ENUGU STATE GOVERNMENT

Ministry of Health

Enugu State Primary Health Care Development Agency

BASELINE MAPPING OF PRIMARY HEALTH CARE WORKERS IN ENUGU STATE

Establishment, Vacancy and the Multi-Year Costed Recruitment and Deployment Plan, 2026 to 2030

Prepared by the Enugu State Ministry of Health
and the Enugu State Primary Health Care Development Agency

MARCH 2026

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Foreword

Enugu State has committed to a functional, equipped and well-staffed primary health facility in every one of our 260 wards, and we have said publicly that access to quality primary care should not depend on where in this State a citizen happens to live. This commitment requires a robust human resources for health in our PHC system.

This report records that the Primary Health Agency operates 566 primary health care facilities with an established requirement of 8,274 posts, and that 1,810 of those posts are filled. It records that the vacancy stands at 6,464. It also records that in several cadres the establishment is not yet fully engaged : seven medical records officers, twenty-two pharmacy technicians and one hundred and three nurses and midwives for the State. And it records that 27 of our 260 focal wards presently have no staff attributable to them at all.

A workforce plan built on an accurate number can be financed, sequenced and defended as it reflects what will provide quality services to the citizens.

The State has not waited on this report to act. His Excellency the Governor approved the recruitment of 2,250 primary health care workers. An open, competitive process was applied and 450 appointees have been onboarded in the first phase. A further 900 will be onboarded before the close of 2026, and the balance in the course of 2027.
This is a phased and sequential approach that gives sustainable improvements in the system.

Three commitments follow from it, and we make them here on behalf of the Ministry. The personnel cost of this programme will be carried on the payroll and reflected in each annual budget, because a recruitment the State cannot sustain is a recruitment it has not truly made. Deployment will follow the equity rule set out in Chapter 8 and not the pull of precedent or proximity, because a workforce concentrated where it is comfortable is of no use where it is needed. And progress will be published annually and laid open to independent verification.

We record our appreciation to the Executive Secretary and staff of the Primary Health Care Development Agency, to the Local Government Health Authority Secretaries who assembled the returns on which this work rests, and to our partners at the National Primary Health Care Development Agency. The work they have done here is thorough.

Enugu State intends to continue to improve our health system with great emphasis on our PHC as the foundation of it all.

Prof. George Ugwu
Honourable Commissioner for Health
Enugu State Ministry of Health

Preface and Acknowledgement

This report has a single organising purpose: to make the Enugu State primary health care workforce countable, and therefore governable. Everything in it proceeds from that.

Three figures have circulated in State workforce planning over the past two years, resting on three different staffing norms, and they have not always been distinguished from one another. Chapter 3 reconciles them openly and states which one this Agency now adopts and why. Where a published figure exists, it is reproduced without alteration; where this report goes further than what has been published, it says so and shows its method. Nothing here is asserted that cannot be traced to a State record, and a companion workbook accompanies this report so that any figure in it can be followed to the ward, the facility and the cadre from which it came.

Two matters are stated plainly rather than left to be discovered. First, of the 450 appointees onboarded in Phase 1, 395 are fully documented on the recruitment schedule; documentation for the remaining 55 was still in progress at the date of compilation and those records are not yet carried on the schedule. The analysis is anchored on 450, being the number appointed and effected, and the position is disclosed so that any reviewer reconciling the schedule against the total understands the difference. Second, the 89.1 per cent ward attribution factor used in Chapter 5 is a derived figure, not a published one, and Annex 3 sets out exactly how it was obtained so that it can be independently reproduced.

I am grateful to the Honourable Commissioner for Health, Prof. George Ugwu, whose direction throughout was that this exercise should report what is, and not what would read well. I thank the Local Government Health Authority Secretaries across the 17 Local Government Areas, who compiled and verified the nominal roll returns that form the evidentiary spine of this report, and the officers-in-charge of our facilities who checked them. I acknowledge the Office of the Accountant General and the Local Government Sub-Treasurers for enabling payroll verification of the Phase 1 cohort, and the Enugu State Civil Service Commission for its partnership on the recruitment process.

I acknowledge the National Primary Health Care Development Agency for the minimum standards against which this analysis is benchmarked, and our partners under the Basic Health Care Provision Fund, whose support has strengthened both the method and the discipline of this work.

Finally, I record what the numbers in this report describe. Ninety-four in every hundred of our primary health care workers are women. Many serve rural wards far from where they trained, a good number as the only skilled provider for a considerable distance, and they have held this system together through a period in which the establishment thinned rather than grew. The recruitment set out in these pages is owed to them before it is owed to anyone else.

Dr Ifeyinwa Ani-Osheku
Executive Secretary and Chief Executive Officer
Enugu State Primary Health Care Development Agency

List of Acronyms

Acronym	Meaning
AOP	Annual Operational Plan
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
CBT	Computer-Based Test
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CONHESS	Consolidated Health Salary Structure
DFF	Direct Facility Financing
EHO	Environmental Health Officer
ENRUWASA	Enugu State Rural Water Supply and Sanitation Agency
ENSPHCDA	Enugu State Primary Health Care Development Agency
EXCO	State Executive Council
HRH	Human Resources for Health
HRIS	Human Resource Information System
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
LGHA	Local Government Health Authority
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NYSC	National Youth Service Corps
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
SMoH	State Ministry of Health
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHO	World Health Organization

Executive Summary

The Enugu State Ministry of Health and the Enugu State Primary Health Care Development Agency have completed a baseline mapping of the State's primary health care workforce. This report states what the establishment requires, what is in post, where the shortfall lies, what has been done about it, and what remains to be done. It is submitted with a companion workbook in which every figure can be traced to the ward, facility and cadre from which it derives.

The network

Enugu State comprises 17 Local Government Areas subdivided into 260 wards. The Agency operates 566 government-owned primary health care facilities, of which 426 are Level 2, 131 are Level 1 and 9 are Type 3. Within that estate, 260 facilities have been designated as the focal network under the Basic Health Care Provision Fund, one in each ward, and these carry the fuller service package including Basic Emergency Obstetric and Newborn Care.

A single governing norm

Three staffing norms have been applied to this network in recent years, producing three different vacancy figures. This report reconciles them in Chapter 3 and adopts one. The norm now governing is that published by the Agency on 31 March 2026: fourteen posts at each of the 566 facilities, together with 350 specialist posts established at Local Government level. The reconciliation is stated openly because an unexplained movement between published figures is properly read as carelessness, and because the movement here has a sound explanation: the transfer of 174 Environmental Health Officers to the WASH unit under ENRUWASA, a strict delineation of the primary health care establishment from non-clinical personnel, and the establishment of specialist posts at Local Government rather than facility level.

The position

On that governing norm the established requirement is 8,274 posts. Staff in post number 1,810. The vacancy is 6,464 posts, being 78.1 per cent of the establishment. Expressed the other way, 21.9 per cent of the established primary health care workforce of Enugu State is presently in place.

The aggregate conceals the more serious finding, which is that in several cadres the establishment is not thin but functionally absent. Seven medical records officers are in post against an establishment of 1,132. Twenty-two pharmacy technicians are in post against 566. One hundred and three nurses and midwives are in post against 1,132, a fill rate of 9.1 per cent, in a network whose focal tier is expected to deliver Basic Emergency Obstetric and Newborn Care. These are not shortfalls at the margin of an otherwise working system. They are the absence of whole functions.

The 260 focal BEmONC network

Applying the same norm to the 260 focal Level 2 facilities, which are the facilities designated to provide Basic Emergency Obstetric and Newborn Care, one in each ward, gives a requirement of 3,990 posts.

Attributing staff to wards by the method set out in Annex 3 gives 1,618 in post and a vacancy of 2,372. The ward-level detail is where the position becomes clinically legible: 27 of the 260 focal wards have no staff attributable to them, only 40 meet the fourteen-post norm, and the median focal ward holds 5 staff.

This report carries the two bases in parallel throughout rather than treating one as principal and the other as commentary. They answer different questions. The 566 facility basis measures the State's total obligation and is the basis on which performance against national thresholds is assessed. The 260 focal basis measures readiness at the facilities where Basic Emergency Obstetric and Newborn Care is expected to be available, and is the basis on which deployment is sequenced. Section 4.4 sets them side by side with the variance between them, and every proportion stated in this report is given on both.

Table 1: Summary position on both measurement bases

Measure	566 facility network	260 focal BEmONC network	Variance
Facilities	566	260	306 fewer
Established requirement	8,274	3,990	4,284 fewer
Staff in post	1,810	1,618	192 fewer
Vacancy	6,464	2,372	4,092 fewer
Proportion of establishment filled	21.9%	40.6%	+18.7 points
Position at the close of 2026, 1,350 appointees	20.9%	56.9%	+36.0 points
Position on completion of the approved 2,250 posts	34.8%	94.9%	+60.1 points

Source: baseline mapping analysis. Both bases apply the governing norm published on 31 March 2026.

Progress to date

His Excellency the Governor approved the recruitment of 2,250 primary health care workers. An open recruitment drew 6,000 applications, of which 4,000 candidates sat a computer-based examination. Phase 1 has onboarded 450 appointees, being 7 per cent of the state-wide vacancy. Phases 2 and 3 will add 900 before the close of 2026, bringing cumulative recruitment to 1,350, or 20.9 per cent. Phases 4 and 5 complete the approved 2,250 during 2027, reaching 34.8 per cent. Of the 450 Phase 1 appointees, 395 are fully documented on the recruitment schedule and documentation for the remaining 55 was in progress at the date of compilation.

Measurement and margin

Measured against the published state-wide vacancy of 6,464, cumulative recruitment of 1,350 by the close of 2026 exceeds the twenty per cent threshold, which requires 1,293 posts. The headroom is 57 posts. Counting only the 395 appointees presently documented, cumulative recruitment stands at 1,295 and the headroom narrows to 2. The State therefore treats completion of the outstanding documentation, and payroll confirmation of the full Phase 1 cohort, as a matter of first priority rather than an administrative formality.

What follows

Chapter 6 records that 663 workers are projected to reach statutory retirement between 2026 and 2030, with 310 falling in 2027 alone, and that 85 staff carry retirement dates already passed and require reconciliation with the Office of the Accountant General. Recruitment must therefore outrun attrition rather than merely accompany it. Chapters 8 and 9 set out the deployment framework and the costed plan, and Chapter 10 the arrangements by which progress will be published and independently verified.

The State's undertaking is specific. Every focal facility in every ward will be brought to the established norm, the priority cadres first, the emptiest wards first, on a published schedule and against figures that can be checked.

1. INTRODUCTION

1.1 Purpose of the exercise

A health system is the sum of the people who work in it. Buildings, equipment, commodities and financing are necessary, but none of them delivers a consultation, attends a birth or administers a vaccine. In primary health care, the workforce is the point at which policy becomes service.

Enugu State has invested substantially in the physical reconstruction of its primary health care estate. That programme has advanced faster than the corresponding workforce programme, and the consequence is a documented mismatch between where the State has built capacity and where it has staffed it. The purpose of this exercise is to measure that mismatch precisely, at the level of the ward, the facility and the cadre, and to set out a financed and sequenced plan to close it.

1.2 Objectives

1. To establish the number, cadre composition and deployment of staff engaged in primary health care service delivery across Enugu State.
2. To reconcile the several staffing norms that have been applied to the State network and to adopt a single governing norm.
3. To quantify the vacancy against that norm, cadre by cadre, both across the full facility estate and across the 260 focal Level 2 facilities.
4. To quantify projected attrition through statutory retirement over the period 2026 to 2030.
5. To record recruitment already effected and to set out a phased, costed and equitable plan for the balance.
6. To establish a verifiable baseline, supported by a traceable data record, against which subsequent progress can be independently measured.

1.3 Scope

The geographic scope is the full administrative territory of Enugu State, being 17 Local Government Areas comprising 260 wards. The institutional scope covers all 566 government-owned primary health care facilities on the State PHC facility register, together with the 260 facilities designated as the focal network under the Basic Health Care Provision Fund.

The personnel scope covers staff engaged in primary health care service delivery. Secondary and tertiary facilities, and the headquarters establishment of the State Ministry of Health, are outside scope. Environmental Health Officers repositioned to the WASH unit under ENRUWASA are outside the primary health care establishment and are excluded, as explained in Chapter 3.

1.4 Method

The exercise proceeded in five steps. First, the facility estate was enumerated from the State PHC facility register and the focal network identified from the Basic Health Care Provision Fund schedule. Second, the staffing norm was reconciled and adopted. Third, the established requirement was computed by applying that norm to the facility base, distinguishing posts established at facility level from posts established at Local Government level. Fourth, staff in post were taken from the Agency's published position and distributed to wards, facilities and cadres using the nominal roll. Fifth, the vacancy was computed cadre by cadre.

One methodological rule governs throughout and is stated here because it materially affects the result. Vacancies are computed for each cadre independently, and a surplus in one cadre is not netted against a deficit in another. A surplus of community health extension workers is not a substitute for an absent midwife, and offsetting the two would yield a smaller number describing nothing real. Where surpluses exist they are identified separately and addressed through redeployment.

1.5 Data sources and their standing

This report distinguishes between figures that govern and figures that describe. The published position of the Agency governs: it is reproduced without alteration and no analysis in this report displaces it. The nominal roll describes: it is used to distribute the published totals across wards, facilities, cadres and Local Government Areas, and to project retirement. Where the two differ in aggregate, the published position stands and the difference is explained.

