

# The Critical Problems Facing Nursing Care in African Countries

Haruna Abubakar H

<sup>1</sup>Usman Dan Fodio University Sokoto Nigeria (Graduated)

**How to cite this article:** Abubakar H. The Critical Problems Facing Nursing Care in African Countries 2024;12(2): 21-26.

## ABSTRACT

As study after study has pointed out, the health care systems in Africa pay little attention to the critical interface between education and good health, especially when it comes to the education of women and mothers, who are the primary line of defense against child diseases, and perform simultaneously most domestic chores and critical agricultural activities. While many medical educational institutions on the continent tend to perpetuate, at times, skewed and irrelevant Eurocentric health training, the national pyramidal health structure, weakened at the village level, and disproportionately favoring the provincial and national hospitals, gives the illusion that rural areas are well-served, when in actuality they are not. This chapter endorses the restrengthening of an uncompromised health care system to make it effective and efficient for both rural and urban areas; one that finds ways of trimming financial and human resource waste; revamps the institutions that train health care and service providers to make the system responsive to the real health needs of the people and not just the wealthy; one that compensates physicians just as civil servants; and aligns the educational system with targeted and expected measurable health outcomes.

Keywords: Health System, Health Facility, Health Center, International Monetary Fund, District Hospital

## INTRODUCTION

This section highlights and summarizes the overall successes and challenges of the health systems in Africa, and is followed by a discussion of the strategies needed to improve the health conditions of the Africans. A health system that functions properly must have the necessary ingredients. These hinge on a multiple of financial, social, economic, environmental, and workforce resources, and a leadership that is committed, with a vision that focuses primarily on the people, particularly the poor, the sick and the disabled, and, through various initiatives, encourages change in individual unhealthy behaviors, all factors that render health difficult and complex to manage. The United Nations describes a health system as a structure that

includes “all actors, organizations, institutions, and resources whose primary purpose is to improve health...Their primary goal is to promote, restore or maintain health, but they also aim to be responsive to people’s legitimate expectations and are financially fair.<sup>1</sup>

Other important elements include: focusing on providing primary health care rather than on acute diseases, as Ethiopia has successfully done, reaching 80% of the population in 2014 a significant improvement over previous years; increasing mobile units to reach the people and not compelling all to come to the health centers; and, according to some, employing the workforce personnel from neighboring countries, who might be paid salaries by their own governments but provided with

---

**Corresponding author:** Haruna Abubakar, Usman Dan Fodio University Sokoto Nigeria( Graduated)

**Email:** harun.abubakar77@gmail.com

Submission: 19 April 2024

Revision: 15 May 2024

Publication: 24 July 2024

allowances and bonuses by the host state, as done in South Sudan. Important also would be creating access to secondary care treatment in emergencies provided by specialized physicians; using, to the extent possible, the most modern technologies for the collection of accurate data, storage, and analysis; utilizing telemedicine to reach remote areas, as India has done recently; placing less reliance on private donors given the economic uncertainties and the fact that most tend to approach disease vertically; empowering women and communities; instituting universal insurance coverage; increasing local funding beyond the 15% recommended by the <sup>2001</sup> Abuja Declaration to reach the <sup>2015</sup> target MDGs; and empowering but also regulating local health care entrepreneurs and pharmaceuticals that would produce generic drugs locally, thus reducing the high cost of medicine. In Africa, drug costs have which has varied from city to city, from region to region, and from country to country, making it difficult to rationalize the system continentally. In fact, wherever regulations exist, they are barely enforced Africa Region Health Report.<sup>2</sup>

How have health systems in Africa following colonial rule performed over the decades? Of the 54 African countries that pledged to increase the health budget to 15% from 4 to 5%, seven have achieved the goal, but, to do this, the majority have had to rely heavily on international donors; seven have actually reduced their budgets, forcing citizens to pay almost half of their health services out-of-pocket or with as much as 90% of the cost in some countries. Even though Africa accounts for 11–13% of the world population, its disease burden is 24% and Sub-Saharan Africa “commands less than 1% of global health expenditure” African Region Health Report<sup>2</sup>. One may also note that, currently, while HIV/AIDS prevalence has gone down among adults aged 15–49 years, as low as 1% worldwide, on the continent of Africa, the overall prevalence rate is 7%. These conditions certainly call for the allocation of more resources because poverty and ill health go hand-in-hand. We can also add that 76% of Africans live on less than \$2.00 a day, and 46.5% on less than \$1.08 a day. Over the past 20 years, the continent has seen its poverty rate spike, while in East and South Asia, the rate has

gone down. Moreover, between 1981 and <sup>2001</sup>, Africa’s GDP decreased by 13%, doubling the number of people living under less than \$1.00 a day from 34 million to 64 million people 64 million from 34 million “African Region Health Report<sup>2</sup>. This number remained static until 2014. Obviously, these bleak figures do not speak well of the health systems currently operating on the continent of Africa, even if one or two of the eight MDGs might have been reached by a handful of countries in 2015.

