BAYELSA STATE PRIMARY HEALTH CARE BOARD

HUMAN RESOURCE FOR HEALTH

GAP ANALYSIS REPORT

October 2024

Table of Contents

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ACRONYM

ANC	Antenatal care
APER	Annual Performance Evaluation REport
BYSPHCB	Bayelsa State Primary Health Care Board
CHAI	Clinton Health Access Initiative
CHEW	Community Health Extension Worker
CHO	Community Health Officer
DHIS	District Health Information System
EHO	Environmental Health Officer
FMOH	Federal Ministry of Health
HCWs	Healthcare workers
HMB	Hospitals Management Board
HRH	Human resource for Health
JCHEW	Junior Community Health Extension Worker
KPIs	Key performance indicators
LEMCHIC	Local Emergency Maternal Child Intervention Centre
LERICC	Local Emergency Routine Immunization Coordinating Centre
LGA	Local Government Area
LGHA	Local Government Health Authority
MICS	Multiple Indicator Cluster Survey
MSP	Minimum Service Package
NICS	National Immunization Coverage Survey
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHCIS	Primary Health Care Information System
PR&S	Planning Research and Statistics
RI	Routine Immunization
RMNCAH+N	Reproductive Maternal Newborn Care Adolescent Health + Nutrition
SBA	Skilled Birth Attendant
SEMCHIC	State Emergency Maternal and Child Intervention Centre
SERICC	State Emergency Routine Immunization Coordination Centre
SHIA	State Health Insurance Agency
SMOH	State Ministry of Health

FOREWORD

It is with great pride and a sense of urgency that I present the findings of the 2024 Human Resource for Health (HRH) gap analysis. This report serves as a crucial resource for understanding the pressing challenges we face in our health workforce and sets the stage for transformative action. In reflecting on the findings from this analysis, I am reminded of similar studies conducted in various regions, which have consistently highlighted the critical importance of a well-distributed and adequately staffed health workforce. Just as those reports have illuminated the pathways to success, this analysis sheds light on the significant gaps we must address—an available workforce of 725 against a daunting shortfall of 2,718 personnel. This stark reality demands immediate and informed intervention. The challenges detailed in this report—high workforce attrition, mal-distribution of health workers, and inadequate working conditions—are not unique to Bayelsa State Primary Healthcare Board. They echo the experiences of many health systems worldwide, where similar patterns of workforce instability have impeded the delivery of quality health services. From these experiences, we learn that effective recruitment, robust retention strategies, and improved working conditions are essential components in building a resilient health workforce. This report outlines a comprehensive manpower development plan designed to tackle these issues head-on. By incorporating best practices from other regions and adapting them to our local context, we have the opportunity to create a sustainable health workforce that is equipped to meet the growing needs of our communities. I extend my sincere gratitude to all stakeholders, health workers, and partners who contributed their insights and expertise to this analysis. Your dedication is vital as we work together to strengthen our health system and ensure that every individual in Bayelsa State has access to quality health care. Let us seize this opportunity to act decisively and collaboratively, paving the way for a healthier future for all residents of Bayelsa State.

CHIEF DR MARKSON FESTUS AMAEGBE-TAMUNO

Chairman

Bayelsa State Primary Health Care Board

EXECUTIVE SUMMARY

This report presents the findings from the 2024 Human Resource for Health (HRH) gap analysis conducted for the Bayelsa State Primary Health Care Board. Utilizing the Minimum Service Package framework, this analysis aims to assess the current state of the primary health workforce and identify critical gaps that hinder effective health service delivery across the state. The analysis indicates a total available workforce of 725 personnel, juxtaposed against a substantial manpower gap of 2,718 vacancies that must be filled to adequately serve the health needs of the population. Similar studies in other regions have demonstrated that addressing workforce shortages is essential for improving health outcomes; however, Bayelsa State faces unique challenges that require tailored interventions. Key findings reveal a pattern of high workforce attrition and elevated employee turnover rates, primarily due to unfavourable working conditions and insufficient incentives. Moreover, there is a notable mal-distribution of health workers, with a significant concentration in urban health centres while rural areas across the eight local government areas (LGAs) remain severely understaffed. The challenges identified in this analysis align with those observed in comparable HRH gap studies. Inadequate manpower, coupled with a lack of systematic recruitment efforts, has left many health facilities struggling to maintain service delivery standards. Poor retention of existing staff exacerbates the situation, driven by factors such as inadequate accommodation, lack of essential social amenities, and ongoing security threats that discourage potential recruits. This scenario mirrors findings from other regions, where similar issues have led to a cycle of workforce instability and diminished health service quality. To address these pressing challenges, this report outlines a comprehensive manpower development plan focused on filling the HRH gap, enhancing recruitment and retention strategies, and ensuring equitable distribution of health personnel. By drawing on successful strategies from other regions, such as targeted workforce engagement initiatives, professional development programs, and improved working conditions, the Bayelsa State Primary Health Care Board can build a resilient health workforce capable of delivering quality care to all communities. This report serves as a crucial call to action for stakeholders and policymakers, emphasizing the need to prioritize the development of human resources for health. By implementing strategic interventions informed by both local context and best practices from similar analyses, Bayelsa State Primary Healthcare Board can enhance its health system's capacity to meet the needs of its population and improve overall community well-being.

CHIEF DR. APPAH WALLIAMS WERI

Executive Secretary

INTRODUCTION

The Human Resource for Health (HRH) is a fundamental component of the healthcare system, playing a crucial role in delivering quality healthcare services. The availability, distribution, and capacity of healthcare workers significantly impact the efficiency and effectiveness of healthcare service delivery. In Bayelsa State, HRH challenges have been a major impediment to achieving optimal healthcare outcomes. Shortages of manpower, poor workforce distribution, and inadequate infrastructural development, and lack of social amenities within and around the facilities were considered as a limitation in the functionality of primary healthcare centres (PHCs).

The primary healthcare workforce consists of doctors, nurses, midwives, CHO, CHEW, JCHEW, pharmacy technician, environmental health superintendents, and other host of healthcare professionals who play a pivotal role in providing health services within primary healthcare space. Primary Healthcare workforce management is an important aspect of the healthcare system that requires; recruitment, training, formalization of appointment, deployment and redeployment, and retention. Primary healthcare workforce availability is vital in achieving health system objectives, enhancing health outcomes, lowering morbidity and mortality rates, and promoting universal health coverage.

Nigeria's health workforce landscape mirrors the global challenges while presenting country-specific issues. Healthcare professionals are scarce, worsened by challenges such as the human capital flight of skilled health workers to more economically developed countries. Like most states in Nigeria, Bayelsa faces challenges in the primary healthcare workforce capacity, with issues of inadequate number of needed PHC workforce and inequitable distribution of PHC health workers across facilities impacting negatively on the facilities' inability to provide a minimum service package (MSP) as a requirement to provide optimal healthcare services. The scarcity of healthcare workers, particularly in rural and under-served areas, exacerbates health disparities and limits access to essential services. Addressing these primary healthcare workforce issues is paramount to enhancing the state's healthcare system, improving health outcomes, and ensuring equitable access to quality healthcare for all residents.

BACKGROUND

The Bayelsa Primary Health Care Board (BYSPHCB) came into being as the then Governor of Bayelsa State, His Excellency Henry Seriake Dickson inaugurated the first Board on the 1st of March 2018. The law made provision in the clause Part XIV Transitional Provision, sub-section ‘’assignment of staff’’ to take ownership of the primary healthcare workforce. This informed the

decision to embark on the human resource for health gap analysis. From the foregoing, the then Board conducted Human Resource for Health (HRH) gap analysis in October 2018 and January 2019. The 2018 HRH gap analysis informed the decision to fund the UNICEF/GAVI memorandum of understanding. Furthermore, the second Board, upon inauguration saw the need to conduct human resource for health gap analysis considering the compelling needs to fill the gaps. The Board in collaboration with the *Clinton Health Access Initiative* (CHAI) conducted vacancy analysis in 2023 and root cause analysis in 2024 as the basis for which the Board could use to conduct its recruitment exercise.

The objective was to understand the state of HRH in Bayelsa State and guide the vacancy analysis and root causes determinants. The objectives of this exercise include;

- to evaluate the availability of the health workforce at PHC facilities compared to MSP standards
- to explore the key drivers of health workforce gaps in PHCs
- to identify and co-create implementable workforce-strengthening opportunities
- To determine the total number of health workers in the state and their distribution across facilities.
- To determine current available workforce compares to MSP requirements in terms of health workers availability and distribution.
- Identification of cadres and geographic locations with the greatest gaps.