Table 2: Data sources, their standing and their use

Source	Standing	Records	Use in this report
ENSPHCDA Human Resources for Health Update Report, signed 31 March 2026	Governing. Published and signed.	Requirement 8,274; in post 1,810; vacancy 6,464	Establishment, staff in post, vacancy, recruitment phasing
ENSPHCDA Nominal Roll 2025	Descriptive. Internal administrative record.	2,093 staff records	Ward, facility, cadre and Local Government distribution; retirement projection; composition by sex
Enugu State PHC Facility Register	Governing for the facility base.	566 facilities	Facility count, service level, ward and Local Government distribution
BHCPF Focal Facility Schedule	Governing for the focal network.	260 facilities, one per ward	Definition and composition of the focal Level 2 network
2026 Staff Recruitment Schedule	Evidentiary.	395 documented of 450 appointed	Cadre and Local Government distribution of the Phase 1 cohort
NPHCDA Minimum Standards for Primary Health Care in Nigeria	Reference benchmark.	18 core posts per facility	Comparator in the norm reconciliation at Chapter 3

All six sources are held by the Agency and are available for inspection.

The nominal roll records 2,093 staff while the published position records 1,810 in post. The difference is one of definition, not of counting. The published position counts only the eleven cadres comprising the primary health care establishment. The nominal roll additionally carries health attendants and assistants, Environmental Health Officers since repositioned to ENRUWASA, and a residue of records whose rank field could not be coded to a cadre with confidence. This report uses the published figure for every statement of establishment and vacancy, and the roll only for distribution.

1.6 Validation

Compiled figures were cross-verified against three independent records: State and Local Government payroll data held by the Office of the Accountant General and the Local Government Sub-Treasurers; the Basic Health Care Provision Fund facility schedule; and the State PHC facility register. Discrepancies were referred to the originating Local Government Health Authority Secretary for reconciliation. The consolidated position was then presented to a stakeholder validation forum comprising Local Government Health Authority Secretaries, facility officers-in-charge, Ward Development Committee representatives and health sector civil society organisations, and their observations were incorporated before finalisation.

1.7 Assumptions and limitations

The credibility of a baseline rests as much on what it admits as on what it asserts. The following are stated without qualification.

- Cadre coding. The rank field of the nominal roll is free text and is not held to a controlled vocabulary. Approximately 5 per cent of records could not be coded to a cadre with confidence and are reported as unclassified. This affects the distributional analysis in Chapters 5 and 6. It does not affect the establishment and vacancy figures in Chapter 4, which are taken from the published position.
- Ward attribution. The factor of 89.1 per cent used in Chapter 5 is derived, not published. It was obtained by matching nominal roll records to focal wards by duty post name and then by ward name. Annex 3 states the method in full so that it can be independently reproduced. A more conservative figure of 61.1 per cent, being records whose duty post names the focal facility itself, is reported alongside it.
- Unmatched records. 255 nominal roll records could not be attributed to a focal ward. They remain in State-level totals and are excluded only from ward-level tables.
- Retirement. Statutory retirement at age 60 is assumed, consistent with recorded retirement dates. Resignation, transfer of service and death in service are not separately modelled, so projected attrition is a conservative floor and not a ceiling. 85 records carry retirement dates already passed and require reconciliation.
- Population. Figures are National Population Commission 2006 census figures projected at 2.8 per cent annually, giving approximately 5,504,611 residents in 2025. They should be substituted with State Bureau of Statistics figures when available.
- Costing. Unit costs in Chapter 9 are indicative, built from grade level salary bands, and are set out in full at Annex 4 for substitution with confirmed figures from the State Ministry of Finance and the Office of the Accountant General. Substituting them changes the cost totals and no other figure in this report.

2. THE PRIMARY HEALTH CARE NETWORK

2.1 Administrative and facility structure

Enugu State is organised into 17 Local Government Areas, subdivided into 260 wards and grouped into three senatorial zones. Primary health care is coordinated by the Enugu State Primary Health Care Development Agency under the policy direction of the State Ministry of Health. At Local Government level, Local Government Health Authority Secretaries manage service delivery across the ward network and report to the Agency. At facility level, officers-in-charge are responsible for daily operations.

The Agency operates 566 government-owned primary health care facilities, all recorded as functional on the State facility register. Distribution across the Local Government Areas is uneven and does not track population closely, reflecting successive rounds of facility construction rather than a governing allocation rule. Igbo-Etiti hosts the largest number at 47 facilities; Enugu North the smallest at 16.

2.2 Facilities by service level

The estate spans three service levels. Level 1 facilities provide a basic outpatient and preventive package. Level 2 facilities carry the fuller primary care package including Basic Emergency Obstetric and Newborn Care, and it is at this tier that the staffing norm bites hardest. Type 3 facilities form a small residual category.

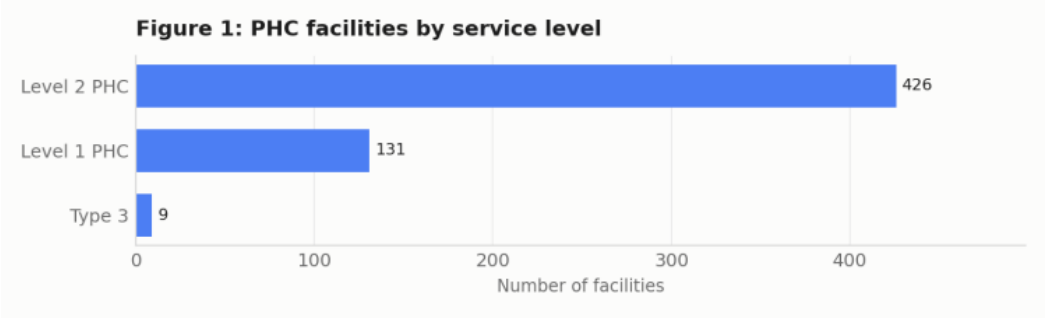


Figure 1: PHC facilities by service level. Source: Enugu State PHC Facility Register.

The predominance of the Level 2 classification, at 426 of 566 facilities, is material for planning: it is the tier that generates the bulk of the State's establishment requirement, and it is the tier from which the focal network is drawn.

2.3 The focal network of 260 Level 2 facilities

Within the Level 2 tier, 260 facilities are designated as the State's focal network under the Basic Health Care Provision Fund. The design principle is one focal facility in each ward, and the schedule confirms complete coverage: all 260 wards carry exactly one designated focal facility. Distribution by senatorial zone is Enugu North 102, Enugu West 81 and Enugu East 77, reflecting the underlying ward structure.

The focal network matters for three reasons. It is the tier at which Direct Facility Financing is anchored, so expenditure and service delivery are already tracked against it. It is the tier at which community health

workers are linked to a named facility. And it is the tier at which Basic Emergency Obstetric and Newborn Care is expected to be available, which makes its midwifery staffing a matter of immediate clinical consequence rather than of establishment arithmetic.

2.4 Population and facility density

On a projected 2025 population of approximately 5,504,611, the 566 facilities give a density of 1.03 facilities per 10,000 population, or one government-owned primary health care facility for approximately every 9,725 residents. Density alone, however, is a weak measure of access. A facility staffed by three workers against an established norm of fourteen is a point on a map before it is a functioning service, and it is that distinction which the remainder of this report addresses.

3. ESTABLISHING THE STAFFING NORM

Before a vacancy can be stated it must be stated against something. This chapter identifies the three norms that have been applied to the Enugu State network, reconciles them, and adopts one. It is placed early and deliberately, because every figure that follows depends on it.

3.1 Why three norms are in circulation

The Agency's 2024 Human Resources for Health Report, published in April 2025, applied a uniform norm of sixteen posts per facility to all 566 facilities, giving a requirement of 9,056 posts against 2,242 in post and a vacancy of 6,814.

The Agency's Human Resources for Health Update Report, signed on 31 March 2026, applied a revised norm of fourteen posts per facility together with 350 specialist posts established at Local Government level, giving a requirement of 8,274 posts against 1,810 in post and a vacancy of 6,464.

The National Primary Health Care Development Agency prescribes a minimum standard of eighteen core clinical and technical posts per primary health care facility, which applied to 566 facilities would give a requirement of 10,188 posts and a vacancy of 8,378.

Three norms, three requirements, three vacancy figures. Left unreconciled, this is properly read by any reviewer as inconsistency. Reconciled, it is a coherent account of a definition that was tightened for good reason.

3.2 Reconciliation

Table 3: Reconciliation of the three staffing norms

Norm	Basis of the norm	Calculation	Requirement	In post	Vacancy
2024 HRH Report (published April 2025)	16 posts per PHC, uniform	566 x 16	9,056	2,242	6,814
2026 HRH Update (published March 2026)	14 posts per PHC plus 350 LGA-level specialist posts	566 x 14 + 350	8,274	1,810	6,464
NPHCDA national minimum standard	18 core clinical and technical posts per PHC	566 x 18	10,188	1,810	8,378

Source: ENSPHCDA 2024 HRH Report; ENSPHCDA HRH Update Report, 31 March 2026; NPHCDA Minimum Standards for Primary Health Care in Nigeria.

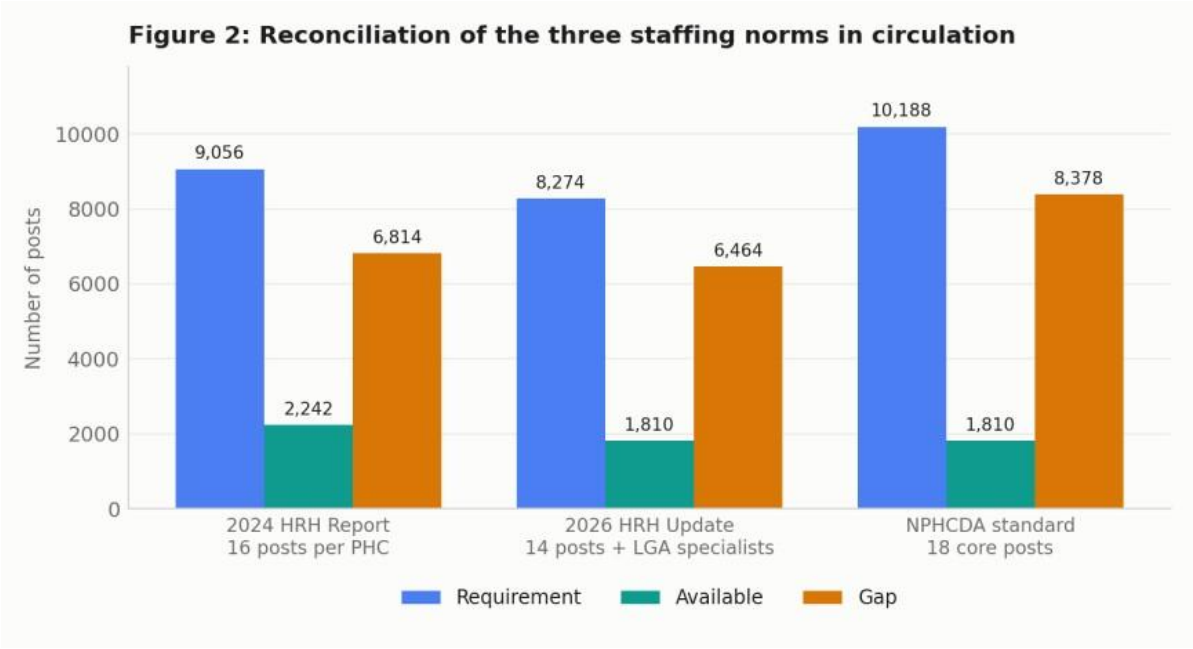


Figure 2: Reconciliation of the three staffing norms in circulation.

The movement from the 2024 norm to the 2026 norm is accounted for by three changes, each of which is a matter of record.

7. Transfer of Environmental Health Officers. The State's organisational restructuring repositioned 174 Environmental Health Officers to the Water, Sanitation and Hygiene unit under ENRUWASA. They perform a public health function of continuing importance but are no longer part of the primary health care establishment, and both the requirement and the staff in post were adjusted accordingly.

8. Strict delineation of the establishment. The 2024 enumeration was deliberately inclusive, capturing every person engaged in or around primary health care service delivery, including administrative and ancillary personnel. The 2026 position counts only the eleven cadres that constitute the primary health care establishment, which reduced counted staff from 2,847 to 1,810. This is a tightening of definition and not a loss of workers.

9. Establishment of specialist posts at Local Government level. Medical Officers, Pharmacists and Medical Laboratory Scientists are not established at every primary health care facility, which would be neither affordable nor clinically necessary. They are established at Local Government level: 170 Medical Officers, being ten per Local Government Area, and 90 Pharmacists and 90 Medical Laboratory Scientists, being approximately five of each per Local Government Area. This removes them from the per-facility calculation and places them in a separate establishment of 350 posts.

3.3 The norm adopted

The governing norm

This report adopts the norm published in the ENSPHCDA Human Resources for Health Update Report of 31 March 2026: fourteen posts established at each of the 566 primary health care facilities, together with 350 specialist posts established at Local Government level.

The established requirement is accordingly 8,274 posts. Staff in post number 1,810. The vacancy is 6,464 posts.

This norm is adopted because it is the most recent published and signed position of the Agency, because the definitional changes underlying it are sound and documented, and because a State that publishes a figure and then quietly measures itself against a different one forfeits the standing on which verification depends.

The NPHCDA minimum standard of eighteen core posts per facility is retained throughout this report as the national benchmark. The State's present norm is a fiscally realistic interim position on the path toward it, and the distance between the two, being 1,914 posts, is stated rather than concealed.

Table 4: The adopted establishment norm

Post	Establishment basis	Number per facility	Established requirement
Medical Officer	Local Government level	Not per facility	170
Pharmacist	Local Government level	Not per facility	90
Medical Laboratory Scientist	Local Government level	Not per facility	90
Nurse / Midwife	Per facility	2	1,132
CHEW	Per facility	4	2,264
Medical Laboratory Technician	Per facility	1	566
Medical Records Officer	Per facility	2	1,132
Pharmacy Technician	Per facility	1	566
JCHEW	Per facility	2	1,132
Cleaner	Per facility	1	566
Security	Per facility	1	566
TOTAL ESTABLISHMENT		**14 per facility plus 350**	**8,274**

Source: ENSPHCDA HRH Update Report, 31 March 2026.