The following observations, made by Wendland in Malawi, dramatize the state of the health systems in most African countries. Describing one hospital in Malawi<sup>11</sup>

*“Inside, especially on a steamy day, you would probably be struck first by the smell: a distinctive compound of sickness and sweat, clothes washed without enough soap, dried blood and fresh blood, death and Jikbrand bleach solution. If you walked down a hallway toward one of the wards where you would be working soon, your feet would slide a little on the concrete floors, worn shiny and smooth by thousands upon thousands of feet. Red plastic signs hanging from the ceiling warned Osalabvula—Oslangolola [No Spitting, No Making Noise]...The rooms were lit only by the open windows during the day to save on electric bills. The high ceilings and concrete walls made the space feel cavernous despite the crowding, and amplified the moans of pain, the keens of grieving, the squeak of medicine trolley, or the conversation and quarrels of families clustered near the beds.*

### Health Systems Issues

Martyn Sama and Vinh-Kim Nguyen hold the view that all societies have had health systems “of some sort” as long as people have tried to protect themselves against diseases. Systems, they say, can be defined as those traditional practices, “often integrated with spiritual counseling and providing both preventive and curative care,” which have “existed for thousands of years and often co-exist today with modern medicine,” often undergoing consistent changes.<sup>3</sup> Their thesis is more relevant as they refer to African stewardship and the crisis the health system is experiencing virtually everywhere

on the continent. They point out that effective stewardship is the government's key role in oversight and trusteeship, which involves formulating health policy, defining the strategic vision clearly, and articulating the direction the leadership wishes to see the health system follow. This is strengthened by exerting influence and vocalizing in word and action the approaches to regulations guiding the health system, and collecting and using intelligence (data and information) effectively. In sum, stewardship implies vision, "overall system design and policy formulation; setting priorities, and "performance and impact assessment for outcomes, promotion of health and advocacy; and establishment of norms, standards, and ethical framework." In their assessment, the two authors note that African systems are among the "most bureaucratic and least effective managed institutions in the public sector. The ministries are fragmented with vertical programs, or ritual chiefdoms, dependent on certain donor funding." The description could not be more accurate to anyone who has visited an African hospital to be treated, as chapters in this volume emphasize, ranging from an uncountable absenteeism to unauthorized financial charges by doctors that circumvent the official care provision in public and private health facilities to delays of treatment on alleged equipment failures<sup>4</sup> thus further sharpen their analysis of African health systems and their stewardships:

*If African health systems are ungovernable, it may be in part because powerful international donors work at cross-purposes, setting competing agendas, cycling policies at a rate that defies bureaucratic assimilation, fragmenting health efforts, and undermining local systems of accountability... There is recognition that accountability, transparency, and vigorous citizenship participation are essential to achieving a viable society, sustainable economic growth, and equitable distribution of benefits and risk of growth. Yet, African countries are characterized by persistent and in many cases worsening social, economic, and gender, and health inequalities.<sup>3</sup> (author's emphasis)*

This major hospital had no recovery rooms for patients. Under such dire circumstances, one asks, how can a "sick" hospital cure the sick?

### **Anglophone Africa: Health Care Systems in Tanzania, Uganda, and Kenya**

The following section highlights the pluses and minuses of selected representative countries in Sub-Saharan Africa that underscore the colonial legacy from Britain, France, Portugal, and Spain, and is designed to simply illustrate the general findings of the nature of the national health systems in Africa. This approach will reveal the intractable colonial health legacies Africa inherited from the colonial past. We may start with the three former members of the East African Community, which were supposed to coordinate health strategies and goals, Tanzania, Kenya, and Uganda and their devastating impact, especially on the poor. It will look at the resources and the current structure of their health care systems, beginning with Tanzania. Tanzania, a country of 44 million, is said to follow a pyramidal model or a bottom-up approach, which begins at the village level and reaches the apex at the most advanced, but also most expensive, approach to providing health care. Obviously, if such a system is not well handled, it can ruin the effectiveness and efficiency of the whole health care system and make it inaccessible to the poor, who often constitute the majority. The UN and the World Bank define poverty in the developing world as a person's condition characterized by an income that is \$1.50 or less a day (others say less than \$2.00 a day). For the sake of simplification, in this work we use the rate of \$2.00/day or less for the poverty level.

