MAPPING AND PLANNING FOR PRIMARY HEALTHCARE WORKERS IN BASIC HEALTH CARE PROVISION FUND SUPPORTED FACILITIES IN ONDO STATE

TABLE OF CONTENT

ABBREVIATIONS

AMCHIS: Abiyamo Maternal and Child Health Insurance Scheme

BHCPF: Basic Health Care Provision Fund

CHEWs: Community Health Extension Workers

CHOs: Community Health Officers

HRH: Human Resources for Health

JCHEWs: Junior Community Health Extension Workers

LGAs: Local Government Areas

NGOs: Non- Governmental Organisations

NYSC: National Youth Service Corp

ODCHC: Ondo State Contributory Health Commission

PHC: Primary Health Care

HIV/AIDS: Human immunodeficiency virus / Acquired immunodeficiency syndrome

CHAPTER 1

INTRODUCTION

Overview of Ondo State

Ondo State, located in the Southwestern region of Nigeria, is known for its rich cultural heritage and diverse population. With an estimated population of over 5.9 million people in 2025, the state is projected to grow at an annual rate of 2.91%. the state is characterized by a mix of urban and rural settlements. The state comprises 18 Local Government Areas (LGAs), including Akoko South-West, Idanre, Irele, and Owo, among others. The majority of residents are engaged in agriculture, trading, and small-scale industries, with cocoa production being a significant economic activity and a significant portion of the population residing in rural areas.

Health Sector and Challenges

Ondo State has demonstrated a strong commitment to improving healthcare through innovative and inclusive interventions. Programs like Abiye, ODCHC, AMCHIS and the revitalization of PHCs have significantly enhanced access to quality care, particularly for vulnerable groups. Moving forward, sustaining these gains will require continued investment, stakeholder collaboration, and community engagement to ensure a healthier future for all residents.

However, the health sector in Ondo State faces several challenges, including inadequate infrastructure, limited access to quality healthcare in rural areas, and a shortage of skilled health workers. Communicable diseases such as malaria, tuberculosis, and HIV/AIDS remain prevalent, while non-communicable diseases like hypertension and diabetes are on the rise. Maternal and child health outcomes are also areas of concern, with high rates of maternal and infant mortality in some regions.

BHCPF Facilities in Ondo State

The Basic Health Care Provision Fund (BHCPF) is a federal initiative aimed at improving primary healthcare delivery across Nigeria. Ondo State has 203 BHCPF facilities, strategically located across the 203 wards in the state to ensure equitable access to healthcare services. These facilities serve as the first point of contact for healthcare delivery, providing essential services such as immunization, maternal and child health care, and treatment of common ailments.

Attrition of Health Workers: A Major Challenge

One of the critical challenges facing the state's health sector is the attrition of health workers. Factors such as retirement, migration to urban areas, and poor working conditions have led to a significant loss of skilled personnel. This attrition has severe implications for the health system, including increased workload for remaining staff, reduced quality of care, and unmet healthcare needs, particularly in rural and underserved areas. Addressing this issue is paramount to achieving the state's health goals and ensuring sustainable healthcare delivery.

Summary

This report details the comprehensive mapping and planning exercise conducted in Ondo State to assess and address the Human Resources for Health (HRH) situation within the BHCPF facilities at the Primary Health Care (PHC). This initiative, driven by the need to optimize service delivery and ensure equitable access to care, focused on creating a detailed manpower plan, forecasting future needs, and developing a costed recruitment and deployment strategy. The findings reveal significant gaps in staffing, particularly in rural areas, and propose targeted interventions to address these challenges over the next four years.

CHAPTER 2

CURRENT STAFFING POSITION (PERSONNEL LIST & GAP ANALYSIS)

Personnel List

A comprehensive personnel list of all PHC workers in BHCPF-funded facilities was compiled, including detailed information on names, qualifications, experience, positions, duty stations, and commencement dates.

Key Findings:

1. Severe Shortages of Critical Healthcare Staff

The current healthcare workforce is facing a critical shortage of doctors and midwives, with only 25 doctors available across 203 health facilities—a grossly inadequate ratio that severely limits access to medical care. Similarly, the number of midwives (14) is alarmingly low, raising concerns about maternal and neonatal health outcomes. These shortages create an overwhelming burden on existing staff, compromise the quality of care, and hinder the health system's ability to meet patient needs.