3.4 Clinical and support posts distinguished

The published establishment total of 8,274 posts includes Cleaner and Security posts, which are support rather than clinical roles. The figures are correct and are reproduced here without alteration, but the description requires precision: the correct term for the total is the primary health care establishment, of which the clinical and technical component is a subset. This report uses that terminology throughout.

Table 5: The establishment separated into clinical and support components

Component	Established requirement	In post	Vacancy	Share of total
Clinical and technical posts	7,142	1,804	5,338	86.3%
Support posts (Cleaner, Security)	1,132	6	1,126	13.7%
TOTAL PHC ESTABLISHMENT	**8,274**	**1,810**	**6,464**	**100.0%**

Source: ENSPHCDA HRH Update Report, 31 March 2026, disaggregated. Published totals unchanged.

The distinction matters for interpretation. Of the 6,464 vacant posts, 5,338 are clinical and technical and 1,126 are support. A reader assessing clinical service capacity should work from the first figure; a reader assessing the full establishment cost should work from the total. Both are given so that neither has to be inferred.

4. ESTABLISHMENT AND VACANCY

4.1 The state-wide position

Against the governing norm the established requirement is 8,274 posts across the 566 facility network. Staff in post number 1,810. The vacancy is 6,464 posts. Stated as a proportion, 21.9 per cent of the primary health care establishment of Enugu State is presently filled and 78.1 per cent is vacant.

Table 6: Established requirement, staff in post and vacancy by cadre, 566 facilities

Cadre	Basis	Per facility	Requirement	In post	Vacancy	Filled
Medical Officer	LGA	n/a	170	31	139	18.2%
Pharmacist	LGA	n/a	90	3	87	3.3%
Medical Laboratory Scientist	LGA	n/a	90	9	81	10.0%
Nurse / Midwife	Facility	2	1,132	103	1,029	9.1%
CHEW	Facility	4	2,264	1,148	1,116	50.7%
Medical Laboratory Technician	Facility	1	566	45	521	8.0%
Medical Records Officer	Facility	2	1,132	7	1,125	0.6%
Pharmacy Technician	Facility	1	566	22	544	3.9%
JCHEW	Facility	2	1,132	436	696	38.5%
Cleaner	Facility	1	566	2	564	0.4%
Security	Facility	1	566	4	562	0.7%
TOTAL			**8,274**	**1,810**	**6,464**	**21.9%**

Source: ENSPHCDA HRH Update Report, 31 March 2026. Cadre vacancies are computed independently and are not netted against cadre surpluses.

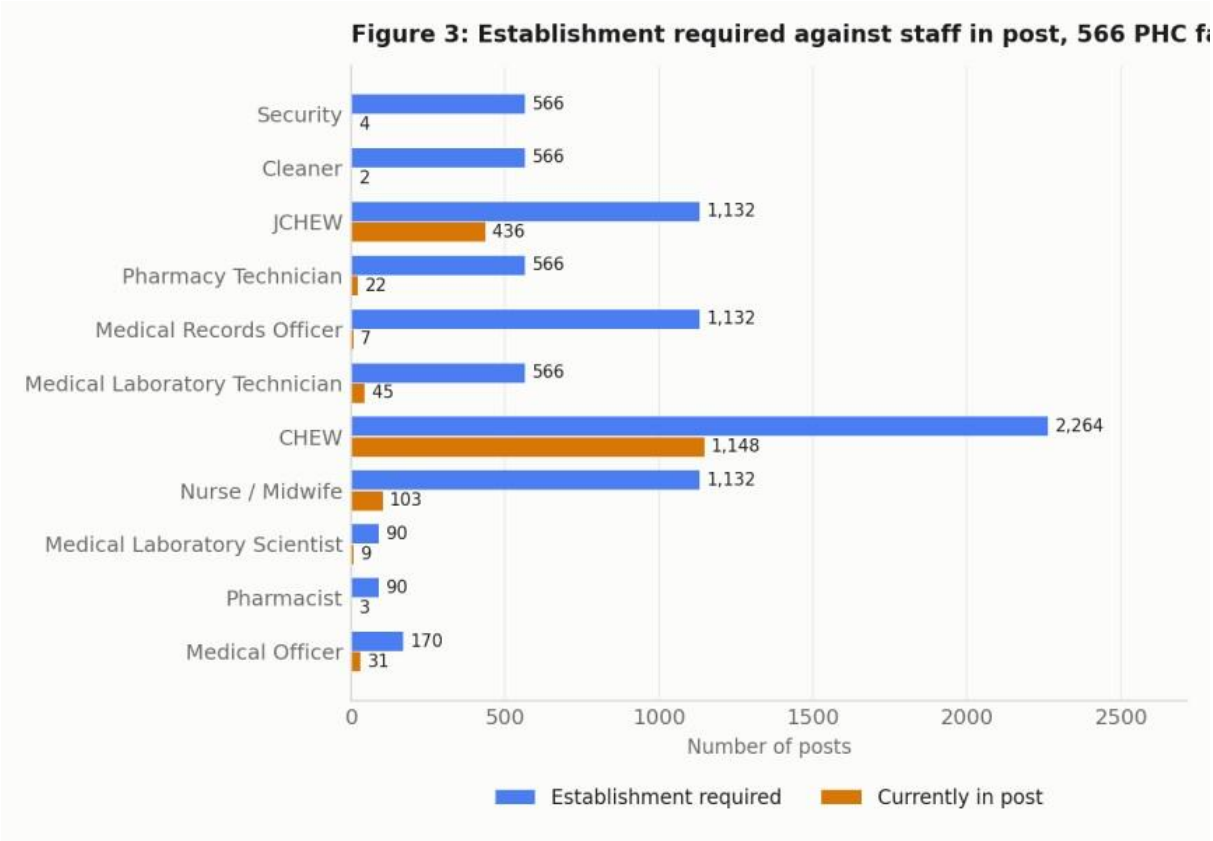


Figure 3: Establishment required against staff in post, 566 PHC facilities.

4.2 Vacancy by cadre

The aggregate vacancy of 6,464 posts is distributed very unevenly across cadres, and the distribution is more informative than the total. Four cadres account for the greater part of it: Medical Records Officers at 1,125 vacant posts, Nurses and Midwives at 1,029, CHEWs at 1,116 and JCHEWs at 696.

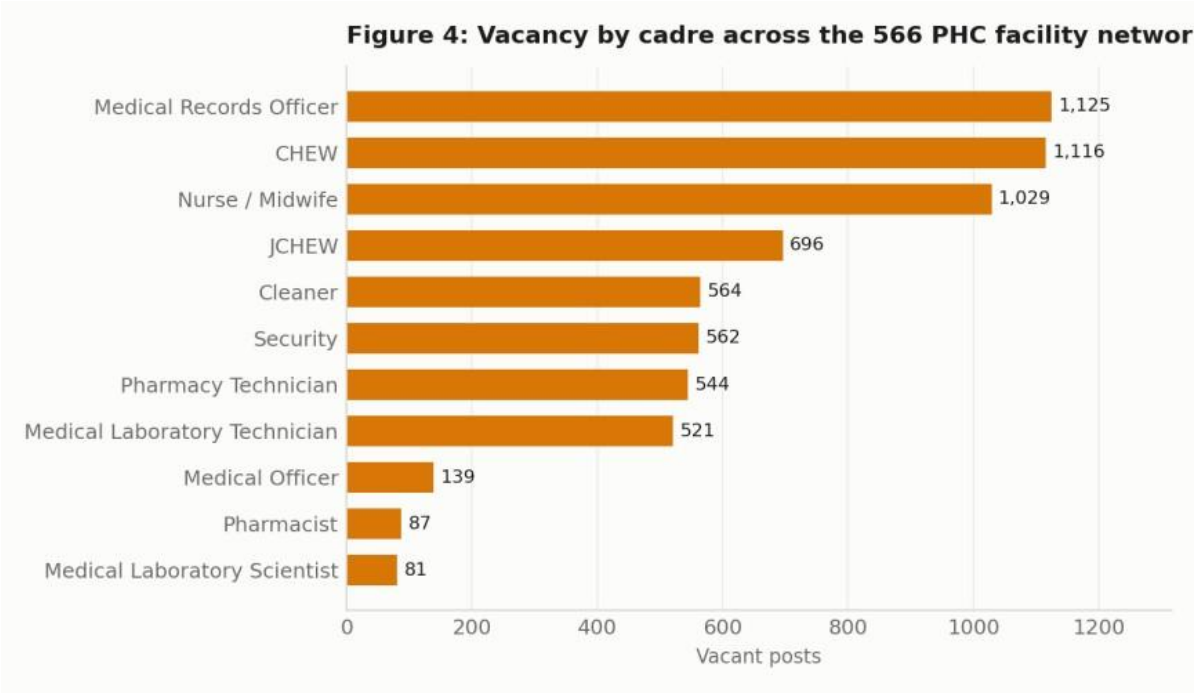


Figure 4: Vacancy by cadre across the 566 PHC facility network.

4.3 Where the establishment is functionally absent

Absolute vacancy figures reward large cadres. The more revealing measure is the proportion of each established cadre actually filled, because it identifies the cadres in which the State does not have a thin service but effectively no service at all.

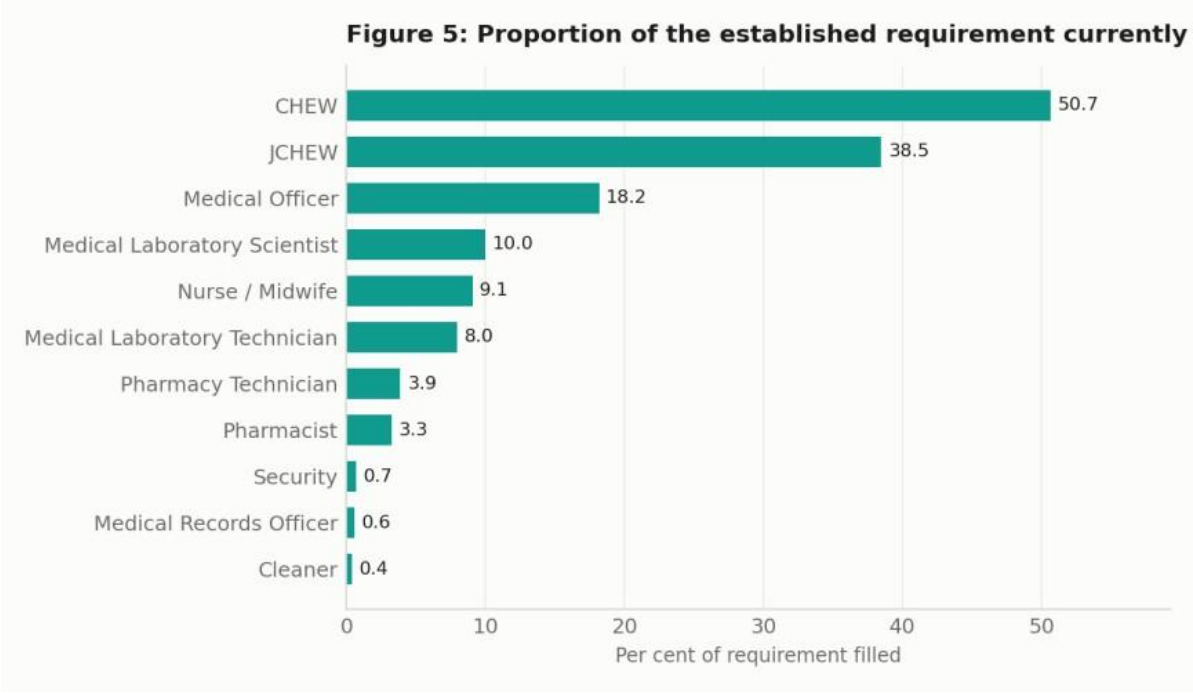


Figure 5: Proportion of the established requirement currently filled, by cadre.

Read against the established norm, the position in five cadres requires to be stated without euphemism.

- Medical Records Officers. Seven officers are in post against an establishment of 1,132, a fill rate of 0.6 per cent. Facility-level data reporting, which underpins every subsequent claim the State makes about service delivery, presently rests on seven people.
- Cleaners and Security. Two cleaners and four security personnel are in post against establishments of 566 each. Infection prevention and facility security are, on the establishment record, essentially unstaffed.
- Pharmacy Technicians. Twenty-two are in post against 566, a fill rate of 3.9 per cent. Commodity management and dispensing across the network rest on this number.
- Nurses and Midwives. One hundred and three are in post against an establishment of 1,132, a fill rate of 9.1 per cent. The focal tier of this network is expected to provide Basic Emergency Obstetric and Newborn Care. That expectation cannot presently be met across 260 wards from 103 midwives.
- Medical Laboratory Technicians. Forty-five are in post against 566, a fill rate of 8.0 per cent. Diagnostic capacity at facility level is correspondingly limited.

Two cadres stand in contrast and are the reason the aggregate figure understates the difficulty. CHEWs are 50.7 per cent filled and JCHEWs 38.5 per cent, and between them they account for 1,584 of the 1,810 staff in post, being 87.5 per cent of the entire establishment in place. Enugu State does not have a broadly staffed primary health care system with gaps in it. It has a community health extension workforce carrying a system that was designed to be delivered by eleven cadres.

This finding governs the recruitment sequence set out in Chapter 7. Recruiting proportionately across cadres would preserve the present imbalance at greater scale. The plan is therefore weighted decisively toward the cadres identified above.

4.4 The two measurement bases carried in parallel

This report carries two measurement bases throughout, and it is important that the relationship between them is understood rather than inferred. They are not competing estimates of the same quantity. They are the same establishment norm applied to two different facility bases, and each answers a question the other cannot.

The 566 facility basis measures the State's total obligation and is the basis on which performance against national thresholds is assessed. The 260 focal BEmONC basis measures readiness at the facilities designated to provide Basic Emergency Obstetric and Newborn Care, one in each ward, and is the basis on which deployment priority is determined. A State can be on track against the first and failing against the second, which is precisely why both are reported.

