Trained but Unemployed: Rethinking Nursing Education, Labour Markets, and Health Workforce Planning in Sub-Saharan Africa

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Abstract: Sub-Saharan Africa (SSA) continues to experience critical shortages and maldistribution of health workers, yet many newly qualified nurses and midwives remain unemployed or underemployed after training. This narrative review (1978–2025) synthesises policy and empirical literature to explain why nurse unemployment persists alongside unmet health service needs. Anchored in health labour market theory, human capital theory, and systems governance perspectives, the review traces the normative policy foundations from Alma-Ata (1978) through later health workforce frameworks, and examines how fiscal constraints, wage-bill ceilings, weak workforce planning, fragmented governance, rapid expansion of nursing education, and precarious private-sector employment contribute to limited absorption of graduates. The review also highlights consequences for practice and health systems, including skills attrition, psychological distress, erosion of professional identity, informal or unpaid 'volunteer' work, and intensified migration intentions, which can further weaken service delivery capacity. The paper argues that the nurse unemployment paradox is primarily a failure of effective demand and coordination rather than a simple surplus of trained personnel, and that solutions require integrated planning linking education intakes, accredited training quality, health financing, and funded posts. Policy options relevant to SSA include institutionalising routine health labour market analysis, aligning education enrolment with medium-term expenditure frameworks, strengthening transition-to-practice pathways, improving regulation of training markets, and using ethical regional and international mobility agreements to reduce waste while protecting health system resilience.

Keywords: Nurse unemployment; Nursing education; Health labour market; Workforce planning; Sub-Saharan Africa; Primary health care

1. Introduction

Sub-Saharan Africa (SSA) faces a persistent and troubling paradox: large numbers of trained nurses remain unemployed or underemployed, even as health systems continue to report critical staffing shortages (Boniol et al., 2022; World Health Organisation (WHO), 2006). Nurses and midwives constitute the backbone of primary health care delivery across the region, yet newly qualified graduates frequently experience prolonged joblessness after completing training (Dovlo, 2005; McQuide et al.,

2013). This contradiction raises urgent questions about how health workforce needs are defined, planned for, and translated into employment within SSA health systems.

Global health policy has long recognised the centrality of nurses to equitable and effective service delivery. Beginning with the Declaration of Alma-Ata (1978), governments committed to ensuring adequate numbers of appropriately trained health personnel to achieve primary health care and population-level health equity (WHO, 1978). Subsequent policy frameworks including the World Health Report on the Global Health Workforce Crisis (WHO, 2006), the Kampala Declaration and Agenda for Global Action (World Health Organisation (WHO), 2008) and the WHO Global Strategy on Human Resources for Health: Workforce 2030 (World Health Organisation (WHO), 2016) have repeatedly reaffirmed the need to strengthen nursing workforces, particularly in low- and middle-income settings. Despite these commitments, employment outcomes for nurses in SSA have not kept pace with the expansion of nursing education and training capacity (WHO, 2020).

The persistence of nurse unemployment challenges assumptions embedded in human capital theory, which posits that investment in education should translate into productive employment and economic returns (Becker, 1993). At the same time, it highlights the relevance of health labour market theory, which distinguishes between population health needs and effective demand for health workers, that is, the availability of funded posts within health systems (WHO, 2016; Kuhlmann et al., 2025). From a systems and governance perspective, nurse unemployment reflects weak coordination between education policy, health financing, labour market regulation, and workforce planning institutions (Campbell et al., 2022; Kizito et al., 2017). These conceptual lenses suggest that unemployment is not simply the result of surplus training, but rather a failure to align education outputs with employment capacity.

Existing research has extensively documented health worker shortages, maldistribution, and international migration from SSA (Kingma, 2018; Lokotola et al., 2024; Walton-Roberts et al., 2017). However, less attention has been paid to the coexistence of nurse unemployment and unmet health service needs, particularly from a policy and education–employment alignment perspective (Correia et al., 2025, 2020; McQuide et al., 2013). When unemployment is discussed, it is often treated as an anomaly or a transitional problem rather than a structurally produced outcome of fiscal constraints, wage-bill ceilings, fragmented workforce planning, and the unregulated expansion of training institutions (Russo et al., 2020; World Bank, 1985). This gap limits understanding of why the nurse workforce paradox persists despite decades of global and regional policy attention.