HEALTH WORKFORCE SITUATION ANALYSIS

The Board conducted a situation analysis across ten (10) thematic areas.

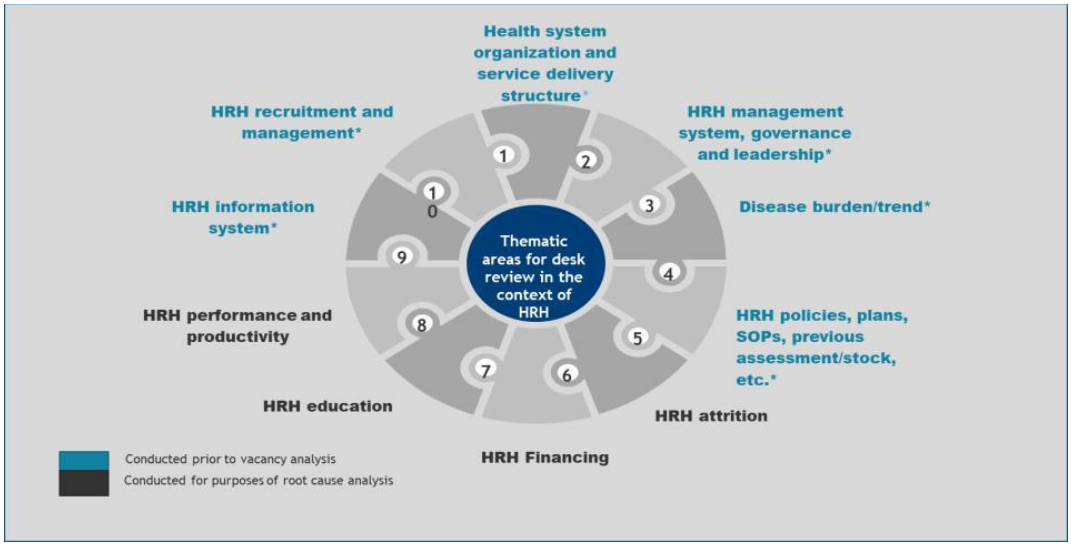

Figure 1: Primary Healthcare workforce situational analysis

a. Health systems organization and service delivery structure

Bayelsa State is a coastal state in the south-south region of Nigeria. It is bordered by Delta State to the north, Rivers State to the east, and the Atlantic Ocean to the south and west. The state capital is Yenagoa, created on October 1st, 1996, Bayelsa State comprises 8 Local Government Areas and 105 political wards. Bayelsans are mainly indigenous Ijaw (Izon) language speaking people with different dialects spoken at different locations in the local government council areas. The main occupations of the people are fishing, farming, sand trading. The State has 2 tertiary facilities, 41 secondary health facilities, and 195 functional primary health facilities. The projected population of Bayelsa State as of 2023 is 2,769, 283 (2006 projected population growth). The target population for children under one year of age, under five, women of reproductive age, and pregnant women are 107,649, 538,247,592,072, and134,562 respectively.

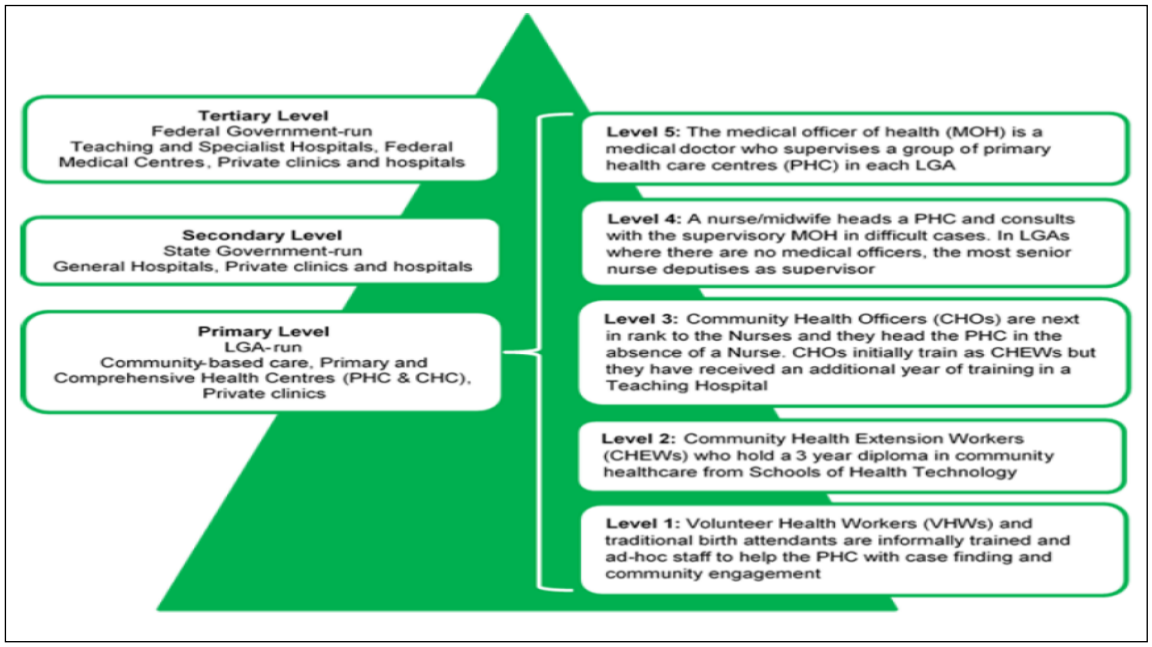

Figure 2: Health system organization and service delivery structure

b. Overview of Health Workforce Governance and Management in Bayelsa State

The Bayelsa State Human Resource for Health Unit is situated in the State Ministry of Health under the Department of Planning, Research, and Statistics (PR&S). The Hospital Management Board, State Primary Health Care Development Agency, Bayelsa State Teaching Hospital, and Federal Teaching Hospitals have respective focal persons who submit health workforce data to the SMOH.

The health workforce unit collects and manages statistical data on human resources in health from all healthcare-providing institutions in the state. It informs relevant stakeholders on the state of HRH in the State and liaises with the FMOH health workforce unit to track the adequacy of skilled health workers and their distribution at the state and national levels. Currently, no Human Resource for Health TWG and Human Resource for Health strategic plan. Also, at the LGA level, there is no Health workforce management system in place. This has led to the weak Health workforce coordination, planning, management, and organizational capacity. The Departments of Administration in the MDAs (SMOH, HMB, SPHCDA, and State Health Insurance Agency (SHIA) oversee workers' postings and transfers, while recruitment is left in the hands of the Local Government service for LGA workers, while the State Civil Service did the same for State workers. There are several key players in the management of Human resources for health in the state. At the State level, The State Ministry of Health, State Primary Healthcare Management board, Hospital Management board and State Civil services Commission play different roles in hiring, posting Management and coordination of HRH. At the LGA level, the Local Government Service Commission, Local Government health authority and in rare cases, LGA chairmen play pivotal roles in the decision-making process around HRH. The state HRH unit is responsible for collecting HRH data, monitoring HRH data, managing the health workforce in both the public and private sectors, analyzing HRH data, and making distribution and planning decisions based on the results of analyzed data. The HRH unit also collaborates with educational and training institutes to enhance the state's human resources and strengthen health systems as universal health coverage evolves. The unit investigates admissions and technical courses that can assist in enhancing its human resource capacity, bridging human resource capacity gaps, and enhancing the quality of service at its health facilities. At the LGA level, the Local Government Primary Health Care Authority (can make decisions regarding staff transfers and postings, but these decisions must be communicated back to the SPHCBA. In addition, it is within their purview to hire ad hoc personnel to support LGA-level activities. Additionally, Primary Health Care (PHC) facilities can recruit ad hoc staff to support facility-level activities and/or engage community workers/volunteers to fill human resource gaps.

c. Disease burden trends

According to the Nigeria Multiple Indicator Cluster Survey (MICS) and the National Immunization Coverage Survey (NICS), Bayelsa State has a high neonatal and under-5 mortality rate (37 per 1,000 live births for neonatal mortality and 100 per 1,000 live births for under-5 mortality). Infectious diseases, such as pneumonia, diarrhoea, and malaria, alongside other health conditions like pre-term, birth complications, birth asphyxia, trauma, and congenital anomalies that remain the leading causes of death for children under 5 years in Bayelsa State.