Table 7: The two measurement bases compared, with variance

Measure	566 facility network	260 focal BEmONC network	Variance	What the variance means
Facilities in the base	566	260	306 fewer	The focal base excludes Level 1, Type 3 and supplementary Level 2 facilities
Established requirement	8,274	3,990	4,284 fewer	Facility level posts fall from 7,924 to 3,640; the 350 Local Government level posts are common to both
Staff in post	1,810	1,618	192 fewer	Ward attribution places 89.1 per cent of facility level staff within a focal ward
Vacancy	6,464	2,372	4,092 fewer	The focal vacancy is 36.7 per cent of the state-wide vacancy
Proportion of establishment filled	21.9%	40.6%	+18.7 points	The focal network is better staffed in proportion, because staffing concentrates at the larger facilities
Phase 1, 450 appointees	7%	19%	+12.0 points	The same recruitment closes a larger share of the smaller base
Phases 1 to 3, 1,350 appointees	20.9%	56.9%	+36.0 points	State-wide progress clears the 20 per cent threshold; focal progress passes the midpoint
Approved establishment, 2,250 appointees	34.8%	94.9%	+60.1 points	The approved expansion nearly closes the focal network but leaves the state-wide obligation two thirds open
Residual vacancy after 2,250	4,214	122	4,092 fewer	Further establishment approval is required for the state-wide residual

Source: baseline mapping analysis. Both bases apply the governing norm published on 31 March 2026.

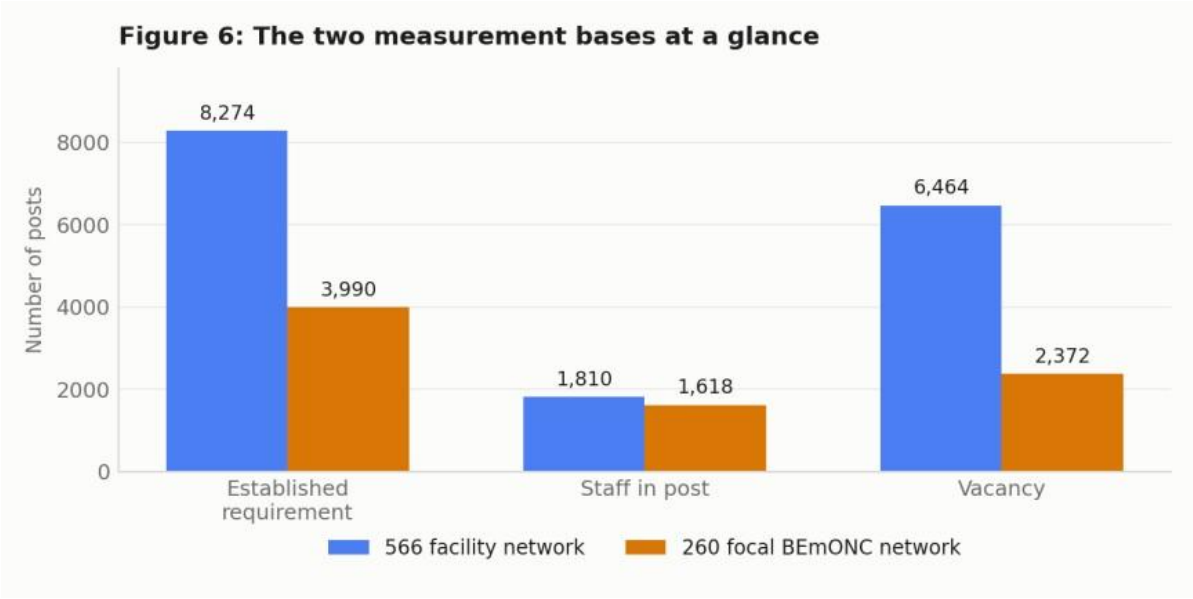


Figure 6: The two measurement bases at a glance.

The implication carried forward

The variance between the two bases is not a technical footnote. It carries three operational consequences that are traced through the remainder of this report.

- Measurement. Performance against the fifteen and twenty per cent thresholds is assessed on the 566 facility basis, on which the State reaches 20.9 per cent by the close of 2026. The focal basis is not used to establish performance and is not required to.
- Prioritisation. Deployment is sequenced on the 260 focal BEmONC basis, because a midwife posted to a supplementary facility in a ward whose focal facility has none does not make that ward capable of Basic Emergency Obstetric and Newborn Care. Chapter 8 gives the focal network first call on every cohort.
- Ambition. The approved 2,250 posts close 94.9 per cent of the focal network but only 34.8 per cent of the state-wide establishment. Presenting only the focal figure would overstate what has been secured; presenting only the state-wide figure would understate what has been achieved where it matters most clinically. Both are therefore stated wherever a proportion is given.

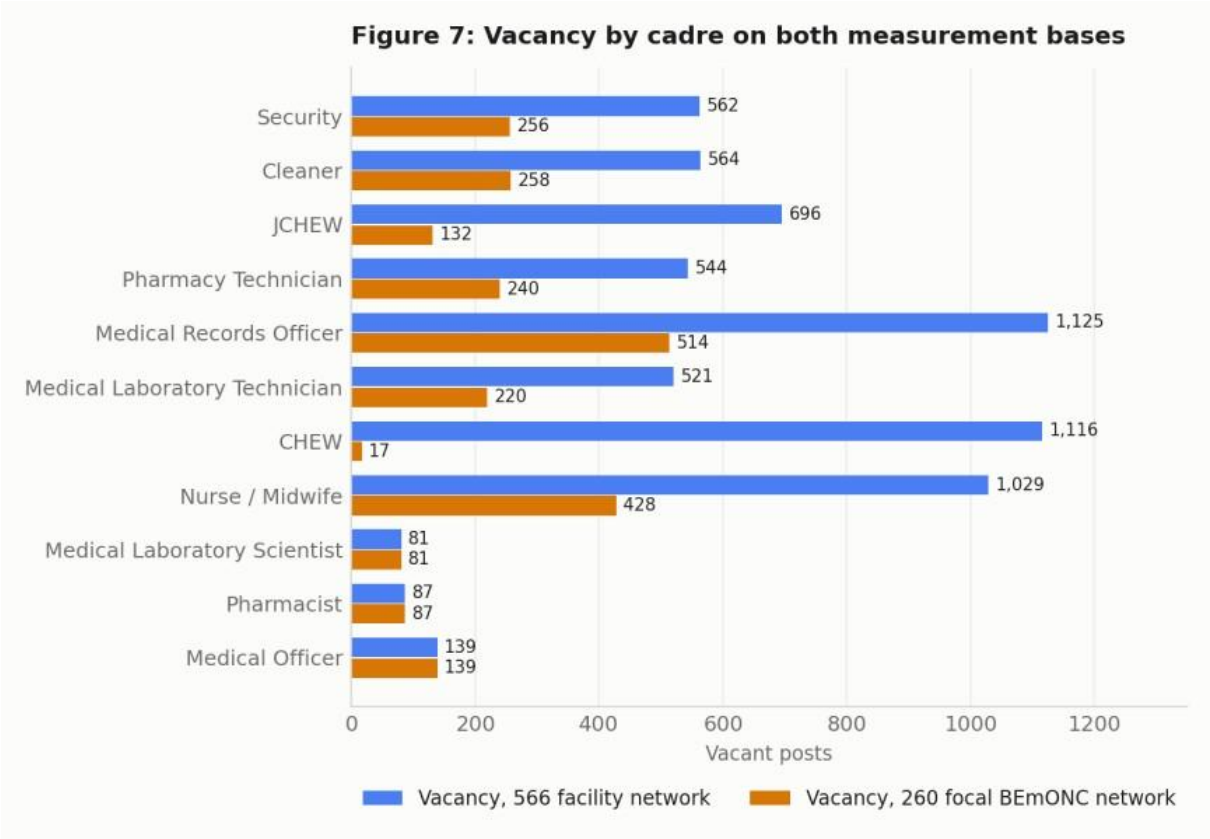


Figure 7: Vacancy by cadre on both measurement bases.

5. THE 260 FOCAL BEmONC NETWORK

This chapter applies the governing norm to the 260 focal Level 2 facilities, which are the facilities designated to provide Basic Emergency Obstetric and Newborn Care, one in each ward of the State. It is carried at the same level of detail as Chapter 4 and is not subordinate to it. The two bases answer different questions and the State reports both: the 566 facility network is the basis on which performance against national thresholds is measured, and the 260 focal BEmONC network is the basis on which service readiness and deployment priority are determined. Section 4.4 sets the two side by side with the variance between them.

5.1 Ward attribution method

Staff in post are recorded against the State establishment, not against the focal network specifically. Attributing them to the focal network requires a stated method, because assuming that the whole establishment is available to 260 facilities would imply the complete withdrawal of staff from the remaining 306 and would not be credible.

The method used is ward attribution, and it rests on a structural fact: each of the 260 wards contains exactly one focal facility. Nominal roll records were matched to a focal ward first by duty post name against the focal facility name, and then by ward name where the first match failed. Of 2,093 records, 1,838 were attributed to a focal ward. Among clinical cadres the attribution rate is 89.1 per cent, and this factor is applied to published facility-level cadre availability. Posts established at Local Government level are not facility-attributed and count in full against both bases.

A more conservative figure is reported alongside it. 61.1 per cent of clinical records carry a duty post that names the focal facility itself. This is the confirmed floor. The 89.1 per cent ward attribution is the working basis, and Annex 3 states the full method so that either may be independently reproduced.

5.2 Establishment and vacancy at the focal network

Applying fourteen posts to each of the 260 focal facilities gives a facility-level requirement of 3,640 posts. Adding the 350 posts established at Local Government level gives a total requirement of 3,990. Ward-attributed staff in post number 1,618, and the vacancy is 2,372 posts.

Table 8: Established requirement and vacancy by cadre, 260 focal BEmONC facilities

Cadre	Basis	Per facility	Requirement	In post	Vacancy	Filled
Medical Officer	LGA	n/a	170	31	139	18.2%
Pharmacist	LGA	n/a	90	3	87	3.3%
Medical Laboratory Scientist	LGA	n/a	90	9	81	10.0%
Nurse / Midwife	Facility	2	520	92	428	17.7%
CHEW	Facility	4	1,040	1,023	17	98.4%
Medical Laboratory Technician	Facility	1	260	40	220	15.4%

Cadre	Basis	Per facility	Requirement	In post	Vacancy	Filled
Medical Records Officer	Facility	2	520	6	514	1.2%
Pharmacy Technician	Facility	1	260	20	240	7.7%
JCHEW	Facility	2	520	388	132	74.6%
Cleaner	Facility	1	260	2	258	0.8%
Security	Facility	1	260	4	256	1.5%
TOTAL			**3,990**	**1,618**	**2,372**	**40.6%**

Source: Baseline mapping analysis. Facility-level cadres carry ward-attributed staffing; Local Government level cadres count in full.

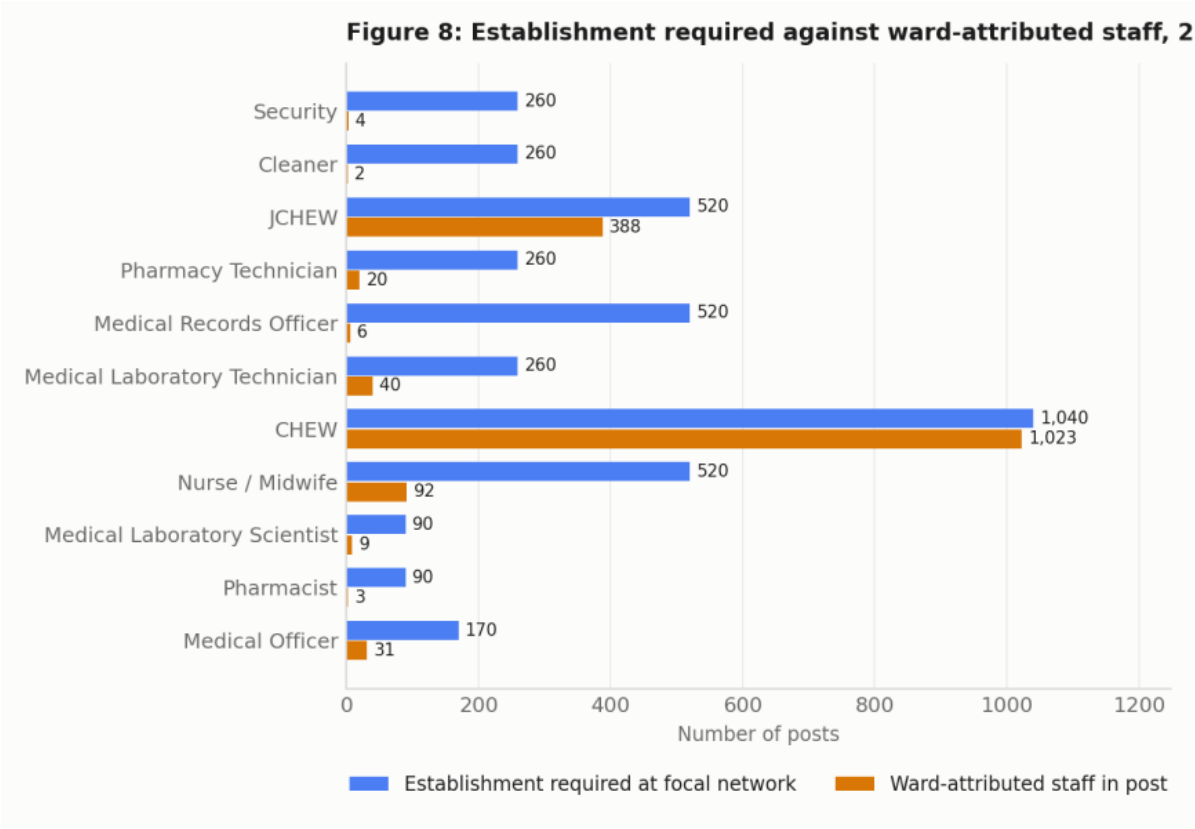


Figure 8: Establishment required against ward-attributed staff, 260 focal PHCs.