The aim of this narrative review is, therefore, to critically examine why trained nurses lack employment in Sub-Saharan Africa despite persistent health workforce shortages. Specifically, the review seeks to analyse how health workforce policies since 1978 have defined the need for nurses, synthesise evidence on the main drivers of nurse unemployment, and evaluate the implications for health systems and nursing education in the region.

1.1 Statement of the Problem

Since the Declaration of Alma-Ata, governments and global health actors have committed to ensuring adequate numbers of appropriately trained health workers, particularly nurses and midwives, to deliver primary health care and achieve equitable health outcomes (WHO & UNICEF, 1978). Subsequent global and regional health workforce frameworks have consistently reaffirmed the central role of nurses in health system performance and universal health coverage in Sub-Saharan Africa (SSA) (WHO, 2006; WHO, 2016). Despite these long-standing policy commitments, SSA continues to experience a paradox in which many newly trained nurses remain unemployed or underemployed alongside persistent health service delivery gaps (Boniol et al., 2022; WHO, 2020).

At a broad level, the literature highlights a gap in understanding how health workforce needs articulated in policy translate into actual employment outcomes for nurses. Existing research has largely focused on documenting shortages, maldistribution, and international migration, often treating nurse unemployment as a temporary or anomalous phenomenon rather than a structurally produced outcome of health labour market dynamics (Kingma, 2018; Walton-Roberts et al., 2017). This reflects an area of ignorance regarding the mechanisms through which recognised population health needs fail to generate effective demand for nurses within SSA health systems.

More specifically, evidence suggests that nurse unemployment is driven by constrained fiscal space, wage-bill ceilings, fragmented workforce planning, and weak coordination between education systems, health financing, and labour market regulation (Dovlo, 2005; McQuide et al., 2013; World Bank, 1985; Campbell et al., 2022). In parallel, the rapid expansion of nursing education, particularly through private institutions, has increased graduate output without corresponding growth in funded posts or structured transition-to-practice pathways (McPake et al., 2015; Ozor, 2020; WHO, 2020).

This review, therefore, addresses the specific problem of persistent nurse unemployment in SSA by examining how health workforce policies since Alma-Ata interact with labour market constraints and the expansion of the education system.

1.2 Objectives

The study was guided by the following objectives:

1. To examine how health workforce policies since the Declaration of Alma-Ata have defined the need for nurses in Sub-Saharan Africa.
2. To analyse the key drivers of nurse unemployment in Sub-Saharan Africa, including fiscal constraints, workforce planning, labour market dynamics, and nursing education expansion.
3. To evaluate the implications of nurse unemployment for health systems, nursing education, and professional practice in Sub-Saharan Africa.

2. Literature Review

2.1 Health workforce policies shaping the need for nurses in Sub-Saharan Africa

Extant literature consistently demonstrates that nurse unemployment in SSA reflects health labour market failures rather than the absence of population need (WHO, 2006; WHO, 2016; Boniol et al., 2022). Studies from Uganda, Kenya, Ghana, Nigeria, Malawi, Tanzania, and South Africa document graduate nurse unemployment, informal volunteerism, and underemployment (George, Gow, & Bachoo, 2013; Mansour et al., 2022) (Dovlo, 2005; McQuide et al., 2013; Ojakaa et al., 2014; Kizito et al., 2017; Mansour et al., 2022; Kuhlmann et al., 2025). Fiscal space constraints, wage-bill ceilings, and public-sector hiring freezes repeatedly emerge as binding constraints on recruitment (World Bank, 1985; Russo et al., 2020). The expansion of private nursing education, without parallel job creation or regulation, has further widened the education–employment gap (McPake, Squires, Agya, & Araujo, 2015; Ozor, 2020; WHO, 2020). Unemployment and underemployment are associated with psychological distress, skill erosion, and heightened migration intentions among nurses (Kingma, 2018; Lokotola et al., 2024; Walton-Roberts et al., 2017). Policy analyses emphasise the importance of integrated workforce planning, labour market analysis, and alignment of education enrolment with medium-term expenditure frameworks to reduce workforce waste (Campbell et al., 2022; Correia et al., 2025, 2020; WHO, 2025).

