EDO STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY (EDSPHCDA)

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The Honourable Commissioner,
Edo State Ministry of Health.

SUBMISSION OF FACILITY MAPPING REPORT AND MULTI-YEAR PRIMARY HEALTH CARE WORKFORCE RECRUITMENT PLAN FOR APPROVAL

I am pleased to submit the facility mapping report on the number and duty stations of Primary Health Care (PHC) workers in the State, along with the multi-year costed PHC workforce recruitment plan for your review and approval.

2. This comprehensive mapping exercise was conducted to provide an accurate and up-to-date account of the Primary Health Care (PHC) workforce, addressing critical staffing gaps and informing strategic workforce planning. Specifically, the exercise covers:

a. A detailed personnel list of PHC workers in facilities supported by the Basic Health Care Provision Fund (BHCPF), including their qualifications, experience, positions, duty stations, and date of commencement.

b. Workforce forecasting to determine expected attrition over the next four years and future staffing needs based on population density, urban-rural distribution, and gender balance.

c. An assessment of the current staffing positions across all PHC facilities, identifying workforce gaps and skill shortages.

d. A costed recruitment and deployment plan outlining strategies for filling identified gaps over the next four years.

e. A sourcing and recruitment strategy to guide the hiring and redeployment of PHC workers.

3. The attached documents provide detailed data, analysis, and recommendations derived from the facility mapping exercise. These findings will serve as a critical input for optimizing human resource planning and ensuring effective service delivery across the PHC system.

4. In light of the above, I kindly request your approval of this report and its recommendations. Please find attached the relevant documents for your consideration.

Dr. Coulson Osoikhia,
Executive Secretary.
28 **/03/2025**

3. Recruitment Channels

- Government recruitment drives for doctors, nurses, and technicians.
- Job fairs and partnerships with medical and nursing schools.
- Collaboration with development partners (e.g., WHO, UNICEF) for technical assistance and funding.
- Online recruitment portals and social media outreach for wider reach.

4. Recruitment Timeline (4-Year Plan)

Year	Key Recruitment Actions
Year 1	Immediate redeployment, begin recruitment drive, and finalize partnerships with institutions.
Year 2	Hire new graduates, expand incentive programs for rural areas.
Year 3	Mid-term evaluation of staffing effectiveness, adjust recruitment strategies.
Year 2	Achieve full staffing targets, implement long-term retention strategies.

5. Cost Considerations

- Salaries and benefits for new hires.
- Training and upskilling costs.
- Relocation and housing incentives for rural postings.

6. Conclusion

This recruitment strategy will ensure all primary healthcare facilities in the state have adequate staffing over the next four years, ultimately improving healthcare service delivery.

Strategy for Sourcing and Recruiting New Primary Healthcare Workers

1. Introduction

The healthcare workforce is critical to the effective functioning of primary healthcare facilities. Based on the workforce gap analysis, a comprehensive recruitment strategy is necessary to address staffing shortages across all LGAs. This strategy outlines the approach for hiring and deploying healthcare workers over the next four years.

2. Recruitment Approach

To efficiently fill the identified gaps, recruitment will be carried out through three main strategies:

- Internal Hiring & Redeployment – Utilizing existing workforce through reassignment.
- External Recruitment – Hiring new healthcare professionals.
- Hybrid Approach – A combination of internal transfers and external hires.

2.1. Internal Hiring & Redeployment

- Redeployment of underutilized staff from overstaffed facilities to those with severe shortages.
- Promotion of qualified lower-level staff to fill critical gaps (e.g., senior nurses).
- Training programs to upskill current employees into higher-demand roles.

2.2. External Recruitment

- Direct hiring of new medical personnel through competitive selection.
- Collaboration with health training institutions (nursing schools, medical colleges) to create a pipeline of graduates for employment.
- Incentivizing rural postings by offering hardship allowances, housing, and career advancement opportunities.

2.3. Hybrid Approach

- Filling urgent gaps through redeployment while initiating external recruitment for long-term staffing stability.
- Partnering with volunteer organizations, NGOs, and contract staff for short-term support while permanent hires are processed.

ASSESMENT OF FUTURE WORKFORCE REQUIREMENTS, FOUR-YEAR PLAN (2025 – 2028)

1. Introduction

The provision of quality healthcare services across all Primary Healthcare (PHC) facilities in the state is dependent on an adequate and well-distributed workforce. However, the current workforce analysis indicates critical staffing gaps across LGAs. This plan provides a strategic approach to address these gaps over the next four years, ensuring an equitable distribution of healthcare personnel. This workforce plan outlines the projected human resource needs for primary healthcare (PHC) facilities across the state based on population density, urban vs. rural distribution, and specific staffing gaps per facility. It provides a framework for allocating, recruiting, and retaining healthcare workers in alignment with the state's health sector strategy.

2. Workforce Assessment & Projections

2. Workforce Assessment Based on Key Factors

2.1 Population Density & Service Demand

- Higher population density areas require more healthcare workers due to increased patient load.