5.3 Distribution of staffing across the 260 wards

The aggregate focal position conceals the finding that matters most for service delivery, which becomes visible only at ward level.

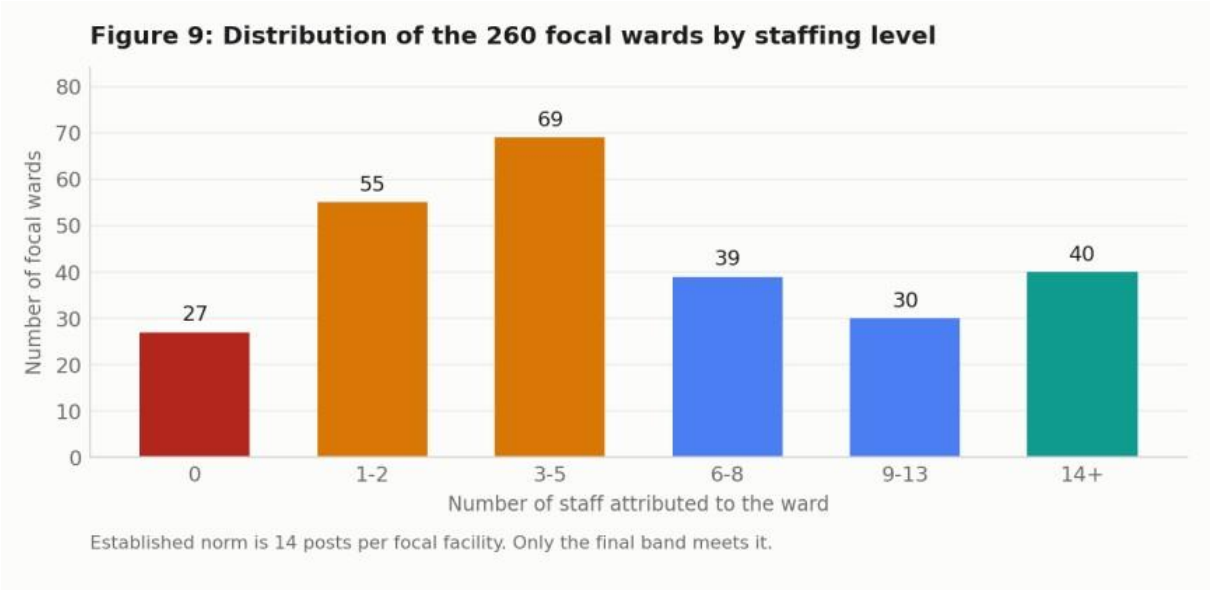


Figure 9: Distribution of the 260 focal wards by staffing level. Source: ward attribution, ENSPHCDA Nominal Roll 2025.

Table 9: Focal wards by staffing band

Staff attributed to the ward	Number of focal wards	Share of focal wards	Cumulative share
None	27	10.4%	10.4%
1-2	55	21.2%	31.5%
3-5	69	26.5%	58.1%
6-8	39	15.0%	73.1%
9-13	30	11.5%	84.6%
14+	40	15.4%	100.0%
TOTAL	**260**	**100.0%**	

Source: ward attribution analysis. The established norm is 14 facility-level posts per focal facility.

Three findings follow, and each is a service delivery statement rather than an establishment statement. 27 focal wards, being 10.4 per cent of the network, have no staff attributable to them on the available records. A further 55 wards hold one or two staff. Only 40 wards, being 15.4 per cent, meet the fourteen-post norm, and the median focal ward holds 5 staff against that norm.

The 27 wards showing no attributable staff require immediate verification rather than immediate conclusion. Some proportion will reflect deployment recorded against a duty post that could not be matched, and the Agency will reconcile each case against the Local Government Health Authority Secretary's return before the first deployment cycle. Where the finding is confirmed, those wards take first

priority in Phase 2 posting under the framework at Chapter 8. Either outcome is actionable, which is the reason for reporting the finding rather than suppressing it.

5.4 Position by Local Government Area

Ward attribution aggregated to Local Government level shows a distribution that does not follow need.

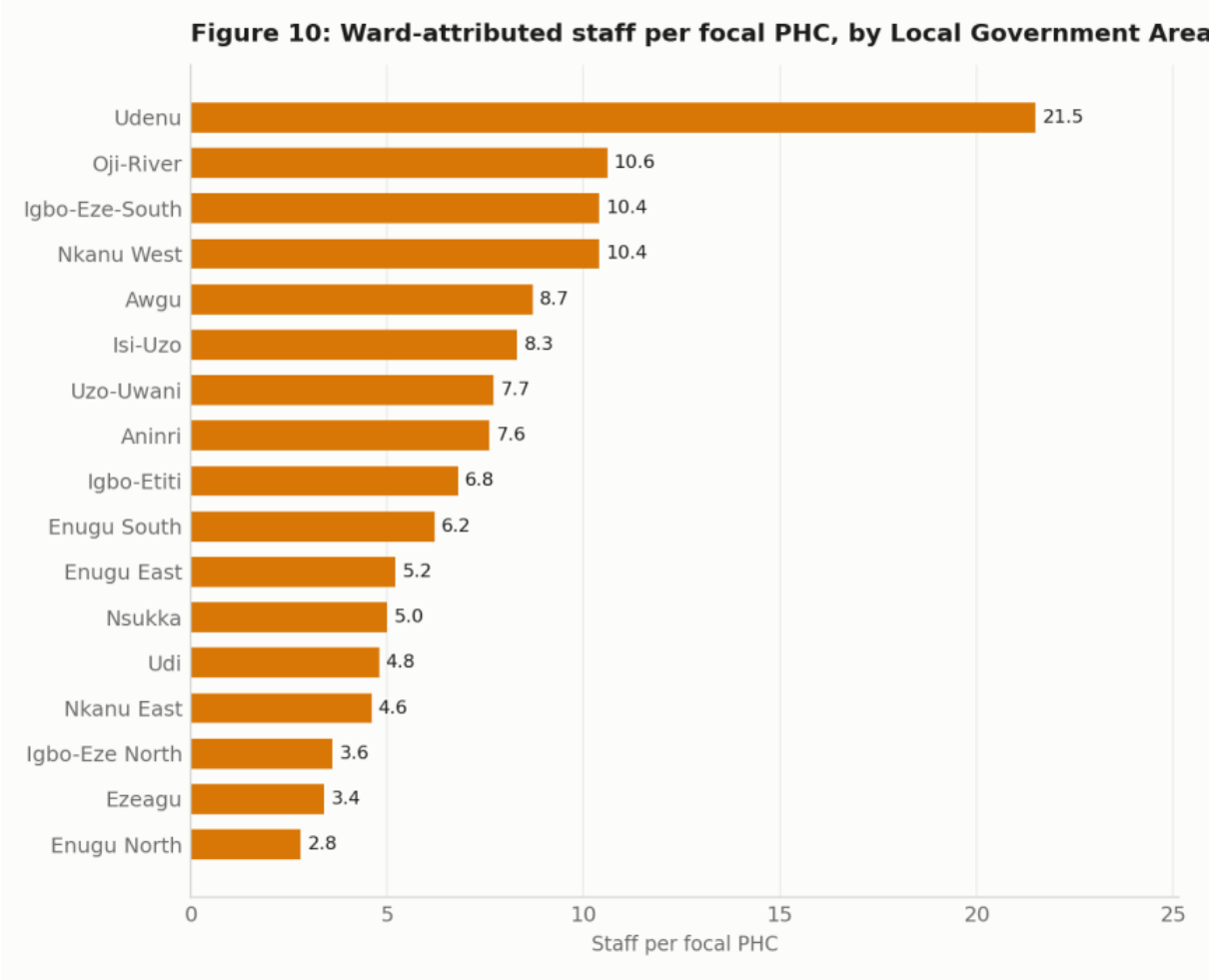


Figure 10: Ward-attributed staff per focal PHC, by Local Government Area.

Table 10: Focal BEmONC network position by Local Government Area

Local Government Area	PHC facilities	Focal PHCs	Ward-attributed staff	Staff per focal PHC	Requirement	Vacancy
Udenu	37	10	215	21.5	140	0
Oji-River	39	20	211	10.6	280	69
Igbo-Eze-South	27	16	166	10.4	224	58
Nkanu West	28	14	145	10.4	196	51
Awgu	33	11	96	8.7	154	58
Isi-Uzo	40	11	91	8.3	154	63
Uzo-Uwani	31	16	123	7.7	224	101

Local Government Area	PHC facilities	Focal PHCs	Ward-attributed staff	Staff per focal PHC	Requirement	Vacancy
Aninri	22	10	76	7.6	140	64
Igbo-Etiti	47	20	135	6.8	280	145
Enugu South	22	13	81	6.2	182	101
Enugu East	26	12	62	5.2	168	106
Nsukka	46	20	100	5.0	280	180
Udi	35	20	97	4.8	280	183
Nkanu East	33	14	65	4.6	196	131
Igbo-Eze North	38	20	71	3.6	280	209
Ezeagu	46	20	69	3.4	280	211
Enugu North	16	13	36	2.8	182	146
STATE TOTAL	**566**	**260**	**1,839**	**7.1**	**3,640**	**1,876**

Source: ward attribution analysis and Enugu State PHC Facility Register. Ordered by staff per focal PHC.

The range is wide and it is not explained by population, facility count or burden of disease. It is explained by the accumulated effect of posting decisions taken over many years without a governing allocation rule. Chapter 8 supplies that rule, and Chapter 11 recommends the redeployment necessary to correct the inherited position at no incremental salary cost.

6. WORKFORCE DYNAMICS

An establishment is not a static quantity. This chapter sets out the three dynamics that will act on the Enugu State primary health care workforce over the planning period: exit through retirement, composition by sex, and the distributional inheritance.

6.1 Projected exits through retirement

Applying the statutory retirement age of 60 to recorded retirement dates on the nominal roll, 663 workers are projected to leave the service between 2026 and 2030. The profile is not smooth. 310 exits fall in 2027 alone, being 46.8 per cent of the five-year total in a single year.

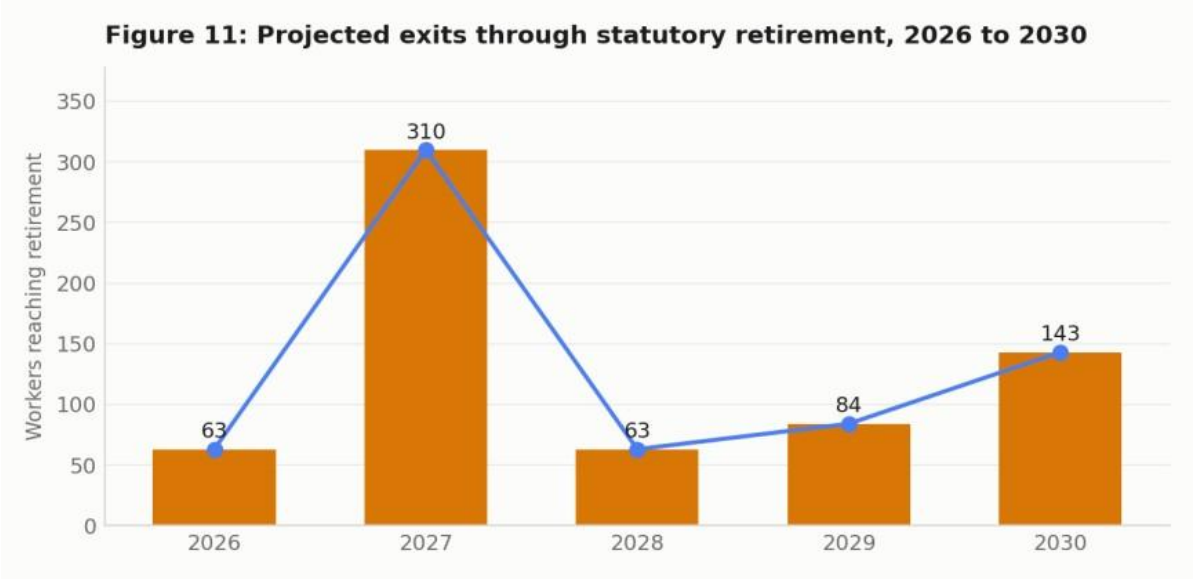


Figure 11: Projected exits through statutory retirement, 2026 to 2030.

Table 11: Projected retirements by year

Year	Projected exits	Cumulative	Share of five-year total
2026	63	63	9.5%
2027	310	373	46.8%
2028	63	436	9.5%
2029	84	520	12.7%
2030	143	663	21.6%
TOTAL	**663**		**100.0%**

Source: ENSPHCDA Nominal Roll 2025, recorded retirement dates. Excludes resignation, transfer of service and death in service.

A further 85 staff on the roll carry retirement dates that have already passed. Their status requires reconciliation with the Office of the Accountant General. To the extent that they have in fact exited, the effective establishment in place is lower than recorded and the vacancy correspondingly wider. This is

stated because a baseline that does not disclose a known uncertainty of this size is not a baseline that can be relied upon.

The planning consequence is direct. Recruitment sized only to the static vacancy would see a material share of its gains absorbed by exits, and disproportionately so in 2027, which is also the year in which Phases 4 and 5 fall. The phasing at Chapter 7 is front-loaded for this reason, and the recommendation at Chapter 11 that the Agency institute rolling rather than episodic recruitment follows from it.

6.2 Composition by sex

The primary health care workforce of Enugu State is 93.7 per cent female, being 1,956 women and 132 men on the nominal roll. This is a materially higher female share than is typical of the health sector nationally, and it follows from the cadre composition described at Chapter 4: community health extension work has long been a predominantly female occupation in south eastern Nigeria.