Across the state, Penta 3 immunization coverage was 70%, skilled birth deliveries accounted for 33.9%, and only 28.2% of births were registered in health facilities, according to the August 2022 DHIS data. Access to basic lifesaving interventions, such as skilled delivery at birth, postnatal care, breastfeeding, adequate nutrition, vaccinations, and treatment for common childhood diseases, has been insufficient. These interventions could have saved many young lives. It is

believed that improving the human resource for health gap and providing accountable funding would support strategies like fixed session, outreach, and mobile service delivery, enabling citizens to access healthcare services in every corner of the state.

d. Health Indices of Bayelsa State

Several efforts have been made to improve routine immunization (RI) and primary healthcare (PHC) services, including RMNCAH+N. Key interventions include the declaration of an emergency and the establishment of the Bayelsa State Emergency Routine Immunization Coordination Centre (SERICC) in 2017, the State Emergency Maternal and Child Health Intervention Centre (SEMCHIC) in 2020, as well as LERRIC and LEMCHIC in the eight Local Government Areas (LGAs). The health sector faces multifaceted challenges, including poor health infrastructure, inadequate funding of PHC services (heavily dependent on partners), and difficult terrain. State health performance has not significantly improved over the years, exacerbated by the impact of COVID-19 on health service delivery. The following thematic areas and data sources were explored to provide a snapshot of the health indices of the state as of April 2023:

- 2021 MICS/NICS Survey Data
- RI_RMNCAH+N ANC (Antenatal Care) and SBA PAPA LQAS Outcome
- RMNCAH+N Scorecard (Administrative data)
- Routine Immunization Data
- COVID-19 Vaccination Performance Data

The primary healthcare sector is characterized by poor health indices, a high number of unimmunized children, and inadequate infant antigen coverage as of April 2023, with under-immunized children totalling 10,573. Southern Ijaw had the highest number of unimmunized children (4,534), while Ekeremor had the lowest (656). The 2023 first quarter State RI-RMNCAH+N scorecard for Bayelsa revealed an improvement in the state's performance, showing 70% Penta 3 coverage (administrative data) and 34% skilled birth attendance coverage.

e. Health Workforce Policies, Plans, And Guidelines

In September 2023, a Human Resource Needs Assessment was conducted, revealing significant workforce gaps and challenges. Despite these findings, Bayelsa State does not have a state-specific Health Workforce Strategy. The state currently relies on the National HRH Strategy, which has not been officially domesticated or adapted to meet Bayelsa's unique healthcare needs. As a result, the Health Workforce Unit lacks the necessary policies, guidelines, and strategic plans required to perform optimally. The absence of a tailored HRH strategy, combined with the substantial workforce shortages, inadequate infrastructure, and poor distribution of healthcare workers, has severely affected service delivery across the state. The Health Workforce Unit continues to advocate for technical support and the development of a localized HRH strategy to address these pressing challenges.

f. Health Workforce Financing

The Bayelsa state government contributes more than 90% of health workforce financing, with 10% coming from FGN and partners. The state government pays salaries of PHC healthcare workers. However, there is no evidence of Health workforce finance planning, resource

mobilization, tracking and harmonization from Government, partners and philanthropies. Resources originally allocated for retired, migrated and dead healthcare workers are not re-allocated to recruit additional HCWs and long-term health workforce costed plan, including training cost, recruitment cost, etc are not available.

g. Health Workforce Education

According to the State Ministry of Health, the state has the critical Health Training Institutions required to train and fill the manpower gap. This indicates that health workforce production is not a challenge in Bayelsa State. However, there has not been a proportional absorption of these health graduates into the workforce, as there has been no healthcare worker recruitment tailored toward the primary healthcare workforce since 2008. Through GAVI funding, the Primary Health Care Development Board had recruited volunteer healthcare workers, and the government on its part had made commitment to absorb these workers at the expiration of the UNICEF/GAVI programme.

h. Health Workforce Performance and Productivity

Bayelsa State Government annually evaluates the performance of all Government staffs, including PHC health workforce, by conducting the general civil service annual performance evaluation report. However, the APER is generic and not applicable to health workforce workflow process and service delivery. There is a need for health workforce-specific productivity and performance management frameworks and tools.

i. Human Resource for Health Information Systems

There is no health workforce registry in the state; however, through funding from UNICEF, the state is currently developing a health workforce registry. A comprehensive workforce registry is critical for providing data essential to health workforce planning and management.

METHODOLOGY

A mixed method of desk review, quantitative vacancy analysis of PHC health workforce data from the National Primary Healthcare Information System (NPHCIS), and stakeholders' consultative root cause analysis workshop were deployed. The assessment covered all eight Local Government Areas (LGAs) in Bayelsa State; data was collection was done across all PHCs in the state, and findings were validated through discussions with key informants, including health facility managers and government officials. The assessment focused on the availability, distribution, and skill mix of health workers within PHCs. Additionally, it examined infrastructure conditions, security challenges, and workforce retention issues. The findings were intended to inform policy development, workforce planning, and service delivery improvements. The assessment aimed to evaluate the availability of the health workforce at PHC facilities compared to the Minimum Service Package (MSP) standards, explore the key drivers of health workforce gaps, and identify strategies for strengthening workforce availability and efficiency. By

conducting a comprehensive HRH gap analysis, the assessment sought to provide data-driven recommendations for improving healthcare access across Bayelsa State.

Data Collection

Health workforce profile dataset from the Primary Health Care Information System (PHCIS) was obtained and the following variables from the dataset extracted: Name/ID, age, gender, cadre, Local Government Area (LGA), facility, facility type, facility location, and contract type was extracted from the dataset. Only permanent staff were including the analysis.

Data Analysis

Simple descriptive statistics was conducted to analyse the dataset, including Total number of health workers. The gap or surplus of health workers compared to MSP requirements. The gap or surplus expressed as both a proportion and absolute numbers.

Simple descriptive statistics method was used to present the findings by:

- Calculating proportions to express the distribution of health workers across facilities and cadres.
- Presenting absolute numbers to quantify the total count of health workers and gaps/surpluses.
- Calculating the gap/surplus compared to MSP:
- Determining the difference between the current workforce and MSP requirements for each cadre and location.
- Express results as proportions and absolute numbers to quantify the extent of gaps or surpluses.

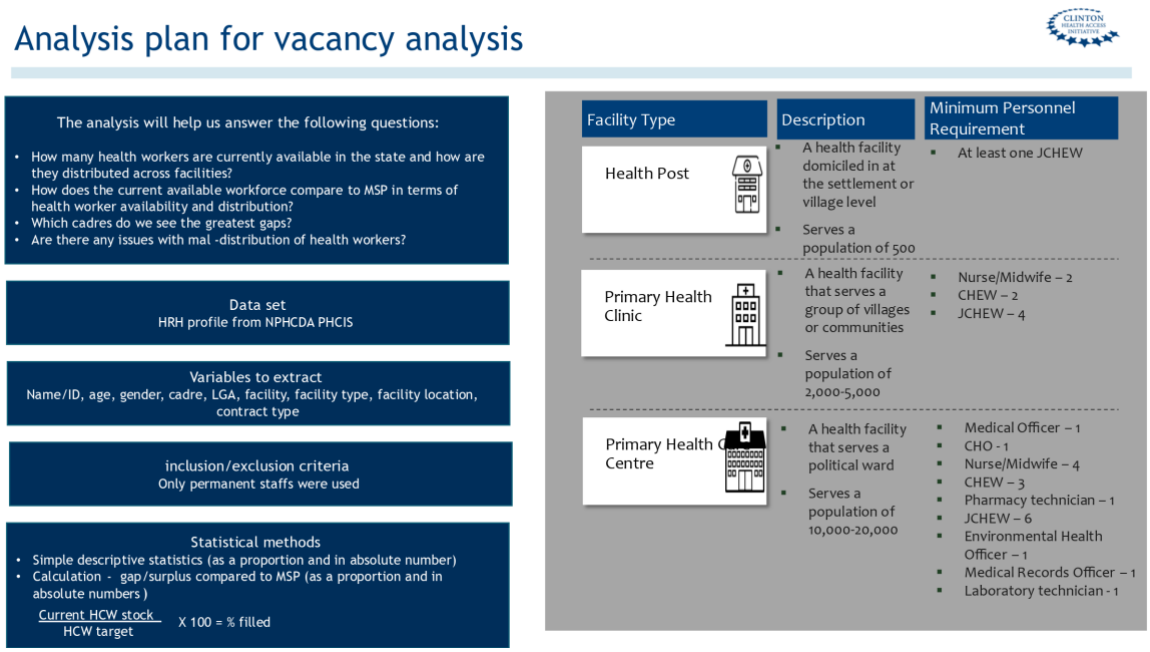

Figure 3: NPHCDA MSP requirements for PHC facilities

Limitation of the Data Source

1. Issues with data accuracy regarding the classification of facilities as urban or rural are prevalent. Examples include health facilities being labelled as both urban and rural and inconsistencies in classification within the same local government area or ward.
2. The analysis does not indicate contract type. Some staff are noted to be casuals and volunteers.
3. Data is said to have been collected in 2022, and some changes might have taken place in the state Health workforce landscape.