Policy foundations. The Declaration of Alma-Ata (1978) positioned primary health care (PHC) as the pathway to "Health for All" and explicitly emphasised the need for sufficient numbers of appropriately trained health personnel, including nurses and midwives, to support and deliver PHC (WHO & UNICEF, 1978). This foundational policy logic ties nurse workforce needs to equity, community-oriented service delivery, and state responsibility for training and deployment.

From crisis framing to labour market approaches. By the mid-2000s, global policy discourse shifted toward a 'health workforce crisis' framing. The World Health Report 2006 highlighted widespread shortages of health workers, most severe in SSA, and called for coordinated action on education, deployment, and retention. In 2008, the Kampala Declaration and Agenda for Global Action reinforced commitments to address shortages and maldistribution through national and global coordination. More recently, the WHO Global Strategy on Human Resources for Health: Workforce 2030 (adopted in 2016) advanced an explicit health labour market framework, emphasising that shortages and unemployment can coexist when education policies and labour market dynamics are misaligned.

Nursing-specific global agendas. The State of the World's Nursing reports (World Health Organisation (WHO), 2020, 2025) have further highlighted the need to invest not only in education but also in nursing jobs and leadership, implicitly recognising that training without employment yields poor returns. Together, these policy milestones establish a consistent normative position: nurses are essential to PHC and UHC, and governments should plan and finance the workforce needed to ensure service coverage. The persistence of nurse unemployment in SSA, therefore, indicates a gap between policy intent and system capability to absorb trained personnel.

2.2 Drivers of nurse unemployment in Sub-Saharan Africa

Evidence from Sub-Saharan Africa consistently indicates that nurse unemployment is driven by constraints on effective demand rather than the absence of population health needs. Early analyses highlighted how fiscal space constraints, public-sector wage-bill ceilings, and recruitment freezes limited health worker employment even in contexts of severe service shortages (Dovlo, 2005; World Bank, 1985). Subsequent studies reinforced that the expansion of nursing education without corresponding growth in funded posts led to graduate accumulation and delayed entry into employment (McQuide et al., 2013; Russo et al., 2020).

Fragmented workforce governance further compounds this problem. Training intakes, accreditation, and employment authorisation are often managed by separate institutions with limited coordination, weakening the link between education output and labour market absorption (Campbell et al., 2022; Kizito et al., 2017; George et al., 2013). The WHO's health labour market framework explicitly recognises that shortages and unemployment may coexist when workforce planning and financing are misaligned (WHO, 2016).

Rapid expansion of nursing education, particularly through private institutions, has also been identified as a key contributor to unemployment. While increased training capacity has improved access to education, it has often outpaced the capacity for clinical placements and entry-level employment opportunities, resulting in informal or unpaid volunteer arrangements for new graduates (Kuhlmann et al., 2025; WHO, 2020).

Labour market segmentation and migration dynamics further shape employment outcomes. Studies show that limited formal employment opportunities and poor working conditions push nurses toward underemployment or international migration, reinforcing workforce instability within domestic health systems (Kingma, 2018; Lokotola et al., 2024; Walton-Roberts et al., 2017).

2.3 Implications of nurse unemployment for health systems and nursing education in Sub-Saharan Africa

The implications of nurse unemployment in Sub-Saharan Africa extend beyond individual labour market outcomes to affect health system performance, nursing education systems, and professional practice. Existing literature conceptualises nurse unemployment as a form of health workforce waste, in which trained human resources are underutilised despite persistent service delivery needs (WHO, 2006; Campbell et al., 2022). Such workforce waste represents both a loss of service capacity and a diminished return on public and private investment in health professional education.

