JIGAWA STATE

STATE HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN 2023-2027

JUNE 2023

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ACRONYMS

APER	Annual Performance Evaluation Report
BHCPF	Basic Health Care Provision Fund
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CONHESS	Consolidated Health Salary Structure
CPD	Continuing Professional Development
DPRS	Department of Planning Research and Statistics
FCDO	Foreign, Commonwealth & Development Office
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
HRH	Human Resources for Health
HRIS	Human Resources Information System
JCHEWs	Junior Community Health Extension Workers
JSMoH	Jigawa State Ministry of Health
JSPHCDA	Jigawa State Primary Health Care Development Agency
KIT	Koninklijk Instituut voor de Tropen
LGA	Local Government Area
MDAs	Ministries, Departments and Agencies
NCDs	Non-Communicable Diseases
NHAct	National Health Act
NHRHSP	National Human Resources for Health Strategic Plan
NMCN	Nursing and Midwifery Council of Nigeria
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OOPE	Out of Pocket Expenditure
PERL	Partnership to Engage, Reform and Learn
PHC	Primary Health Care
RMNCAH+N	Reproductive, Maternal, Newborn Child and Adolescent Health plus Nutrition
SDGs	Sustainable Development Goals
TWG	Technical Working Group
UHC	Universal Health Coverage

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WISN	Workload Indicators of Staffing Needs

FOREWORD

The strategic development and management of human resources for health (HRH) is a vital component of Jigawa State's mission to achieve sustainable development goals in the health sector. The HRH unit of the Department of Planning Research and Statistics, in collaboration with the Global Fund through the Royal Tropical Institute Netherlands and other stakeholders, has successfully developed a State Human Resources for Health Strategic Plan for the period 2023-2027. The objective of this plan is to provide appropriate, feasible and cost-effective strategies for ensuring adequate production and equitable distribution of competent health workers across the 27 LGAs in the state.

Prior to the development of the strategic plan, a comprehensive analysis was conducted to identify HRH-relevant gaps and challenges in the health system that limit the state's capacity to provide qualitative, equitable, effective and efficient healthcare.

The National Health Act of 2014 prescribes adequate HRH as a prerequisite for a robust health system. The Jigawa State Human Resource for Health Strategic Plan articulates the process of strengthening the systems and structures that facilitate planning, recruitment, distribution, retention and management of HRH in the state. It is the perfect tool for guiding policymakers and development partners in mobilising and allocating resources for HRH development. I, therefore, implore public and private sector stakeholders to collaborate with the HRH unit of the Department of Planning Research and Statistics for the efficacious implementation of this strategic plan, ultimately leading to improved health outcomes and increased life expectancy throughout Jigawa State.

Dr XX,

Honourable Commissioner,

State Ministry of Health,

Dutse,

Jigawa State

ACKNOWLEDGEMENTS

The dedication and input of a team of individuals and organisations were crucial in developing the State Human Resource for Health Policy and Strategic Plan, 2023-2027. This initiative was led by the Department of Planning Research and Statistics, State Ministry of Health, in line with the National Strategic Health Development Plan II for 2018-2022.

The Honourable Commissioner for Health, Dr. XXX, and the Permanent Secretary for Health, Dr. YYY, provided the necessary political and technical guidance, ensuring that the policy and strategic plan are grounded in sound evidence and aligned with the state's health agenda. Administrative support from the Director Planning Research and Statistics, VVVV, was also instrumental in the process. I commend the staff of the Human Resource for Health unit, especially Dr Usman Ahmed, and counterpart at the State Primary Health Development Agency, Malam Musa Nababa and ……, for their dedication and resilience in ensuring the timely completion of this essential document. The administrative support from the [position], [name], was instrumental in the process, providing the necessary resources and guidance to ensure the successful completion of the project.

Furthermore, the support of the Global Fund through the Royal Tropical Institute, Netherlands; Foreign, Commonwealth & Development Office Lafiya programme and the World Health Organization (WHO) was invaluable to the success of this exercise. The financial and technical assistance helped strengthened the HRH unit's capacity and ensured that the policy and strategic plan are aligned with international best practices. Their expertise and commitment to ensuring the quality and relevance of the policy and strategic plan were critical in ensuring that the needs of the Jigawa State health system were adequately addressed.

On behalf of the State Ministry of Health, I extend my heartfelt gratitude to all HRH stakeholders who contributed to this effort. Their input and support were critical in ensuring that the policy and strategic plan are comprehensive, evidence-based, and aligned with the state's health agenda. I commend them for their commitment to improving the health of Jigawa State citizens and look forward to working with them in the implementation of the policy and strategic plan.

XXXX,
Director, Department of Health Planning Research and Statistics,
State Ministry of Health,
Dutse-Jigawa State,
[Month] 2023.

EXECUTIVE SUMMARY

The health workforce plays a pivotal role as the foundation of health system performance, and its indispensability lies in its ability to ensure affordable, accessible, and high-quality health services. To this end, the degree to which Jigawa State will be able to meet its health commitments and goals largely depends on the number, skills, competencies, and availability of health workers and how they are organised and distributed equitably to deliver integrated and people-centred health services. Increasingly, many states in Nigeria, including Jigawa are paying attention to policies, plans, and strategies that address health workers' needs to improve health outcomes.

Globally, there exists a significant shortage of health workers estimated at 17.4 million, of which nearly 2.6 million are doctors, nearly 9 million are nurses and midwives, and the remaining comprises other healthcare personnel. The most acute shortages are observed in South-East Asia, with 6.9 million vacancies, and Africa, with 4.2 million vacancies. While the absolute shortage is most pronounced in South-East Asia due to the larger populations of countries in this region, the African Region grapples with the most severe challenges in relative terms, accounting for population size. Alarming projections by the World Health Organisation indicate that by 2030, the deficit of healthcare workers is expected to persist at over 14.5 million, representing a mere 17% reduction in health workforce shortage.

As reported in the 2018 National Health Workforce Profile, the number of health workers in the country has increased significantly over the preceding five years because of increased production capacity from health training institutions in the public and private sectors. However, the percentage increase in the stock of health workers is less than the population growth rate and varies across the states in the country. While Nigeria has a doctor density of 36.3 medical doctors per 100,000 population, Jigawa State's doctor density is 1.9 medical doctors per 100,000 population. The country has 88.1 nurses per 100,000 population and 58.9 midwives per 100,000 population, in contrast to Jigawa State, with 11.8 nurses and 2.8 midwives per 100,000 population. Similarly, Nigeria has 30 Community Health Extension Workers and 22.5 Junior Community Health Extension Workers per 100,000 population, while the state has 20.5 Community Health Extension Workers and 10.4 Junior Community Health Extension Workers per 100,000 population.

Despite the remarkable progress made by the State Ministry of Health and the State Primary Health Care and Development Agency in addressing HRH issues, challenges remain, which vary across Local Government Areas. The main challenges include uncoordinated HRH practices by the various stakeholders leading to inefficiencies, weak HRH coordination mechanisms and information systems,

insufficient leadership capacity to provide effective stewardship on HRH issues, and maldistribution of health workers across the state, local governments, rural areas and urban areas. Furthermore, despite the high production of health workers from health training institutions, the absorption capacity of the public sector is quite low due to financial constraints. By examining innovations, this strategic plan strives to ensure adequate and competent health workers are effectively deployed to improve health services and outcomes.

The State Human Resources for Health Strategic Plan 2023-2027 sets strategic directions for HRH planning, management, and development for the next five years. The plan adopts a whole-of-government approach and will serve as a roadmap for the development of the health workforce at local government levels and inform the development of annual operational plans at all health system levels. This Strategic Plan builds its strategic directions from the Global Human Resources for Health: Workforce 2030, African Regional Framework For The Implementation Of The Global Strategy On Human Resources For Health: Workforce 2030, National Health Act of 2014, 2016 National Health Policy, and the Second National Strategic Health Development Plan 2018-2022. This strategy considers the lessons learned from previous national and state HRH strategies and evidence from HRH strengthening programmes and research.

The development of this strategic plan was a joint consultative effort of several individuals and institutions led by the State Ministry of Health and State Primary Health Care Development Agency, with departments, agencies, and parastatals also playing key roles. The Federal Ministry of Health, Nigeria Primary Health Care Development Agency, implementing partners, bilateral and multilateral organizations were also involved, among other key stakeholders who willingly contributed their expertise and experience. They envisioned the state of HRH by 2030 and formulated HRH goals and strategic objectives to address current and emerging challenges and constraints.

To better align the health workforce to the universal health coverage aspirations, the strategic plan's interventions are informed by a theory of change anchored on three (3) key workforce objectives: **coverage**, **motivation,** and **competence**. The plan hopes to address the most critical human resource for health challenges, across multiple intervention areas through the support of all relevant stakeholders. The five strategic objectives are highlighted below:

Strategic Objective 1: Strengthen HRH governance, stewardship, and accountability: Interventions under this strategic objective seek to institutionalise HRH units and equip them with qualified, skilled, competent, and motivated staff in adequate numbers to sustain achievements. This will ensure improved sustainable mechanisms for HRH funding and enhance capacity for HRH

planning, management, development, coordination, and reporting across all levels. Implementing responsive HRH management systems at governance and service delivery levels will be critical. The strategies will strengthen the state and LGA HRH units to sustain achievements.

Strategic Objective 2: Ensure the production of adequate numbers of qualified health workforce: This objective seeks to strengthen the quality assurance process for HRH training institutions to focus on the need to scale up the production of a competent health workforce. It also aims to improve efficiency in instructional design and teaching. Strengthening the faculty to increase student enrolments, improve teaching to ensure qualified competent health workers are produced. The state will need to embrace need-based production and capacity development (pre and in-service) of health workers who are fit for purpose. Further emphasis should be placed on in-service training.

Strategic Objective 3: Ensure the development of monitoring and evaluation for HRH, including systems for HRH Information System and Registry: This objective serves to strengthen systems needed to make health workforce information to be real-time, current, and accurate data on the health workforce at all levels. It seeks to establish mechanisms for annual HRH data reviews and reporting for evidence and decision-making. A multi-sectoral system to institutionalise the State Health Workforce Accounts will be established to improve the availability, quality, and use of data on the health workforce through monitoring a set of indicators.

Strategic Objective 4: Optimize the recruitment, utilization, retention, and performance of the available health workforce: This objective will promote evidence-based recruitment, deployment, and retention of health workers at all levels of care. Improving the retention of health workers will involve investing in conducive working and living conditions in rural and remote areas, ensuring appropriate financial and intrinsic incentives as well as supportive supervision. Emphasis will be given to regular performance reviews to enhance accountability, productivity, and reward at all levels of health care delivery.

Strategic Objective 5: Strengthen coordination and partnership for HRH: The focus will be on strengthening the coordination of stakeholders (public, private, regulatory, professional associations, and development partners) at all levels to support the HRH agenda. Other non-traditional stakeholders will also be brought on board as HRH issues cut across many sectors.

The total financial resource requirement estimates for the strategic period 2023-2027 is ₦186 million, with an average of ₦37 million needed per year Table 13 summarises financing requirements for the strategic plan 2023-2027 by strategic objectives. Objective 1 (Strengthen HRH Governance,

Stewardship and Accountability) will cost ₦50,654,758 or 27%; Objective 2 (Ensure Production of adequate numbers of qualified Health Workers) will cost ₦22,868,642 or 12%, while Objective 3 (Ensure the development of monitoring and evaluation for HRH including Systems for HRH Information System and Registry will cost ₦54,170,575 or 29%. Objective 4 (Optimize the recruitment, utilisation, retention and performance of the available Health workers) will cost ₦30,922,604 or 17% while Objective 5 (Strengthen Coordination and Partnership for HRH Agenda) will cost ₦27,192,155 or 15%.

CHAPTER 1: INTRODUCTION

1.1 Background

Globally, there is an acute shortage of human resources for health (HRH). Low- and middle-income countries bear the greatest burden, especially in sub-Saharan Africa and some parts of South-East Asia.[1] The World Health Organisation (WHO), in its Global Strategy on HRH: Workforce 2030, projects that Africa will need to increase its health workforce stock by 63% to achieve universal health coverage (UHC) by 2030. [2]

The 2018 Country Health Workforce Profile reports that Nigeria has a doctor-population ratio of 36.3 per 100,000 population and suffers a significant and chronic shortage of health workers for its population needs, especially in the country's northern parts. [3] For example, Jigawa State in Northern Nigeria, on which this strategic plan focuses, has one of the lowest HRH densities in the country. Layered on this challenge is the problem of poor retention and maldistribution. The Jigawa state health system is undergoing major restructuring in line with health reforms that aim to provide effective and quality health care to its citizens. However, the persistent shortage of human resources and their maldistribution pose a significant obstacle to implementing health reforms.

The 2021 state health workforce profile shows that the state has a total of 143 medical doctors, which equates to 1.9 medical doctors per 100,000 population (doctor-to-population ratio of 1: 52,400) based on the 2022 projected population of 7, 498, 900. Also, the state has 888 nurses and 207 midwives registered by the Nursing and Midwifery Council of Nigeria (NMCN). This number of nurses and midwives translates to 11.8 nurses per 100,000 population (nurses to population ratio of 1: 8,444) and 2.8 midwives per 100,000 population (midwives to population ratio of 1:36,227).

The growing population's health needs, disease patterns, and emerging conditions call for strategies to improve the production, recruitment, and retention of well-trained, competent, and equitably well-distributed health workers to achieve UHC and sustainable development goals (SDGs), amongst other state-level commitments. Thus, there is a need to model workforce needs comprehensively.