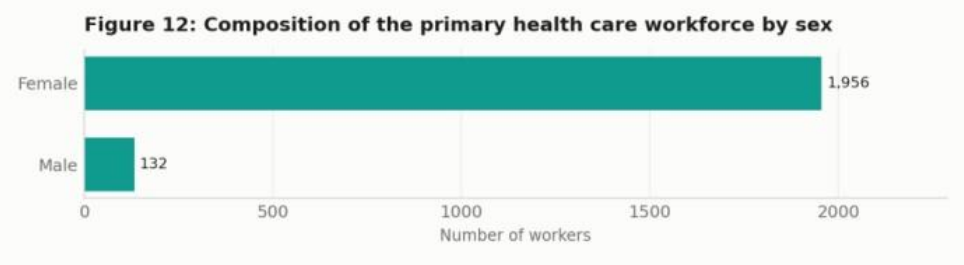


Figure 12: Composition of the primary health care workforce by sex. Source: ENSPHCDA Nominal Roll 2025.

The State assesses this position evenhandedly. Strong female representation in primary care is an asset and is treated as one. The evidence associating the presence of female providers with improved care-seeking for antenatal care, facility delivery and child immunisation is consistent, and Enugu State's position on this measure is a strength to be protected rather than corrected.

At the same time, a workforce drawn overwhelmingly from one part of the population narrows the recruitment pool at precisely the point at which the State needs to expand it substantially, and it concentrates the operational risk that arises where posting decisions interact with household mobility constraints. The State's approach, set out at Chapter 8, is therefore to sustain female participation while widening male entry into the shortage cadres, and to remove the practical obstacles that make rural posting harder for women than for men.

6.3 Distributional inequity

The third dynamic is inherited rather than prospective. As Chapter 5 records, staffing per focal facility varies several-fold between Local Government Areas without reference to population, facility count or need.

Two consequences follow for the plan. First, a share of the apparent shortfall in the least-staffed Local Government Areas can be met by redeployment from the best-staffed at no incremental salary cost, and the State intends to use that headroom before it uses the payroll. Second, and more important, unless the deployment of new appointees is governed by an explicit and enforced allocation rule, a recruitment

programme of 2,250 posts will reproduce the existing imbalance at nearly three times its present scale. That is the specific risk the framework at Chapter 8 is designed to prevent.

7. RECRUITMENT PROGRESS AND FORWARD PLAN

7.1 The approved establishment expansion

His Excellency the Governor approved the recruitment of 2,250 primary health care workers. The Agency conducted an open recruitment through online application, which drew 6,000 applications. Of these, 4,000 candidates sat a computer-based examination, structured as a forty-minute auto-timed assessment with immediate disclosure of scores at the close of the allotted period. Selection proceeded from that examination through certificate verification and structured interview.

The process is recorded here in that detail because the transparency of the selection method is part of what makes the resulting appointments defensible. An establishment expansion of this size, conducted without an open and auditable process, would invite challenge on grounds unrelated to workforce planning.

7.2 Phase 1 outcome

Phase 1 has onboarded 450 appointees across all cadres, being 7 per cent of the state-wide vacancy of 6,464 posts.

Table 12: Phase 1 recruitment outcome by cadre

Cadre	Vacancy at baseline	Recruited	Share of vacancy filled	Vacancy remaining
Medical Officers	139	46	33.1%	93
Pharmacists	87	18	20.7%	69
Medical Laboratory Scientists	81	18	22.2%	63
Nurse / Midwife	1,029	36	3.5%	993
CHEW	1,116	108	9.7%	1,008
Medical Laboratory Technician	521	37	7.1%	484
Medical Records Officer	1,125	40	3.6%	1,085
Pharmacy Technician	544	39	7.2%	505
JCHEW	696	25	3.6%	671
Cleaner	564	40	7.1%	524
Security	562	43	7.7%	519
TOTAL	**6,464**	**450**	**7.0%**	**6,014**

Source: ENSPHCDA HRH Update Report, 31 March 2026.

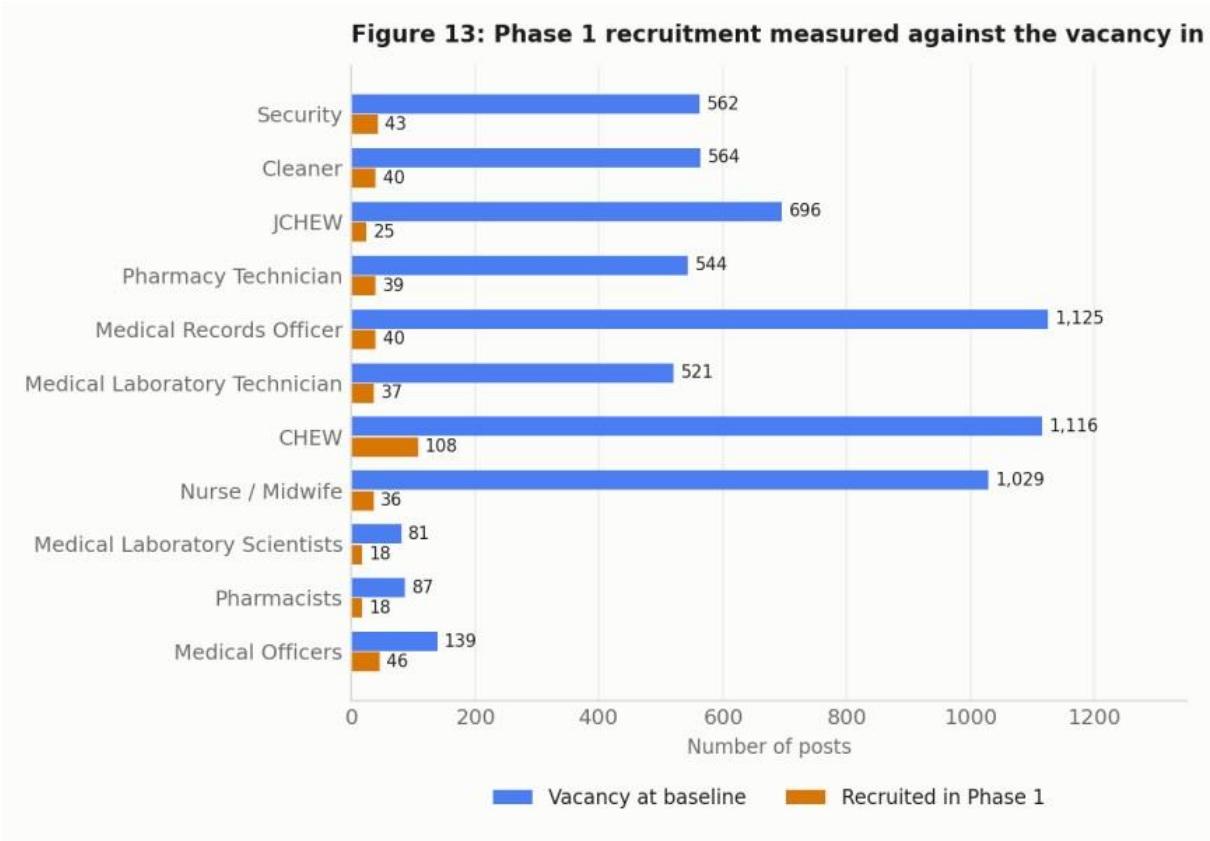


Figure 13: Phase 1 recruitment measured against the vacancy in each cadre.

Phase 1 was distributed across every cadre rather than concentrated, which was appropriate to a first tranche whose purpose was in part to test the recruitment machinery. Two features of the outcome inform the design of the phases that follow. Recruitment into Medical Officers achieved 33.1 per cent of that cadre's vacancy, the highest proportion of any cadre, which reflects both the smaller establishment and the availability of qualified applicants. Recruitment into Nurses and Midwives achieved 3.5 per cent and into Medical Records Officers 3.6 per cent, which are the two cadres where the establishment is closest to absent. Phase 2 onward is weighted accordingly.

7.3 Documentation status of the Phase 1 cohort

Statement on the Phase 1 record

450 appointees were onboarded in Phase 1 and the analysis throughout this report is anchored on that figure, being the number appointed and effected.

Of the 450, 395 are fully documented on the 2026 Staff Recruitment Schedule with name, cadre, grade level and Local Government Area of posting. Documentation for the remaining 55 appointees was still in progress at the date of compilation of this report, and those records have not yet been entered on the schedule.

The 55 are appointees of the same process, selected on the same criteria and onboarded in the same phase. The difference is one of administrative completion and not of appointment status.

The Agency is completing the outstanding documentation and payroll confirmation as a matter of priority, and the completed schedule will be published as an addendum to this report. Section 7.5 sets out why that completion carries consequence beyond record keeping.

7.4 Phasing to 2027

The approved 2,250 posts are being filled in five phases. Phases 2 and 3 add 900 appointees before the close of 2026, and Phases 4 and 5 complete the approved establishment expansion during 2027.

Table 13: Recruitment phasing and cumulative position on both bases

Phase	Period	Appointees	Cumulative	Share of state-wide vacancy	Share of focal network vacancy
Phase 1	Completed	450	450	7.0%	19.0%
Phase 2	Q2-Q3 2026	450	900	13.9%	37.9%
Phase 3	Q4 2026	450	1,350	20.9%	56.9%
Phase 4	Q1-Q2 2027	450	1,800	27.8%	75.9%
Phase 5	Q3-Q4 2027	450	2,250	34.8%	94.9%
TOTAL	**2026 to 2027**	**2,250**	**2,250**	**34.8%**	**94.9%**

Source: ENSPHCDA HRH Update Report, 31 March 2026, and baseline mapping analysis.

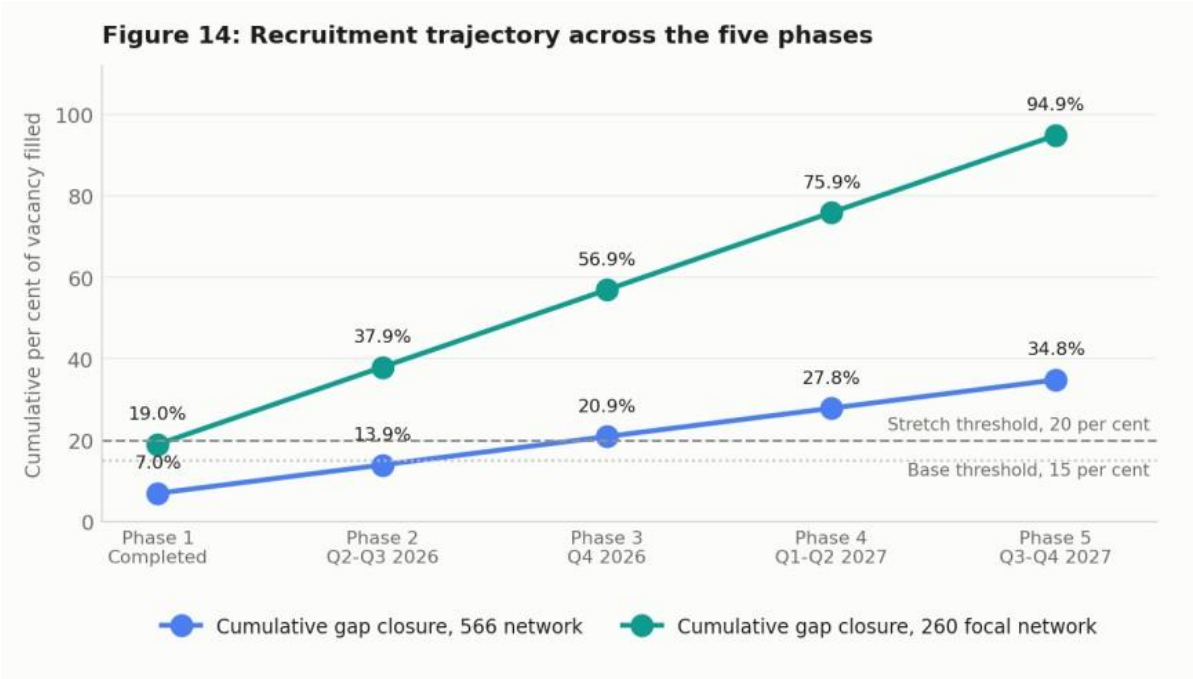


Figure 14: Recruitment trajectory across the five phases, measured against both bases.

Completion of the approved 2,250 posts brings cumulative recruitment to 34.8 per cent of the state-wide vacancy and 94.9 per cent of the focal network vacancy. The residual state-wide vacancy at that point is 4,214 posts, and closing it will require a further establishment approval which the Agency will bring forward within the 2027 budget cycle. This report states that requirement explicitly rather than allowing the approved 2,250 to be read as sufficient.

7.5 Measurement against national thresholds

Performance is assessed against the proportion of the identified staffing vacancy filled, with a base threshold of fifteen per cent and a stretch threshold of twenty per cent. The State's position is set out below, computed against the published state-wide vacancy.

Table 14: Threshold test, carried on both measurement bases

Measure	566 facility basis	260 focal BEmONC basis
Published vacancy	6,464	2,372
Posts required to reach the base threshold of 15 per cent	970	356
Posts required to reach the stretch threshold of 20 per cent	1,293	475
Cumulative appointees at the close of Phase 3	1,350	1,350
Proportion of vacancy filled at the close of Phase 3	20.9%	56.9%
Headroom above the stretch threshold	57 posts	875 posts
Cumulative appointees counting only documented records	1,295	1,295

Measure	566 facility basis	260 focal BEmONC basis
Headroom above the stretch threshold, documented records only	2 posts	820 posts

Source: baseline mapping analysis. The 566 facility basis is the basis on which performance is assessed; the focal basis is reported alongside it for completeness.

Three conclusions follow, and the State draws them plainly. The first is that Enugu State meets the stretch threshold on its own published state-wide figures, without recourse to any narrower measurement base. The focal BEmONC analysis is reported in parallel because service readiness requires it, not because performance depends on it.