FINDINGS

HRH STATUS IN 2018

In 2028 HRH gap analysis used self-administered structured questionnaire, and Board members were grouped into LGAs. On the spot assessment of the health facilities were done. A total of 1,135 primary healthcare workforce was handed over to the Board, with 201 health centres. The HRH gap analysis showed that a total of 3,005 critical primary healthcare workers were required to meet the requisite requirement as prescribed by the minimum service package (MSP); medical doctors (100), community health officer (44), nurses/midwives (605), CHEW (225), JCHEW (874), pharmacy technicians (78), environmental health superintendents (16), medical record officers (26), laboratory technicians (33), health attendants (383), security officers (403), and general maintenance workers (202).

HRH STATUS IN 2024

The vacancy analysis showed that Bayelsa State has 725 permanent PHC healthcare workers, of which 60% were females and 40% males, while volunteer workers were 218. Critical shortages of doctors, nurses/midwives, and JCHEWs were recorded, with 97%, 98%, and 93% deficits, respectively. A desk review revealed that Bayelsa has limited health training institutions for these low cadre of healthcare workforce, and recruitment of health workers tailored toward the primary healthcare workforce has been stagnant for several years.

Furthermore, none of the PHC centres or PHC clinics in Bayelsa met the Minimum Service Package (MSP) requirements for human resources for health, with a significant maldistribution of health workers across the eight (8) Local Government Areas (LGAs). Sagbama and Yenagoa LGAs, for instance, account for 32% of the total PHC facilities, with acute shortage of workers.

High density of PHC facilities were located in rural areas, with high number of health workers concentrated in urban PHC facilities such as Yenagoa LGA.

Insights from the root-cause analysis workshop indicated that the following were the key drivers of poor health workforce outcomes.

- A weak health workforce governance and management capacity.
- Limited budget allocation and financing of health workforce towards recruiting new health workforce.
- Lack of a health workforce information system to manage data that drive decision-making.
- Poor retention and incentive strategies

Bayelsa State has a total of 725 health workforce of Minimum Service Package (MSP) cadres and 94 non-MSP cadres that provides services at primary healthcare centers

HRH Availability by LGA

State/LGA	MSP Cadres								
	Doctor	Nurse/Midwife	CHO	CHEW	JCHEW	Laboratory Personnel	Pharmacy Personnel	Environmental Health Personnel	Medical Record Personnel
Bayelsa State	5	18	77	243	80	59	42	100	101
BRASS	1		6	25	8	4	1	7	5
EKEREMOR	1		5	31	9	5	5	9	21
KOLOKUMA/OPOKUMA	1	4	9	36	4	4	6	8	9
NEMBE			20	36	16	17	13	23	19
OGBIA		1	2	35	19	12	6	34	23
SAGBAMA			5	25	10	7	4	6	10
SOUTHERN IJAW		2	14	28	9	7	2	4	3
YENAGOA	2	11	16	27	5	3	5	9	11

HRH Availability by LGA

State/LGA	Non-MSP Cadres							
	Dental Personnel	Administrative Staff	Health Assistant	Health Educator	Medical Social Worker	Nutrition Officer	Public Health Officer	Others
Bayelsa State	49	1	13	20	4	2	3	2
BRASS	4		3					
EKEREMOR	3		3	1				
KOLOKUMA/OPOKUMA	3		1				1	
NEMBE	13			5	1	1		2
OGBIA	11		4	5	1	1	1	
SAGBAMA	2		1	1	2			
SOUTHERN IJAW	1		1					
YENAGOA	12	1		8			1	

6

Figure 4: HRH availability by LGA

Prof. Seiyefa Brisibe
Hon. Commissioner, Ministry of Health

By MSP standard, only 20% of the required positions are filled, with additional 2980 healthcare workers needed to provide minimum service package at the Primary Healthcare centers in the state.

Vacancy/Surplus by Cadre in the State

Cadre	Available Permanent HCWs	Required by MSP	% of required filled	Gap/Surplus (#)	% GAP	# Non-permanent staff (MSP cadres)	# of permanent staff (non-MSP cadres)	# of non-permanent staff (non-MSP Cadres)
Doctor	5	195	3%	-190	-97%	1		
Nurse/Midwife	18	780	2%	-762	-98%	61		
CHO	77	195	39%	-118	-61%	8		
CHEW	243	585	42%	-342	-58%	106		
JCHEW	80	1170	7%	-1090	-93%	42		
Laboratory Personnel	59	195	30%	-136	-70%	13		
Pharmacy Personnel	42	195	22%	-153	-78%	1		
Environmental Personnel	100	195	51%	-95	-49%	8		
Medical Record Personnel	101	195	52%	-94	-48%	9		
Total MSP Health Workers	725	3705	20%	-2980	-80%	249	94	25

Doctors, Nurse/midwife and JCHEW cadre constitute the largest shortage

Figure 5: Vacancy/Surplus by cadre

There is a gross shortage of Doctor, Nurse/midwife and JCHEW cadres across all LGAs of the state, with only 3%, 2% and 7% of the required positions filled respectively for the three listed cadres.

Vacancy/Surplus by Cadre and LGA

LGA	# of facilities	Doctor				Nurse/Midwife				CHO			
		Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled
BRASS	14	1	14	-13	7%		56	-56	0%	6	14	-8	43%
EKEREMOR	22	1	22	-21	5%		88	-88	0%	5	22	-17	23%
KOLOKUMA/OPOKUMA	14	1	14	-13	7%	4	56	-52	7%	9	14	-5	64%
NEMBE	26		26	-26	0%		104	-104	0%	20	26	-6	77%
OGBIA	27		27	-27	0%	1	108	-107	1%	2	27	-25	7%
SAGBAMA	32		32	-32	0%		128	-128	0%	5	32	-27	16%
SOUTHERN IJAW	30		30	-30	0%	2	120	-118	2%	14	30	-16	47%
YENAGOA	30	2	30	-28	7%	11	120	-109	9%	16	30	-14	53%
Total	195	5	195	-190	3%	18	780	-762	2%	77	195	-118	39%

Vacancy/Surplus by Cadre and LGA

LGA	# of facilities	CHEW				JCHEW				Laboratory Personnel			
		Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled
BRASS	14	25	42	-17	60%	8	84	-76	10%	4	14	-10	29%
EKEREMOR	22	31	66	-35	47%	9	132	-123	7%	5	22	-17	23%
KOLOKUMA/OPOKUMA	14	36	42	-6	86%	4	84	-80	5%	4	14	-10	29%
NEMBE	26	36	78	-42	46%	16	156	-140	10%	17	26	-9	65%
OGBIA	27	35	81	-46	43%	19	162	-143	12%	12	27	-15	44%
SAGBAMA	32	25	96	-71	26%	10	192	-182	5%	7	32	-25	22%
SOUTHERN IJAW	30	28	90	-62	31%	9	180	-171	5%	7	30	-23	23%
YENAGOA	30	27	90	-63	30%	5	180	-175	3%	3	30	-27	10%
Total	195	243	585	-342	42%	80	1170	-1090	7%	59	195	-136	30%

Vacancy/Surplus by Cadre and LGA

LGA	# of facilities	Pharmacy Personnel				Environmental				Medical Records Personnel				Additional Non-MSP
		Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	Available HCWs	MSP Req by MSP	Gap/Surplus	% of required filled	
BRASS	14	1	14	-13	7%	7	14	-7	50%	5	14	-9	36%	7
EKEREMOR	22	5	22	-17	23%	9	22	-13	41%	21	22	-1	95%	7
KOLOKUMA/OPOKUMA	14	6	14	-8	43%	8	14	-6	57%	9	14	-5	64%	5
NEMBE	26	13	26	-13	50%	23	26	-3	88%	19	26	-7	73%	22
OGBIA	27	6	27	-21	22%	34	27	7	126%	23	27	-4	85%	23
SAGBAMA	32	4	32	-28	13%	6	32	-26	19%	10	32	-22	31%	6
SOUTHERN IJAW	30	2	30	-28	7%	4	30	-26	13%	3	30	-27	10%	2
YENAGOA	30	5	30	-25	17%	9	30	-21	30%	11	30	-19	37%	22
Total	195	42	195	-153	22%	100	195	-95	51%	101	195	-94	52%	94

Figure 6: Vacancy/Surplus by LGA

But for JCHEW and Laboratory personnel cadres, rural locations have the highest shortage of health workforce at primary healthcare facilities in the state.