[1] World Health Organization. Global strategy on Human Resources for Health: Workforce 2030. Geneva: World Health Organization; 2016
[2] Ibid
[3] Federal Ministry of Health. Nigeria Health workforce Country Profile 2018. Abuja, Federal Republic of Nigeria; 2019.

While there is a growing awareness of the importance of ensuring the availability of adequate numbers of qualified, skilled, competent, and motivated health workers that are equitably distributed through various initiatives and reforms in the state, significant challenges still exist. These include the maldistribution of health workers across the state, suboptimal function of human resources information systems, poor coordination among HRH stakeholders, inadequate funding of HRH activities, and weak leadership and management skills in HRH.[4] As part of the strategy for meeting the population's needs, policies and plans must be developed to facilitate HRH production, recruitment, deployment, retention, and management strategies that ensure adequate healthcare workers are available to effectively and efficiently meet the population's needs. Prior to this initiative, the state had made efforts to address HRH issues in an integrated manner. The development of the State Health Policy for HRH in 2010 precedes this current effort to domesticate the National HRH Strategic plan (2021 - 2025). The domesticated version of the National HRH Strategic plan will guide the strategic directions for managing the health workforce five years after its finalisation. While building on the previous efforts and lessons learnt from the earlier strategies and trends in human resources, this State HRH Strategic Plan is guided by the National Health Act and responds to the National Health Policy 2016 as well as the second National Strategic Health Development Plan (NSHDP) 2018 - 2022. Nigeria and, by extension, Jigawa State is a signatory to several regional and global commitments which have shaped this strategy. They include sustainable development goals (SDGs), Global Human Resources for Health: Workforce 2030, African Regional Framework for the Implementation of the Global Strategy on Human Resources for Health: Workforce 2030, and the Common African Position on the Post 2015 Agenda that seeks to achieve universal access to health care in the continent.

1.2 Link to Global, Regional, National and State Policies and Commitments

The National HRH Strategic Plan, global and regional commitments

Nigeria is a signatory to several commitments. This plan for the health sector is equally aligned with the health sector commitments as in the SDGs and the 2018 Astana Declaration on Primary Health Care. The Common African Position on the Post 2015 Agenda (African Union 2014) seeks to achieve universal and equitable access to quality health care in Africa, and specifically the Road Map for Scaling up the HRH for improved health service delivery in the African Region - 2012 - 2025. Also consulted is the Ouagadougou Declaration on Primary Health Care (2008) which seeks to reactivate

[4] Federal Ministry of Health, Nigeria. National human resources for health policy. Abuja, Federal Republic of Nigeria; 2015.

the principles of Primary Health Care (PHC) within the context of health system strengthening, and finally, the Global Strategy on HRH: Workforce 2030.

The four global HRH objectives are as follows:

a. to optimize performance, quality, and impact of the health workforce through evidence-informed policies on HRH, contributing to healthy lives and well-being, effective UHC, resilience, and strengthened health systems at all levels;
b. to align investment in HRH with the current and future needs of the population and health systems, taking account of the labour market dynamics and education policies to address shortages and improve the distribution of health workers, to enable maximum improvements in health outcomes, social welfare, employment creation, and economic growth;
c. to build the capacity of institutions at sub-national, national, regional, and global levels for effective public policy stewardship, leadership, and governance of actions on HRH and
d. to strengthen data on HRH for monitoring and ensuring accountability for implementing national, regional and global strategies.
The four global HRH strategy components aim to deliver thirteen milestones—seven by 2020 and six by 2030. The seven global milestones to be delivered by Nigeria and other Nations by 2020 include the following:
a. Inclusive institutional mechanisms for coordination and intersectoral workforce agenda.
b. HRH branch responsible for developing and monitoring policies and plans.
c. Regulatory mechanisms to promote patient safety and adequate oversight of the private sector.
d. Establishment of accreditation mechanisms for health training institutions.
e. Progress on health workforce registries to track health workforce stock, education, distribution, flows, demand, capacity, and remuneration.
f. Progress on sharing data on HRH through national health workforce accounts and submitting core indicators to the WHO secretariat annually.
g. Bilateral and multilateral agencies are strengthening health workforce assessment and information exchange.
The second set of objectives to be achieved by countries, including Nigeria, by 2030 include:
a. Countries will have made progress toward halving inequalities in access to a health worker.
b. Countries will have made progress toward improving the course completion rates in medical, nursing, and allied health professionals training institutions.

c. Countries will have made progress toward halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel.

d. All bilateral and multilateral agencies will have increased synergies in official development assistance for education, employment, gender, and health, supporting national health employment and economic growth priorities.

e. Partners in the SDGs will have made progress in reducing barriers to accessing health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations.

The National HRH Strategic Plan envisions the Federal, State, and LGAs' aspiration toward achieving UHC. The 2014 Presidential Summit Declaration affirms that UHC is critical to ensuring equitable access to high-quality, affordable health care for all Nigerians. The National Health Act is a viable framework whose implementation can fast-track progress toward UHC. This Act aims to provide the framework for allocating adequate resources to health to strengthen PHC through the Basic Health Care Provision Fund (BHCPF). Fifty per cent (50%) of the fund is to be managed by the National Health Insurance Agency, which will ensure access to a minimum package of health services for all Nigerians, and 45% by the National Primary Healthcare Development Agency (NPHCDA) for PHC facility upgrade and maintenance, provision of essential drugs, and deployment of human resources to PHC facilities. The Federal Ministry of Health (FMoH) will manage the remaining 5% for national health emergencies and response to epidemics. Counterpart funding from state and local governments is at the core of the National Health Act implementation. Resource mobilisation and accountability are critical factors for successfully implementing the National Health Act. Although there is substantial evidence that public financing is essential to achieving UHC, government expenditure on health has been very low in Nigeria, and domestic resource mobilisation is weak. It is important to note that if Nigeria truly desires to progress toward achieving UHC, the need for equitable access to basic healthcare services is central. Other important factors include essential medicines and technologies; sustainable financing or funding of healthcare services; a strong, effective, efficient, qualitative, and well-run health system with basic health infrastructure. The need for adequate and equitable distribution of well-trained, skilled, and motivated health workers must also be addressed. Adequate finances must be established through available funding sources (including tax-based revenues; budgetary allocations to health; adoption of risk-pooling financing mechanisms such as health insurance schemes; and other funding sources).

The National HRH Strategic Plan and the National Health Act (2014)

The National Health Act provides a framework for regulating, developing, and managing a health system and standards for offering health services to all Nigerians. The Act provides for developing policies and guidelines for monitoring HRH provision, distribution, development, management, and utilisation in the country. The developed policies must facilitate an adequate distribution of human resources, the provision of skilled and well-trained staff to meet the population's needs, and the efficient and effective utilisation of human resources while respecting the rights and obligations of all personnel within the healthcare system. The HRH strategic directions and priorities of the National HRH strategic plan are aligned with the National Health Act provisions.

National HRH Strategic Plan and the National Health Policy 2016

The National Health Policy has a vision of providing UHC to all Nigerians. The main policy goal is strengthening Nigeria's health system, particularly PHC, to deliver effective, efficient, equitable, accessible, acceptable, and comprehensive healthcare services. National Health Policy 2016 has a goal of providing the appropriate and adequate health workforce at all levels of the health system by:

a. Strengthening the utilisation of evidence-based planning and projection of the HRH, including medium and long-term planning for health.
b. Improving the production of HRH, including training specialised health worker cadres through the completion and implementation of a national HRH policy and strategic plan and their adaptation by the state governments.
c. Fostering effective collaboration with the regulatory bodies in the education and health sectors.
d. Promoting reforms on the performance management systems for all cadres of health workers.
e. Instituting measures that promote equitable distribution and retention of the health workforce at all levels of the health system, including improving the conditions of service, especially in rural settings.
f. Strengthening the capacity of professional regulatory bodies to ensure compliance with the ethical standards and norms for service delivery.
g. Strengthening the HRH information system and ensuring the health workforce registry becomes functional and efficient.
h. Developing and implementing mechanisms to minimise rivalries between professional health workers and minimise industrial unrest (strikes).
i. Developing and implementing measures to address the post-graduate speciality training challenges in healthcare.

j. Developing and implementing measures to reduce the existing conflict of interest problem of medical/health workers.

k. Ensuring the effective and efficient use of 10% of the BHCPF for developing human resources for PHC.

l. Effective management of the health workforce during emergencies.

m. Providing adequate safeguards against internal and external health workforce migration in line with global standards.

To achieve all these thrusts, a competent fit-for-purpose workforce is critical in its right numbers and equitably distributed across all levels of care with an emphasis on PHC.

National HRH Strategic Plan and the NSHDP II (2018-2022)

The NSHDP II provides the health sector with a medium-term roadmap to move the country toward accomplishing National Health Policy goals and objectives. NSHDP II will guide national and subnational governments on the health sector priorities. Additionally, it recognises and identifies key actions that other sectors should collaborate with or jointly implement with the health sector to address the social determinants of health in the pursuit of health-related SDGs. The plan acknowledges that the performance of a health system and its impact on health outcomes are influenced significantly by its health workforce's size, distribution, and skill mix. Therefore, it commits to having the right number and skill mix of competent, motivated, productive, and equitably distributed health workforce to provide optimal and quality healthcare services through five priority areas with milestones for monitoring results. The five areas are:

- Ensuring coordination and partnership for aligning investment of current and future needs and institutional strengthening for the HRH agenda.
- Ensuring the production of adequate numbers of qualified health workers.
- Ensuring the development of HRH monitoring and evaluation, including HRH Information System and registry systems.
- Ensuring effective health workforce management through retention, deployment, work condition, motivation, and performance management.
- Strengthening health workforce planning for effective management.

National HRH Strategic Plan and National HRH Policy 2020

The Nigerian HRH policy recognises the health workforce as the heartbeat of health service delivery. It envisages a health workforce that will enhance the delivery of UHC and the attainment of the SDGs. The main thrust of the policy includes strengthening the HRH structures to facilitate effective planning, production, recruitment, management, development, and retention of health workers at all levels of care. It emphasises the importance of collaboration between governments, the private sector, and all other actors in ensuring efficient utilisation of the existing workforce. The overall goal of the policy is to ensure that adequate numbers of well-motivated and competent health workers are available to provide quality services where needed.

Jigawa State Comprehensive Development Framework III (CDF III) (2022 - 2025)

In accordance with the state's vision and in alignment with the constitutional provision, the primary and strategic objective of the Jigawa State Development Strategy is to pursue policies that ensure economic growth and guarantee sustained progress in improving fundamental human development indicators. To achieve this goal, it is necessary to enhance the capabilities and productivity of the human resources. Consistent with this policy, one of the goals within the health sector is to enhance the quality, deployment, retention, composition, and quantity of the healthcare workforce. In this regard, the health sector should conduct a review of the existing State HRH 2010 strategic plan to address the present demands for human resources in health.

1.3 The State HRH Strategic Plan (2023 - 2027) Development Process and Target Audience

The State HRHSP was meticulously developed through comprehensive consultations involving diverse stakeholders to foster commitment, ownership, and accountability. The process encompassed a holistic approach that commenced with a thorough review of the national HRH strategic plan (2021-2025). This was followed by assessing state-level data, official statistics from relevant ministries, and insights gathered from stakeholders to reflect local needs and priorities accurately.

Subsequently, inclusive consultations were held with diverse stakeholders, including the State Ministry of Health (SMoH), the State Primary Health Care Development Agency (SPHCDA), and relevant training institutions, to solicit input and ensure widespread buy-in, ownership, and commitment. To aid in the analysis of existing HRH data, an independent consultant was engaged, and in cases where necessary, a comprehensive statewide data collection exercise was conducted to thoroughly assess the

status of HRH, management systems, procedures, and practices. Drawing from the findings of this exercise, a draft strategic plan was developed as an adaptation of the National HRH strategic plan. Key stakeholders reviewed the adapted national document during a four-day deliberation and discussion. Wider consultations and validation were held with the Jigawa State HRH technical working group to develop the final draft.

Overall, this plan reflects the desire of the state to reverse the perennial poor HRH density and highlights the goals, structures, policy, and strategic direction. This Plan underscores the importance of establishing or strengthening systems and structures at various levels in the healthcare delivery system to facilitate the recruitment, deployment, retention, and management of health workers through reliable evidence. Furthermore, it emphasises the importance of collaboration between state and non-state actors. It is primarily intended for Jigawa SMOH, SPHCDA, Ministry of Local Government, and health training institutions as they are responsible for harnessing the potential of the existing HRH. Nevertheless, adopting and using this strategic plan requires an integrated, coordinated approach among government ministries beyond that for health. Accordingly, stakeholders also include the Ministry of Education and its training institutions, Ministry of Budget and Planning, responsible for allocating funds. This strategic plan is also intended for the stakeholders throughout the healthcare system who work with the various cadres of health workers. Finally, the people of Jigawa State are the focus of this strategic plan, and that must be put into consideration while implementing this strategic plan.