The second is that the margin on the governing basis is thinner than the headline suggests. On the full Phase 1 cohort the headroom above the stretch threshold is 57 posts. Counting only appointees presently documented on the recruitment schedule, it is 2. Completion of the outstanding documentation for the 55 Phase 1 appointees, and payroll confirmation of the full cohort, is therefore not an administrative tidiness but a substantive requirement, and it is treated as such in the recommendations at Chapter 11.

The third is that the two bases move at very different speeds, and the difference is the point. The same 1,350 appointees close 20.9 per cent of the state-wide vacancy and 56.9 per cent of the focal BEmONC vacancy. Sequencing deployment to the focal network therefore converts a modest state-wide advance into a substantial gain in the facilities where Basic Emergency Obstetric and Newborn Care is expected to be available. That is the operational argument for the allocation rules at Chapter 8.

7.6 Recruitment strategy

Volume targets do not by themselves produce health workers. The Agency will pursue the following strategies, each matched to a constraint identified in this report.

- Vacancy-led recruitment against named duty stations. Recruitment will be driven from the facility-level vacancy schedule generated by this baseline, with the emptiest wards advertised first. Posts will be advertised against a named duty station, so that a candidate applies to a specific facility and accepts its location at the point of application rather than at the point of posting.
- Weighting toward the cadres of functional absence. Phases 2 to 5 will be weighted toward Nurses and Midwives, Medical Records Officers, Pharmacy Technicians, Medical Laboratory Technicians and JCHEWs. Proportionate recruitment across cadres would preserve the present imbalance at greater scale.
- Rolling rather than episodic recruitment. Episodic mass exercises produce long absorption delays between selection and deployment. Recruitment will move to a rolling cycle sized to what the onboarding and payroll systems can absorb without backlog.
- Investment in the training pipeline. The shortfalls in medical records, pharmacy technology, laboratory technology and midwifery cannot be recruited out of a pool that is not being trained. The Agency will work with the State Schools of Nursing and Midwifery and the School of Health Technology to expand admission aligned to the cadre requirements in this report, and will report intake against those requirements annually.
- Community-tied sponsorship. Candidates from underserved wards will be sponsored through training on condition of return to serve in their communities of origin for a defined period. This addresses rural retention, the mobility constraint that falls disproportionately on married women, and the training pipeline simultaneously, and it is the most durable of the measures listed here.
- Redeployment before recruitment. Where a cadre is in surplus at one facility and vacant at another within reach, the Agency will redeploy in consultation with the staff concerned and their representatives before adding to the payroll.
- Transfer of service and re-engagement. Vacancies will be opened to qualified staff in State secondary facilities seeking voluntary conversion to primary care, and recently retired nurses and midwives will be offered short-term contracts for mentoring and supervision of junior staff, which addresses the 2027 exit peak directly.
- National Youth Service Corps placement. The Agency will maximise Corps placements of medical officers, nurses, midwives and laboratory personnel into primary facilities, supported by investment in secure accommodation in partnership with Local Governments and community associations.
- Digital establishment control. A Human Resource Information System will be deployed to hold the nominal roll to a controlled cadre and grade vocabulary, automate retirement forecasting, and support redeployment and attendance monitoring. The coding limitations acknowledged at section 1.7 are the direct case for this investment.

8. DEPLOYMENT FRAMEWORK

Recruitment determines how many workers the State has. Deployment determines whether they are where they are needed. This chapter sets out the rules that will govern the posting of every appointee under this programme. They are stated as binding rules rather than as principles, because the distributional inheritance described at Chapters 5 and 6 is precisely what discretionary posting produces over time.

8.1 The allocation rules

10. The focal network has first call. Every one of the 260 focal Level 2 facilities is brought to the established norm before any facility in the network is staffed above it.
11. The emptiest wards are staffed first. Wards holding no attributable staff take absolute priority in Phase 2, followed by wards holding one or two. Allocation proceeds up the staffing bands set out at Table 7 and does not skip.
12. Midwifery cover precedes midwifery depth. No focal facility receives a third midwife until every focal facility holds the established complement, because Basic Emergency Obstetric and Newborn Care cannot be delivered from a facility with none.
13. Not less than 75 per cent of each cohort is posted to rural duty stations, reflecting the rural concentration of both the facility estate and the vacancy.
14. Local Government Areas below the State average staffing ratio receive priority allocation until they reach it. Local Government Areas above the State average receive no new allocation in a cadre until the State-wide position in that cadre reaches the established norm.
15. Community health workers are deployed against a named focal Level 2 facility, and the linkage is recorded in the deployment register at the point of posting rather than reconstructed afterwards.
16. Redeployment precedes recruitment. Where a cadre is in surplus at one facility and vacant at another within reasonable reach, the surplus is redeployed in consultation with the staff concerned before a new post is filled.
17. Rural postings are supported. Accommodation, security arrangements and the rural posting allowance are provided at designated rural duty stations, on the principle that a posting the State has not made liveable is a posting it will not fill.

8.2 Gender equality and social inclusion in deployment

The composition described at section 6.2 shapes how these rules are applied. Three measures apply specifically.

- Accommodation provision at rural duty stations is prioritised, because the absence of secure housing bears most heavily on women posted away from their households and is a principal reason rural postings are declined.
- Community-tied sponsorship recruits candidates to serve in their communities of origin, which removes the mobility constraint rather than compensating for it.

- Recruitment communication for the shortage technical cadres is directed at widening the applicant pool, so that the State is not seeking to fill 1,125 medical records posts and 544 pharmacy technician posts from a narrow segment of the available population.

Service-side inclusion measures continue under existing programmes: community mobilisation through Ward Development Committees, engagement with traditional and religious leadership, and targeted outreach for antenatal care, immunisation and facility delivery. The deployment of new appointees to the focal network is what gives those measures something to refer people to.

9. COSTED PLAN AND FISCAL IMPLICATION

This chapter costs the closure of the state-wide vacancy over the period 2026 to 2030. The approved 2,250 posts are filled in 2026 and 2027; the residual is programmed across 2028 to 2030 subject to the further establishment approval identified at section 7.4.

9.1 Basis of the costing

Costs are built across seven heads: personnel cost for the cumulative establishment in place; the recruitment exercise; onboarding and pre-deployment training; work tools and equipment for new posts; rural posting allowances; programme overheads; and contingency. Personnel cost is cumulative, so each year carries the full-year cost of every appointee recruited in that year and in all preceding years. A weighted average annual personnel cost of N1,431,498 is applied, derived from the grade level bands at Annex 4 weighted by the cadre composition of the vacancy. Costs are inflated at 15 per cent annually from a 2026 base.

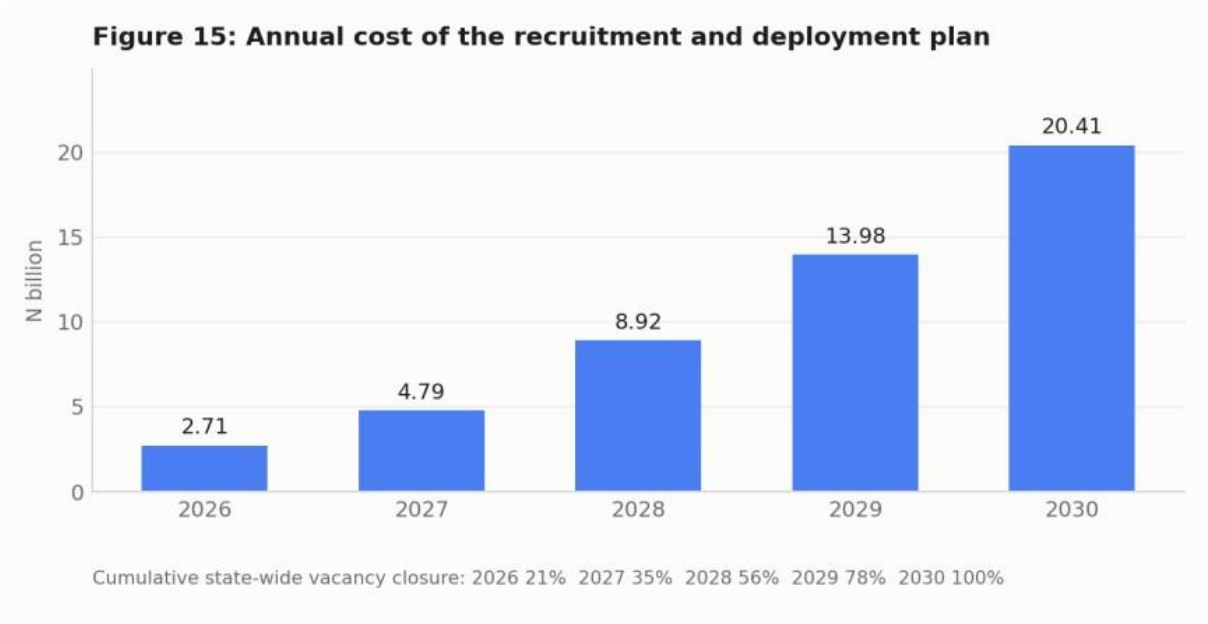
All unit assumptions are set out in full at Annex 4 and are presented for substitution with confirmed figures from the State Ministry of Finance and the Office of the Accountant General. Substituting them changes the cost totals in this chapter and no other figure in this report.

9.2 The costed plan

Table 15: Multi-year costed recruitment and deployment plan, N million

Cost head	2026	2027	2028	2029	2030
Appointees recruited in year	1,350	900	1,400	1,400	1,414
Cumulative establishment in place	1,350	2,250	3,650	5,050	6,464
Recruitment exercise	33.75	25.87	46.29	53.23	61.83
Onboarding and pre-deployment training	101.25	77.63	138.86	159.69	185.48
Work tools, equipment and capital	202.50	155.25	277.72	319.38	370.96
Personnel cost	1,932.52	3,704.00	6,910.02	10,994.50	16,183.90
Rural posting allowances	121.50	232.87	434.44	691.24	1,017.50
Programme overheads	193.25	370.40	691.00	1,099.45	1,618.39
Contingency at 5 per cent	129.24	228.30	424.92	665.87	971.90
TOTAL, N million	**2,714.01**	**4,794.33**	**8,923.25**	**13,983.37**	**20,409.97**

Source: baseline mapping analysis and financial estimation. Five-year total N50.82 billion. Unit assumptions at Annex 4.



9.3 Fiscal implication

The cost profile rises across the period because personnel cost accumulates. The 2026 requirement of N2,714.01 million rises to N20,409.97 million in 2030, giving a five-year total of N50.82 billion. Of that total, personnel cost accounts for the substantial majority and is a recurrent obligation rather than a programme expense.

The State draws the consequence explicitly. The personnel cost of this programme must be carried as a standing charge on the State and Local Government payrolls and reflected in each successive annual budget. A recruitment financed as a project is a recruitment that ends when the project ends. The Ministry of Health will accordingly present the personnel implication of each phase to the State Executive Council in advance of the phase, and the Agency will not proceed to a phase whose payroll provision has not been secured.

10. GOVERNANCE, MONITORING AND VERIFICATION

10.1 Institutional arrangements

Responsibility for the primary health care workforce is shared. The State Ministry of Health sets policy and establishes posts. The Enugu State Primary Health Care Development Agency manages deployment, supervision and performance. The Enugu State Civil Service Commission conducts recruitment and confirms appointments. Local Government Health Authority Secretaries host facilities, manage local deployment and administer a share of the payroll through the Local Government Sub-Treasurers.

The division is workable but has historically produced two recurring failures: recruitment decided without reference to facility-level vacancy data, and posting decided without a governing allocation rule. This report supplies the first. Chapter 8 supplies the second. The Primary Health Care Under One Roof framework, whose full implementation the State has committed to, consolidates the governance under a single authority and is the durable remedy.

10.2 What will be monitored

The Agency will report annually against the following measures. Each is traceable to a State administrative record capable of independent verification, and each is reproducible from the companion workbook.

- Appointees recruited and deployed in the year, by cadre, verified against payroll records held by the Office of the Accountant General and the Local Government Sub-Treasurers.
- Cumulative proportion of the published state-wide vacancy filled, reported against the trajectory at Table 13.
- Number of the 260 focal facilities meeting the established fourteen-post norm, and the number holding the established midwifery complement.
- Number of focal wards holding no attributable staff, reported against the baseline figure of 27 established at Table 9.
- Community health workers deployed and linked to a named focal Level 2 facility, from the deployment register.
- Proportion of each cohort deployed to rural duty stations, against the 75 per cent floor.
- Staffing ratio by Local Government Area, reported against the State average to demonstrate convergence.
- Exits in the year against the projections at Table 9, and reconciliation of the 85 records carrying expired retirement dates.

10.3 Publication and verification

This report, on approval by the State Executive Council and signature by the Honourable Commissioner for Health, will be published on the website of the Enugu State Ministry of Health and will remain publicly available for the duration of the programme. The companion recalculation workbook will be published

alongside it, so that any figure in this report can be traced to the ward, facility and cadre from which it derives.

The Agency will make available for inspection the six source records listed at Table 2, the deployment register, and the payroll confirmations for each phase. Annex 5 maps each verification requirement to its location in this report and to the State record against which it can be checked.

11. RECOMMENDATIONS

The following recommendations arise directly from the findings of this exercise. Each identifies the body responsible and the finding from which it follows.