Tanzania's health care structure begins with the thousands of village health services scattered throughout the country at the bottom, superseded, in ascending order, by dispensary health services, district hospitals, regional hospitals, and referral and consultant hospitals at the top.<sup>5</sup>

### **Hispanophone Africa: Equatorial Guinea**

With only three quarters of a million people, Equatorial Guinea, is a former Spanish colony that achieved its independence in <sup>1968</sup>. Equatorial Guinea is considered to be a high income country, mainly as a result of the enormous oil reserves being extracted and refined mainly by the Marathon Oil Corporation, making it one of the five

major producers of oil in Africa. As expected, the country suffers from the same tropical diseases as others in the region: malaria, TB, measles, yellow fever, leprosy, trypanosomiasis, schistosomiasis, meningitis, and others such as HIV/AIDS. Overall, infectious diseases represent 85% of the consultations in the country, and diarrhea alone accounts for half of the visits, while flu, the major endemic illness, represents 61% of the country's illnesses. TB's deadly impact is estimated at 15% among patients on treatment, and most of it is due to late diagnosis and HIV co-infections. About 60% of its population lives in rural areas, with a life expectancy at birth of 52.08 years compared to the average in Sub-Saharan Africa of 55.92, still a major accomplishment for a country located in some of the worst disease-prone areas of the continent. Another major accomplishment of this tiny state is the fact that more than 50% of the population now has access to clean drinking water, when in several parts of Africa the figure does not reach 36%. Also, maternal mortality rate stands at 240 per 100,000 live births<sup>6</sup>, compared to the average of 494.53 per 100,000 across Sub-Saharan Africa; the percentage of births attended by skilled health workers stands at 64.6 contrasted to 33.14% in other Sub-Saharan African countries (USAID<sup>7</sup>). The prevalence rate of HIV is 4.7% compared to 7.0% in the Sub-Saharan region. Against malaria, Equatorial Guinea has a relatively higher rate of children sleeping under a bed net in the region, 2.7%, as opposed to 0.7 in the rest of Sub-Saharan Africa. However, the under-five mortality rate is estimated at 100.3 per 100,000 live births, which is higher when compared to the rest of Sub-Sahara, where, on the average, it is 94.27 per 100,000. Yet, fertility here is extremely high at 5.4 per woman<sup>(2011)</sup>, a little higher than in the rest of Sub-Saharan Africa, estimated at 5.23 per woman.

Looking closely at the health system in the area of leadership and governance one of the building blocks of a good health system Equatorial Guinea scores very low, 1.87<sup>(2012)</sup>, when the average in Sub-Saharan Africa is 0.74, with the point estimate in 2012 at 1.65, compared to the Sub-Saharan average and other high income countries of 0.83 and 0.65, respectively (USAID<sup>7</sup>). On health financing, the second building block, Equatorial

Guinea spends only 3% of its GDP on health, despite its huge oil revenues, when, elsewhere in Africa, the figure is around 5.0–6.34%. However, to its credit, Equatorial Guinea does not over rely on international donors for health funding: 1.75% of the health budget is made up of international donations compared to 23.8% average for the rest of Sub-Saharan Africa. Because the government does not provide health insurance coverage to its citizens, notwithstanding the vast oil revenues, citizens spend about 93.5% in health costs using out-of-pocket money, contrasted to the average cost attributed to people in Sub-Saharan Africa, namely, 73.7%.

Concluding this section, we must say that, despite the several differences that exist among the current health systems in Africa, the major structural format and organization are the same<sup>8</sup>. when they write that the health care system in Africa is organized under a National Ministry of Health (MOH) and Departments within the ministry address key health issues such as the regulation and oversight of public hospitals, preventive care services, and maternal and child health.