From a health systems perspective, multiple studies highlight that unemployed or underemployed nurses embody foregone service delivery potential, particularly in primary health care and underserved rural settings (McQuide, Kolehmainen-Aitken, & Forster, 2013; WHO, 2006). While facilities may report staffing shortages and high workloads, centralised recruitment constraints and limited fiscal space prevent the deployment of available nursing labour, thereby weakening system responsiveness and resilience (World Bank, 1985). This disconnect between available skills and funded posts has been identified as a critical vulnerability during health emergencies, where surge capacity depends not only on training but also on employment readiness (Campbell et al., 2022).

The literature also documents important implications for nursing education systems. Persistent unemployment alters the perceived returns to nursing education, shaping both student motivations and institutional incentives. Several studies suggest that when domestic employment opportunities are limited, nursing education is increasingly pursued as a pathway to international labour markets rather than local service provision (Kingma, 2018; Lokotola et al., 2024). This outward orientation can influence curriculum priorities, student expectations, and career planning processes within training institutions.

At the institutional level, nursing schools, particularly private providers, may face pressure to expand enrolment to maintain financial sustainability, even in contexts where labour market absorption is weak (WHO, 2020). Rapid expansion of student numbers without proportional growth in clinical training infrastructure can strain teaching hospitals, dilute the quality of supervision, and reduce opportunities for hands-on learning (Kuhlmann et al., 2025). The literature raises concerns that such dynamics risk compromising training quality and graduate readiness, further complicating transitions into employment.

Implications for professional practice and well-being are also widely reported. Prolonged unemployment and underemployment are associated with skill decay, reduced clinical confidence, and erosion of professional identity among nursing graduates (Walton-Roberts et al., 2017; WHO, 2025). Graduates who are unable to access structured transition-to-practice opportunities may experience difficulties re-entering formal employment, increasing the likelihood of leaving the profession altogether or accepting work outside their field of training.

Finally, several studies highlight the interrelationship between unemployment and migration. Limited employment prospects at home intensify migration intentions among nurses, while international recruitment of experienced staff can exacerbate domestic service gaps without automatically generating new employment opportunities for unemployed graduates (Lokotola et al., 2024; Kingma, 2018; Walton-Roberts et al., 2017). This dynamic reinforces concerns that nurse unemployment and workforce shortages may coexist as mutually reinforcing outcomes of misaligned education, labour market, and financing systems.

3. Methodology

3.1 Study Design

This study used a narrative review design to integrate diverse sources of evidence (policy documents, peer-reviewed research, and selected credible reports) on nurse unemployment in SSA.

The narrative review design was supported by heterogeneous, policy-driven evidence base on nurse unemployment, which precludes pooled analysis and requires integrative synthesis across diverse sources.

3.2 Data Sources and Search Strategy

Literature was identified from policy repositories (e.g., WHO publications and declarations), multidisciplinary scholarly databases (e.g., PubMed/MEDLINE, Google Scholar), and global health journals. Search terms combined concepts related to nursing and employment, for example: "nurse AND unemployment", "nursing graduate AND job", "health labour market AND Africa", "wage bill ceiling AND health workforce", "nursing education expansion AND employment", and "human resources for health policy". The time window (1978–2025) was selected to capture foundational PHC policy commitments (starting with Alma-Ata) and the subsequent evolution of health workforce policy and evidence, including post-COVID analyses.

3.3 Selection of Literature

Sources were selected purposively based on their relevance to at least one review objective and the outlet's credibility. Priority was given to: (i) global or regional policy documents defining health workforce needs; (ii) empirical studies and reviews reporting nurse unemployment or underemployment in SSA; and (iii) analyses of fiscal, governance, and education system determinants of health workforce absorption. Opinion pieces and media reports were used sparingly and only to illustrate policy debates when supported by higher-quality sources.

3.4 Inclusion and Exclusion Criteria

3.4.1 Inclusion Criteria

(i) Policy documents, reports, and peer-reviewed studies addressing nurse employment, unemployment, or underemployment in Sub-Saharan Africa.
(ii) Literature examining health workforce policy, health labour markets, nursing education, fiscal constraints, or workforce planning relevant to nurse employment.
(iii) Sources published between 1978 and 2025, corresponding to the Declaration of Alma-Ata and subsequent health workforce policy evolution.
(iv) Publications in English and from credible academic journals or recognised international and regional organisations.