Rural distribution and vacancy/surplus by urban

Cadre	Available(#)		Gap/surplus (#)		% of required filled	
	Rural	Urban	Rural	Urban	Rural	Urban
Doctor	2	3	-173	-17	1%	15%
Nurse/Midwife	6	12	-694	-68	1%	15%
CHO	62	15	-113	-5	35%	75%
CHEW	215	28	-310	-32	41%	47%
JCHEW	78	2	-972	-118	7%	2%
Laboratory Personnel	55	4	-120	-16	31%	20%
Pharmarcy Personnel	34	8	-141	-12	19%	40%
Environmental Health Personnel	89	11	-86	-9	51%	55%
Medical Records Personnel	90	11	-85	-9	51%	55%

Figure 7: Rural and urban distribution

Health Facility Distribution

Facility Distribution: All of the 194 facilities were reported as Primary Healthcare centres. Out of 194 PHCs in the State, Sagbama and Yenagoa LGAs has the highest number of primary healthcare facilities (32%) in the Bayelsa State, and 90% of the PHC facilities in the state were located in rural settlements. There were no primary health clinics and primary health posts in Bayelsa State.

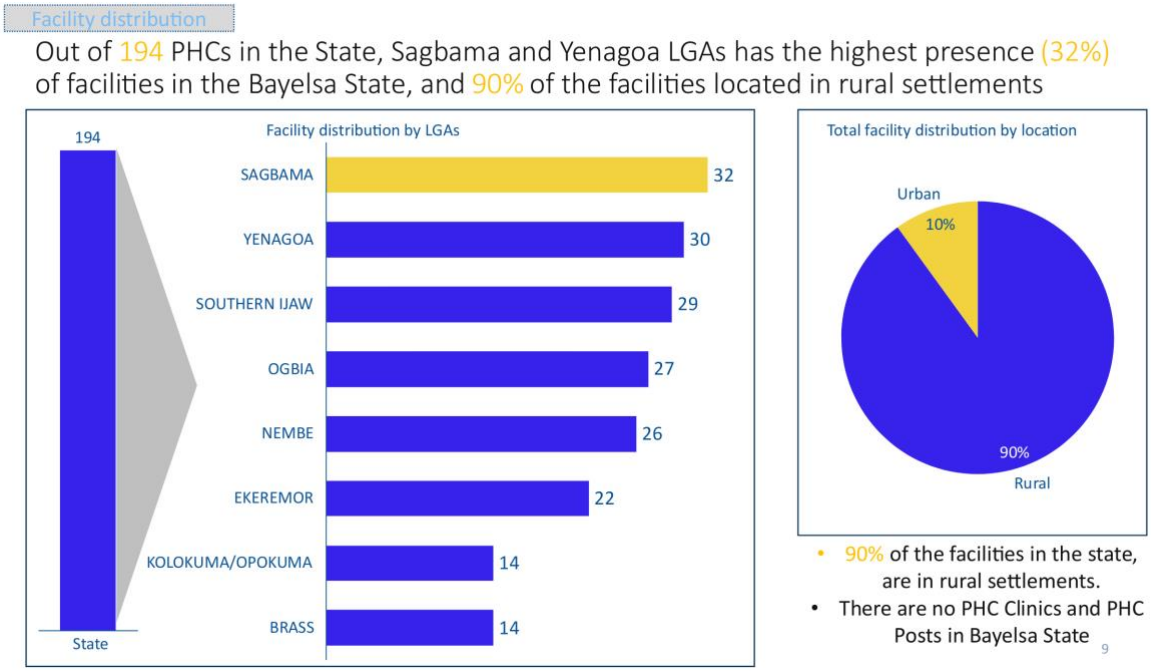

Figure 8:Facility distribution by LGAs

Health Workforce Distribution by LGA

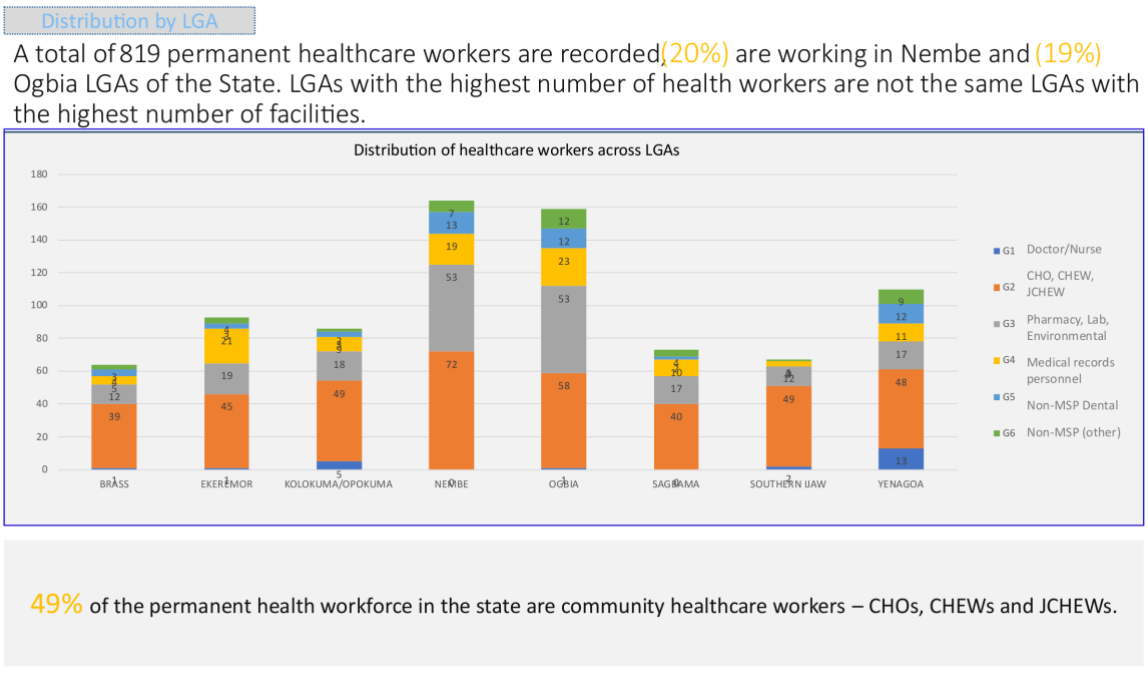

Figure 9: Facility distribution of permanent and non-permanent workers

Health Workforce Distribution By Cadre

CHEW, Medical records and Environmental personnel constitute 54% of all primary healthcare workforce, and 60% of health workforce in primary health care settings were females and 30% of

the total permanent staffs were predominantly CHEWs.

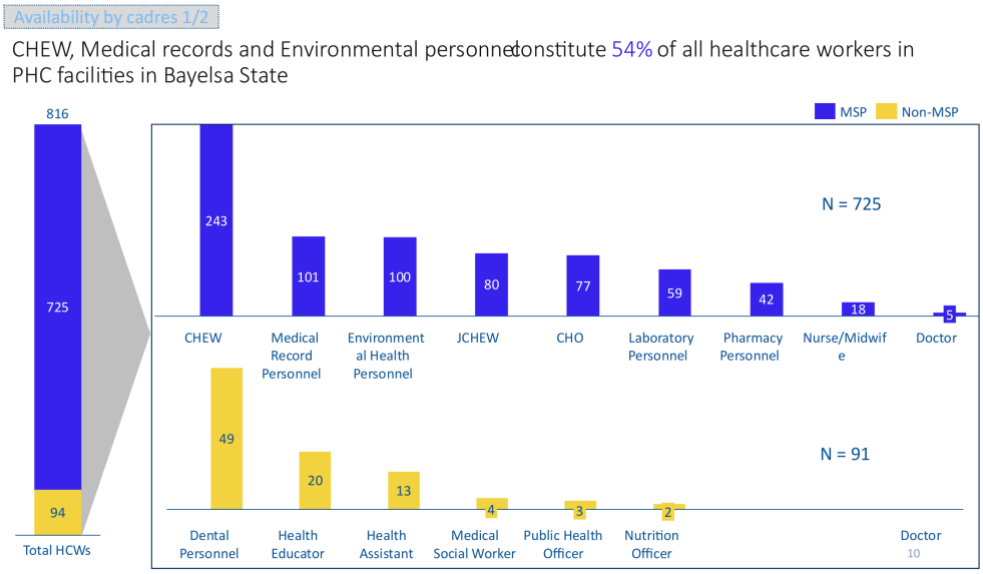

Figure 10: Healthcare workforce distribution of permanent workers and non-permanent workers