### **Poverty and Health in Africa**

This discussion establishes the fact that health and poverty are twin sisters that reinforce one another, to the extent that, on the one hand, if someone is poor, he is most likely going to live an unhealthy life because health requires access to resources, a level of general literacy, and awareness of disease prevention in particular. On the other hand, if someone is unhealthy, the likelihood is that he will not be able to function properly in society and might spend all his meager resources and energies trying to be well, which might perpetuate his state of poverty or force him to lead an unfulfilling life. Poverty is a consequence of social and political inequalities or disparities that should never be allowed and can be eradicated just as the disease itself. This is not to deny, of course, that individual behavior may lead one to poverty. However, it is also clear that no one wishes to be poor. Many people are trapped in a vicious cycle of poverty since the day they are born, and therefore the risk to their

health is high. As the WHO says, “the poorest almost always experience higher mortality levels, die younger (on average), and experience higher levels of child and maternity mortality,” because “causality between poverty and ill health is bi-directional, demonstrated in both macro-level (cross-national and national) and micro-level (individual, household, and community) studies” Quoted from World Bank.<sup>9</sup>

In countries such as the Central African Republic, mortality rates of infants and under-fives for the “assets poorest quintile of the population is always more than twice that of the richest quintile” World Bank<sup>9</sup>. Thus, it is the responsibility of the government and society to ensure that everyone is given equal opportunity to develop unhindered both physically and mentally and pursue happiness on this earth and not be forced to postpone this right to the afterlife, if one believes the latter exists. ECOSOC is clear on the obligation governments have in eliminating poverty as a priority and health systems’ moral obligation to make care accessible to all citizens: “Closing the gap [between rich and poor] is a matter of social justice we should do it because it is the right thing to do. It is an intensely moral issue. We put at the center of what we were trying to achieve empowerment, which we think of a material, psycho-social and political, having a voice. In the spirit of justice, we seek to help create the conditions for people to lead flourishing lives.” ECOSOC Members<sup>10</sup>. No matter how poor one might be, however, the international community (except some significant segments of the US), overwhelmingly believes that health and access to quality health, as defined by the UN, are not a privilege of a few but a human and a citizen’s right no matter where he or she might reside<sup>11</sup>.

## CONCLUSION

The integrated review highlights that majority of countries within Sub Saharan Africa are experiencing common challenges ranging from strained training institutions due to increased enrolments, inadequate faculty capacity, lack of infrastructure and resources, high demand for clinical training sites. To ensure improved quality and quantity of production, developmental partners have increased allocation of financial

resources for infrastructure and teaching and learning material. Efforts are being done to expand number of clinical sites, build faculty capacity and increase collaboration with clinical institutions for clinical instructors and mentors. Curriculum reforms are being implemented to reposition the nursing workforce for a competence based approach, community based education and inter-professional training. Clinical simulation and technology based teaching strategies are on the increase to accommodate the demands for new ways of teaching and learning.

**Funding:** Self

**Ethical Clearance:** NA

**Interest:** Nil

## REFERENCES

1. Mooketsane KS, Phirinyane MB. Health governance in Sub-Saharan Africa. *Globl Soc Policy*. 2015;15(3):345–348. [PMC free article] [PubMed] [Google Scholar]
2. Negeri KG, Halemariam D. Effect of health development assistance on health status in sub-Saharan Africa. *Risk Manag Healthc Policy*. 2016;9:33. [PMC free article] [PubMed] [Google Scholar]
3. Akinyemi JO, Chisumpa VH, Odimegwu CO. Household structure, maternal characteristics and childhood mortality in rural sub-Saharan Africa. *Rural Remote Health*. 2016;16(2):3737. [PubMed] [Google Scholar]
4. Keino S, Plasqui G, Etyyang G, van den Borne B. Determinants of stunting and overweight among young children and adolescents in sub-Saharan Africa. *Food Nutr Bull*. 2014;35(2):167–178. [PubMed] [Google Scholar]
5. Scheffler RM, Tulenko K, et al. The deepening global health workforce crisis: forecasting needs, shortages, and costs for the global strategy on human resources for health (2013-2030) *Ann Glob Health*. 2016;82(3):510. [Google Scholar]
6. Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the sustainable development goals. *BMC Med*. 2015;13:101. [PMC free article] [PubMed] [Google Scholar]
7. Kinfu Y, Dal Poz MR, Mercer H, Evans DB. The health worker shortage in Africa: are enough physicians and nurses being trained? *Bull World Health Organ*. 2009;87(3):225–230. [PMC free article] [PubMed] [Google Scholar]
8. Global Health Workforce Alliance W. *A universal truth: no health without a workforce*. Geneva: World Health Organization; 2013. [Google Scholar]
9. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an

- interdependent world. *Lancet*. 2010;376(9756):1923–1958. [PubMed] [Google Scholar]
10. Crisp N. A global perspective on the education and training of primary care and public health professionals. *London J Prim Care*. 2012;4(2):116–119. [PMC free article] [PubMed] [Google Scholar]
11. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010;376:1923–1958. [PubMed] [Google Scholar]