequate, secure and well-organized health systems and
services that allow citizens to meet with physicians and get regular checkups when needed. More so, it
continues to produce a report, the Health of the People, which is the first report to focus on the
inhabitants of Africa. Despite the fact that Africa holds the world’s most profound public health crisis, the
WHO’s report believe that over time, Africa can resolve the shortage of human resources for health, with
international support and the support of WHO.

East, Central, and Southern African (ECSA) Health Community

The East, Central and Southern African (ECSA) Health Community was set up in 1974 under the
Commonwealth Secretariat in London. It was established as a means to promote health in the region.
Following 1980, the organization’s ownership was passed on to 14 member states in sub-Saharan
Africa, namely: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South
Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Together their populations amount to over
190 million people, thereby making the ECSA Health Community one of the biggest health organizations
in the area. Its main goal is to focus on advocating for better health, research and information sharing, as
well as capacity building. It works to support and assist the initiatives being out forward to promote and
develop the health sector in sub-Saharan Africa. Since its inception, the ECSA Health Community has been involved in the establishment of a training scheme on healthcare management as well as financing a set of events regarding the Regional Drug Forum.

The Human Resources Development and Capacity Building Program was established by ECSA-HC as a means to solve the ongoing human resources for health crisis in Africa. Its initiation came after member states decided that in order to truly and effectively implement health policies, health professionals need to be trained properly. Its key focus is on the development of human capacity, the strengthening of HRH’ management and leadership, as well as collaboration and communication. The program has had many successes and achievements in the past, of which some are: the making of electronic human resources databases and the regulation of Allied Health Professions, which are people who work in healthcare systems to provide diagnostic, technical or therapeutic services for patients, in ECSA.

South Africa

South Africa is often considered to have a better healthcare system than its neighboring countries. This is due to the fact that in 1970, South Africa was the only country in Africa which had a physician density above 2.0 per every 10,000 people. In 2013, South Africa had a physician density of 0.776 per 1000 people. This is a hopeful improvement however, the amount of vacant positions for doctors in South Africa was 56% in 2013. This is because, half of the South African population lives in rural area and an insignificant 3% of recently graduated physicians take on new jobs there, instead they choose to go work in the private sector of the healthcare system, with 70% of them working there. Between the years of 1996 up until 2008, there was an impairment in the growth of the number of healthcare workers. However, there was in fact a reasonable increase after 2006, but this needed to be maintained and sustained. This slow growth could be attributed to the disorganized and unfunded public health sector, and the inefficient recruitment processes. In South Africa, around 150,509 health professionals were registered with the Health Professions Council of South Africa (HPCSA) in 2010, and 231,036 nurses registered with the South African Nursing Council. In its collaboration with the WHO to create the country’s Strategic Agenda, South Africa’s goal was to maintain the best distribution of the health workforce to ensure that there is no significant divide between rural areas and urban cities, as well as between the private healthcare sector and the public one.

In South Africa, the public system aids the immense majority of the population, and yet it is profoundly understaffed and underfunded. The private sector tends to the upper class, the wealthiest 20% of the population, and the healthcare system is not understaffed. Regardless, South Africa is working on improving their healthcare systems as in 2005, the government spent 8.7% of the GDP on health care.
**Ethiopia**

With the release of the 2006 WHO Report, and being characterized as having one of the lowest physician densities in the world, with a ratio of 1:48,000, Ethiopia’s population was rapidly growing and the number of healthcare workers was not matching. The country faced a lot of health-related problems ranging from communicable diseases such as HIV and Malaria to Tuberculosis. As a result, Ethiopia became aware that in order to improve human resources for health, it would require decades. Therefore, in 1990, Ethiopia established a long-term strategy to improve its healthcare system. Increasing and training a new workforce was prioritized in achieving better health.

Ten years before the WHO report, Ethiopia finalized its first HRH plan in 1995, which included an accurate measure of the financial needs of every planned expansion and well-thought plans. It focused on the funding of the primary health care services in a sustainable and efficient manner, as it also set a goal for reaching worldwide healthcare for all by the year 2035. This, and the HRH plans to follow all became a means of support nationally and internationally.