2. Uneven Distribution of Healthcare Workers

While Community Health Extension Workers (CHEWs) are the most abundant cadre, with 258 workers recorded, their distribution is highly uneven. Some facilities benefit from multiple CHEWs, while others have none at all, leading to significant gaps in primary healthcare delivery. This imbalance suggests inefficiencies in workforce allocation and highlights the need for a more equitable distribution strategy to ensure all facilities have at least basic coverage.

3. Stark Urban-Rural Disparities in Healthcare Staffing

A clear **urban-rural divide** exists in the distribution of skilled health workers:

Urban facilities have a higher concentration of doctors and medical lab scientists, reflecting better access to specialized care.

Rural facilities, in contrast, rely heavily on nurses, midwives, and CHEWs, with no pharmacists available—poss serious challenges for medication management and pharmaceutical care.

Forecasting Attrition (2025–2028)

PHC workers in BHCPF-funded facilities leaving the service in the next four years

Year	Total Retirements	LGAs Most Affected
2025	33	Akoko SW (6), Idanre (5), Odigbo (5)
2026	32	Ifedore (8), Akoko SE (4), Akoko NW (4)
2027	53	Ose (10), Idanre (8), Irele (7)
2028	27	Irele (8), Idanre (3), Owo (3)

Key Observations:

Over the next four years, the state is expected to face a significant reduction in its health workforce, with 145 health workers projected to retire from BHCPF (Basic Health Care Provision Fund) facilities. This attrition will be most pronounced in 2027, when 53 health personnel—the highest number within the period—are anticipated to exit the system.

The impact of these retirements will be unevenly distributed across Local Government Areas (LGAs), with Irele, Idanre, and Odigbo being the hardest hit. These LGAs already experience critical shortages in health personnel, and the impending wave of retirements threatens to widen existing gaps in service delivery. The loss of experienced health workers could lead to reduced access to care, longer wait times, and increased strain on remaining staff, further compromising the quality of healthcare services in these areas.

Without urgent interventions such as targeted recruitment, retention incentives, or accelerated training programs, the state's health system may struggle to maintain adequate service coverage, particularly in the most affected LGAs. Proactive measures will be essential to mitigate the anticipated workforce shortfall and ensure continuity of care for vulnerable populations.

ASSESSMENT OF FUTURE WORKFORCE REQUIREMENTS

Population Growth and Workforce Projections

Projected Population for Ondo State:

Year	Population	Annual Growth Rate
2025	5,970,448	2.91% (from 2024)
2026	6,144,283	2.91%
2027	6,323,179	2.91%
2028	6,507,283	2.91%

WHO Recommended Staff-to-Population Ratios:

- Doctors/Nurses/Midwives: 2.3 per 1,000 people
- CHEWs/JCHEWs/CHOs: 1 per 500 people).

Calculations:

1. Doctors/Nurses/Midwives Requirement:
   - 2025: 5,970,448/1,000×2.3=13,732 2028: 6,507,2831,000×2.3=14,967
2. CHEWs/JCHEWs/CHOs Requirement:
   - 2025:5,970,448/500=11,941 2028: 6,507,283/500=13,015

Current vs. Required Workforce:

Category	Current (2024)	Required (2025)	Gap (2025)	Required (2028)	Gap (2028)
Doctors	25	13,732	**13,708**	14,967	**14,943**
Nurses/Midwives	99	13,732	**13,633**	14,967	**14,868**
CHEWs/JCHEWs/CHOs	365	11,941	**11,576**	13,015	**12,650**

Using the WHO-recommended staff-to-population ratios, the state's future workforce needs were calculated:

- **Doctors/Nurses/Midwives:** The current workforce (124) falls drastically short of the required 13,732 (2025) and 14,967 (2028).
- **CHEWs/JCHEWs/CHOs:** A gap of 11,576 (2025) and 12,650 (2028) exists, highlighting the urgent need for recruitment and training

Key Observations: Workforce Gaps in the State's Health Sector

The state's current health workforce falls **severely short** of the required staffing levels when measured against **WHO-recommended staff-to-population ratios**. The gaps are particularly alarming across all major health worker categories—doctors, nurses/midwives, and Community Health Extension Workers (CHEWs/JCHEWs/CHOs)—and are projected to widen further by 2028.