Urban LGAs (e.g., Oredo, Egor, Ikpoba Okha) have relatively better staffing but still face shortages in key areas such as doctors and pharmacists.

- Rural areas have lower population density but may require more outreach workers due to geographic spread and access challenges.

Rural LGAs (e.g., Owan East, Ovia South-West, Akoko Edo) are severely understaffed, particularly in medical doctors, nurses, and laboratory technicians.

2.2 Urban vs. Rural Staffing Needs

- Urban PHCs: Higher demand for specialized roles such as laboratory scientists and pharmacists.

- Rural PHCs: Higher demand for community health workers and nurses to provide outreach services.

2.3 Specific Staffing Gaps per Facility & LGA

- Based on LGA workforce gaps, the estimated per-facility requirement was calculated by evenly distributing LGA-level shortages across an assumed number of PHCs per LGA.
- Example Breakdown (Estimated Per Facility in One LGA):
- Medical Officers: 1 per facility
- Nurses/Midwives: 2 per facility
- CHEWs (Community Health Extension Workers): 3 per facility
- Laboratory Scientists: 1 per facility
- Pharmacists: 1 per facility
- Health Records Officers: 1 per facility

3. Facility-Level Staffing Projections (Next Four Years)

Projected Workforce Demand: With a projected annual population growth rate of approximately 2.5%, the demand for PHC workers will continue to increase, especially in underserved rural areas.

- Yearly projections will address shortages through phased hiring and redeployment.
- Workforce prioritization will be based on critical service gaps and population needs.

Year 1-2 (Short-Term Goals)

- Fill 50% of critical staffing gaps in high-demand urban PHCs.
- Deploy additional CHEWs and nurses in underserved rural areas.

Year 3-4 (Long-Term Goals)

- Full staffing of all PHCs to meet national healthcare worker ratios.
- Strengthen retention strategies, including incentives for rural postings.

2.2. Specific Staffing Gaps by Cadre

Cadre	Required	Actual	Gap	Priority Areas
Doctors	174	45	142	Rural LGAs, maternity and emergency services

Pharmacists	151	12	140	Drug distribution & medication management
Nurses/Midwives	1124	310	811	Maternal and child health, emergency care, rural clinics
CHO	205	148	57	Supervision of PHC workers, primary care coordination
CHEW	923	470	449	Preventive healthcare, immunization, maternal and child health services
JCHEW	1118	175	944	Rural and hard-to-reach areas, immunization, health education
Health Record	293	36	254	Medical data management, digital health records, facility administration
Health Attendant	820	467	374	Patient support, sanitation, hospital logistics
Pharmacy Tech	260	13	247	Dispensing, medication inventory management, assisting pharmacists
Lab Scientist	134	17	116	Disease diagnosis, research, laboratory analysis

Lab Technicians	255	20	233	Disease diagnosis & surveillance, routine medical tests
Ambulance Drivers	79	22	57	Emergency response, referrals, patient transportation
Security Personnel	732	162	565	Facility safety, crowd control, asset protection

3. Recruitment and Workforce Development Strategy (2025 – 2028)

3.1. Yearly Workforce Expansion Targets

Cadre	Total Gap	2025 Target	2026 Target	2027 Target	2028 Target
Doctors	142	35	35	36	36
Pharmacists	140	35	35	35	35
Nurses/Midwives	811	203	202	203	203
CHO	57	14	14	14	15
CHEW	449	113	112	112	112
JCHEW	944	236	236	236	236
Health Record	254	64	63	63	63
Health Attendant	374	94	93	93	94
Pharmacy Tech	247	62	61	62	62
Lab Scientist	116	29	29	29	29
Lab Technicians	233	58	58	58	59
Ambulance Drivers	57	14	14	14	15
Security Personnel	565	142	141	141	141

4. Workforce Recruitment and Sourcing Plan

4.1. Internal Redistribution

- Reallocating overstaffed roles: Some facilities in urban areas with excess support staff (e.g., security) will be reallocated to under-served rural areas.
- Cross-training of staff: Nurses in low-patient volume areas will be trained in basic laboratory diagnostic skills.

4.2. External Recruitment

- Direct Hiring: The government will conduct annual recruitment drives for critical healthcare roles.

- Public-Private Partnerships (PPP): Collaborations with private hospitals and NGOs to provide temporary staffing support in areas of high need.

- Incentivized Recruitment: Salary bonuses, rural housing allowances, and career advancement incentives will be provided to attract professionals to rural LGAs.

4.3. Community-Based Workforce Development

- Training of Community Health Workers (CHWs): Scaling up CHW programs to fill gaps in remote areas.

- Scholarship and Bond Programs: Medical students will receive financial support with a service agreement to work in rural facilities for at least three years.

4.4. Technology and Alternative Staffing Solutions

- Telemedicine Expansion: Doctors from urban areas will provide remote consultation for rural PHCs.

- Task-Shifting Policy: Equipping nurses and CHWs with additional skills in maternal care, diagnostics, and emergency response to compensate for doctor shortages.