11.1 Immediate, before the close of the 2026 cycle

1. Complete the Phase 1 documentation and payroll confirmation. The Agency should complete documentation for the 55 Phase 1 appointees not yet carried on the recruitment schedule, and secure payroll confirmation for the full cohort of 450, publishing the completed schedule as an addendum to this report. Section 7.5 establishes that the headroom above the twenty per cent threshold on the governing basis is 57 posts on the full cohort and 2 posts on documented records alone. Responsible: ENSPHCDA with the Office of the Accountant General.
2. Verify the 27 focal wards recording no attributable staff. Each case should be reconciled against the return of the Local Government Health Authority Secretary before the Phase 2 posting cycle, and confirmed cases given absolute priority in that cycle. Responsible: ENSPHCDA with the Local Government Health Authority Secretaries.
3. Reconcile the 85 records carrying expired retirement dates. The effective establishment in place, and therefore the true vacancy, depends on the outcome. Responsible: ENSPHCDA with the Office of the Accountant General.
4. Approve and publish this report and its companion workbook. Approval by the State Executive Council, signature by the Honourable Commissioner for Health, and publication on the website of the Ministry of Health. Responsible: State Ministry of Health.

11.2 Within the 2026 and 2027 cycles

5. Weight Phases 2 to 5 toward the cadres of functional absence. Nurses and Midwives, Medical Records Officers, Pharmacy Technicians and Medical Laboratory Technicians are filled at between 0.6 and 9.1 per cent of establishment. Proportionate recruitment would preserve that imbalance at greater scale. Responsible: ENSPHCDA with the Civil Service Commission.
6. Apply the deployment framework at Chapter 8 as a binding rule. Posting should be governed by the allocation rules and reported against them, not left to discretion. Responsible: ENSPHCDA.
7. Execute redeployment of surplus cadres to under-staffed wards. This corrects a several-fold inherited inequity at no incremental salary cost and should be completed within the 2026 and 2027 cycles, in consultation with the staff concerned and their representatives. Responsible: ENSPHCDA with the Local Government Health Authority Secretaries.
8. Secure payroll provision in advance of each phase. The personnel cost should be carried as a standing charge on the State and Local Government payrolls, and no phase should proceed whose payroll provision has not been secured. Responsible: State Ministry of Health with the Ministry of Finance.

9. Bring forward the further establishment approval. The approved 2,250 posts close 34.8 per cent of the published vacancy. Approval for the residual should be sought within the 2027 budget cycle. Responsible: State Ministry of Health.

11.3 Structural, over the planning period

10. Deploy a Human Resource Information System. The nominal roll should be held to a controlled cadre and grade vocabulary, with automated retirement forecasting, attendance monitoring and redeployment support. Approximately 5 per cent of records in the present roll could not be coded to a cadre with confidence, and that is the case for this investment. Responsible: ENSPHCDA.
11. Expand the training pipeline in the shortage cadres. Admission into the State Schools of Nursing and Midwifery and the School of Health Technology should be aligned to the cadre requirements in this report, supported by community-tied sponsorship for candidates from underserved wards. A vacancy of 1,125 medical records posts cannot be recruited from a pipeline that is not producing them. Responsible: State Ministry of Health with the training institutions.
12. Programme rural accommodation and security alongside recruitment. A posting the State has not made liveable will not be filled at any realistic salary. Responsible: State Ministry of Health with Local Governments.
13. Complete implementation of Primary Health Care Under One Roof. Consolidating governance, financing and human resource management under a single authority is the durable remedy for the coordination failures described at Chapter 10. Responsible: State Ministry of Health.
14. Move toward the national minimum standard. The State's present norm of fourteen posts per facility is an interim position. The distance to the NPHCDA standard of eighteen core posts is 1,914 posts, and the State should set a date by which it intends to adopt the national standard in full. Responsible: State Ministry of Health.

12. CONCLUSION

This exercise establishes, on a verified and traceable basis, the position of the Enugu State primary health care workforce. Against an established requirement of 8,274 posts across 566 facilities, 1,810 are filled and 6,464 are vacant. In several cadres the establishment is not thin but functionally absent: seven medical records officers, twenty-two pharmacy technicians and one hundred and three nurses and midwives for a State of five and a half million people. At ward level, 27 of the 260 focal facilities have no staff attributable to them and only 40 meet the established norm.

The State has reported these figures rather than a more comfortable aggregate, and has reconciled openly the three staffing norms that have circulated in its own planning documents. That reconciliation is offered as evidence of method. A State that cannot explain the movement between its own published figures cannot expect its next figure to be believed.

Enugu State has also acted. An open and auditable recruitment drew six thousand applications and examined four thousand candidates. 450 appointees have been onboarded, 900 more will be onboarded before the close of 2026, and the approved establishment expansion of 2,250 posts completes in 2027.

The State reports its progress on both measurement bases, because each carries a different consequence. At the close of Phase 3 the State will have filled 20.9 per cent of the published state-wide vacancy, which exceeds the twenty per cent stretch threshold on the State's own published figures and without recourse to any narrower measure. The same 1,350 appointees close 56.9 per cent of the vacancy at the 260 focal facilities designated to provide Basic Emergency Obstetric and Newborn Care. Completion of the approved 2,250 posts reaches 34.8 per cent state-wide and 94.9 per cent at the focal network. Neither figure is offered in place of the other. The first states what the State owes; the second states what its wards will feel.

The margin, however, is 57 posts, and 2 posts counting only appointees presently documented. This report does not present that as a technicality. It presents it as the reason the outstanding documentation and payroll confirmation are the first recommendation in Chapter 11 rather than the last.

What remains is delivery, and delivery depends on three things within the State's control. The personnel cost must be carried on payroll and budgeted annually rather than financed as a project. Deployment must follow the allocation rules at Chapter 8 rather than the pull of precedent. And progress must be published against figures that can be independently checked, which is the purpose of the companion workbook accompanying this report.

The measure of success is not the plan. It is whether a woman in labour in a rural ward of Ezeagu or Nkanu East finds a midwife when she reaches her ward facility. That is the standard this report sets, and it is the standard against which Enugu State asks to be assessed.

ANNEXES

Annex 1: Baseline mapping team

S/N	Role	Institutional position
1	Chairman	Permanent Secretary, Enugu State Ministry of Health
2	Co-Chairman	Executive Secretary and Chief Executive Officer, ENSPHCDA
3	Secretary	Director, Planning, Research and Statistics, Ministry of Health
4	Assistant Secretary	Director, Planning, Research and Statistics, ENSPHCDA
5	Member	Director of Human Resources, ENSPHCDA
6	Member	Local Government Health Authority Secretaries, one per senatorial zone
7	Member	Human Resources for Health Focal Person, ENSPHCDA
8	Member	Human Resources for Health Focal Person, Ministry of Health
9	Member	Director of Finance and Accounts, ENSPHCDA
10	Member	Representative, Enugu State Civil Service Commission
11	Member	Representative, Medical and Health Workers Union of Nigeria, Enugu State Council

Names and signatures to be inserted on approval.

Annex 2: Data collection instrument

The following fields were compiled for each member of the primary health care establishment. The instrument is reproduced so that the basis of the data is transparent and so that subsequent rounds may be collected identically.

Field	Description
Local Government Area	Local Government Area of posting
Ward	Ward of the duty station
Name of worker	Full name as carried on payroll
Sex	Male or female
Date of birth	Basis for derivation of statutory retirement date
Qualification and year	Highest professional qualification and year obtained
Date of first appointment	Entry into service
Date of last promotion	Effective date of current grade
Present rank and grade level	Cadre and grade level
Duty post	Named facility of deployment
Facility service level	Level 1, Level 2 or Type 3, and focal network designation
Type of appointment	Permanent, contract or volunteer
Date of retirement	Statutory retirement date

Field	Description
Staff identification number	Payroll identifier
Payroll status	Confirmed on State or Local Government payroll

Annex 3: Ward attribution method

This annex states the method used at Chapter 5 to attribute staff in post to the 260 focal Level 2 facilities, so that the result may be independently reproduced.

Basis

Each of the 260 wards contains exactly one designated focal facility, confirmed against the Basic Health Care Provision Fund facility schedule. Staff recorded as serving in a ward are therefore serving in the catchment of that ward's focal facility, whether or not they are posted to the focal facility itself.

Procedure

18. Each nominal roll record was normalised on Local Government Area, ward and duty post fields, with punctuation and generic facility descriptors removed.
19. Each record was matched to a focal ward within its Local Government Area, in the following order of precedence: duty post name against focal facility name; duty post name against focal ward name; ward field exact match against focal ward name; ward field partial match against focal ward name.
20. Records matching at the first level of precedence are recorded as confirmed at the focal facility. Records matching at any level are recorded as attributable to the focal ward.
21. The resulting attribution rate for clinical cadres was applied to published facility-level cadre availability to derive staff in post at the focal network. Posts established at Local Government level were not facility-attributed and count in full.

Table A3.1: Outcome of the attribution

Measure	Records	Rate
Nominal roll records processed	2,093	
Records attributable to a focal ward	1,838	87.8%
Records confirmed at the focal facility by duty post name	1,228	58.7%
Records not attributable to a focal ward	255	12.2%
Clinical cadre attribution rate, applied in Chapter 5		89.1%
Clinical cadre confirmed-at-facility rate, reported as the floor		61.1%

Source: baseline mapping analysis. Full record-level output is held in the companion recalculation workbook at sheet 6.

The working basis adopted in Chapter 5 is the ward attribution rate. The confirmed-at-facility rate is reported alongside it as the conservative floor, and the difference between the two, being records serving in the ward but at a facility other than the focal one, is the redeployment resource identified at Chapter 8.

Annex 4: Costing assumptions

The financial model at Chapter 9 rests on the following unit assumptions. They are indicative, derived from grade level salary bands, and are stated in full so that the State Ministry of Finance and the Office of the Accountant General may substitute confirmed figures. Substituting them changes the cost totals at Chapter 9 and no other figure in this report.

Table A4.1: Indicative annual personnel cost by cadre

Cadre	Indicative grade level	Indicative annual gross, N
Medical Officer	GL 13	4,200,000
Pharmacist	GL 10	2,400,000
Medical Laboratory Scientist	GL 10	2,400,000
Nurse and Midwife	GL 09	1,800,000
CHEW	GL 08	1,440,000
Medical Laboratory Technician	GL 07 to 08	1,320,000
Medical Records Officer	GL 07 to 08	1,320,000
Pharmacy Technician	GL 07 to 08	1,320,000
JCHEW	GL 07	1,200,000
Cleaner	GL 02 to 04	960,000
Security	GL 02 to 04	960,000
Weighted average across the vacancy profile		**N1,431,498**

Table A4.2: Other unit assumptions

Assumption	Value	Basis
Recruitment exercise	N25,000 per candidate processed	Advertising, computer-based testing, screening, interview and certificate verification
Onboarding and pre-deployment training	N75,000 per appointee	Orientation, induction and pre-deployment training
Work tools, equipment and capital	N150,000 per appointee	One-off provision of workspace share, furniture and basic equipment
Rural posting allowance	N120,000 per annum	Payable at designated rural duty stations against verified attendance
Proportion of establishment rural-posted	75 per cent	The deployment floor set at Chapter 8
Programme overheads	10 per cent of personnel cost	Supervision, in-service training, instructional materials and stationery
Contingency	5 per cent of subtotal	Standard provision
Annual inflation	15 per cent from a 2026 base	Indicative, to be reset annually against outturn

Annex 5: Verification crosswalk

This annex maps each element of the verification protocol to its location in this report and to the State record against which it may be independently checked.

Verification requirement	Location in this report	State record for verification
Baseline mapping approved by the State Executive Council	To be attached on approval	Executive Council conclusion and approval memorandum
Report signed by the Commissioner responsible for health	Foreword	Signed original held at the Ministry of Health
Report published on the Ministry of Health or State Government website	Section 10.3	Published address and date of publication
Multi-year costed recruitment and deployment plan	Chapter 9, Table 15	Financial model and Annex 4 assumptions
All elements of the definition and description included	Chapters 1 to 9 and Annexes 1 to 4	This report and the companion workbook
Alignment with the State Health Annual Operational Plan	Chapter 9 and Chapter 10	Enugu State Health Annual Operational Plan 2026
Annual report of actions taken on filling staffing gaps	Section 10.2	Annual progress report, to be published
Staffing of Level 2 facilities providing BEmONC, base target 15 per cent	Table 14; achieved during Phase 2	Payroll records, Accountant General and Sub-Treasurers
Staffing of Level 2 facilities providing BEmONC, stretch target 20 per cent	Table 14; 20.9 per cent state-wide, 56.9 per cent at the focal network	Payroll records, Accountant General and Sub-Treasurers
Community health workers linked to Level 2 facilities and deployed, 20 per cent	Chapter 8, rule 6	Deployment register with named focal facility linkage
Workers recruited or redeployed linked to Level 2 facilities	Chapter 8, rules 1 and 6	Deployment register and facility posting schedule
Traceability of every reported figure	Annex 6	Companion recalculation workbook, 12 sheets

Annex 6: Contents of the recalculation workbook

The companion workbook accompanying this report contains the full record underlying every figure stated here. It is published alongside this report.

Sheet	Contents
1. Read me	Purpose, governing sources, the two measurement bases, ward attribution method and limitations
2. Norm reconciliation	The three staffing norms, their calculation and the norm adopted
3. Gap statewide 566	Established requirement, staff in post and vacancy by cadre across the 566 facility network
4. Gap focal 260	The same, applied to the 260 focal BEmONC facilities on the ward attribution basis
5. Clinical and support	The establishment separated into clinical and technical posts and support posts
6. Ward register 260	All 260 focal wards with designated facility, cadre spread, attributed staff, requirement and vacancy
7. PHC register 566	All 566 facilities with Local Government Area, ward, service level and focal designation
8. LGA summary	Facilities, focal facilities, workforce, staffing ratios, requirement and vacancy by Local Government Area
9. Cadre spread by LGA	Distribution of every cadre across the 17 Local Government Areas
10. Phase 1 recruitment	Phase 1 outcome by cadre with proportion of vacancy filled and vacancy remaining
11. Phasing and thresholds	The five-phase schedule and the threshold test, with editable threshold inputs
12. Retirement projection	Projected exits by Local Government Area and year, 2026 to 2030

All computed cells in the workbook are live formulas. Changing an input recalculates the dependent figures.

End of report.