3.4.2 Exclusion Criteria

(i) Studies focusing exclusively on non-nursing health cadres without explicit relevance to nursing employment outcomes.
(ii) Publications addressing high-income countries only, without transferable relevance to Sub-Saharan Africa.
(iii) Opinion pieces, commentaries, or media articles lacking empirical or policy grounding.
(iv) Studies outside the defined time frame or without clear linkage to workforce employment or labour market dynamics.

3.5 Data Analysis and Synthesis

Evidence was synthesised thematically using the three review objectives as an organising framework. First, policy milestones were mapped to identify how the nurse workforce need was defined over time. Second, empirical and analytical literature was coded into driver categories (effective demand/fiscal constraints; workforce planning; education capacity and quality; labour market structure; governance and regulation; migration dynamics). Third, implications were summarised across health systems, education, and professional practice, leading to policy and practice recommendations.

3.6 Ethical Considerations

This review used publicly available documents and did not involve primary data collection from human participants; therefore, formal research ethics approval was not required. Nonetheless, the authors aimed to present sources accurately and avoid misrepresenting country contexts.

4. Results and Discussion

4.1 Health workforce policies shaping the need for nurses in Sub-Saharan Africa

Extant literature consistently demonstrates that nurse unemployment in SSA reflects health labour market

failures rather than the absence of population need (WHO, 2006; WHO, 2016; Boniol et al., 2022). Studies from Uganda, Kenya, Ghana, Nigeria, Malawi, Tanzania, and South Africa document graduate nurse unemployment, informal volunteerism, and underemployment (George et al., 2013; Kizito, Baingana, Mugagga, Akera, & Sewankambo, 2017; McQuide et al., 2013; Ojakaa, Olango, & Jarvis, 2014). Fiscal space constraints, wage-bill ceilings, and public-sector hiring freezes repeatedly emerge as binding constraints on recruitment (World Bank, 1985; Russo et al., 2020). The expansion of private nursing education, without parallel job creation or regulation, has further widened the education–employment gap (McPake et al., 2015; Ozor, 2020; WHO, 2020). Unemployment and underemployment are associated with psychological distress, skill erosion, and heightened migration intentions among nurses (Kingma, 2018; Lokotola et al., 2024; Walton-Roberts et al., 2017). Policy analyses emphasise the importance of integrated workforce planning, labour market analysis, and alignment of education enrolment with medium-term expenditure frameworks to reduce workforce waste (Campbell et al., 2022; Correia et al., 2025, 2020; WHO, 2025).

The policy trajectory is consistent in recognising nurses as essential to PHC and UHC, but it evolves in how it frames the pathway from training to jobs. Alma-Ata established the normative requirement for adequate numbers of trained personnel for PHC delivery. The 2006 workforce crisis framing elevated the urgency of addressing shortages, while the 2008 Kampala Declaration emphasised coordinated action on education and retention. Workforce 2030 reframed these issues through a health labour market lens, explicitly acknowledging that unemployment and shortages can coexist when training outputs are not linked to funded posts and when labour market conditions are volatile. Nursing-focused reports (2020; 2025) further highlight the need to invest in jobs, not education alone. Taken together, these policies imply that nurse unemployment in SSA represents a failure of implementation and coordination rather than a lack of policy recognition of need.

4.2 Drivers of nurse unemployment in Sub-Saharan Africa

This narrative review identifies four interlocking drivers of nurse unemployment in Sub-Saharan Africa: constrained effective demand for nurses, fragmented workforce planning and governance, expansion of nursing education without corresponding absorption mechanisms, and labour market segmentation characterised by precarious employment. Importantly, these drivers do not operate independently; rather, they reinforce one another to produce persistent unemployment and underemployment among newly trained nurses despite documented service delivery needs.

The findings suggest that nurse unemployment in SSA is not primarily a function of excess supply, but a manifestation of structural and institutional failures within health labour markets. In particular, the conversion of population health needs into funded employment opportunities is systematically blocked by fiscal and governance constraints. This interpretation aligns with health labour market theory, which distinguishes between need, supply, and effective demand, and explains how shortages and unemployment can coexist when financing and planning are misaligned (WHO, 2016).