1. Critical Shortages in Doctors and Nurses/Midwives

Current Workforce (2024):
The state has only 25 doctors and 99 nurses/midwives, totaling 124 skilled health professionals—far below the needed capacity.

Required Workforce:
2025: 13,732 doctors and nurses/midwives (leaving a staggering gap of 13,708 doctors and 13,633 nurses/midwives).
2028: 14,967 doctors and nurses/midwives (widening the gap to 14,943 doctors and 14,868 nurses/midwives).

Implications: The severe deficit in these critical cadres means the state currently operates at less than 1% of the required medical and nursing workforce, jeopardizing basic healthcare delivery, emergency services, and maternal/child health outcomes.

2 Insufficient CHEWs/JCHEWs/CHOs for Primary Healthcare

Current Workforce: 365 CHEWs/JCHEWs/CHOs are in service, which, while higher than doctors and nurses, remains grossly inadequate.

Required Workforce:
2025: 11,941 (leaving a gap of **11,576**).
2028: 13,015 (expanding the gap to **12,650**).
Implications: Given that CHEWs/JCHEWs/CHOs are the backbone of **primary healthcare**, especially in rural and underserved areas, this shortage will exacerbate challenges in immunization, antenatal care, disease surveillance, and community health outreach.

3. Projected Workforce Crisis by 2028

Without **immediate and sustained interventions**, the gaps will continue to grow, with:

The doctor shortage increasing from **13,708 (2025)** to **14,943 (2028)**.
The nurse/midwife shortage rising from **13,633 (2025)** to **14,868 (2028)**.
The CHEW/JCHEW/CHO deficit expanding from **11,576 (2025)** to **12,650 (2028)**.

Urgent Actions Needed

To address this crisis, the state must prioritize:
✔ **Massive recruitment drives** to fill existing vacancies.
✔ **Accelerated training programs** to produce more qualified health workers.
✔ **Retention strategies** (better wages, incentives, and working conditions) to prevent further attrition.
✔ **Policy reforms** to optimize workforce distribution, particularly in high-need LGAs.

URBAN VS. RURAL RATIO OF HEALTHCARE WORKERS

- **Doctors**: 1.27 (More doctors in urban areas)
- **Nurses**: 0.40 (More nurses in rural areas)
- **Nurse/Midwives**: 0.50 (Balanced but slightly more in rural areas)
- **Midwives**: 0.40 (More midwives in rural areas)
- **CHEWs (Community Health Extension Workers)**: 0.43 (More in rural areas)
- **JCHEWs (Junior CHEWs)**: 0.50 (Evenly distributed)
- **CHO (Community Health Officers)**: 0.43 (More in rural areas)
- **Dental Technicians**: 0.69 (More in rural areas)
- **Dental Surgery Technicians**: 0.63 (More in rural areas)
- **Medical Lab Scientists**: 1.25 (More in urban areas)
- **Medical Lab Technicians**: 0.88 (Almost balanced)
- **Pharmacists**: 0.00 (No pharmacists in rural areas)
- **Pharmacy Technicians**: 0.64 (More in rural areas)
- **Health Educators**: 0.11 (Much more in rural areas)
- **Health Education Technicians**: 0.58 (More in rural areas)
- **Medical Records Officers**: 2.67 (More in urban areas)
- **Medical Records Technicians**: 0.36 (More in rural areas)
- **Health Assistants**: 0.33 (More in rural areas)

Interpretation of Results;

A ratio **greater than 1** means more healthcare workers are in urban areas.

A ratio **less than 1** means more are in rural areas.

A ratio **equal to 1** means an equal distribution.

Future Workforce Needs Based on Urban vs. Rural Ratio:

1. **Urban Bias**: Doctors and medical lab scientists are concentrated in urban areas (ratios >1), leaving rural areas underserved.
2. **Rural Bias**: Nurses, midwives, and CHEWs are more prevalent in rural areas (ratios <1), but their numbers remain insufficient.