After the HRH plan was established, the Ethiopian government invested an increasing amount of money into the health sector of the country, to attract more physicians and simply to improve the HRH crisis. This in turn led to an improved infant mortality rate. To put Ethiopia’s advancement of funding into perspective, the budget for the health sector was an estimate of 144 million USD in 2001. Consequently, Ethiopia successfully raised its physician density from 0.43 per 1000 population to 0.86 in 2008. Likewise, it extended its admission of medical doctor trainees from below 300 in 2005 to more than ten-fold the number, 3100 in 2012. As a result, Ethiopia managed to overcome the barriers and increased its healthcare workforce dramatically over the past thirty years.

**Democratic Republic of Congo**

The Democratic Republic of Congo is often said to have one of the worst healthcare systems in Africa. It is plagued with limited development and lacks the necessary medical facilities it requires to operate effectively. The limited medical services available are not free and patients are supposed to pay in cash for their treatment beforehand. Prescription medicines and over-the-counter drugs such as paracetamol are not present for people to purchase in local or stores or even pharmacies. The DR Congo has the world’s second-highest rate of infant mortality, while the highest being another country in Africa: Chad. The estimated life expectancy is 59 years for males, and 61.6 for women. As stated by UNICEF, 43.5% of the children under five are malnourished and undersized. While 1.1% of the adults between the ages of 15-49 were living with HIV/AIDS in 2012. The effects of the Ebola outbreak are still felt in DR Congo as the death toll exceeded 1000 people in May of 2019.
The substandard healthcare system in DR Congo is a result of a deteriorating economy and the lack of a well-constructed government and strong national leadership. The economy's collapse heavily affected the DR Congo, as the Gross Domestic Product (GDP) went from US$ 450 per capita in 1970, to US$50 in 2001, causing more than 70% of the population to become poverty-stricken, including the human resources for health available in the country. Due to the lack of financial support from the government, the public health sector and healthcare systems became dependent on foreign aid and payments from the citizens themselves. Nevertheless, Congo has made significant progress during the last few years, as a result of improved authority and expenditure in priority health issues by the government as well as foreign international supporters. With the help of USAID, an American agency that offers international aid for development, DR Congo has been free of polio for four consecutive years, which is regarded as a great achievement seeing as the country is large in size and lacks the modern infrastructure which helps with providing health services.

Relevant UN Treaties and Events

- Global Health and Foreign Policy, 10 May 2011, *(A/RES/65/95)*
- Health workforce strengthening WHA64.6, 24 May 2011, *(WHA64/2011/REC/1)*
- Strengthening nursing and midwifery WHA64.7, 24 May 2011, *(WHA64/2011/REC/1)*
- Global Health and Foreign Policy: Health Employment and Economic Growth, 8 December 2016, *(A/71/L.41)*

Previous Attempts to solve the Issue

Task-shifting

A successful attempt to solve the issue is task-shifting. It is when a task is moved to a group of less specialized health workers where suitable in order to allow the highly qualified health workers to complete other, more specialized procedures. This reorganization makes room for more services to be provided to a greater number of patients thus improving healthcare coverage and making efficient use of the available human resources for health. Many countries in Africa use task-shifting to advance their health systems. It was most prominent during the HIV/AIDS epidemic when the shortage of healthcare professionals highly accelerated the problem. For example, when there is a lack of physicians at hand, a qualified nurse would most likely be able to prescribe and give out the appropriate medication. Likewise, people from the community can possibly provide a wide spectrum of services, thereby allowing the qualified nurses to proceed with other tasks. This is especially beneficial as it is very time-efficient, since training a new community of healthcare providers takes between an estimate of one week and one year.
depending on the abilities needed. While it takes around 3 to 4 years’ worth of training for a nurse to become fully qualified, and 6 years for a medical student to be able to practice as a doctor.

To illustrate this, in Ethiopia, nurses spend around 20% of their time counselling patients with HIV, taking samples of blood and sending them off to the lab. In this case, task-shifting would be very useful as trained health workers could perform these relatively less specialized tasks and save 20% of the nurses’ time while they complete more specialized tasks and improve the healthcare workforce. This not only supports the workforce but also provides local jobs for the community. The issue lies within how organized task-shifting is and how the process is carried out. If serious and specialized tasks are passed on to unqualified health workers, many problems could arise and in the worst case scenario, the results could be fatal. Nevertheless, in countries such as Ethiopia in which task-shifting was carried out efficiently, the nation benefited greatly in sharing and reducing the workload on the limited number of healthcare professionals. Thereby, task-shifting could be regarded as a successful short-term solution that may sustain countries until further plans to solve the issue are put in place and initiated.