CHAPTER 2: SITUATION ANALYSIS OF JIGAWA STATE

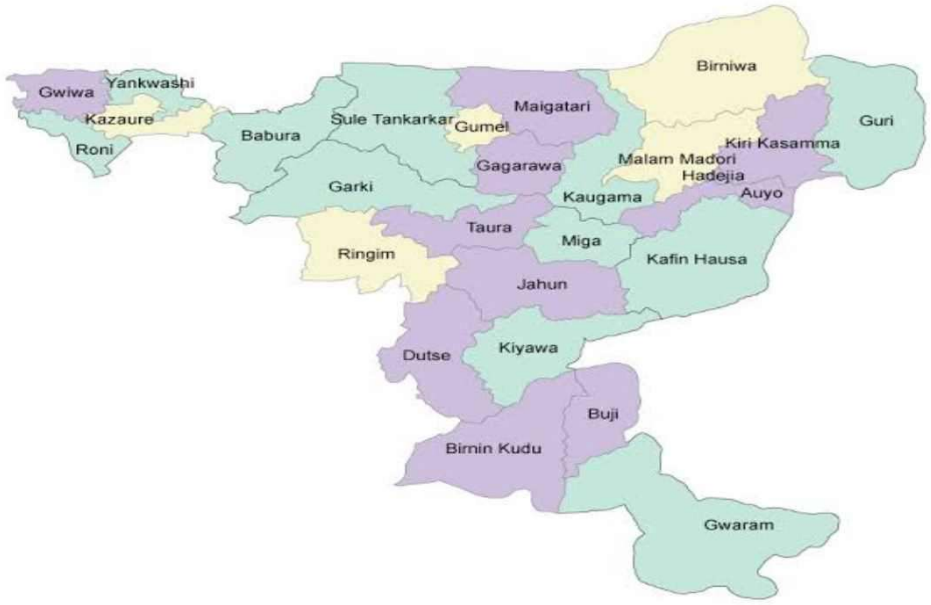
2.1 Location, Administration and Indicators

Location and administration

Jigawa State is located in the North-West Geopolitical Zone of Nigeria, between latitudes 11.00°N to 13.00°N and longitudes 8.00°E to 10.15°E. It shares borders with Kano and Katsina States to the west, Bauchi State to the east, and Yobe State to the northeast. To the north is an international border with the Republic of Niger.

The Administration of Jigawa State, similar to the other 35 states in Nigeria, consists of three branches: the Executive, the Legislature, and the Judiciary. Jigawa State consists of 27 Local Government Areas, which are further divided into 30 State Constituencies, grouped into 11 Federal Constituencies and 3 Senatorial Districts, in line with the provisions of Section 7(1) of the 1999 Constitution, which guarantees the existence of democratically elected local government councils, all 27 Local Governments are governed by elected Local Councils.

Figure 1: Map of Jigawa State



Population and socioeconomic profile

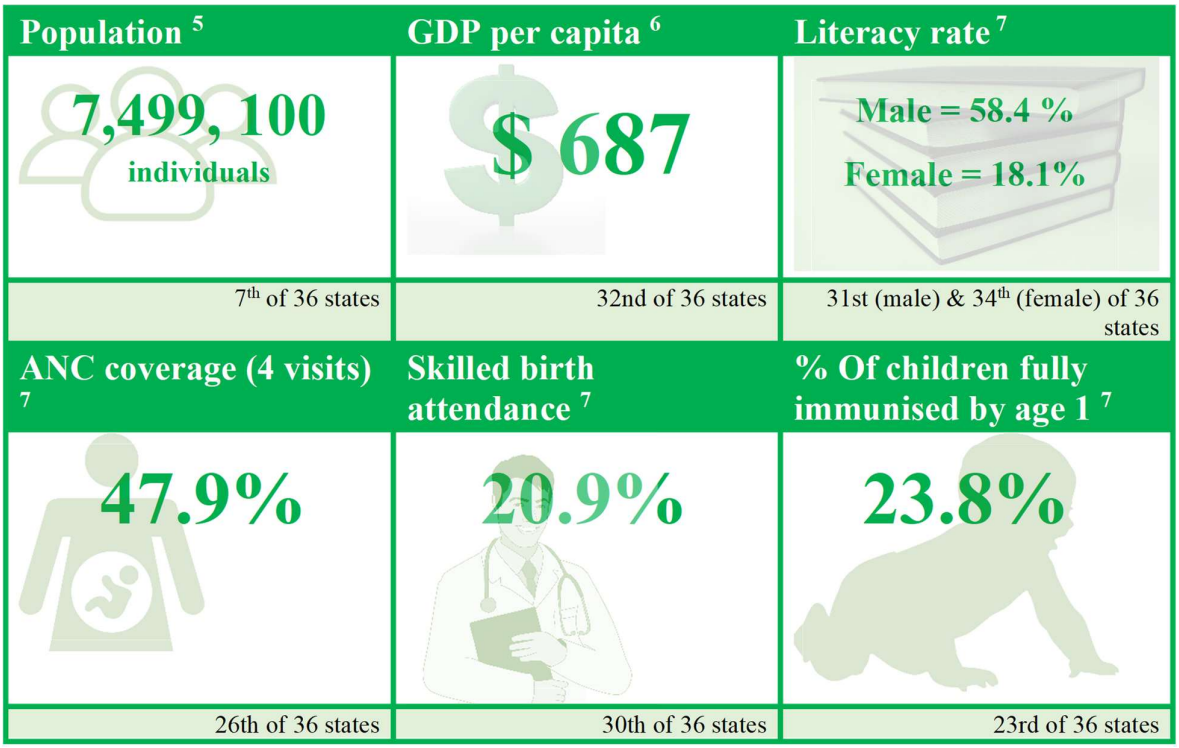
Figure 2 illustrates some of the key statistics in the state. As of March 2022, Jigawa had an estimated population of about 7.5 million individuals across the 27 LGAs and was Nigeria's 7th most populous

state. [5] With a Gross Domestic Product (GDP) per capita of $ 687, it ranks 32nd of 36 states, suggesting a low economic output per person. [6] Similarly, the state has one of the country's lowest male (58.4%) and female (18.1%) literacy rates.

Despite significant multisectoral gains within the state, Jigawa has some of the poorest health indicators in the country (Figure 2). The state ranks among the lowest nationally for the percentage of ANC coverage (4 visits) at 47.9%, skilled birth attendance at 20.9%, and immunisation by age 1 at 23.8 %, reflecting some of the lowest rates in the country. [7]

[5] NIGERIA: States & Cities. Available at https://www.citypopulation.de/en/nigeria/cities/
[6] 2020 State of States ranking. Available at https://stateofstates.kingmakers.com.ng/Default.aspx
[7] Nigeria Demographic and Health Survey 2018. Available at https://www.dhsprogram.com/publications/publication-fr359-dhs-final-reports.cfm

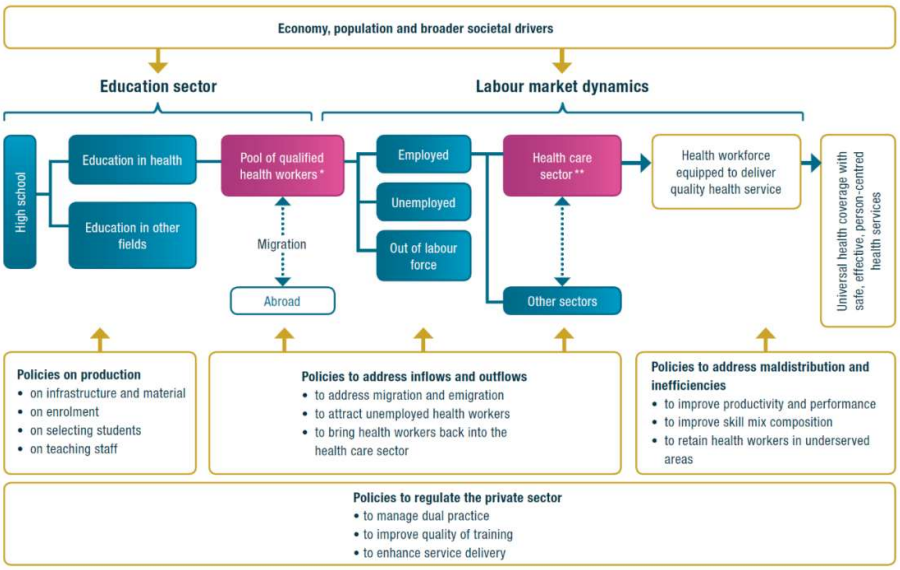
Figure 2: Key statistics for Jigawa State



2.2 Health Labour Market Analysis

This section highlights the health labour market in Jigawa State drawing on the HRH situation analysis conducted in 2021/22. As shown in Figure 3, the health labour market analysis illustrates the health labour market dynamics and the contribution of health workforce policies to the attainment of equitable access to quality health services and UHC. The Health Labour Market Analysis is a dynamic and complex system that generates information required to inform policymaking, strategic investments, and effective health workforce planning at national and sub-national levels. It also provided a comprehensive understanding of the key factors influencing the supply and demand of health workers. This improves the ability to forecast and plan for the health worker needs of the future and guide short-term strategies to address immediate issues. The approach looks into the production of health workers through the education system from secondary school to training institutions and then the production of a pool of active skilled health workforce equipped to deliver quality health services where they are needed.

Figure 3: Policy levers to shape health labour market



Source: Sousa A, Scheffler M R, Nyoni J, Boerma T "A comprehensive health labor market framework for universal health coverage" Bull World Health Organ 2013; 91:892– 894

Education and labour market dynamics

Education sector: Jigawa State has an inadequate production pool for HRH. The education and training of health workers is a key determinant of the supply of health labour in the state. The availability of new graduates from the training institutions depends on several factors, such as the number of slots available in training programmes and the admission criteria, the location, and the social orientation of the health training. It also depends on potential health workers' decision whether to pursue a health profession and obtain the required education. Those decisions will be based, at least in part, on the attractiveness of the salaries and potential returns for the years of study and financial investment needed (e.g., tuition fees, books, etc.). The pool of qualified health workers is the number of individuals who have been trained, but the supply is only the number of qualified health workers willing to work at the prevailing wage rate.

Labour market dynamics: As shown by the health labour market framework, appropriate employment conditions need to be in place to ensure retention within the system; otherwise, there is a risk of brain drain and waste of resources. In reality, the level of employment within the state's health sector will be largely determined by health labour market dynamics and, to a lesser extent, the population's health needs. The health labour market encompasses several dimensions. The combination of fund

availability, governance, political priorities, demand and supply of trained health workers determines the wages, the number of health workers employed, the number of hours they work, their geographic location, employment setting, productivity, and their performance.

The demand for healthcare workers at the PHC level is determined by the state and LGAs that hire and pay health workers to provide services in health facilities and other settings such as the community. The LGAs continue to compete for employment and retention of health workers based on their wage rates, regularity of payment, benefits packages, working conditions, and other labour regulations and rules. The level of competitiveness of the LGAs across the state will influence how attractive they are to health professionals (including new graduates) compared to other LGAs and other states. Health workers will be more inclined to work in the health sector if the wage is higher and the working conditions are good; there are career opportunities, there are few or no safety concerns, and social amenities are available.

In Jigawa State, doctors, nurses and midwives' shortages occur because of an overall lack of workers to fill the jobs in question, suggesting that unless additional strategies are put in place to increase production in the training schools, the shortage of health workers may persist. While the state has not formally adopted the task-shifting task-sharing policy, there is anecdotal evidence that workers other than physicians, nurses and midwives provide health services.

Despite policies and efforts to decrease health workforce inequalities across LGAs, major inequalities persist across the 27 LGAs (see Table 5 for the distribution). An urban LGA such as Hadejia has 92.02 nurses, 12.27 midwives, and 62.47 CHEWs per 100, 000 population. In contrast, a rural LGA like Maigatari has 1.31 nurses, 0.00 midwives and 12.81 CHEWs per 100,000 population. These data suggest that poorer LGAs have difficulty attracting and retaining health workers. Therefore the population has less access to health services and may have worse health outcomes than those in affluent areas. This inadequate health workforce capacity to provide health services to the entire population is a major challenge for equitable access to health services and UHC. Thus, retaining health workers in underserved and poor areas deserves increased policy attention.

State HRH strategies: Jigawa State health system continues to restructure the health system to address the HRH challenges through overseas training of medical students to become doctors, recruitment of high cadre staff, establishing additional training institutions, and bonding arrangements with sponsored health workers. Table 1 considers some of the state's HRH-relevant strategies, including the benefits and challenges of each strategy.

