REPORT DOCUMENTATION

Health Labour Market Analysis in Six Nigerian States 2026

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Excel · Python · Node.js · Word · HTML

69	6	5	2030
pages in five parts and fourteen chapters	States, one in each geopolitical zone	annexes including the recommendations matrix	end year of the projections

This is a government report of the Federal Ministry of Health and Social Welfare. This document explains how the report was produced. It does not reproduce the findings or figures in it. The full report is available on request where the Ministry allows it.

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01 THE STORY BEHIND THE REPORT

Six States each wrote their own Health Labour Market Analysis. Each one is detailed and each one is about one place. A national planner reading six long reports cannot easily tell which problems are local accidents and which are shared.

The consolidated report is the answer. It sets the six analyses side by side, finds what repeats, notes where the States truly differ, and says which findings the records support and which they do not.

It covers Abia, Delta, Gombe, Nasarawa, Ondo and Sokoto, one in each geopolitical zone, and runs to 69 pages. It was prepared under the leadership of the Federal Ministry of Health and Social Welfare, with support from UNICEF Nigeria and technical implementation by the Innovative Hub for Research in Africa (IHfRA).

02 MY ROLE

- Wrote the consolidated report from the six state analyses.
- Set the common definitions that make the States comparable, above all the clinical workforce and the single density formula.
- Built the cross-state synthesis, the evidence-gap review and the recommendations matrix.
- Costed the recommendations and set the implementation and monitoring arrangements.

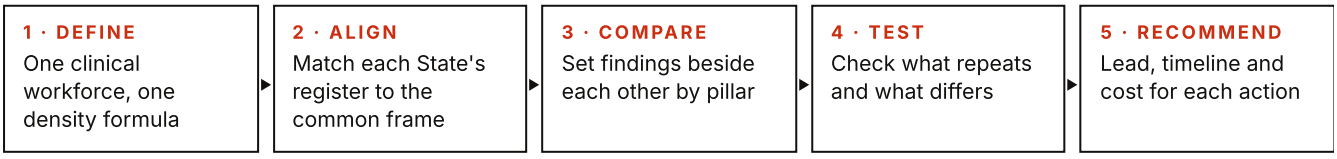
03 WORDS USED IN THIS DOCUMENT

Word	What it means
HLMA	Health Labour Market Analysis. It treats the health workforce as the product of two markets, one that educates people and one that employs them.
Pillar	One of the four parts of the WHO framework: supply, economic demand, population health need and financial space.
Thematic area	A chapter group of the report. The questions are sorted into five: population health need, economic demand, education and production, supply and distribution, and financing.
Policy question	A question the State asked the analysis to answer, for example "are staff posted where the people are?".
Clinical workforce	Doctors, nurses and midwives, community health cadres, pharmacy, laboratory, radiography and dental cadres. Densities use these cadres only.
Density	Clinical workers for every 10,000 people. It lets a small area and a large area be compared fairly.
WHO threshold	44.5 doctors, nurses and midwives per 10,000 people, the level the WHO links to the health goals of the SDGs.
Staff Availability Ratio	Workers the State has, divided by workers the threshold says it needs. A ratio of 1 means the need is met.
Register	A list kept by one office, such as a nominal roll, an establishment list or a training return.
Release	The money actually paid out against an approved budget. Approval is a promise; release is the cash.
Pace	A stated yearly growth in the clinical workforce used in a projection. It is a policy scenario, not a forecast.
Void	A register that exists but is empty. In this work a void is recorded as a finding and is never filled with a guess.
Deep-dive State	A State where field surveys were added to the administrative record.
Scoping State	A State analysed from the administrative record alone.
Comparability	Whether two States' numbers were produced the same way, so that setting them beside each other is fair.

04 THE QUESTIONS THE REPORT SET OUT TO ANSWER

1. What health needs, and so what workload, do the six States share?
2. Do they all fund and employ health workers in the same way?
3. Do their training pipelines produce enough, and do the graduates find posts?
4. Is the workforce where the people are, and does it stay?
5. How does money reach the workforce, and how much of it arrives?
6. What would the workforce look like by 2030 on different hiring paces?
7. Which of these questions can the records answer, and which cannot they?

05 HOW THE CONSOLIDATED REPORT WAS BUILT



Making the States comparable

Each State had used somewhat different registers and recorded different things. Before any finding could be compared I wrote down, for each State, which register lies behind its workforce count and how the clinical workforce was classified. Chapter 2 of the report explains how to read a cross-state comparison, and the report does not rank States where the records do not support a ranking.

Annex C: data sources and instruments by State

A table at the back of the report records, for each State, the sources and the instruments used. A reader can see at a glance which States have field surveys and which rest on registers alone.

Annex D and E: questions and recommendations

Annex D gives the policy questions and findings across the six States. Annex E sets out the recommendations as a matrix of State, lead institution and timeline, so each action has an owner.

