Gabriel Toma looks at this emerging medical manpower crisis

African Healthcare Exodus

KEY POINTS

Sub-Sahara Africa needs another one million workers to fight HIV, AIDS, malaria and TB. But this shortfall has been created by migration of trained doctors and nurses to richer nations, rather than an inadequate supply of locally trained personnel. Migration is fuelled by a desire for better working conditions and training, better wages, prestige and the desire to help family. It is potentiated by the lack of good role models, poor handover to nationals and a 'poor mentality'. Shining out from this gloomy picture are some inspiring best-practice models. Solutions are achievable, but results will come only when Africans mobilise their resources with all support possible from the worldwide church.

As the continent with the most poor people, Sub-Sahara Africa is a place of great need. More than 350 million (out of a population of 765 million) people live on less than a dollar a day; and, unlike other poverty-stricken continents, this proportion is rising.[1]

In 2000 Africa's debt stood at 334 billion dollars. Every year, eight billion dollars are repaid but another five to six billion dollars of debt are simply rescheduled. Tanzania alone spends nine times more on debt repayment than on healthcare.

How is this debt to be repaid? Africa is home to 70% of the world's HIV positive population and 87.5% of HIV positive children.[2] So, as AIDS ravages African life expectancy, there are fewer and fewer people fit enough to work, boost economies and repay debt. Continuing political instability and corrupt governments eat further into the meagre money-pots.[3] Under these circumstances, there is no chance of Sub-Sahara Africa ever being debt free.

Staffing crisis

Africa is staggering under the world's heaviest disease burden but has the lowest health care professional:patient ratio; for example, Uganda's doctor:patient ratio is 1:24,700.[4]

There is an unprecedented exodus of African healthcare professionals and it is worsening by the day. Of the 600 Zambian doctors trained since independence, only 50 are said to have remained in the country.[5] Ghana has lost more than 12,000 health professionals since 1993.[6]

My own survey of Nigerian medical students showed that at least 60 percent want to add to this brain drain. Of the 40 percent who may remain, less than 20 percent plan to make decisions based on the needs around them or stay in rural regions.

So, where have these departing professionals gone and how severe is the resulting shortage? A recent study by the Joint Learning Initiative, which includes the World Health Organization, concluded that Sub-Sahara Africa needs another one million workers to fight HIV, AIDS, malaria and TB. Rich nations poaching African doctors and nurses was identified as the major factor in this shortage.[7] A Canadian survey revealed that 23 percent of practising physicians were trained abroad. More than twenty percent of American physicians graduate overseas.[8]

Self-actualisation

Most African health facilities do not have adequate infrastructure. There is never enough up-to-date equipment. Very few Sub-Sahara post-graduate educational programmes provide a level of training that provides self-actualisation for most physicians. Having turned to the developed world for such training, beneficiaries find it hard to return to their former conditions.

Advantageous positions

Medical training is very costly for an African family. Financial sacrifices are made in the hope that the doctor-to-be will one day help his/her extended family. Such a doctor who then goes on to complete developed world educational programmes is generally regarded highly, having achieved economic empowerment and influence. There is a lot of pressure to stay put in their host country and benefit the extended family.[9]

Many of us think of ourselves first. Our family and circumstances inform our choices and decisions. We are less concerned about the needs around us, or our Lord's wishes.

Westernisation

There are areas of Africa where the Christian influence of early missionaries is difficult to differentiate from westernisation. This has made it difficult for many Africans to return to their

home countries or villages; the conditions there no longer match what they have come to embrace as *the* way of life.

Missionary transition

Some mission societies have done very well in handing over mission leadership to local nationals. Still, how much preparation was given to the nationals before they were handed such responsibilities? Do national leaders now truly own the missionary vision? It should be noted that, in some situations, leadership transitions were forced by political circumstances.

Poor mentality

Most Africans see themselves as poor; indeed, most are poor. Yet, even worse than being poor is the possession of a *poor mentality* - wallowing in self pity and blaming every ill on poverty. Such an attitude of dependence on outside help causes individuals to be so absorbed with their own needs that they are not able to see the needs of others, let alone consider helping them.

Role models

There are very few examples of strong African leadership in healthcare missions. In part, this may be due to a lack of vision, a failure to be burdened for the lost. Strong leadership commands respect, and could be a great influence on the decisions of the next generation of African doctors.

Churches

Lack of church support has contributed significantly to the dearth of healthcare workers. Very few churches have demonstrated commitment to healthcare missions in their finances, or in spiritual, emotional and social support of missionaries. Worse still, corruption amongst some church and mission leaderships has discouraged and disillusioned many sincere young healthcare professionals. People hate to see their sacrifices enriching leaders' pockets.

Materialism

The worldwide trend for materialism has captured African societies. Throughout developing Africa there is a strong craving for wealth, pleasure and personal convenience. Yet it is so much easier to satisfy these cravings in the developed world.

Specialist training

Western medical training and expertise encourages specialisation and sub-specialisation. So often western-trained African doctors find it difficult to fit back into their original rural communities. Much western medical technology is unavailable anywhere within a whole African country, let alone in individual rural communities. It becomes frustrating for such highly-trained people to remain in rural set-ups. The natural trend is to move to centres where the challenges of modern facilities exist.

Shining examples

Shining out from this gloomy picture are some inspiring examples.

In Nigeria, the Baptist Medical Centre and ECWA Evangel Hospital have established themselves as credible high quality training centres for family medicine. Many of their doctors accept good training in place of high salaries. This has provided a steady stream of physicians for these institutions. Many graduates stay on as the high quality care they are able to offer fulfils them more than money.

The SIM Hospital in Galmi has a slightly different arrangement. It has forged a cooperation with Evangel Hospital and the Christian Medical and Dental Association of Nigeria, and provides itself with a steady stream of physicians. As Niger shares borders with Nigeria, travelling distances for Nigerian doctors are relatively short; cultural and language differences are not so marked so culture shock is minimised. The hospital is also considering starting a family medicine training programme.

The Haggai Institutes in Singapore and Maui, Hawaii, have remained committed to training indigenous missionaries since 1969. So far, over 48,000 Asian, Latin American and African leaders have returned to their societies, identified the resources that God has placed there, and used them to reach their own peoples. They have remained in business, and are still growing because their methods have been effective. A good percentage of their graduates are Africans who have remained in Africa to provide leadership for evangelism.

There are also good Indian models. The Emmanuel Hospital Associations have been able to retain their medical staff by training and exposing them to missions from undergraduate level.

What can we do?

The thrust of health care mission in Sub-Sahara Africa must be to get Africans to mobilise their own resources. The worldwide Church needs to recognise this and support it in every way. It is not just an African problem. It is a problem for the whole Church. What can we do?

- Discuss the issues.
- Provide role models.
- Share examples of training models.
- Devise fulfilling careers for the younger generation.
- Encourage character development.
- Provide strong emotional, social and spiritual support.

Above all, we must pray. Only God can give a vision to African healthcare professionals, one so bright that personal concerns fade away. Only he can enable Africans to own the vision of reaching our own people for him.

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Photo: Wellcome

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