Table 1: Summary of recent HRH-relevant strategies influencing the health labour market

Strategy group	Strategy description	Benefits	Challenges
To increase the production of health workers	1. Establishment of two additional colleges of nursing and midwifery to the existing one at Birnin Kudu	Potential to increase the annual production of nurses and midwives	Additional teaching staff will be required to maintain the recommended teacher: student ratio
	Foundation year programme	Encourages the production of female nurses and midwives from underserved regions who are bonded to serve their communities for a stipulated period	Where bonding rules are not properly enforced, sponsored female nurses and midwives do not return to serve the community that nominated them
	Sponsorship of state indigenes to train as doctors outside the country	Potential to significantly increase the number of doctors available in the state	The cost of training might be less in local institutions which may provide an experience that is more contextually relevant to health practice in Jigawa State
	Establishment of bonding arrangement with students pursuing health disciplines in Nigerian higher institutions	Potential of increasing workforce number in the state	Some students don't comply with the bonding agreement upon graduation
	In-service training of all health professional cadres	Improvement of skills for better service delivery	Improved skills may make workers more attractive to external markets, thereby contributing to brain drain
To address health worker inflows and outflows	Partner support with the recruitment of midwives to provide services at the PHCs	This initiative can potentially reduce the health workforce gap and address some of the maternal health challenges at the PHC level	Dependence on partners may not be sustainable in the long term Poor retention of midwives that are not culturally adapted to the community of primary assignment
	Basic Health Care Provision Fund supports the recruitment of HRH at the PHC level	Increase in health workforce at the PHC level	Allowance paid is not competitive or commensurate with expertise resulting in poor retention
To address maldistribution and inefficiencies	Local Governments' fiscal autonomy	Local governments with financial autonomy can plug existing HRH gaps without the assistance of the state	Health worker shortages in PHCs in LGAs that are less financially capable of attracting health workers. Health workers may be deployed to communities based on political considerations rather than based on need
	Provision of accommodation and security for midwives serving in rural areas	The availability of accommodation and local security incentivises retention in rural communities	Lack of other amenities such as potable water, internet services, banks and good schools deter nurses and midwives from living in their communities

Implications of the existing health labour market strategies

This framework was used to identify the major HRH-relevant strategies that have been formulated (and implemented) in recent years. As shown in Table 1, these strategies have their strengths and weaknesses and may impact:

a. The production of new graduates

In the past years, major efforts have been undertaken by the state government to address the shortage of health workers through increased production. These strategies have effectively increased the number of new graduates in the state. Still, additional considerations must be given to the factors limiting successful implementation. The increase in the number of training institutions needs to be matched with a commensurate increase in the number of highly qualified trainers engaged by the state to ensure that the quality of training is not compromised. For the investment in training to effectively result in the recruitment and retention of healthcare professionals in regions where their services are most needed, it is imperative to establish contextually-relevant incentives.

b. Inflows and outflows of health workers

Inflows and outflows refer to the movement of health workers into and out of the state's overall health workforce. Partner support with the recruitment of midwives has been beneficial in ensuring the availability of high-priority staff at the rural LGAs. Asides unsustainability of partner support, huge ambiguity surrounds the inflow and outflow of health workers, which the Civil Service Commission, SMoH and SPHCDA coordinate. For effective coordination, the HRH data system will need to be strengthened for prompt documentation of new intakes and those lost to retirement, resignation, migration and death, thereby informing need-based recruitment. In recent years, recruitment drives have been negatively affected by poor funding, embargos on engaging lower cadre staff while poor coordination of health worker exits persist.

c. Maldistribution and retention of health workers

Health workers available for service delivery are maldistributed between the rural and urban LGAs in the state. Providing accommodation and security for midwives in rural areas reflects a huge effort by host communities and the state to retain staff posted to rural areas. Nonetheless, these efforts do not suffice for optimal retention as other factors such as cultural compatibility, availability of internet, banks, potable water and electricity also play key roles in the decision to remain in an LGA. Additionally, the presence of these amenities in the more urban LGAs, which often have a greater

capacity to provide better working conditions for health workers, will influence distribution. More so, the LGAs have some autonomy to recruit health workers. Poor health staff retention in the rural LGAs creates an extra burden on the remaining staff. Asides from the inadequacy of health worker numbers, the lop-sidedness of HRH distribution also exists with cadre, sex, type of contract and level of care which are discussed in Section 2.5.

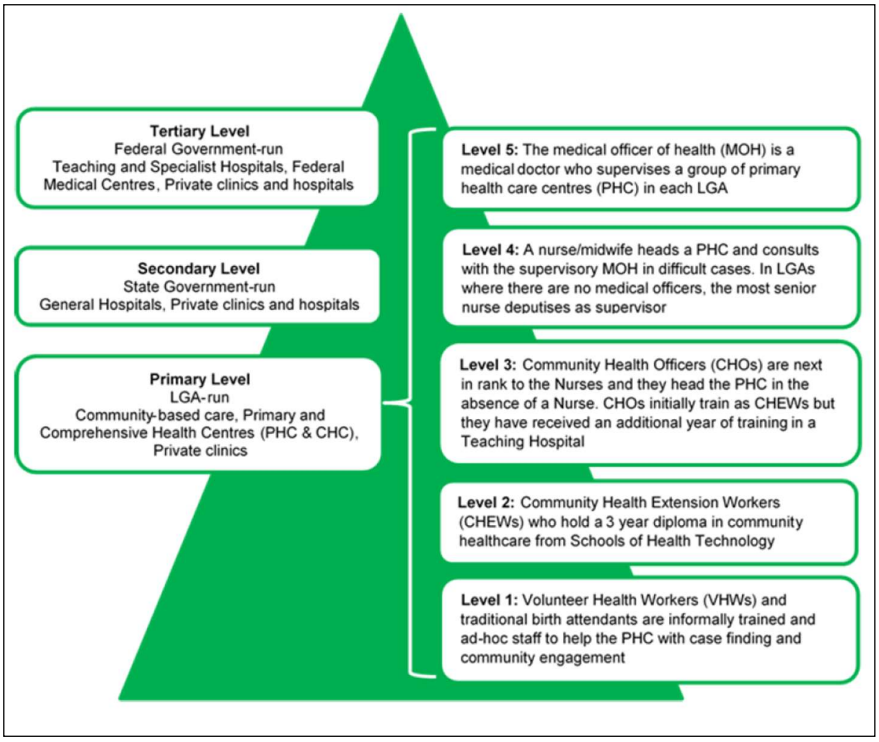
2.3 Health Systems Organisation and Service Delivery Structure

The organisation of the health service delivery in Nigeria, and by extension, Jigawa State, is shown in Figure 3. All three tiers of government share the responsibility of providing governance to the health facilities at the three levels of care. The Federal Government is largely responsible for providing policy guidance, planning, and technical assistance for coordinating the state-level implementation of the National Health Policy and establishing health management information systems. Additionally, the Federal Government is entrusted with the responsibilities of disease surveillance, drug regulation, vaccine management, and regulation of health professional training. Furthermore, the Federal Government oversees the administration of most teaching and specialist hospitals, along with certain medical centres, such as the Federal Medical Centre in Birnin Kudu.

Jigawa State operates public health facilities that include a tertiary hospital,14 general hospitals, two specialised hospitals (Tuberculosis and leprosy referral hospital, Psychiatric Hospital), over 700 public PHCs, and some private health facilities. The SMoH, SPHCDA, and the LGAs share the responsibility of managing health facilities and programmes. Training medical students, nurses, midwives, health technicians and providing technical assistance to local government health programmes and facilities are also the responsibility of the state authorities.

The 27 LGAs oversee the operations of PHC facilities within their geographic areas. This includes providing basic health services, health promotion, and community health hygiene and sanitation. The health system also comprises the private health sector (profit and non-profit) as well as traditional and spiritual healers.

Figure 4: Organization of service delivery in Nigeria

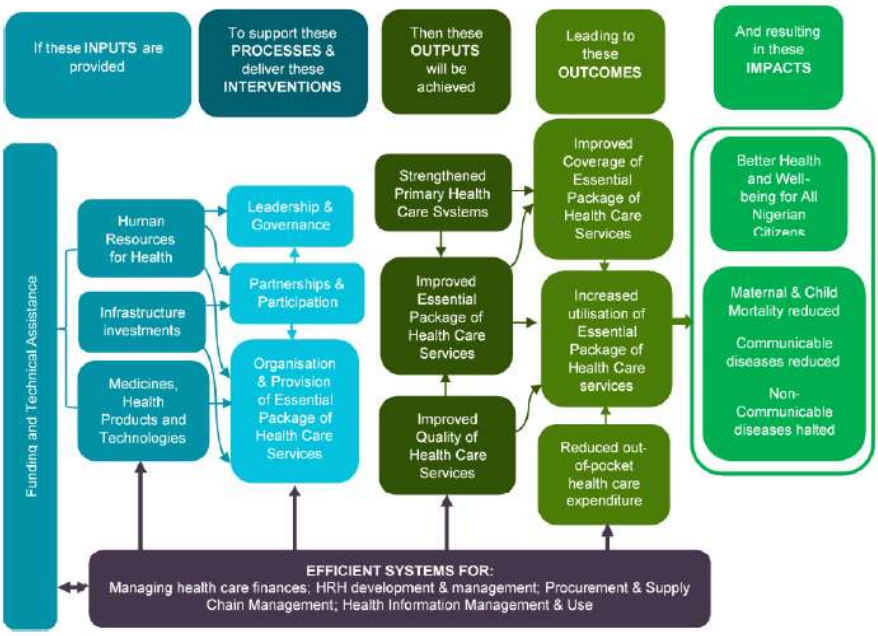


***Source**: NSHDP ll*

2.4 Overview of HRH Management in Jigawa State

Health workforce governance or stewardship capacity at the state and LGA levels are fundamental to steering the health workforce agenda in Jigawa State for effective service delivery. A functional health system is essential for Jigawa State to deliver UHC and ensure that the state achieves the SDG health targets. The essence of the HRH in attaining the health sector goal is recognised in the NSHDP II (Figure 4).

Figure 5: NSHDP II Theory of change



Current evidence suggests that the health workforce is the weakest of the six pillars of the health system both at the state and LGA levels. Jigawa State health system is only as strong as the performance of the health workforce. Different stakeholders have a role in HRH governance within the health sector. These include the Ministries of Education, Finance, Agriculture, and Environment. Other agencies include the Civil Service Commission, Local and state governments, regulatory bodies, professional associations, trade unions, academia, and development partners. The HRH unit has the role of coordinating the stakeholders to achieve their mandate.

Strengthening HRH governance at the state level is critical if Jigawa State is to effectively work on attaining UHC and SDGs. Two obstacles that hinder strengthening HRH are governance capacities and insufficient investments. Jigawa State continues to enhance the HRH governance structure through the HRH steering committee, technical working group and HRH-dedicated units but will need to improve financial investments in HRH. This will include strengthening the HRH units at the Directorate of Planning, Research and Statistics in SMoH and SPHCDA with the requisite number of qualified staff and teams. These teams can effectively support the health system and manage the health workforce towards providing improved and better health services.

Jigawa State has an HRH structure comprising various policy dialogue platforms:

a. State-level HRH steering committee oversees HRH activities in the state and guides the conceptualization, implementation and use of information from Health Workforce Registry. This committee meets twice a year. This committee is to establish a functional HRH structure at the SMoH that will oversee SPHCDA, including the twenty-seven LGA PHC offices, Jigawa State Contributory Health Care Management Agency (JICHMA), secondary and specialist hospital, the health training institution, and private health sector in the state. Additionally, it will guide the conceptualisation, implementation and use of information from Health Workforce Registry.

b. The HRH technical working Group regularly update the Health Workforce Registry and publish HRH data to inform planning via periodic bulletins and provides advisory and data-based technical support to the Steering Committee.

This group is to provide advisory and data-based technical support to the Steering Committee in bringing up relevant and evidence-based recommendations and enabling routine HRH data updates on the Health Workforce Registry. The group publishes HRH data to inform planning through periodic bulletin.

c. A local government-level taskforce of LGA representatives meets every quarter to submit and validate data and discuss HRH issues.

However, the HRH structure in Jigawa State will benefit from strengthening it with adequate human and capital resources, enabling it to transcend operating only at the administrative level to driving policy and strategic direction with less reliance on funding from development partners.

Analysis of the functions indicates that the HRH units are responsible for five functions. They mainly undertake policy and plan development and implementation; management of HRH Information system; HRH research and documentation; and monitoring and evaluation. Personnel management, including recruitment and performance management, is coordinated by the Civil Service Commission, while every department in the JSMOH and JSPHCDA coordinates the training and development of its staff. Table 2 shows the seven HRH management functions and those handled by the HRH branch in the SMOH.

Table 2: The seven HRH functions and those handled by the HRH unit

HRH Governance: Level	Policy Development	Plan Development & Implementation	Personnel management	Training & Development	HRH info. Systems	Research, studies, and documents	HRH M&E
Ministry	Commissioner	Commissioner	Commissioner	Commissioner	Commissioner	Commissioner	Commissioner
Department	DPRS	DPRS (SMOH) Dir. Admin & Finance (JSPHCDA)	Director Admin & Finance (JSMOH & JSPHCDA)	Director Admin & Finance (JSMOH & JSPHCDA)	DPRS	DPRS at SMOH and DPM&E at JSPHCDA	DPRS DPM&ME
Unit	Deputy Director	HRH (JSMOH) Deputy Director HRH (JSPHCDA)	Administrative Officer (JSMOH) Dep Dir HRH (JSPHCDA)	Personnel Officer	Deputy Directors HRH at SMOH	Deputy Director of Research at SMOH Deputy Director M&E at JSPHCDA	HRH unit at SMOH and JSPHCDA
LGA/Hospital facilities	Focal person	Focal person	Staff Officer at Hospital and HRH focal person at LGA	Focal person at LGA and Staff Officer at Hospital	Focal persons	Focal Person	Focal Person

The HRH unit primarily engages in policy planning, implementation management of HRH Information systems, HRH research and documentation, and monitoring and evaluation. Nevertheless, it must be emphasised that the role of HRH should be strategically positioned at the state level to support HRH functions effectively. Personnel management and staff training and development fall outside the purview of the HRH unit. Personnel management, including recruitment and performance management, is coordinated by the Civil Service Commission. At the same time, each department in the SMoH and SPHCDA is responsible for coordinating the training and development of its staff.