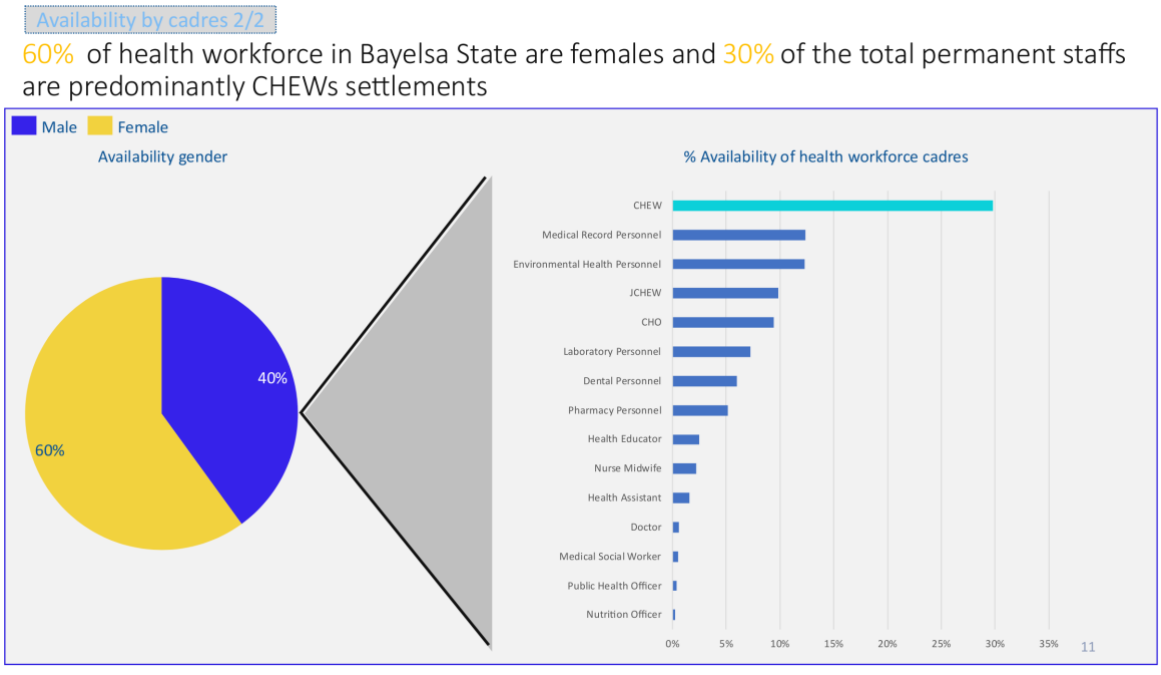

Figure 11: Healthcare workforce distribution by gender

Urban/Rural Distribution By Gender

More female healthcare workers were found in urban facilities. Inequality in gender distribution and mix across urban and rural PHCs and implication on service delivery be reviewed by the state

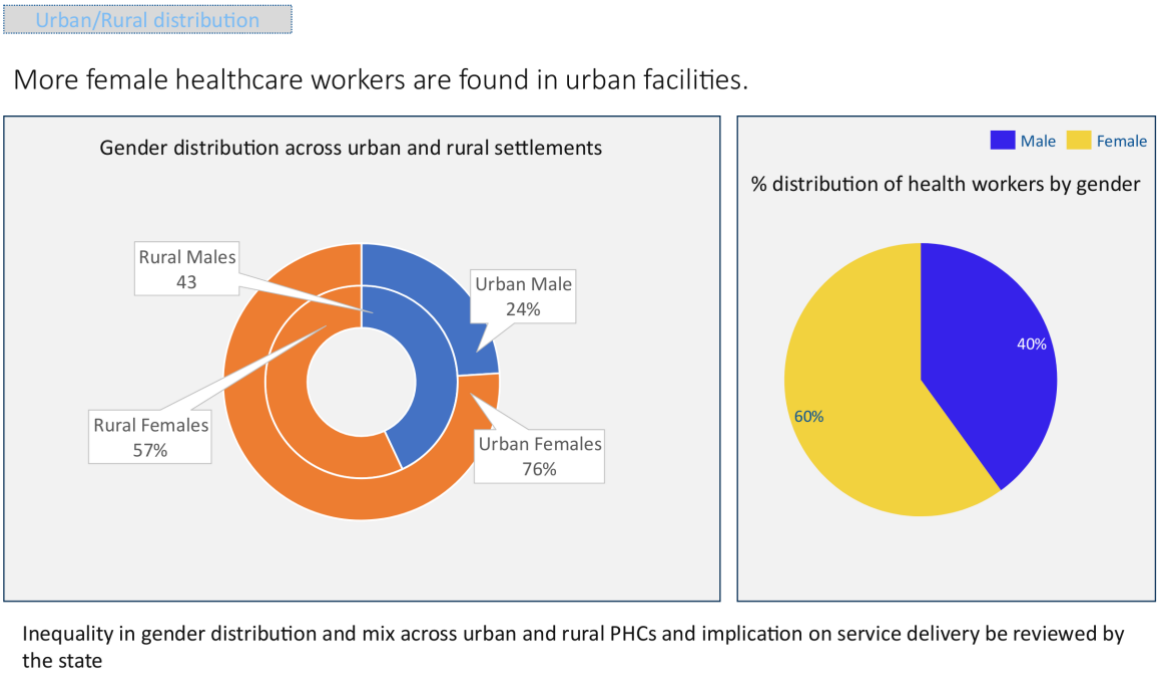

Figure 12: Healthcare workforce distribution by gender and urban/rural

Comparison of 2018 HRH Gap Analysis Versus 2024 HRH Gap Analysis

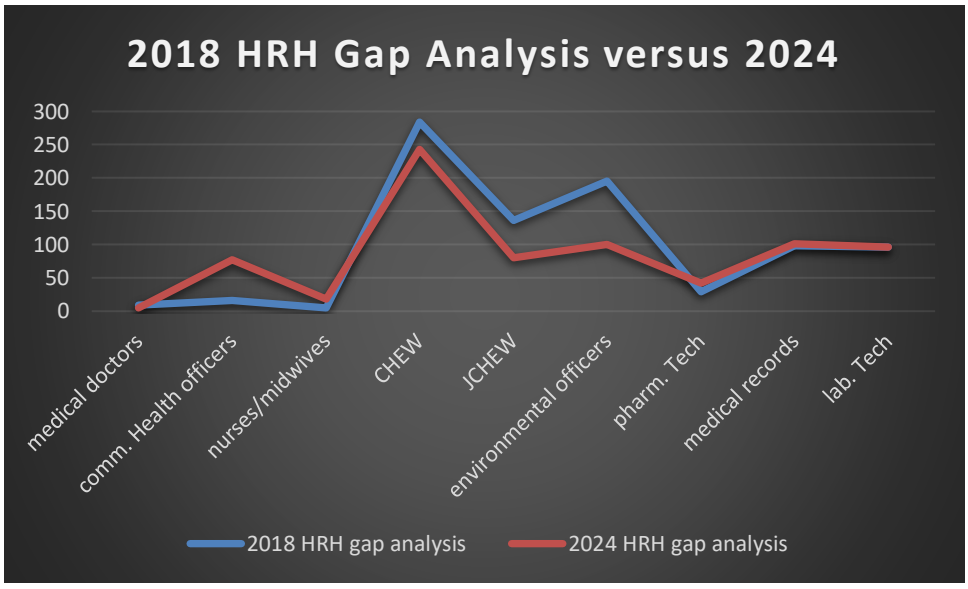

Figure 13: 2018 HRH gap analysis versus 2024 HRH gap analysis

Health Workforce Proceeding on Retirement (5 Year Retirement Plan)

Table 1: Health workforce retirement plan

YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
BRASS LGA		
2025	1	1
2026	2	3
2027	1	5
2028	1	2
2029	7	3
TOTAL	12	15
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
OGBIA LGA		
2025	-	-
2026	6	4
2027	3	3
2028	6	3
2029	4	3
TOTAL	19	13
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
KOLOKUMA/OPOKUMA LGA		
2025	2	1
2026	-	1
2027	2	5
2028	2	1
2029	2	2
TOTAL	8	10
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
SAGBAMA LGA		
2025	3	1
2026	2	5
2027	3	5
2028	3	1