The Abuja Declaration of 2001

Another attempt at solving the issue is the establishment of the Abuja Declaration of 2001. As part of the Abuja Declaration, all of the members of the African Union, which is equal to all of the nations in Africa, vowed to spend at least 15% of their states' annual financial plan on their healthcare systems in order to develop it and maintain it, also while asking Western benefactors to increase their donations. Nevertheless, this attempt was deemed a failure, since in 2010, the WHO announced that only one African nation has met this target, which is Ethiopia. While 16 countries in Africa have increased their budget for the healthcare system, 11 decreased it and 9 nations kept it the same. This highlights the crisis and the lack of will that some of these nations possess to improve the healthcare system. Had most nations focused on achieving the goals of the declaration, more countries would have managed to self-sustaining ourselves.

Possible Solutions

Financial and non-financial incentives for healthcare professionals to work in Africa

In order to solve the crisis that is the shortage of human resources for health, national healthcare systems must provide incentives for physicians and new graduates to practice health care in Africa. One of the main reasons why Africa lacks in healthcare professionals is due to the fact that healthcare professionals, such as physicians or nurses, have minimal wages which do not amount to their hard work. In a financially driven world, people look for job opportunities which provide them with financial stability and a comfortable lifestyle. The key is that we get African nations to appeal to the workforces’ needs, and meet their demands, as this would substantially increase the number of human resources for
health in Africa. To do this, governments must provide the average health worker with the necessary equipment and amenities needed, and improving the working conditions for them to work effectively. In the case where a country completely lacks the ability to do that due to financial problems and such, donations from Non-Governmental Organisations, which promote better healthcare should perhaps provide these equipment to initiate the first step into solving the crisis. Likewise, incentives such as proper housing and a safe environment to live in are essential to attract the needed healthcare workforce. However, this should not be at the expense of the patients and citizens of the country. The money needed to provide these incentives could perhaps be from the nation’s budget or overseas donations, and healthcare should remain accessible and not extensively expensive for the population. However, due to the fact that many current world leaders are corrupt, this plan could so simply be undermined by a lack of sufficient attention and honest leaders. Nevertheless, perhaps UN officers could vigilantly monitor the situation in Africa as a constant reminder to help solve the crisis.

**Education and training facilities**

Moreover, the insufficient training opportunities in Africa play a vital role in the lack of human resources for health. Around two-thirds of the countries in sub-Saharan Africa have a single medical school to provide training for medical students, and 11 countries do not have a medical school at all. Providing better education and training facilities such as medical schools and enhanced medical programs for students should become a priority for African nations. This will in turn encourage more African citizens to get the qualification required for them to practice medicine and provided that the incentives are effective, stay in Africa and increase the number of human resources for health. This could be done in different ways. For example, the money African nations receive as donations from foreign benefactors could be used for this purpose: to build the schools and purchase the required items. An alternative is that, universities and medical schools should offer scholarships for students in Africa who have suffered greatly and deserve a chance to learn.

**Mandatory training in rural areas**

There is a great contrast between the number of health professionals in urban cities and in rural areas in African nations. This divide could be solved by extending the number of years physicians spend during residency and the retirement age for workers, while also issuing a mandatory period of service in rural areas. Since the retirement age in Africa is generally early compared to that in Europe and the West, African nations should look to extend the retirement age to raise the number of working health professionals, as often skilled workers stop working regardless of their good health and will to perform their duties. For example, the Ghanian government called upon all retired health professionals to apply for reappointment, and two-thirds of the qualified workers did. The compulsory training in rural areas would result in more of the population being attended to by professionals and would be a sufficient short-term solution to the shortage of human resources for health. This solution could be enhanced by
enrolling students from rural areas in medical schools, as well as building training schools and facilities in rural areas to allow more healthcare professionals to work there and also to encourage the natives of the area to get the required qualification to practice. This is also to get the youth and the future generations involved in healthcare professions, in order to avoid facing another crisis as such in the future.

Guiding Questions

1. How can African people get the care they need if there are not enough health workers in Africa?
2. Why is this issue more prominent in African countries than other countries?
3. How can we better prepare for future epidemics that may strike Africa with the current lack of human resources for health?
4. How can we encourage African physicians to stay in Africa and not migrate to MEDCs?
5. How do we prevent the uneven divide of health professionals in urban cities and rural areas?
6. Until the crisis is resolved, what are some short-term solutions for the shortage of human resources for health?

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