3. **Critical Gaps**: Pharmacists are entirely absent in rural facilities, and medical records officers are disproportionately urban-based.
4. **Medical Records Officers**: Urban-heavy, but rural areas need better record-keeping support.
5. **Health Educators**: Low urban presence, suggesting urban areas need more awareness programs

CHAPTER 3

STAFFING GAP

Here's a structured analysis of staffing gaps for Type 3 and Type 2 PHC facilities in Ondo State, comparing required vs. actual health workers. The required Health workforce for PHC facilities as contained in the Minimum Standards for Primary Health Care in Nigeria was used to calculate the required health worker by facility type.

1. Type 3 Facilities Analysis

Key Staffing Gaps:

Role	Required	Actual	Gap	Gap %	Critical Shortages
Doctor	103	25	**78**	75.7%	76% facilities lack doctors.
Nurse/Midwife	412	72	**340**	82.5%	Only 17.5% of needs met.
CHEW	309	142	**167**	54.0%	54% shortage; uneven distribution.
JCHEW	618	13	**605**	97.9%	Near-total absence (98% gap).
CHO	103	51	**52**	50.5%	Half of facilities lack CHOs.
Lab Scientist/Tech	103	70	**33**	32.0%	Moderate gap in diagnostics.
Pharmacist/Tech	103	15	**88**	85.4%	Critical for drug management.
Health Assistant	206	198	**8**	3.9%	Nearly adequate.

Observations:

An in-depth analysis of **Type 3 health facilities** reveals **severe workforce shortages** across essential medical roles, jeopardizing service delivery, particularly in primary and secondary healthcare. While some cadres are critically understaffed, others show **inefficient distribution**, presenting opportunities for strategic workforce reallocation.

1. Severe Shortages in Core Medical Staff

Doctors (75.7% Gap)

Three out of every four facilities operate without a doctor, forcing nurses and midwives to take on advanced roles beyond their training. Emergency care, chronic disease management, and surgical services are likely compromised.

Nurses/Midwives (82.5% Gap).

Nurses and midwives are the backbone of patient care—this shortage leads to overworked staff, increased medical errors, and poor maternal/child health outcomes. Many facilities rely on underqualified personnel to fill the void, risking patient safety.

Junior Community Health Extension Workers (JCHEWs) (97.9% Gap – Near-Total Absence)

JCHEWs are crucial for **c**ommunity health outreach, immunization, and disease surveillance—their near-complete absence means preventive healthcare is collapsing in rural and peri-urban areas. Overburdened CHEWs (who already face a 54% shortage) cannot compensate for this deficit.

Pharmacists/Pharmacy Technicians (85.4% Gap).

Drug management, prescription oversight, and medication safety are severely compromised. Facilities may face stockouts, improper drug dispensing, and increased risks of antimicrobial resistance due to lack of supervision.

2. Moderate but Concerning Gaps in Support Roles

Community Health Officers (CHOs) (50.5% Gap).

Half of facilities lack CHOs, weakening primary healthcare leadership and clinical decision-making.

Laboratory Scientists/Technicians (32% Gap).

While the gap is smaller, diagnostic delays likely persist, affecting disease detection (e.g., HIV, malaria, TB) and treatment efficacy

Overstaffing:

- Medical record officers exceed requirements, suggesting redeployment opportunities.

2. Type 2 Facilities Analysis

Key Staffing Gaps:

Role	Required	Actual	Gap	Gap %	Critical Shortages
Nurse/Midwife	200	27	**173**	86.5%	Only 13.5% of needs met.

CHEW	200	116	**84**	42.0%	Moderate shortage.
JCHEW	400	11	**389**	97.3%	Near-total absence.
Health Assistant	200	121	**79**	39.5%	Manageable gap.

Observations:

A detailed assessment of Type 2 health facilities reveals alarming workforce shortages, particularly among frontline health workers responsible for maternal, child, and preventive healthcare. While some cadres show moderate staffing levels, the near-total absence of Junior Community Health Extension Workers (JCHEWs) and the severe deficit of nurses/midwives pose grave risks to service delivery, especially in rural and peri-urban communities.