2029	4	3
TOTAL	15	15
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
NEMBE LGA		
2025	3	-
2026	4	5
2027	10	8
2028	7	10
2029	6	7
TOTAL	30	30
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
EKEREMOR LGA		
2025	1	1
2026	-	-
2027	4	-
2028	4	-
2029	4	-
TOTAL	13	1
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
SOUTHERN IJAW LGA		
2025	4	-
2026	1	2
2027	4	8
2028	6	4
2029	3	9
TOTAL	18	23
YEAR	RETIREMENT BY AGE	RETIREMENT BY YEAR OF SERVICE
YENEGOA LGA		
2025	3	1
2026	4	5
2027	7	8
2028	8	4
2029	9	6
TOTAL	31	24

KEY CHALLENGES

The Human Resource for Health (HRH) gap analysis for Bayelsa State Primary Healthcare Board has revealed a multifaceted array of challenges that significantly affect the primary health workforce. These issues have profound implications for the quality of health care delivery and the overall health outcomes of the population. The following discussion addresses key factors identified in the fact sheet, including poor retention, inadequate healthcare workers, stagnation and lack of recruitment, retirement without replacement, mal-distribution of staff, lack of social amenities, security threats, lack of incentives, and inadequate staff accommodation.

a. Inadequate Healthcare Workers

The overall shortage of healthcare workers remains a pressing concern in Bayelsa State. With an inadequate number of trained professionals to meet the health care needs of the population, existing health facilities struggle to provide comprehensive services. This shortage is particularly acute in rural areas, which often have limited access to qualified personnel. Addressing this gap requires strategic workforce planning, including targeted recruitment drives that focus on increasing the number of healthcare workers in underserved areas.

b. Stagnation of Staff and Lack of Recruitment

The Bayelsa State Primary Health Care sector is significantly hindered by the stagnation of existing staff and a lack of effective recruitment strategies. These issues contribute to workforce shortages, decreased staff morale, and diminished quality of care for patients. Many healthcare workers face career stagnation with limited opportunities for advancement. This lack of upward mobility can lead to frustration and disengagement, diminishing overall job satisfaction and motivation. The absence of proactive recruitment initiatives has resulted in unfilled vacancies across health facilities. This shortage of personnel exacerbates the workload for existing staff, often leading to burnout and compromised patient care. The combination of stagnant career pathway and inadequate recruitment creates a challenging work environment. Overburdened staff may experience increased stress levels, affecting their performance and the quality of services provided to patients. Staff stagnation and the lack of recruitment contribute to higher turnover rates, as employees seek better opportunities elsewhere. This ongoing cycle leaves health facilities understaffed and struggling to maintain consistent care. Without timely recruitment to replace departing staff, health facilities may face knowledge gaps and disruptions in service delivery. This can hinder the continuity of care and negatively impact patient outcomes.

c. Retirement of Health Workers Without Replacement

The retirement of experienced health workers without adequate replacement is another significant challenge. As seasoned professionals exit the workforce, they take with them valuable knowledge and experience. Failing to replace these retiring staff members results in a knowledge gap and further strains the available workforce. To mitigate this issue, it is crucial to implement

succession planning and ensure that new recruits are trained and integrated effectively into the health system.

d. Poor Retention of Health Workforce

One of the most critical challenges facing the primary health workforce in Bayelsa State is the poor retention of health workers. Factors such as inadequate working conditions, low morale, and lack of professional development opportunities contribute to high turnover rates. When skilled professionals leave, it disrupts continuity of care and places additional stress on remaining staff. To enhance retention, it is essential to create a supportive work environment that provides ongoing training and growth opportunities, alongside a clear career progression pathway.

e. Mal-distribution of Staff

One of the most pressing issues affecting the primary health workforce in Bayelsa State is the mal-distribution of health staff. While some health facilities are overstaffed, others, particularly in rural and underserved areas, face severe shortages. This uneven distribution leads to inequities in access to health services, where communities in remote locations struggle to receive adequate care. The concentration of health workers in urban centers not only exacerbates health disparities but also places an undue burden on facilities that are already overwhelmed. Addressing this issue requires strategic workforce planning, including incentives for health workers to serve in underserved areas and the implementation of policies that promote equitable distribution.

f. Lack of Social Amenities

The absence of basic social amenities such as portable water and electricity in and around health centres significantly hinders the operational capacity of these facilities. Health workers are often forced to operate in conditions that are not conducive to delivering quality care. Lack of clean water and reliable electricity can compromise sanitation, affect the storage of medications, and hinder the ability to perform essential medical procedures. To attract and retain health workers, it is crucial to invest in the infrastructure of health facilities. Ensuring that health centres are equipped with basic amenities can improve working conditions and increase job satisfaction among staff.

g. Kidnapping and Security Threats

Security threats, including kidnapping and violence against health workers, are critical concerns that hinder the effectiveness of the primary health workforce. Such threats create a hostile environment, leading to increased anxiety and reluctance among health workers to perform their duties, especially in high-risk areas. The fear of violence can contribute to absenteeism, staff turnover, and difficulty in recruiting new personnel. Addressing security concerns through enhanced protection measures, community engagement, and collaboration with law enforcement is essential to create a safer working environment for health workers.

h. Lack of Incentives

The lack of incentives for health workers is another significant barrier to maintaining a motivated and effective workforce. Financial compensation alone may not be sufficient to attract and retain skilled professionals in the health sector. Additional incentives, such as bonuses, professional development opportunities, and recognition programs, can enhance job satisfaction and loyalty among staff. By implementing a comprehensive incentive package, the Bayelsa State Primary Health Care Board can foster a more committed workforce, ultimately leading to improved health service delivery.

i. Inadequate Staff Accommodation

Inadequate staff accommodation poses a significant barrier to retaining healthcare workers, particularly in rural areas. Many health workers are forced to commute long distances, leading to fatigue and increased absenteeism. Providing suitable housing options for healthcare personnel can improve retention rates and enhance the overall quality of care delivered to communities.

MANPOWER DEVELOPMENT PLAN

This Manpower Development Plan outlines a strategic approach to address the manpower gaps within Bayelsa State Primary Healthcare Board over a five-year period. The plan focuses on immediate and long-term strategies to enhance workforce capacity, improve staff retention, and ensure that the agency is equipped to meet its operational goals and objectives.

Objectives

- Identify and address current manpower gaps
- Enhance recruitment and retention strategies
- Promote professional development and training
- Establish succession planning to ensure continuity
- Foster a positive work environment that encourages employee engagement

The 2024 HRH gap analysis indicates a total workforce of 725 and a substantial gap of 2,718 vacancies that need to be filled. This manpower development plan outlines strategic initiatives aimed at addressing these gaps over the next five years. The plan focuses on immediate recruitment strategies, training and development, employee retention, and long-term capacity-building measures.

IMMEDIATE STRATEGIES (YEAR 1)

a. Workforce Assessment

- Identify specific roles and skills needed to fill the 2,718 vacancies.
- Assess the current workforce's skills and competencies to identify training needs.

b. Recruitment Campaign

- Develop a Targeted Recruitment Strategy

- Launch a comprehensive recruitment drive across various platforms including job fairs, social media, and partnerships with educational institutions.
- Utilize incentives such as signing bonuses or relocation assistance for hard-to-fill positions.

c. Streamlined Hiring Process

- Implement a Standardized Recruitment Process
- Develop clear job descriptions and requirements for all positions.
- Establish a fast-track application and onboarding process to reduce time-to-hire.

SHORT-TERM STRATEGIES (YEARS 2-3)

a. Training and Capacity Building

- Establish Training Programs
- Create training modules based on the needs identified during the workforce assessment.
- Offer workshops, online courses, and mentorship programs to enhance existing staff skills.

b. Retention Initiatives

- Implement Employee Engagement Programs
- Conduct regular employee satisfaction surveys and facilitate feedback sessions to understand staff needs and concerns.
- Develop recognition and reward programs to motivate and retain existing employees.

c. Career Development Pathways

- Create Clear Advancement Opportunities
- Outline career pathways for employees to understand potential growth within the organization.
- Provide leadership training for high-potential staff to prepare them for future roles.