2.5 Disease Burden Trends in Jigawa State and Their Implications on HRH

To address the state's disease burden, adequate human resources are required if access and coverage have to be achieved at all levels of care across the 27 LGAs in the state. The disease profile in the state is similar to that of Nigeria. The 2018 global burden of disease study shows that Nigeria has progressed in some health indicators. However, it is still undergoing an epidemiological transition, and communicable diseases comprise the majority of diseases in the country. Although there has been some decline in maternal and childhood mortality since 2003, the pace of reduction and geographical disparities in the distribution of the burden remains a huge concern. The country has the highest prevalence of Neglected Tropical Diseases in Africa, accounting for 25% of the global burden. Non-communicable Diseases (NCDs) contribute significantly to adult mortality and morbidity. The major NCDs include cardiovascular diseases (hypertension, stroke, and coronary heart disease), diabetes mellitus, cancers, sickle cell disease, and chronic obstructive pulmonary diseases including asthma. Others include mental health disorders, violence, road traffic injuries, oral and eye pathologies. The prevalence of NCDs is predicted to rise even more in the coming decades.

Table 3: Ten leading causes of death in Nigeria

Rank	Leading causes of death in Nigeria
1	Lower respiratory infections
2	Neonatal disorders
3	HIV/AIDS
4	Malaria
5	Diarrhoeal diseases
6	Tuberculosis
7	Meningitis
8	Ischemic heart disease
9	Stroke
10	Cirrhosis

Source: GBD Compare 2018, Nigeria-CDC

The leading causes of death include lower respiratory infections, neonatal disorders, HIV/AIDS, malaria, diarrhoeal diseases, and tuberculosis, as shown in Table 3. The high disease burden and emerging trends required access to well-trained, well-distributed, right-skill mix and culturally-sensitive health workers. This strategic plan proposes to ensure the availability of skilled and responsive health workers to respond to the needs and provide people-centred services to the population.

2.6 Health Workforce Stock

As of 2021, Jigawa State had 143 doctors equivalent to 1.9 doctors per 100,000 population (doctor-to-population ratio of 1:52441). There are also 888 nurses, equivalent to 11.8 nurses per 100,000 populations (nurses to population ratio of 1:8,445), and 207 midwives, equivalent to 2.8 midwives per 100,000 population (midwives to population ratio of 1:36,228). The state has 29 pharmacists, equivalent to 0.4 pharmacists for every 100,000 residents (pharmacists to population ratio of 1: 258,590). There are 128 community health officers (CHOs) in the state, equivalent to 1.7 CHOs per 100,000 people (CHO to population ratio of 1:58,587), 1536 community health extension workers (CHEW), equivalent to 20.5 CHEWs per 100,000 people (CHEW to population ratio of 1:4,882), 778 Junior Community Health Extension Workers (JCHEWs), equivalent to 10.4 JCHEWs per 100,000 people.

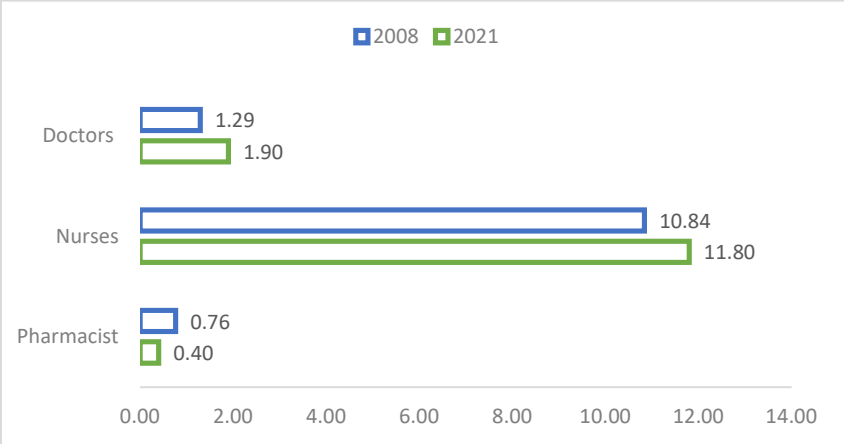
Table 4: Stock of health workers in Jigawa State

Cadre	Stock	Per 100,0000	Per population
Doctors	143	1.9	1:52441
Nurse	888	11.8	1:8445
Midwife	207	2.8	1:36228
Pharmacist	29	0.4	1:258590
Physiotherapist	22	0.3	1:340868
Medical lab scientist	69	0.9	1:108683
Community health officer	128	1.7	1:58587
Community health extension worker	1536	20.5	1:4882
Junior community health extension worker	778	10.4	1:9639
Medical lab assistant	52	0.7	1:144213
Medical technician	473	6.3	1:15854
Pharmacy technician	117	1.6	1:64095
Radiographer	38	0.5	1:197345
Record technician	1	0.0	1:7499100
Administrative professional	5164	68.9	1:1452
Dental surgery assistant	3	0.0	1:2499700
Dental technologist	82	1.1	1:91452
Dental therapist	23	0.3	1:326048
Dispensing optician	4	0.1	1:1874775
Health information manager	171	2.3	1:43854
Public analyst	2	0.0	1:3749550
Dental health technician	4	0.1	1:1874775
Environmental health officer	939	12.5	1:7986
Financial professional	45	0.6	1:166647
Health record officer	211	2.8	1:35541
Health professional associate	663	8.8	1:11311
OTHERS (Medical imaging processing technician + Orthopedic Plaster technician)	3	0.0	1:2499700
TOTAL	**11795**		

Source: SMoH 2021

Jigawa State has experienced an increase in the number of health workers between 2008 and 2021 to meet the demands of the growing population. This is largely attributable to government policies and strategies, including bonding undergraduate students in health-related disciplines, increased production capacities of the training institutions, overseas training of medical students, and recruitment drive, including engagement of health workers from outside the state. Analysis to compare 2021 HRH figures with the 2008 figures is illustrated in figure 6 with three cadres. Overall, it shows an increase in the density of doctors and nurses but not pharmacists suggesting that the increase in the number of health workers may be skewed towards certain cadres.

Figure 6: Health Worker Density per 100,000 population



Source: SMOH 2008, 2021

There is a critical shortage of health workers in certain local government areas based on the distribution of existing health workers within the LGAs. Figure 6 illustrates the density of selected health care cadres per 100,000 populations.

Table 5: Distribution of health workers across LGAs

S/N	LGA	Population	Health worker density (per 100 000 population)						
			Doctors	Nurses	Midwives	Pharmacists	CHO	CHEW	JCHEW
1	Auyo	227400	0.00	3.96	3.96	0.00	0.88	29.46	5.72
2	Babura	366200	0.27	8.74	4.37	0.00	2.73	33.59	7.37
3	Birnin Kudu	540100	13.89	30.74	2.96	0.56	1.48	14.81	4.26
4	Birniwa	244200	0.82	11.06	2.87	0.41	0.00	11.06	1.64
5	Buji	167300	0.00	0.00	0.60	0.00	1.79	29.89	6.58
6	Dutse	431800	9.26	41.22	5.09	2.78	1.62	3.24	19.22
7	Gagarawa	141300	0.00	2.12	0.71	0.00	5.66	36.09	21.23
8	Garki	258400	0.00	0.00	1.16	0.00	0.77	10.45	18.19
9	Gumel	182900	0.55	32.80	2.19	0.55	0.00	28.43	14.22
10	Guri	194900	0.00	0.51	2.57	0.00	0.00	32.32	10.77
11	Gwaram	466600	0.86	4.07	1.50	0.64	4.07	14.36	10.29
12	Gwiwa	221400	0.00	0.00	3.16	0.00	0.45	11.74	6.32
13	Hadejia	179300	3.35	92.02	12.27	1.67	1.67	62.47	10.60
14	Jahun	395300	0.76	6.58	3.54	0.76	3.54	34.66	12.65
15	Kafin Hausa	459600	0.87	5.66	4.13	0.00	1.74	16.75	5.66
16	Kaugama	221800	0.00	0.90	3.61	0.00	0.45	35.17	14.88
17	Kazaure	277100	1.44	18.40	5.41	0.72	0.00	15.52	5.05
18	Kiri kasamma	331200	0.00	0.00	1.21	0.00	1.51	20.83	10.27
19	Kiyawa	297400	0.34	4.03	3.03	0.00	3.03	27.91	9.08
20	Maigatari	304500	0.00	1.31	0.00	0.00	0.00	12.81	1.97
21	Malam Madori	283400	0.00	0.00	0.71	0.00	2.47	23.99	10.59
22	Miga	219900	0.00	0.45	2.27	0.00	1.36	13.19	35.02
23	Ringim	330900	0.30	22.06	0.91	0.30	1.51	18.43	15.71
24	Roni	133100	0.00	13.52	3.01	0.00	8.26	27.80	15.78
25	Sule Tankarkar	231800	0.00	0.00	0.43	0.00	0.43	9.92	0.86
26	Taura	226700	0.00	5.73	0.44	0.00	0.00	3.97	2.65
27	Yankwashi	164400	0.61	1.22	1.22	0.00	0.61	14.60	20.68
Jigawa State		**7498900**	**1.91**	**11.84**	**2.76**	**0.39**	**1.71**	**20.48**	**10.37**

Source: SMOH 2021

2.5.1 Number of registered health workers

Health workers in public and private health facilities and within agencies are profiled through the State health workforce registry, which is domiciled within the HRH units of the SMOH and SPHCDA. Furthermore, HRH units maintain professional standards among health workers by facilitating Continuing Professional Development (CPD) and promoting in-service training.

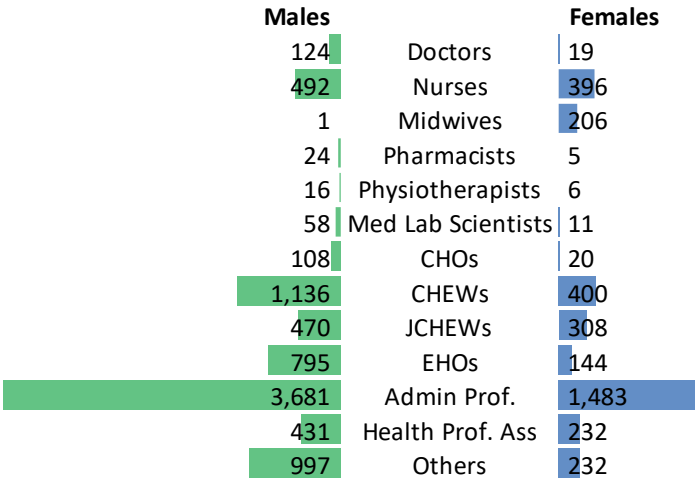
2.5.2 Health workforce by gender

Among the 11,795 health workers in the state, 8333 are males, while 3462 are females. Figure 7 shows the distribution of different cadres by gender. Overall, there is a male predominance across all

cadres except for midwives. This underscores the need to make gender considerations relevant to the production and deployment of health workers.

In addition to determining HRH needs, gender-disaggregated information on recruitment, training, distribution, and attrition is needed to improve the efficiency of HRH functions. Such information should be complete, accurate, reliable, timely, up-to-date, and made available for decision-making at all levels. The gender mix of health providers in favour of men means that access to same-sex caregivers is significantly reduced for the female population, who comprise the greater number of those accessing basic healthcare.

Figure 7: Distribution of health workers by gender



Source: SMOH 2021

2.5.3 Health workforce by contract type

Of the health workers, 7355 have a permanent contract while 4440 were engaged in non-permanent contracts.

Table 6: Distribution of health workers by contract type

Cadres	Permanent	Contract	Casual	Volunteer
Doctors	119	19	4	1
Nurses	811	58	16	3
Midwives	124	63	19	1
Pharmacists	20	7	1	1
Physiotherapists	21	1	-	-
Med lab scientists	48	3	16	2
CHOs	120	1	6	1
CHEWs	1320	32	151	33
JCHEWs	624	11	123	20
EHOs	494	48	301	96
Administrative professionals	2541	501	1960	162
Health professionals associate	428	17	190	28
Others	762	47	354	66

Source: SMoH 2021

2.5.4 Availability and skill mix of health workforce across levels of care

Overall, the primary level facilities have the largest population of health workers, while tertiary health facilities have the lowest population. Further analysis shows that the distribution of health professionals like doctors, nurses, is skewed towards secondary and tertiary levels of care while the converse applies to lower cadres, being skewed towards the PHCs.

Table 7: Distribution of health workers across levels of care and institutions

Cadres	Primary	Secondary	Tertiary	Private	MDAs	HTI
Doctors	5	21	109	3	5	
Nurses	76	546	171	7	26	62
Midwives	91	85	13		13	5
Pharmacists	2	10	14	-	-	3
Physiotherapists	-	12	10	-	-	-
Med lab scientists	13	27	17	-	3	9
CHOs	68	16	-	1	34	9
CHEWs	1,031	252	3	18	225	7
JCHEWs	599	85	3	26	64	1
EHOs	556	77	8	7	284	7
Administrative professionals	2,325	1,252	549	64	668	306
Health professional associates	285	265	29	2	72	10
Others	562	414	110	32	95	16

2.7 Health Workforce Attrition

Attrition in the public sector is mainly due to several reasons, including retirement, death, dismissal, and voluntary resignation. Other reasons include internal or external migration, including leaving the public sector for the private sector for more attractive occupations or migration to other states with better remuneration packages or from a state-owned facility to a federal facility with better remuneration packages. Furthermore, attrition may occur from a lack of access to professional development and further education for those in rural areas, weak regulatory environments, inadequate supervision, and heavy workloads, among others. Measuring attrition and identifying determinants should be an integral part of managing health workers, but this is often ignored in favour of reporting health outcomes and process indicators such as the number of health workers recruited and trained. Attrition that disrupts the continuity of care and retraining costs can undermine health services.