1. Severe Shortages in Essential Cadres

Nurses & Midwives (86.5% Gap – Only 13.5% of Needs Met)

Implications:

Maternal and child health services are at extreme risk—deliveries, postnatal care, and neonatal emergencies may lack skilled attendants.
Overworked staff face burnout, increasing the likelihood of medical errors and patient dissatisfaction.
Facilities may depend on unqualified personnel to fill gaps, compromising care quality.

Junior Community Health Extension Workers (JCHEWs) (97.3% Gap – Near-Total Absence)

Implications:

JCHEWs are critical for immunization drives, disease surveillance, and community health education—their absence severely weakens preventive healthcare.
Outreach programs (e.g., malaria control, family planning, nutrition campaigns) will suffer, leading to higher disease burdens in vulnerable populations.
Without JCHEWs, CHEWs (already facing a 42% gap) are overstretched, reducing their effectiveness in primary care.

2. Moderate but Concerning Gaps in Other Roles

Community Health Extension Workers (CHEWs) (42% Gap – Better Staffed Than Type 3 Facilities)

Implications:
While the CHEW shortage is less severe than in Type 3 facilities (54% gap), it still means nearly half of required positions are vacant.
Uneven distribution likely persists, with some facilities adequately staffed while others struggle.
CHEWs are forced to compensate for missing JCHEWs, diluting their focus on clinical care.

Health Assistants (39.5% Gap – Manageable but Needs Attention)

Implications:
Health assistants support patient flow, basic procedures, and records management—this gap may lead to administrative bottlenecks but is less critical than clinical shortages.
Redeployment or task-shifting could help mitigate this gap.

3. Comparative Insights: Type 2 vs. Type 3 Facilities

Nurses/Midwives:
Type 2 facilities have a higher relative shortage (86.5% gap vs. 82.5% in Type 3), worsening maternal and child health risks.

JCHEWs:
Both facility types face near-total absence (97%+ gap), crippling community-based care.

CHEWs:
Type 2 facilities are better staffed (42% gap vs. 54% in Type 3), but distribution disparities remain.

CHAPTER 4

DEPLOYMENT STRATEGY

Comprehensive Health Workforce Deployment Strategy (2025-2028)

To address the critical staffing gaps in Type 2 and Type 3 health facilities, a phased, incentive-driven deployment strategy will be implemented over four years (2025–2028). This plan prioritizes geographic equity, retention incentives, and proactive attrition mitigation to ensure sustainable healthcare delivery across the state.

A. Geographic Prioritization (Phased Deployment by LGA)

Year 1 (2025): Emergency Staffing in Highest-Gap LGAs

Focus Areas:

Akoko South-West, Irele, Idanre (highest doctor/nurse shortages, maternal health risks).
Odigbo (high 2025 retirements, worsening existing gaps).

Key Actions:
✔ **Targeted Recruitment Drives:**
Partner with medical/nursing schools to fast-track graduates to these LGAs.
Offer early career incentives (signing bonuses, student loan repayment).

✔ **Mandatory Rural Posting for New Hires:**
Fresh graduates must complete **2-year rotations in** priority LGAs before urban transfers.

Years 2–4 (2026–2028): Expansion to Underserved Areas

Next-Priority LGAs:
Ese-Odo, Ilaje, Ose (remote, hard-to-reach populations with low health access).
Ifedore, Akoko North-East (rising attrition risks).

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Key Actions:
✔ Gradual Incentivized Expansion:
Introduce higher rural allowances (25%+ salary increment) for these areas.
Priority infrastructure upgrades (electricity, water, staff quarters).

✔ Community Engagement for Retention:
Involve local leaders in staff retention efforts (e.g., housing support, social integration).

B. Incentivization & Retention Mechanisms

1. Financial Incentives

✔ **Rural Retention Bonuses:**
20–30% salary top-up for workers in Odigbo, Irele, Ese-Odo.
Lump-sum bonuses after 3 years of service.
✔ Debt Relief & Education Sponsorships:
Student loan forgiveness for 5-year rural service commitments.
Scholarships for midwifery/community health trainees from underserved LGAs.

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2. Non-Financial Incentives

✔ Housing & Infrastructure Support:
Furnished staff quarters with WiFi, electricity backup.
Transportation allowances for remote postings.
✔ Career Advancement Pathways:
Priority promotions for rural service.
Specialized training opportunities (e.g., emergency obstetrics, ultrasound).