Constrained effective demand emerges consistently across SSA contexts, where public-sector recruitment is constrained by fiscal space, wage-bill ceilings, and hiring freezes, even in the presence of documented staffing gaps (McQuide et al., 2013; World Bank, 1985). These constraints convert recognised workforce needs into unmet demand, leaving graduates without access to formal employment.

Fragmented workforce planning further exacerbates this problem. Training intakes, professional accreditation, and recruitment authorisations are often managed by separate institutions, ministries of education, health, finance, public service, and regulatory councils with weak coordination mechanisms (Campbell et al., 2022; George et al., 2013; Kizito et al., 2017). Where medium-term expenditure frameworks fail to explicitly incorporate health workforce recruitment, nursing graduates accumulate faster than the funded establishment posts can be filled.

The rapid expansion of nursing education, particularly through private institutions, has been widely documented across SSA (WHO, 2020). While this expansion has increased training output, it has often occurred without proportional investment in clinical placement capacity, internship or transition-to-practice posts, and entry-level employment opportunities. As a result, newly qualified nurses are frequently channelled into unpaid or informally structured "volunteer" roles as a substitute for formal employment and supervised practice (Kuhlmann et al., 2025; Correia et al., 2025, 2020).

Finally, labour market segmentation and precarious employment arrangements further obscure the true extent of nurse unemployment. Private sector facilities often offer short-term contracts, low wages, or part-time work, while many nurses accept employment outside their profession altogether. This hidden underutilisation can coexist with service delivery shortages, particularly in rural and public facilities, reinforcing the illusion of scarcity alongside unemployment (Lokotola et al., 2024; Walton-Roberts et al., 2017).

An apparently counterintuitive finding is the coexistence of unemployed nurses and understaffed facilities within the same health systems. However, this contradiction becomes explicable when the workforce needs are distinguished from the financed demand. Facilities may experience shortages at the point of care, while centralised recruitment constraints prevent the hiring of available nurses. Thus, unemployment does not signal a lack of need, but rather institutional incapacity to translate need into employment (WHO, 2016).

The implications of these findings are profound. For health systems, nurse unemployment represents workforce waste, lost returns on training investment, and reduced system resilience. For nursing education, persistent unemployment undermines the social contract between training institutions and students, distorts enrolment incentives, and risks producing graduates for whom local employment is structurally unattainable. For individual nurses, prolonged unemployment is associated with skill erosion, psychological distress, and increased migration intentions, which can further destabilise health workforce availability (Kingma, 2018; WHO, 2025).

As a narrative review, this analysis does not provide pooled quantitative estimates of nurse unemployment prevalence or capture all country-specific variations across SSA. The available literature is uneven, with some countries better represented than others, and informal or hidden forms of underemployment may be underreported. Nevertheless, the consistency of themes across diverse settings strengthens the credibility of the identified drivers.

Future research should prioritise country-level health labour market analyses that integrate data on training output, vacancies, funded posts, unemployment, and underemployment. Longitudinal studies examining transitions from graduation to employment would help clarify pathways into unemployment and inform transition-to-practice policies. Additionally, research evaluating the effectiveness of integrated workforce planning and financing reforms is needed to identify scalable solutions for aligning nurse training with employment needs in SSA.

4.3 Implications of nurse unemployment for health systems and nursing education in Sub-Saharan Africa

This review finds that nurse unemployment in Sub-Saharan Africa has multi-level implications for health systems, nursing education, and professional practice. At the system level, unemployment contributes to workforce waste and reduced resilience; at the education level, it distorts training incentives and capacity; and at the individual level,

it undermines professional competence, well-being, and retention.

These findings indicate that nurse unemployment is not a neutral labour market outcome, but a systemic inefficiency with cascading effects across health service delivery and professional development. From a health labour market perspective, the failure to absorb trained nurses reflects weak translation of workforce need into financed employment, while from a systems perspective, unemployment disrupts the feedback loops linking education, deployment, and service outcomes. This interpretation underscores the fact that unemployment itself becomes a driver of further workforce instability.