LONG-TERM STRATEGIES (YEARS 4-5)

a. Sustainability and Workforce Planning

- Develop a Long-Term Workforce Planning Model
- Analyse trends in workforce needs and adapt recruitment strategies accordingly.
- Create a forecasting model to anticipate future staffing needs based on community health demands.

b. Strengthening Partnerships

- Collaborate with Educational Institutions
- Establish partnerships with universities and training schools to create a pipeline for new graduates entering the workforce.
- Develop internship and residency programs to attract talent and provide hands-on experience.

c. Succession Planning

- Implement a Succession Planning Strategy

- Identify critical roles within the organization and develop succession plans to ensure continuity.
- Mentor and train potential successors to prepare them for leadership roles.

d. Monitoring and Evaluation

- Establish KPIs for Workforce Development
- Monitor metrics such as turnover rates, employee satisfaction scores, and training participation rates.
- Conduct annual reviews of the manpower development plan to assess its impact and make necessary adjustments.

e. Budget Considerations

- Initial Budget Allocation
- Allocate funds for recruitment campaigns, training programs, and employee engagement initiatives.

f. Long-Term Funding

- Develop a sustainable budget model to support ongoing professional development and workforce planning efforts.

RECRUITMENT PLAN

Recruitment Plan for 2,980 Health Workers (5-Year Plan)

Yearly Recruitment Targets

1. **Year 1:** Recruit 600 workers.
2. **Year 2:** Recruit 620 workers.
3. **Year 3:** Recruit 650 workers.
4. **Year 4:** Recruit 620 workers.
5. **Year 5:** Recruit 490 workers.

Table 2: Proposed Timeline

Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Needs Assessment	✓				
Budget Allocation	✓				
Advertising	✓	✓	✓	✓	✓
Selection and hiring	✓	✓	✓	✓	✓
Onboarding and Training	✓	✓	✓	✓	✓
Retention Strategy Review		✓	✓	✓	✓

COSTED WORKPLAN FOR HEALTHCARE WORKFORCE GAP (2025-2029)

Table 3: Costed workplan for healthcare workforce gap for 2025

Cadre	Grade Level	Number of Personnel	12 months	CONHESS ₦	Amount (₦)
				₦	₦
Doctors	12/2	43	12	194,755.33	100,493,750.28
Nurses/midwives	08/2	137	12	151,358.92	248,834,064.48
Comm. Health. Officer	08/1	32	12	147,652.28	56,698,475.52
CHEW	07/2	69	12	135,942.75	112,560,597.00
JCHEW	06/2	192	12	106,307.58	244,932,664.32
Laboratory Tech	07/1	35	12	132,792.25	55,772,745.00
Pharm. Tech	07/1	38	12	148,545.08	67,736,556.48
Environmental Tech	07/1	27	12	132,792.25	43,024,689.00
Medical Record Tech	07/2	27	12	135,942.75	44,045,451.00
Total		**600**		1,286,089.19	974,098,993.08

Table 4: Costed workplan for healthcare workforce gap for 2026

Cadre	Grade Level	Number of Personnel	12 months	CONHESS ₦	Amount (₦)
				₦	₦
Doctors	12/2	46	12	194,755.33	107,504,942.16
Nurses/midwives	08/2	143	12	151,358.92	259,731,906.72
Comm. Health. Officer	08/1	34	12	147,652.28	60,242,130.24
CHEW	07/2	70	12	135,942.75	114,191,910.00
JCHEW	06/2	190	12	106,307.58	242,381,282.40
Laboratory Tech	07/1	37	12	132,792.25	58,959,759.00
Pharm. Tech	07/1	40	12	148,545.08	71,301,638.40
Environmental Tech	07/1	30	12	132,792.25	47,805,210.00
Medical Record Tech	07/2	30	12	135,942.75	48,939,390.00
Total		**620**		**1,286,089.19**	**1,011,058,168.92**

Table 5: Costed workplan for healthcare workforce gap for 2027

Cadre	Grade Level	Number of Personnel	12 months	CONHESS ₦	Amount (₦)
				₦	₦
Doctors	12/2	46	12	194,755.33	119,190,261.96
Nurses/midwives	08/2	143	12	151,358.92	250,650,371.52
Comm. Health. Officer	08/1	34	12	147,652.28	69,101,267.04
CHEW	07/2	70	12	135,942.75	120,717,162.00
JCHEW	06/2	190	12	106,307.58	241,105,591.44
Laboratory Tech	07/1	37	12	132,792.25	66,927,294.00
Pharm. Tech	07/1	40	12	148,545.08	80,214,343.20
Environmental Tech	07/1	30	12	132,792.25	57,366,252.00
Medical Record Tech	07/2	30	12	135,942.75	58,727,268.00
Total		**620**		**1,286,089.19**	**1,063,999,811.16**

Table 6: Costed workplan for healthcare workforce gap for 2028

Cadre	Grade Level	Number of Personnel	12 months	CONHESS ₦	Amount (₦)
		₦	₦	₦	
Doctors	12/2	46	12	194,755.33	105,167,878.20
Nurses/midwives	08/2	143	12	151,358.92	252,466,678.56
Comm. Health. Officer	08/1	34	12	147,652.28	62,013,957.60
CHEW	07/2	70	12	135,942.75	115,823,223.00
JCHEW	06/2	190	12	106,307.58	242,381,282.40
Laboratory Tech	07/1	37	12	132,792.25	60,553,266.00
Pharm. Tech	07/1	40	12	148,545.08	71,301,638.40
Environmental Tech	07/1	30	12	132,792.25	49,398,717.00
Medical Record Tech	07/2	30	12	135,942.75	50,570,703.00
Total		**620**		**1,286,089.19**	**1,009,677,344.16**

Table 7: Costed workplan for healthcare workforce gap for 2029

Cadre	Grade Level	Number of Personnel	12 months	CONHESS ₦	Amount (₦)
		₦	₦	₦	
Doctors	12/2	46	12	194,755.33	58,426,599.00
Nurses/midwives	08/2	143	12	151,358.92	254,282,985.60
Comm. Health. Officer	08/1	34	12	147,652.28	17,718,273.60
CHEW	07/2	70	12	135,942.75	91,353,528.00
JCHEW	06/2	190	12	106,307.58	265,343,719.68
Laboratory Tech	07/1	37	12	132,792.25	22,309,098.00
Pharm. Tech	07/1	40	12	148,545.08	30,303,196.32
Environmental Tech	07/1	30	12	132,792.25	7,967,535.00
Medical Record Tech	07/2	30	12	135,942.75	24,469,695.00
Total		**620**		**1,286,089.19**	**772,174,630.20**

RECOMMENDATIONS & ACTION PLAN

To address these challenges and optimize PHC availability in Bayelsa, the state stakeholders, in a co-creation workshop, recommended the following.

- Constituting a health workforce coordination platform.
- Building the capacity of health workforce managers and focal persons on Human Resources for Health management and development.
- Developing a costed state-specific health workforce strategic plan and policy.
- Improving health workforce financing to facilitate absorption/recruitment of essential PHC workforce.
- Establishing a state-level health workforce information system.

Strategies for Addressing HRH Shortages

- Immediate recruitment of health workers, particularly in underserved LGAs.
- Redistribution of existing staff from overstaffed to understaffed facilities.
- Establishment of training institutions to increase workforce production.

CONCLUSION

The HRH needs assessment in Bayelsa State has highlighted critical workforce shortages, infrastructural deficits, and governance challenges that undermine the effectiveness of PHC service delivery. Addressing these challenges requires a multi-sectoral approach, with targeted interventions in recruitment, training, workforce redistribution, and policy implementation. By adopting the proposed strategies, Bayelsa State can strengthen its health workforce, improve healthcare accessibility, and enhance overall health outcomes for its population. The HRH gap analysis in Bayelsa State highlights several critical challenges that must be addressed to strengthen the primary health workforce. By tackling issues such as poor retention, inadequate staffing, stagnation in recruitment, retirement without replacement, mal-distribution, lack of social amenities, security threats, insufficient incentives, and inadequate accommodation, the Bayelsa State Primary Health Care Board can foster a more effective health workforce. Strategic investments and comprehensive policy reforms focused on these areas are essential for building a resilient health system that meets the needs of all communities in Bayelsa State. Ultimately, addressing these challenges will lead to improved health outcomes and a more sustainable health care system. This comprehensive manpower development plan aims to effectively address the significant HRH gaps identified in the 2024 analysis. By implementing immediate recruitment strategies, enhancing training programs, and fostering a culture of engagement and career development, [Your Agency Name] will not only fill the 2,718 vacancies but also create a

sustainable and competent workforce that meets the health needs of the community. Through ongoing evaluation and adaptation, the agency can ensure it remains responsive to future workforce demands.

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Bayelsa State Primary Health Care Board

Prof. Seiyefa Brisibe
Hon. Commissioner, Ministry of Health