3. Quality-of-Life Improvements

✔ Mental Health & Wellness Programs:
Counseling services for isolated health workers.
Regular team-building retreats.
✔ Family Support:
School fee subsidies for workers' children.
Spousal job linkage initiatives.

C. Attrition Mitigation & Workforce Optimization

1. Proactive Replacement of Retiring Staff

✔ Early Warning System:
Track retirement timelines 12 months in advance.
Pre-hire replacements to allow 3-month overlap for mentorship.
✔ Legacy Knowledge Transfer:
Mandatory handover protocols—retiring staff must train replacements before exit.

2. Task-Shifting & Cross-Training

✔ CHEWs → Basic Nursing Duties:
Train 200 CHEWs in emergency delivery, wound care, IV insertion.
✔ Health Assistants → Pharmacy Support:

Certify 50+ assistants in essential drug dispensing.

3. Flexible Staffing Models

✔ Floating Pool of Locum Staff:
Part-time doctors/nurses rotate between multiple facilities.
✔ Volunteer Community Health Corps:
Engage retired health workers, NYSC corps members for outreach.

D. Monitoring & Accountability Framework

1. Real-Time Workforce Tracking

✔ Digital HR Dashboard:
Track vacancies, deployments, attrition trends in real time.
✔ Quarterly LGA Performance Reviews:
Assess staffing ratios, maternal/child health outcomes.

2. Consequences for Non-Compliance

✔ Penalties for Refusal of Rural Posting:
Delayed promotions for urban-seeking staff.
Mandatory 1-year rural service before transfers.

3. Stakeholder Engagement

✔ LGA Health Workforce Committees:
Include traditional rulers, NGOs, facility heads to monitor progress.
✔ Public Transparency Reports:
Publish quarterly staffing updates to ensure accountability.

Conclusion: A Sustainable, Equity-Driven Workforce Plan

This **four-year deployment strategy** ensures:
✅ **Immediate relief** for worst-hit LGAs (2025).
✅ **Long-term retention** via incentives & infrastructure (2026–2028).
✅ **System resilience** through **cross-training, attrition buffers, and accountability measures**

CHAPTER 5

COSTED RECRUITMENT AND DEPLOYMENT PLAN

Here's a 4-Year Costed Recruitment & Deployment Plan to address the identified staffing gaps across all BHCPF facilities (Type 2 and Type 3) in Ondo State, integrating attrition forecasts and phased hiring:

1. Workforce Gap Summary (2024 Baseline)

Role	Total Gap	Immediate Priority
Doctors	78	Emergency recruitment
Nurses/Midwives	513 (340+173)	Critical for maternal care
CHEWs	251 (167+84)	Community health focus
JCHEWs	994 (605+389)	Urgent for rural outreach
CHO/Lab Techs/Pharmacists	173 (52+33+88)	Specialized role

2. Phased Recruitment Plan (2025–2028)

Goal: Close 100% of gaps by 2028, adjusted for retirements.

Recruitment Principles

Internal Promotions (20% of hires):
Fill senior roles (e.g., Lead CHEWs, Nursing Officers) from existing staff
Career progression incentives to boost morale

External Recruitment (80% of hires):
Targeted campaigns in high-need specialties (midwifery, rural medicine)
Partnerships with 6 medical/nursing schools for direct graduate placement

Attrition Buffering:
Replace 110% of projected retirees (2027 peak: 53 workers)

Annual Targets & Costs:

Year	Doctors (₦413K/month)	Nurses (₦214K/month)	CHEWs (₦157.9K/month)	JCHEWs (₦93K/month)	Total Annual Cost (₦)
2025	20 (₦99M)	150 (₦385.2M)	70 (₦132.6M)	250 (₦279M)	**₦895.8M**
2026	20 (₦99M)	150 (₦385.2M)	70 (₦132.6M)	250 (₦279M)	**₦895.8M**
2027	20 (₦99M)	150 (₦385.2M)	70 (₦132.6M)	250 (₦279M)	**₦895.8M**
2028	18 (₦89M)	63 (₦161.8M)	41 (₦77.7M)	244 (₦272.3M)	**₦600.8M**
Total	**78** (₦386M)	**513** (₦1.317B)	**251** (₦475.5M)	**994** (₦1.109B)	**₦3.288B**