5. Monitoring & Evaluation Framework

- Annual Workforce Assessment: Review staffing levels and adjust hiring targets based on emerging needs.

- Performance Metrics: Evaluate patient-to-healthcare worker ratios, service delivery quality, and staff retention rates.

- Quarterly Stakeholder Engagement: Engage community leaders, partners, and healthcare workers to address challenges in workforce retention and service delivery.

6. Conclusion

The 2025 – 2028 Primary Healthcare Workforce Development Plan aims to ensure that every LGA has an adequate number of qualified personnel to deliver essential health services. By implementing a phased recruitment strategy, leveraging technology, and investing in community-based health workers, the state will significantly improve healthcare access, especially in rural areas.

COSTED RECRUITMENT AND DEPLOYMENT PLAN (2025 – 2028)

1. Introduction

This document presents the costed recruitment and deployment plan for primary healthcare (PHC) workforce development over the next four years (2025–2028). The plan is structured to address existing staffing gaps through a combination of new hires, redeployments, and incentive-based recruitment strategies.

2. Workforce Gaps and Recruitment Targets

2.1. Yearly Workforce Expansion Targets

Cadre	Total Gap	2025 Target	2026 Target	2027 Target	2028 Target
Doctors	142	35	35	36	36
Pharmacists	140	35	35	35	35
Nurses/Midwives	811	203	202	203	203
CHO	57	14	14	14	15
CHEW	449	113	112	112	112
JCHEW	944	236	236	236	236
Health Record	254	64	63	63	63
Health Attendant	374	94	93	93	94
Pharmacy Tech	247	62	61	62	62
Lab Scientist	116	29	29	29	29
Lab Technicians	233	58	58	58	59
Ambulance Drivers	57	14	14	14	15
Security Personnel	565	142	141	141	141

3. Recruitment Strategy and Costing

3.1. Estimated Annual Salary and Recruitment Costs per year

Cadre	No of Staff recruited yearly	Annual Salary per staff	Total Estimated Annual Salary (N)	Recruitment/ Training Cost (N)	Deployment and Other Costs (N)	Total (N)
Doctors	36	5,706,000	205,416,000	3,000,000	500,000	208,916,000
Pharmacists	35	4,806,000	170,000,000	3,000,000	450,000	173,450,000
Nurses/Midwives	811	2,280,000	1,849,080,000	7,000,000	500,000	1,856,580,000
CHO	57	2,160,000	123,120,000	3,000,000	200,000	126,320,000
CHEW	449	1,800,000	808,200,000	5,000,000	300,000	813,500,000
JCHEW	944	948,000	894,912,000	8,500,000	600,000	904,012,000
Health Record Officers	254	1,800,000	457,200,000	5,000,000	300,000	462,500,000
Health Attendant	374	948,000	354,552,000	3,000,000	350,000	357,902,000
Pharmacy Tech	247	1,800,000	444,600,000	6,000,000	350,000	450,950,000
Lab Scientist	116	1,800,000	208,800,000	4,500,000	150,000	213,450,000
Lab Technicians	233	1,800,000	419,400,000	5,000,000	300,000	424,700,000
Ambulance Drivers	57	1,800,000	102,600,000	3,000,000	150,000	105,750,000
Security Personnel	565	3,000,000	1,695,000,000	6,000,000	150,000	1,701,150,000
Total (N)	4178	30,648,000	7,732,880,000	62,000,000	4,300,000	7,799,180,000

3.2. Recruitment Approach

-Direct Hiring: Government-led recruitment for doctors, nurses, and lab technicians.

-Contract-Based Hiring: Short-term contracts for pharmacists and ambulance drivers.

-Public-Private Partnerships (PPP): Collaboration with private hospitals and NGOs for temporary staff support.

-Community-Based Health Workers (CHWs): Expansion of CHW programs to bridge service gaps in rural areas.

4. Redeployment Strategy

-Internal Redistribution: Relocating excess security personnel and support staff from overstaffed urban areas to rural facilities.

-Cross-Training: Nurses in low-patient volume areas to be trained in laboratory diagnostics.

- Task-Shifting: Expanding nurses' and CHWs' roles in maternal care and emergency response.

5. Incentive Plan

-Rural Deployment Allowances: ₦100,000 per month for doctors and ₦50,000 for nurses/midwives in rural LGAs.

-Housing and Transport Grants: Subsidized accommodation and travel reimbursements.

-Career Growth Opportunities: Training sponsorships and scholarships for advanced medical training.

6. Monitoring and Evaluation

-Annual Workforce Review: Tracking recruitment progress and adjusting strategies accordingly.

-Quarterly Performance Audits: Evaluating patient-to-staff ratios and service quality.

-Feedback Mechanism: Engaging healthcare workers and community members for continuous improvement.

6. Conclusion

The 2025–2028 costed recruitment and deployment plan aims to bridge critical workforce gaps in primary healthcare facilities. By implementing a phased recruitment strategy,

incentivizing rural deployment, and optimizing existing resources, the state will significantly enhance healthcare service delivery.