2.8 Health Workforce Financing

The weaknesses in financing the health workforce include weak institutional structure, inconsistent policy implementation, and low government investment in health. Implementing specific HRH plan, management, and development activities in the health budgets, outside of salaries and related entitlements, is sub-optimal mainly due to insufficient funds. Jigawa State has no dedicated budget lines for the activities mentioned above.

Coordination of health workforce financing: The financing of HRH is done through several modes. The sources of financing are either public or private. Generally, public funding for HRH is not earmarked under a dedicated HRH budget line in the health sector. Whereas some financing for HRH may be consolidated in the annual health budget, its management would be in other public institutions whose remit covers the HRH function. These include HRH salaries managed by the ministries of Finance and/or Budget and Economic Planning, HRH training budgets often managed by the Office of the Head of Service and HRH recruitment managed by the Civil Service Commission and Local Government Service Commission. The SMoH mostly manage only the core administrative and operational costs.

Consequently, a substantial amount of funding for HRH appears not to pass through the SMOH budget systems. The way the health budget is structured and managed is fragmented, thus making it difficult to disaggregate expenditures according to the focal themes of HRH, such as development, training, education, motivation, research, monitoring and evaluation, information management and strategic management. It is difficult to pinpoint the actual volume of public funding that goes to HRH as the state government is yet to establish a budget system for HRH in the health sector.

Management of HRH funds in the public sector: Assessing HRH financing only from the standpoint of the public sector health budget often undervalues the volume of public funding for HRH. Notwithstanding, state government spending on HRH via allocations to the health sector has seen an increase in the annual health budget. The budget is primarily expended on recurrent expenditure, of which the greater ration is spent on salaries and allowances of health workers. The available data shows that besides remunerations and benefits, there is usually insufficient fiscal space to accommodate HRH strategies in the health budget directly.

Private sector contribution to HRH: HRH financing occurs through multiple mechanisms. For example, international donors (bilateral and multilateral agencies) fund HRH development through health-focused interventions. It is recognised that many international development programmes and partners earmark funds to support various HRH components. Such partners include the Global Fund, FCDO, UNICEF and WHO. These funds are, however, channelled through direct implementation of programmes in HRH such as training, workshops and procurement. These expenditures are not routinely captured in the SMoH budgets. Thus, it is difficult to ascertain the volume. This presents yet another dimension to the seeming opaqueness of the volume of financing that goes to HRH in the state. It is difficult to ascertain the volume of these non-public donor financing initiatives. Considering the role of out-of-pocket expenditure (OOPE) in financing health, it is also noted that

health workers invest their funds in their career and professional development either in-country or abroad from the weak implementation of in-service training and CPD programmes. These constitute a significant but unrecognisable part of the financing for HRH but are not consolidated into a central expenditure tracking system of HRH. Another key challenge in the private financing of HRH is the mode of delivery of its multiple vertical funding streams, which is not well coordinated. Hence, there exists a conflict in both strategy and application, leading to redundant efforts, disproportionate support for specific Local Government Areas (LGAs) while neglecting others, wasteful utilisation of resources, and inefficiencies. It is, therefore, difficult to assess who is funding what and how much is spent going by the way partners are unwilling to share information on their financing strategies and funding for HRH. All the above reasons threaten sustainable financing and funding for the state's HRH strategies and reform activities. It is, therefore difficult to determine the relative amount of this volume of funds in financing HRH in the state.

2.9 Health Workforce Production and Training

According to the state record, Jigawa State has one teaching hospital in Dutse, and a College of Nursing and Midwifery in each of the three senatorial districts. The colleges have varied levels of accreditation. Furthermore, there is a college of health sciences and technology located in Jahun to train CHEWs and JCHEWs, among other cadres.

As shown in Table 5 below, the state has one public medical school with partial accreditation and the capacity to produce 50 medical doctors annually, three public colleges of nursing and midwifery with provisional to full accreditation and a total capacity to graduate 175 nurses and 70 midwives annually, one private college of nursing and midwifery with a capacity to graduate 50 nurses and 50 midwives. [8],[9] The college of nursing and midwifery in Babura and the department of nursing at Khadijat University are yet to be assigned quotas.

The production of health workers extends beyond state boundaries to encompass other states and international jurisdictions. At present, there are a total of 367 students who are currently participating

[8] Medical and Dental Council of Nigeria. Available at https://www.mdcn.gov.ng/page/education/accredited-medical-schools-in-nigeria-as-at-october-2022
[9] Nursing and Midwifery Council of Nigeria. Available at https://www.nmcn.gov.ng/apschool.html
10. Community Health Practitioner and Regulatory Board of Nigeria. Available at https://www.chprbn.gov.ng/#

in training programmes outside of Jigawa State, as part of a bonding arrangement. This figure comprises 109 interns/house officers and 31 BSc Nursing students who have recently been sponsored to pursue their studies at Al-Istiqama University in Kano. The aggregate count of foreign-trained medical students amounts to 220, with 160 students studying in Sudan and 60 students in China, of which 31 students who were trained in China have graduated and subsequently returned. When operating at maximum capacity, the state should achieve an annual production of 121 doctors, 225 nurses, and 120 midwives, all of whom can be deployed to different healthcare facilities.

The local training institutions are regulated and coordinated by multiple organisations including the Federal Ministry of Education, Ministry of Health, National University Commission and other health professionals' regulatory bodies. [10] In collaboration with these multiple organisations, training institutions in the state can scale up the production of critical and competent health workers creating a pipeline for recruitment. This will provide a viable source for employers to recruit competent individuals to the health workforce.

However, enrolment and production of health workers in the Jigawa State health training institutions are currently not determined by evidence-based HRH needs nor reflect the staffing gaps across the LGAs. There is a need to be inclusive to enshrine admission policies that consider educationally disadvantaged populations with low literacy rates as admission into most training programmes for health workers would require secondary education. Furthermore, there is a need to track and address challenges encountered during the upward movement of candidates along the pipeline including entry to training institutions, attrition while training, and availability of job vacancies. Stakeholders should track retention of students and put mechanisms in place to address factors that contribute to attrition such as poor academic performance, financial constraints and personal circumstances.

Table 8: Medical training institutions and accreditation status

Name of training institution	Cadre produced	Accreditation status	Graduation quota
College of Medicine and Allied Health Professions, Federal University, Dutse, Jigawa State	Doctors	Partial accreditation	50 students
School of Nursing, Birnin-Kudu: Community Nursing Programme	Nurses	Full Accreditation	100 students
School of Basic Midwifery, Birnin-Kudu: Community Midwifery Programme	Midwives	Full accreditation	70 students
College of Nursing, Hadejia: Community Nurisng Programme	Nurses	Full accreditation	75 students

Iqra College of Nursing Sciences, Dutse: School of Nursing	Nurses	Provisional accreditation	50 students
Iqra College of Nursing Sciences, Dutse: School of Midwifery	Midwives	Provisional accreditation	50 students
College of Nursing Sciences, Babura: School of Nursing	Nurses	Provisional accreditation	No information
College of Nursing Sciences, Babura: School of Midwifery	Midwives	Provisional accreditation	No information
Department of Nursing Sciences, Khadijat University, Majia,	Nursing	Under accreditation process	No information
College of Health Science and Technology, Jahun	Community Health Extension Workers	Full accreditation	No information

2.10 Health Workforce Performance and Productivity

Implementing performance management in the health workforce is essential to improving accountability, efficiency, productivity, and quality of care. The state and LGAs have instituted some form of performance management systems that outline clear sets of deliverables to be achieved within certain timelines aligned to a fiscal year. These deliverables are usually drawn from health sector development plans and priorities. Systems, processes, and mechanisms of health workers' supervision in the health sector appear well-established but poorly implemented.

Mechanisms for measuring the performance and productivity of health workers exist but only as part of the general civil service performance monitoring system using the pre-designed Annual Performance Evaluation Report (APER) process. Jigawa State and its LGAs have adopted a similar approach, although the APER is not adequately cascaded to individual workers, making it difficult to differentiate a productive and non-productive worker. There are difficulties linking health deliverables to existing performance management systems for civil servants, thus the need for domesticating the forms to the health sector needs. Jigawa State adopts both financial and non-financial incentives for motivating health workers. The SMoH and SPHCDA have not developed a set of indicators or systems to specifically measure or compare workers' performance in the health sector. At the organisational level, organisation performance monitoring and management are also poorly developed. Generally, therefore, integrated performance management specific to the health sector which combines several monitoring activities, including the tracking of workloads is not well developed. Periodic health worker productivity surveys are not routine practices.

Low morale amongst health workers is a challenge limiting the performance, accountability, and productivity of health workers with consequences on quality health care delivery. The main factors

causing low morale include poor remuneration and work environment, high workloads, inadequate social support, unfavourable working conditions, and frequent shortages of supplies. These are worse in rural and remote areas.

There are government initiatives to address some of the issues, like revising salaries through the Consolidated Health Salary Structure (CONHESS) for hospitals, albeit with challenges concerning implementation modalities by the various states. Several incentives have also been implemented, like housing, health insurance, vehicle loans, and some hazard allowances have been availed to health workers at various levels. The non-financial incentives, like recognition, career advancement, and job enhancement, are sparingly implemented, although evidence suggests that these play a key role in health worker retention.

Future endeavours need to incorporate training needs assessments and stakeholders called upon to address competency gaps among health workers. Government shall ensure that all the health staff irrespective of their work locations, are regularly provided with training updates to enhance their knowledge, skills, and attitudes in their assigned roles and responsibilities. Efforts should also be consolidated to ensure detailed job descriptions are available for all cadres to enhance optimal supervision.

2.11 Human Resources for Health Information Systems

The established State HWR Platform is electronic and web-enabled and is considered the single and authoritative source of information on HRH in the state. Validated health workforce information is collated, aggregated, and centralised using a bottom-up process from LGA, to the state level. The validated HRH data flow process from LGAs to the state level relies on data-submitting health entities. These submitting health entities are health bodies that are authorities for HRH information at their respective administrative levels.

Furthermore, the state has made remarkable strides toward establishing HRH information systems and registries. A reliable HRH information system ensures real-time information on healthcare workers for planning and decision making. One of the main challenges limiting effective and evidence-based planning and management of HRH in the health sector is the inadequacy of HRH data and baseline information. The state government has established as an integral part of health management information systems (HMIS) a Human Resource Information System (HRIS) at all levels, including public and private sectors and ensures that the systems are linked to provide information for decision making. The state's human resource information and data management

operate through a combination of paper-based nominal rolls with multiple forms and electronic systems. There are limitations to using these data and information systems due to non-timely receipts of this data to the centralised systems leading to irregular updates. Due to an absence of a unitary framework for HRH information flow, effective and evidence-based planning and management are limited due to fragmented data and inconsistent baseline information. It makes it hard to project and forecast adequate staffing numbers required to meet the health needs as planned. The HRH information system in the state should also strengthen workforce data collection from the private sector. The state is striving to strengthen HRH data collection through the State Health Workforce Accounts (SHWA) to support tracking of capacity-building that health workers have participated in and HRH policy performance towards UHC.

2.12 Human Resources for Health Recruitment and Management

The state civil service commission has the authority to recruit all civil servants into the public service, including senior cadres of health workers for the health sector's secondary level, which the SMOH does. This function is conducted in collaboration with other agencies that may not be health-related. For PHC, the SPHCDA, and Local Government Service Commissions at the LGA level, manage the recruitment of selected healthcare worker cadres.

Recruitment decisions are based on norms in some cases. Registers and staff records are all updated through periodic staffing returns from the facilities. The mechanisms for recruitment vary from LGA to LGA. The recruitment processes also vary, usually in response to vacancies arising from health worker attrition, voluntary resignations, retirements and death. In some cases, it is also necessitated by the need to fill previously unfilled positions. The SMoH and SPHCDA receive requests for additional staff from the administration department or through needs identified from the staff returns to inform the requirements. Officers in charge at the office of the Head of Service approve the requests based on the available staffing budgets and positions. On approval, the Civil Service Commission, Local Government Service Commission and Health Management Board can initiate and implement the recruitment process based on guidelines. The advertisements are publicised in government gazettes or major dailies. The appointing authorities conduct the recruitment process with the participation of representatives or directors of the requesting health departments. Usually, there are three to six months or longer between the sourcing and issuing appointment letters before recruited officers are officially absorbed into the public health service.

The challenges involve the lengthy processes of recruitment that are not responsive to the dynamics of health sector workforce requirements. The lack of workforce projections and forecasts per cadre compounds the problem further. Population-based calculations currently used, are not sufficiently responsive, on their own, to the demographic variations or epidemiological changes and economic situations that impact HRH demands. Despite severe shortages across the state, the lingering embargo on recruitment (e.g., CHEWs) has placed serious limitations on the capacity of the health sector to absorb the load of fresh graduates produced from the health training institutions.

The recruitment process for health workers typically hinges upon the availability of new vacancies arising from staff attrition, with distribution prioritised based on urgency or severity of the situation. Multiple agencies are involved in this process, similar to other HRH practices. The various departments and services take responsibility for the redistribution of their staff to where they are most needed. The main challenge is that the models used are not usually updated regularly. So, the distribution may not be proactive enough to respond to the labour market especially when attrition rates are high. Evidence-based models like the Workload Indicators of Staffing Need (WISN) is being considered in Jigawa State. It is anticipated that the patterns of distribution of health workers in the state can be identified and the imbalances across LGAs can be addressed. For example, and as shown in Table 5, Hadejia has 3.35 doctors, 92.02 nurses and 12.27 midwives per 100,000 population. This is in sharp contrast to Maigatari with 0.00 doctors, 1.31 nurses and 0.00 midwives per 100, 000 population.