Intervention Focus:

2025
Flood worst-gap LGAs (Akoko SW, Irele) with 60% of new hires
Launch "Midwifery Rapid Deployment Initiative" for 50 emergency placements

2026–2027 (Consolidation Phase)

Maintain 2025 recruitment levels (₦895.8M/year)

Introduce:
"Return to Service" bonuses (₦500K lump sum) for retired nurses rejoining

2028 (Final Gap Closure)

Cadre	Target	Annual Cost (₦)
Doctors	18	89,208,000
Nurses	63	161,784,000
CHEWs	41	77,686,800
JCHEWs	244	272,304,000
Total		**₦600,802,800**

Cumulative 4-Year Investment: ₦3,288,316,800

This ₦3.29 billion investment will transform Ondo State's health workforce by:
✅ **Eliminating 100% of critical gaps** by 2028
✅ **Reducing maternal deaths** by an estimated 40% through nurse/midwife deployment
✅ **Restoring preventive care** via JCHEW saturation

4. Funding Sources & Partnerships

1. BHCPF Allocation
2. State Health Budget
3. Donor/Private Sector

CHAPTER 6

RECOMMENDATIONS

1. **Recruitment and Deployment:**
    - Prioritize rural and underserved areas for new hires.
    - Implement mandatory rural rotations for fresh graduates.
2. **Training and Capacity Building:**
    - Enhance skills of existing staff through targeted training programs.
    - Partner with training institutions to ensure a steady supply of qualified graduates.
3. **Monitoring and Evaluation:**
    - Establish a robust HRH information system to track progress.
    - Regularly review staffing levels and adjust strategies as needed.
4. **Stakeholder Collaboration:**
    - Engage community leaders to support health worker retention.
    - Collaborate with NGOs to train and deploy community health workers.
5. **Funding and Sustainability:**
    - Advocate for increased budgetary allocations to health.
    - Explore innovative financing mechanisms, such as public-private partnerships.

CONCLUSION

The mapping and planning exercise underscores the urgent need to address the human resource gaps in Ondo State's primary healthcare sector. With a growing population and significant attrition of health workers, strategic recruitment, equitable deployment, and robust retention measures are critical to achieving Universal Health Coverage.

By implementing the proposed costed plan and leveraging partnerships, the State can build a resilient health workforce capable of meeting current and future healthcare demands. This will not only improve health outcomes but also ensure that every resident, regardless of location, has access to quality healthcare services

DDRS/SWAP Coordinator,

In attainment of Disbursement Linked Indicator (DLI) 5.2 of HOPE Governance project the baseline mapping and planning for Primary Healthcare workers in Basic Health Care Provision Fund supported facilities in Ondo State to identify gaps, retention forecasting and develop strategy for sourcing and filling identified gaps.

2 Place on page 83-89 of file is the report of the baseline assessment. Detailed personnel list/ LGA is placed a.b.c. of file.

3 For your perusal and further necessary action

4 Thank you.

MAK 25/3/2025

Mrs Akingboye Motunrayo

HRH DO.

DHPRS

Above refers, Please

2. placed on Pages 83-89 of file is the Summarised report of the baseline assessment for Primary Health Care Workers in Basic Health Care Provision Fund (BHCPF) Supported health facilities for approval.

3. Thank you.

DDRS/SWAP D.O

28/03/25

PS,

Pg. 83-89 of file refers, please

(2. Kindly approve the baseline assessment of primary health care workers in BHCPF supported health facilities.

(3) Thank you

DHPRS 28/3/2025.

GA(H)

Please peruse the report of baseline mapping and Planning for PHC as on pages 83 to 89. Kindly Consider

the report and approve ~~them~~ it to be uploaded on the website of the Ministry & will be processed to the EXCO.

PS 28/3/25

PS

The report of baseline mapping and planning for PHC on pages 83-89 noted. This is approved to be uploaded On the website of the ministry. Kindly process same for consideration at the State Executive Council please.

CA-Health

29/03/2025