For health systems, unemployment represents a loss of service capacity and investment efficiency. Trained but unemployed nurses embody foregone opportunities to expand coverage, reduce workload, and improve quality of care, particularly in under-resourced and rural facilities (WHO, 2006; Campbell et al., 2022). Evidence from SSA shows that health facilities may remain understaffed even when unemployed nurses are available, largely due to financing constraints and rigid recruitment controls (McQuide et al., 2013; World Bank, 1985).

For nursing education, persistent unemployment reshapes student motivations and institutional behaviours. Studies suggest that when local employment prospects are limited, students increasingly view nursing education as a pathway to migration rather than domestic service, reinforcing external labour orientation in curricula and career planning (Kingma, 2018; Lokotola et al., 2024). At the same time, training institutions, particularly private providers, may face incentives to expand enrolment for revenue despite weak labour market absorption, placing pressure on clinical teaching platforms and potentially diluting training quality (WHO, 2020).

At the level of professional practice and well-being, prolonged unemployment and underemployment are associated with skill decay, psychological distress, and erosion of professional identity (Walton-Roberts et al., 2017; WHO, 2025). Graduates unable to access supervised practice may lose clinical confidence, increasing the risk of attrition from the profession or delayed re-entry into formal employment.

A counterintuitive outcome is that nurse unemployment can intensify health workforce shortages rather than alleviate them. As unemployed nurses pursue migration or leave the profession altogether, the pool of experienced practitioners shrinks. However, the departure of experienced nurses does not automatically trigger an expansion in the recruitment of unemployed graduates, as hiring remains constrained by fiscal and governance limits.

This produces a self-reinforcing cycle in which unemployment and shortage coexist within the same system (WHO, 2016).

The implications are substantial. For policymakers, nurse unemployment signals inefficient use of public and private investment and undermines health system resilience, particularly during shocks such as epidemics. For nursing education regulators, it raises ethical and planning questions about enrolment, accreditation, and accountability for graduate outcomes. For the nursing profession, unemployment threatens morale, retention, and the sustainability of domestic career pathways, with long-term consequences for workforce stability and service quality.

The implications discussed here are drawn from a synthesis of diverse sources and may not apply uniformly across all SSA contexts. Variations in financing structures, private sector roles, and migration opportunities mean that the intensity and manifestation of impacts differ by country. In addition, informal and unpaid work remains under-documented, potentially underestimating the true burden of underemployment.

Future research should examine longitudinal career trajectories of nursing graduates to assess how unemployment shapes skills, well-being, and retention over time. Studies evaluating the impact of transition-to-practice programmes, bonded employment schemes, and integrated workforce financing reforms would provide critical evidence on how to mitigate the negative consequences identified. Further research is also needed on how education institutions respond to labour market signals and how regulation can align training capacity with employment outcomes.

5. Conclusions and Recommendations

5.1 Conclusions

Nurse unemployment in SSA is best understood as a health labour market coordination failure in which training expansion has not been matched by financed posts, integrated workforce planning, and regulated education markets. Foundational policy commitments have consistently affirmed the need for nurses; however, effective demand has remained constrained by fiscal policies, fragmented governance, and weak alignment between education and employment systems. Without reforms, the region risks continued workforce waste alongside persistent service delivery gaps.

5.2 Recommendations

From the findings, the following recommendations are made:
1. Institutionalise integrated health workforce planning that links nursing education intake, accreditation, and recruitment to a single national workforce plan and medium-term expenditure framework.
2. Use routine health labour market analysis to monitor unemployment, underemployment, vacancies, and distribution, and to adjust training quotas and recruitment targets accordingly.
3. Protect and expand entry-to-practice pathways (internships, supervised practice, rural bonding with incentives) so that new graduates transition into competent employment rather than unpaid volunteerism.
4. Strengthen regulations of nursing education expansion (public and private), including clinical placement standards, minimum educator-to-student ratios, and transparent reporting of graduate employment outcomes.
5. Adopt ethical mobility and bilateral agreements that recognise international demand while safeguarding domestic service coverage, including return pathways, circular migration options, and investment in domestic jobs.

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