Disparities influence the maldistribution of health workers in living and working conditions across the 27 LGAs, rural and urban areas. Therefore, retaining workers in some situations that lack basic social amenities becomes hard even though more health workers are needed. Access to appropriate and adequate work equipment, training opportunities, and support systems tend to make work in tertiary and secondary facilities in urban areas more attractive than the other facilities, especially in rural areas.

The issue of disparities in remuneration between the federal and state levels in the health sector increases internal migration from state to federal health facilities. Some health workers even opt to take lower positions with higher salaries and benefits from federal facilities. Thus, even within states, the distribution of health workers varies from facility to facility. In other circumstances, the implementation of vertical health programmes like HIV/AIDS, malaria, Tuberculosis and MNCH, by development partners, also poses significant threats to the health worker availability. These

programmes pay comparatively higher packages further fuelling the disparities in distribution between departments.

2.13 Health Workforce Governance and Leadership

Leadership and governance, also known as stewardship, is about the role of governments in health and its relation to other actors whose activities impact health. It involves overseeing and guiding the system both private and public. It includes policy guidance, information gathering and analysis, collaboration and coalition building, regulations, systems design and accountability. HRH systems, structures, practices and management are still evolving in Jigawa State. The responsibility of overall strategic leadership, governance and oversight, including policy formulation and enforcement of guidelines for HRH, rests with the state Steering Committee on HRH and HRH technical working group. The responsibilities are co-shared among several institutions within and outside the health sector, each having its responsibility performed autonomously. For example, SMoH collaborates with the Civil Service and Local Government Services Commission in the case of recruitment and with the Ministry of Education in cases of pre-service education planning and management.

HRH is coordinated within the Directorate of Planning Research and Statistics (DPRS) collaboratively with other institutions within and outside the health sector. The HRH work should impact the different units of services delivery like reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N), communicable and non-communicable diseases, among others.

Jigawa State has established HRH units with focal persons. To enhance functionality, however, the offices need to be adequately staffed and funded to prevent tardiness in HRH operations. The unit activities include HRH administration, information management, and technical HRH functions. The SMoH and SPHCDA HRH unit's capacity needs financial strengthening to support, monitor and report on the state HRH activities. However, this is not feasible due to constrained finances and inadequate institutional capacity due to numbers and competencies.

2.14 Analysis of the External Environment

Table 7 uses SWOT and PESTEL frameworks to consider the external factors that can either enhance or act as a barrier to HRH activities within the state. The external factors, opportunities and threats are embedded within the PESTEL framework. Acknowledgement of the relevance of these factors should inform strategic plans and decisions.

Table 9: PESTEL and SWOT analysis of the state's HRH environment

Variable	Implication on HRH	Opportunities	Threats
Political	Government policies that impact HRH can affect the implementation of UHC	Government commitment to HRH within existing structures	Policies that place an embargo on the employment of certain cadres of health staff
Economical	HRH activities require financial resources	Increased financial commitment to HRH by various stakeholders	Weak implementation of assigned fund
Societal issues	Increasing population, improving health-seeking behaviour and changing demographic trends may influence demand for HRH services	Health outcomes can be improved by improving health-seeking behaviour and addressing the needs of diverse populations	HRH will require additional investments to meet the growing and diverse needs of the population
Technological issues	Information Technology may be harnessed in the implementation of HRH activities	Use of technology for providing services, training /e-learning, and generating insights from HRH data for decision making	Over-reliance on technology and inadequate capacity and system to harness Information Technology
Ecological	Ecological impact of climate change such as flooding which may cut geographic access to health facilities	Increased awareness and use of ecological fund	Frequent occurrences of flooding may affect the provision of services by health workers.
Legislative framework	Changes in laws and regulations (e.g., LGA autonomy) may affect the implementation of HRH activities	The National Health Act provides a legal framework for HRH	Weak implementation of existing laws and regulations

CHAPTER 3: STRATEGIC DIRECTION

3.1 Vision of Jigawa State HRH Strategic Plan 2023-2027

Figure 8: Vision of the Jigawa State HRH Strategic Plan

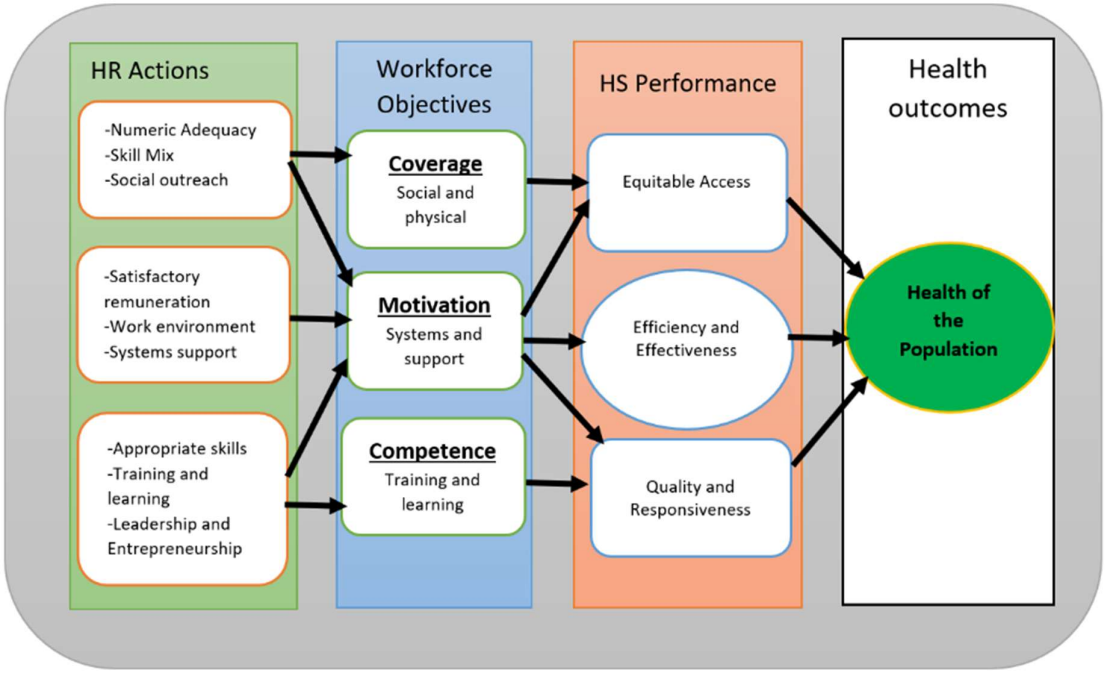
3.2 Theory of Change

In order to attain favourable health outcomes for Jigawa State within the framework of UHC and SDGs, the health system must function at an optimal level, characterised by equitable, accessible, efficient, effective, high quality and responsive health system delivery. To achieve these in the five-year period of this plan, three workforce objectives need to be attained - coverage of the population by the workforce (including ensuring that the citizens have access to the health worker s/he needs physically and through social protection); the motivation of the workforce; and improved competence of the workforce. The following actions are critical for the actualisation of these objectives:

- Ensuring numeric adequacy of the health workforce.
- Achieving an effective skill mix of the health workforce.
- Ensuring that the right health workers are available to Jigawa State citizens irrespective of LGA and economic status.
- Ensuring the health workers are satisfactorily remunerated and work in a satisfactory work environment.

- Ensuring that the health system supports the health worker to perform optimally.
- Ensuring that the health workers acquire the skill appropriate for his/her work.
- Ensuring that appropriate training and learning are available to Jigawa State health workers inclusive of appropriate orientation and curriculum as well as continuous learning.
- Effective leadership of HRH at the state and LGA levels including effective financing, monitoring, evaluation, learning, and innovation.

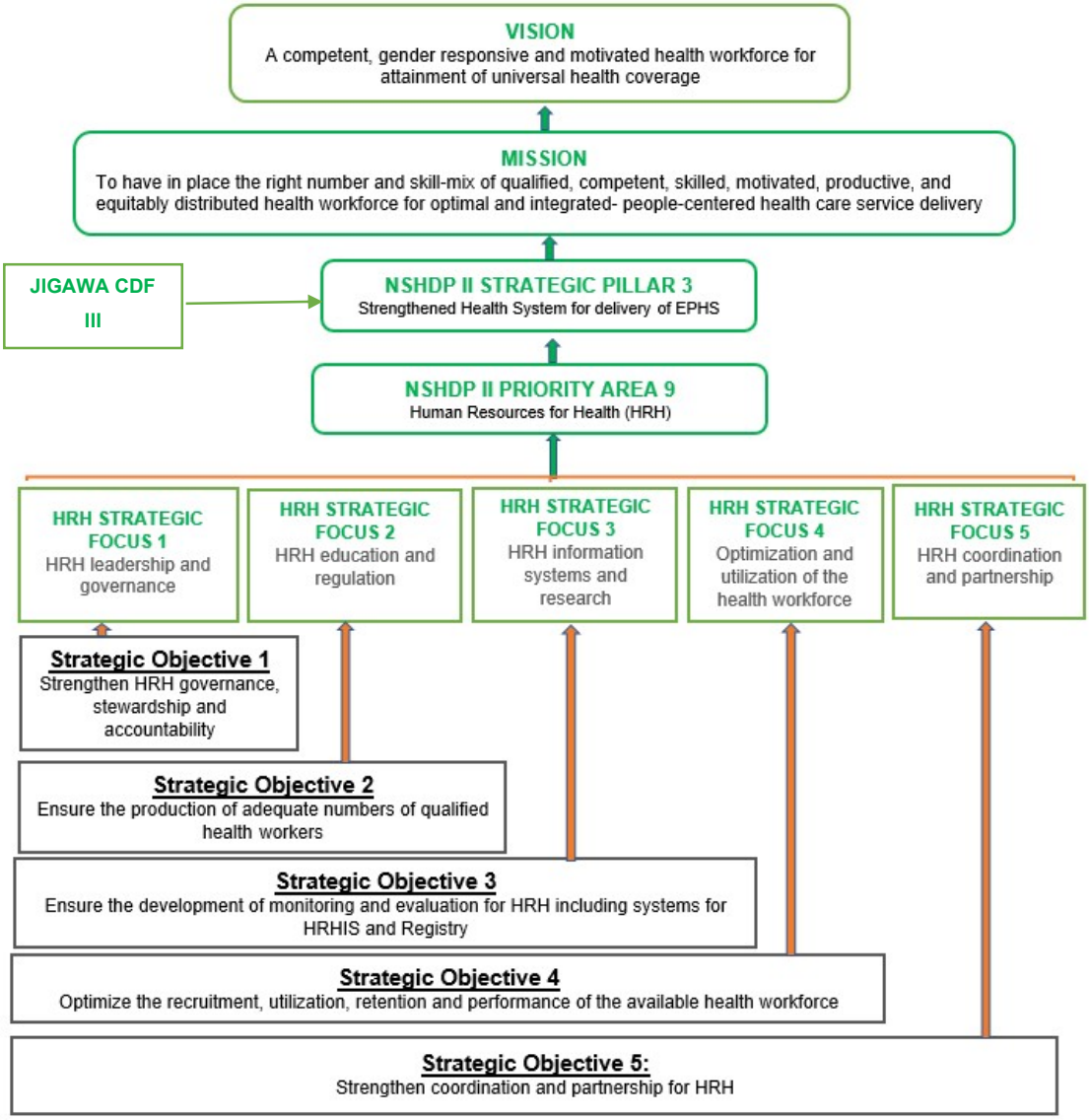
Figure 9: Theory of Change (Credit: USAID/WHO HSS Assessment manual 2007)



3.3 The Strategic Framework

Figure 10 presents the pillars derived from National Human Resources for Health Strategic Plan (NHRHSP) 2021-2025 as Jigawa State HRHSP components that align with Jigawa State Comprehensive Development Framework III (2022-2026).

Figure 10: Jigawa state HRH Strategic Framework 2023-2027



Jigawa State's strategic direction is based on the National HRH strategic plan 2021-2025, which has five strategic objectives. They include (1) Strengthen HRH governance, stewardship, and accountability, (2) Ensure the production of adequate numbers of qualified health workforce (3) Enhance the functionality of the HRH Information System, (4) Optimise the recruitment, utilisation, retention, and performance of the available health workforce and (5) Strengthen

coordination and partnership for HRH at state level. Each strategic objective has key strategic interventions, specific interventions expected outputs, and key performance indicators.