06 HOW THE KEY NUMBERS ARE WORKED OUT

Clinical density

Density is the first number every chapter leans on. It is simple, but it is easy to get wrong, so the rules are fixed before any table is built.

THE FORMULA

```
density  =  clinical workers  ÷  population  ×  10,000

Excel:   =ROUND( B2 / C2 * 10000 , 1 )
```

HOW IT WORKS, STEP BY STEP

1. Count only the cadres on the clinical list. Health information, environmental health and lay community workers are set aside.
2. Use one population figure, from one year, for every row, so that every density shares a denominator.
3. Divide the workers by the population, then multiply by 10,000.
4. Compare with the 44.5 threshold, and say which cadres the threshold was written for.

> **An everyday example.** A district with 1,200 clinical workers and 400,000 people has 1,200 ÷ 400,000 × 10,000 = 30 workers per 10,000. That is two thirds of the threshold.

Staff Availability Ratio and shortfall

THE FORMULA

```
requirement  =  population ÷ 10,000 × 44.5
ratio        =  workers available ÷ requirement
shortfall    =  requirement − workers available
```

> **An everyday example.** A State of 500,000 people needs 500,000 ÷ 10,000 × 44.5 = 2,225 workers. If it has 1,000, the ratio is 0.45 and the shortfall is 1,225.

Builds on: Clinical density. The same workers and the same population feed both.

Projection to the end year, by pace

A forecast needs a long history of the workforce. The States do not have one, so I did not fit a trend. I built scenarios, each with a stated yearly growth in clinical workers, and showed what each one does to density and to the gap.

THE FORMULA

```
workforce(year+1)   =  workforce(year)   × (1 + pace)
population(year+1)  =  population(year)  × (1 + growth)
density(year)       =  workforce(year) ÷ population(year) × 10,000
```

07 WHAT IS IN THE REPORT

Part	Chapters
I	1 Introduction · 2 Methodology and comparability
II	3 Population health need · 4 Economic demand · 5 Education and production · 6 Supply, distribution and retention · 7 Health workforce financing
III	8 Clinical workforce projections to 2030 · 9 Needs-based requirements and staff availability ratios
IV	10 Common patterns and State differences · 11 The evidence gaps
V	12 Recommendations · 13 Implementation, costing and monitoring · 14 Conclusion
Annexes	A State profiles · B Clinical cadre classification · C Data sources and instruments by State · D Policy questions and findings · E Recommendations matrix by State, lead institution and timeline

08 CHAPTER BY CHAPTER

The table follows the contents page of the consolidated six-state report. Page numbers are those printed in the report. A section starts on the page shown and runs to the start of the next one.

Section	Title	Page	The question it answers
1	Introduction	15	Why the report exists and what it covers
2	Methodology and Comparability	18	How the analysis was done
3	Population Health Need	21	Need: how many workers the population requires
4	Economic Demand for Health Workers	26	Demand: what the State can afford to employ
5	Education and Production	30	Education: who is trained and how many qualify
6	Supply, Distribution and Retention	33	Supply: who works where, and who stays
7	Health Workforce Financing	37	Finance: what is spent and when it is released
8	Clinical Workforce Projections to 2030	40	Where the workforce is heading
9	Needs-Based Requirements and Staff Availability Ratios	43	How far supply meets need
10	Common Patterns and State Differences	45	How the findings fit together
11	The Evidence Gaps	48	What the records cannot yet answer
12	Recommendations	50	What to do about it
13	Implementation, Costing and Monitoring	55	How to carry it out and track it

Section	Title	Page	The question it answers
14	Conclusion	59	The close of the argument

09 HOW TO READ IT IN TWENTY MINUTES

A READING ORDER FOR A BUSY READER

1. Read the executive summary first. It gives the main findings, and the report is organised around five analytical pillars: need, demand, education, supply and finance.
2. Turn to Section 10, Common Patterns and State Differences (page 45), to see how the findings connect.
3. Read Section 11, The Evidence Gaps (page 48), to see which policy questions the records could not answer and which document would answer them.
4. Go back to the pillar that matters most to your decision and read that section in full.

10 LIMITATIONS STATED IN THE REPORT

The six States used different registers and recorded different things, so the report explains how to read cross-state comparisons and does not rank States where the records do not support it. Attrition is incomplete in every State. Some findings come from the record alone and others from field surveys, and the report marks which is which.

11 OUTPUTS AND HOW THEY WERE USED

One national-level reading of six state analyses, with recommendations that States and the Federal Government can act on with instruments they already hold. The recommendations cover protecting and publishing budget releases for the workforce, absorbing qualified workers against funded vacancies, retaining scarce clinical cadres, and staffing primary care and rural facilities with security and hardship support.

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