3.4 Summary of Strategic Objectives, Strategies, Outputs and Indicators

Table 10: Strategic objective one summary table

Strategic objective 1: Strengthen HRH governance, stewardship and accountability Outcome: HRH structures made functional at the state and LGA levels								
Strategic Intervention (S1)	Specific activity	Key performance indicator (s)	Baseline	Annual targets				
				2023	2024	2025	2026	2027
Intervention 1.1.1: Institutionalise the HRH units at the state and LGA levels and equip them with qualified, competent and motivated staff in adequate numbers.	1.1.1.1: Strengthen the HRH units at state and LGA levels.	Number of LGAs with functional HRH units as evidenced by submission of monthly reports.	27	27	27	27	27	27
		Number of LGAs implementing HRH policies and strategic plans	0	13	27	27	27	27
	1.1.1.2: Develop an investment case for financial sustainability for HRH in collaboration with other ministries.	Number of LGAs with HRH budget lines	0	5	10	15	20	27
	1.1.1.3: Strengthen institutional leadership and governance capacities of the state's HRH units	Percentage of HRH unit members that had at least one training session on leadership and governance during the year	10	30	60	100	100	100
	1.1.1.4: Track the implementation of the State HRH Strategic Plan	Percentage of HRH Strategic Plan interventions that have been implemented.	0	30	60	80	100	100
	1.1.1.5: Develop and distribute HRH implementation framework and fact sheets to the LGA HRH units	Number of LGA HRH units with HRH implementation framework and fact sheets	0	18	20	22	27	27
Intervention 1.1.2: Improve the state and LGA capacity for HRH planning and reporting.	1.1.2.1: Develop an evidence-based, costed HRH annual operational plan at the state and LGA levels, with priority level assigned to each activity.	Number of LGAs that have developed a harmonised costed HRH annual operational plan.	0	10	25	27	27	27
		Number of LGAs implementing HRH policies and strategic plans	18	23	27	27	27	27
	1.1.2.2: Conduct quarterly review meetings on the implementation of the HRH annual operational plan	Number of quarterly reviews conducted in a year	2	4	4	4	4	4
	1.1.2.3: Develop annual HRH reports at state and LGA levels	Number of LGAs submitting annual HRH reports	27	27	27	27	27	27

Strategic objective 1: Strengthen HRH governance, stewardship and accountability Outcome: HRH structures made functional at the state and LGA levels								
Strategic Intervention (S1)	Specific activity	Key performance indicator (s)	Baseline	Annual targets				
				2023	2024	2025	2026	2027
Intervention 1.1.3: Strengthen sustainable mechanisms for adequate funding of HRH plan and implementation at state and LGA levels.	1.1.3.1: Institute public-private partnership (PPP) mechanism for funding HRH plan and implementation.	Number of LGAs with funding for HRH utilising PPP	0	14	27	27	27	27
	1.1.3.2: Advocate for sustained financing from the SMoH, SPHCDA (BHCPF) and ministry for Local Govt in collaboration with other line ministries, partners, and stakeholders	Percentage of HRH budget secured from the SMoH, SPHCDA (BHCPF) and Ministry for Local Govt in collaboration with other line ministries, partners, and stakeholders.	50	55	60	65	70	75

Table 11: Strategic objective two summary table

Objective 2: Ensure the production of adequate numbers of qualified health workforce Outcome: Improved access to adequate and qualified health workforce to accelerate the achievement of UHC								
Strategic Intervention (S1)	Specific activity	Key performance indicators	Baseline	Actual targets				
				2023	2024	2025	2026	2027
Intervention 2.1.1: Strengthen quality assurance process for HRH training institutions.	2.1.1.1: Strengthen the capacity of regulatory bodies to perform their roles of HRH accreditation and regulation at all levels.	Percentage of health training institutions fully accredited by the relevant regulatory bodies.	23	50	75	85	95	100
	2.1.1.2: Develop, review, and revise training curricula in line with emerging health needs.	Percentage of training curricula that have been developed, reviewed, or revised in line with emerging health needs.	50	60	70	80	90	100
	2.1.1.3: Scale-up continuing professional development (CPD) programmes targeting HRH trainers.	Percentage of HRH trainers who have completed at least one CPD programme in the completed year.	50	60	70	80	90	100
Intervention 2.1.2: Strengthen the linkage between HRH training institutions, regulatory bodies and other stakeholders to ensure health workforce engagement aligns with health workforce needs and production/improve/scale-up production of the health workforce to match demands/needs	2.1.2.1: Establish and institutionalise platforms for engagement with HRH training institutions, regulatory bodies, community leaders, policymakers, legislators and other stakeholders.	Percentage of stakeholder groups engaged in the groups identified	0	15	20	60	75	100
		Number of LGAs with health worker production matching identified needs	0	5	10	20	27	27
	2.1.2.2: Develop/implement other pre-service and in-service training programmes as appropriate.	Number of new HRH training initiatives actively implemented in the year.	2	3	4	5	6	7
	2.1.2.3: Strengthen training institutions with human and capital resources, including ensuring an adequate number of tutors for the number of students.	Percentage of training institutions with adequate teacher-student ratio, as recommended by the accreditation body.	20	100	100	100	100	100
Intervention 2.1.3: Consider gender dynamics and skill mix in the health workforce to improve service delivery.	2.1.3.1: Promote gender sensitivity in the production of HRH through informed enrollment, retention and management strategies.	Percentage of female candidates in the total annual enrollment at the training institutions	30	35	40	50	50	50
	2.1.3.2: Promote evidence-based production of HRH that reflect the skill mix needed at primary, secondary and tertiary healthcare level and addresses	Number of LGAs implementing evidence-based gender-sensitive strategies to inform enrolment, retention and management of health workers	3	10	15	17	22	27

Objective 2: Ensure the production of adequate numbers of qualified health workforce Outcome: Improved access to adequate and qualified health workforce to accelerate the achievement of UHC								
Strategic Intervention (S1)	Specific activity	Key performance indicators	Baseline	Actual targets				
				2023	2024	2025	2026	2027
	healthcare needs and population dynamic	Percentage of health facilities at all levels with appropriate gender balance.	50	70	90	100	100	100
		Number of LGAs with appropriate skill-mix of HRH at all levels of care based on evidence	5	10	15	20	27	27

Table 12: Strategic objective three summary table

Objective 3: Enhance the functionality of Human Resources for Health Information System Outcome: Reliable and quality health workforce data made available at all levels for decision making								
Strategic Intervention (S1)	Specific activity	Key performance indicator(s)	Baseline	Actual targets				
				2023	2024	2025	2026	2027
3.1.1: Strengthen HRHI Information System at all levels	3.1.1.1: Establish/strengthen the State Health Workforce Registry.	Numbers of LGAs with functional and updated workforce registries linked to SHWR.	21	25	27	27	27	27
	3.1.1.2: Develop/strengthen and regularly update a comprehensive HRH database.	Percentage of state MDAs and LGAs regularly updating HRH information in the SHWR	100	100	100	100	100	100
	3.1.1.3: Strengthen Human Resources Capacity on HRH Information System for improved collection, collation, storage, analysis and evidence use.	Percentage of health personnel trained in the use of HRH Information System.	0	40	60	100	100	100
3.1.2: Establish a mechanism for annual HRH data reviews and reporting for evidence and decision making at the state and LGA levels	3.1.2.1: Support the National Health Workforce Accounts Survey in the state for HRH Information System reporting in line with the Global Strategy on HRH Workforce (GSHRH) 2030, using the health labour market analysis framework.	Number of annual HRH profiles published at state and LGA levels.	0	5	15	27	27	27
	3.1.2.2: Conduct biannual reviews to assess functionality and utilisation of HRH data.	Number of HRH reviews conducted at the state and LGA levels.	1	2	2	2	2	2
3.1.3: Improve HRH research-based (data-driven) decision making.	3.1.3.1: Develop HRH research framework	Percentage of HRH research projects conducted based on state priorities	33	50	70	80	100	33
	3.1.3.2: Conduct operational research that provides information to improve the production and utilisation of professional cadres and skill mix required for a response health system	Percentage of state-focused research outputs that informed decisions to improve HRH development, planning and management at state levels	33	50	70	80	100	100

Table 13: Strategic objective four summary table

Objective 4: Optimise the recruitment, utilisation, retention and performance of available health workforce Outcome: Adequately recruited, deployed, motivated and productive health workers distributed at all levels of care								
Strategic Intervention (S1)	Specific activity	Key performance indicator(s)	Baseline	Actual targets				
				2023	2024	2025	2026	2027
4.1.1: Promote recruitment, deployment and retention of health workers at all levels of care, guided by evidence-based practices	4.1.1.1: Advocate for the implementation of safety guidelines and insurance policies for health workforce (private and public).	Percentage of health workers retained 2-years post engagement	30	50	70	80	90	95
	4.1.1.2: Establish innovative approaches in telemedicine, task shifting and task sharing.	Percentage of health workers that participated in capacity building session that utilised telemedicine.	30	50	70	80	90	95
		Number of LGAs implementing adapted Task Shifting and task Sharing (TSTS) policy.	0	10	15	27	27	27
	4.1.1.3: Strengthen the implementation of the Patients' Bill of Right to enhance oversight of the public and private sector.	Percentage of patients who are aware of their rights under the Patients' Bill of Right.	30	40	50	60	70	80
	4.1.1.4: Strengthen effective recruitment and deployment policies and practices to promote rational utilisation of health workers using norms and standards.	Percentage of health workers who are deployed in positions that match their skills and qualifications.	30	50	70	100	100	100
	4.1.1.5: Provide adequate health workers and support staff, irrespective of working location; access to structured in-service training relevant to their job description; job specification and functions at least once every 2 years; and evidence of participation used as a condition for the renewal of registration for professionals.	Percentage of health workers and support staff who have received at least one structured in-service training in the past three years.	30	50	70	100	100	100
	4.1.1.6: Create and sustain a conducive working environment to attract and retain health professionals in areas where their services are most needed.	Number of LGAs implementing the health workers retention policy	5	10	15	20	27	27
		Percentage of health workers who resigned during the year.	8	6	5	4	3	2

Objective 4: Optimise the recruitment, utilisation, retention and performance of available health workforce Outcome: Adequately recruited, deployed, motivated and productive health workers distributed at all levels of care								
Strategic Intervention (S1)	Specific activity	Key performance indicator(s)	Baseline	Actual targets				
				2023	2024	2025	2026	2027
	4.1.1.7: Develop concise job descriptions for all the categories of health workers with clear delineation of roles and responsibilities to minimise friction.	Percentage of health worker cadres with a job description that is concise, up-to-date, and relevant to their role.	10	40	50	60	80	90
	4.1.1.8: Enforce the bonding arrangement to ensure sponsored student return to the state to provide services based on contract	Percentage of sponsored students who return to the state to provide services after completing their education	80	90	95	100	100	100
	4.1.1. 9: In liaison with the relevant authorities deploy doctors and other health professionals to PHC facilities as a priority.	Percentage of PHC facilities that have the required number of doctors and other health professionals	10	20	25	40	50	60
	4.1.1.10: Advocate NYSC to post doctors and nurses to the state.	Number of doctors and nurses posted to the state by NYSC	20	30	40	45	50	50
	4.1.1.11: Re-distribute staff based on workloads and norms as well based on human resource development plans	Percentage of staff who are working in a role that is aligned with their skills and experience	50	60	70	80	90	95
4.1.2 Improve HRH performance management systems at all levels	4.1.2.1. Establish/strengthen performance-based management systems	Number of LGAs implementing performance management systems based on HRH priorities and appropriate job descriptions	0	10	15	27	27	27
	4.1.2.2. Review and implement existing HRH recruitment and deployment policies/guidelines to promote gender and social inclusion, as well as equity.	Percentage of HRH positions that are filled by women and members of marginalised groups.	20	30	40	40	40	40
	4.1.2.3. Collaborate with Office of the Head of Civil Service and Civil Service Commission, to articulate job descriptions for all cadres of health workers.	Percentage of health worker cadres with competency-based job description	50	60	70	80	100	100
4.1.3 Strengthen the task shifting and task sharing implementation with required guidelines	4.1.3.1 Adapt and implement the national TSTS policy in response to state-specific HR needs.	Number of LGAs implementing adapted TSTS policy	0	10	15	27	27	27

Objective 4: Optimise the recruitment, utilisation, retention and performance of available health workforce Outcome: Adequately recruited, deployed, motivated and productive health workers distributed at all levels of care								
Strategic Intervention (S1)	Specific activity	Key performance indicator(s)	Baseline	Actual targets				
				2023	2024	2025	2026	2027
	4.1.3.2: Develop and implement a costed framework for TSTS based on evidence.	Percentage of LGAs implementing TSTS interventions and have reported a positive impact on health outcomes.	0	50	70	80	100	100
	4.1.3.3: Conduct periodic reviews to assess level of implementation of the TSTS policy.	Number of LGAs that reviewed implementation of their TSTS policy at least once every two years.	0	10	15	27	27	27
	4.1.3.4: Institute mechanisms for continuous supportive supervision at all levels.	Percentage of health workers who received at least one supportive supervisory visit per quarter during the year.	25	50	70	80	100	100

Table 14: Strategic objective five summary table

Objective 5: Strengthen coordination and partnership for HRH at state and LGA levels Outcome: Institutionalised HRH coordination and partnership mechanisms at all levels								
Strategic Intervention (S1)	Specific activity	Key performance indicator(s)	Baseline	Actual targets				
				2023	2024	2025	2026	2027
5.1.1 Strengthen partnership for HRH programmes and activities	5.1.1.1. Update database of stakeholders and partners implementing HRH at all levels	Percentage of stakeholders and partners whose information is updated in the database within 6 months of their involvement in HRH activities.	70	80	90	100	100	100
	5.1.1.2. Strengthen appropriate public/private partnership to ensure coherence and support for HRH plans.	Percentage of public/private partnerships that are aligned with the government's HRH plans.	70	80	90	100	100	100
		Number of LGAs with validated joint annual PPP HRH plan	0	5	8	13	20	27
5.1.2 Strengthen coordination of stakeholders (public, private, regulatory, professional associations and development partners) at all levels	5.1.2.1. Strengthen stakeholders coordinating platforms (State Steering Committee and TWG and LGAs HRH	Percentage of stakeholders who report being satisfied with the level of coordination and collaboration between stakeholders	70	80	90	100	100	100
	5.1.2.2 Use HRH units as a secretariat for the state HRH observatory to facilitate the cross learning of HRH practices and the promotion of the best staff management practices in the State.	Number of LGAs with functional mechanisms for coordination of stakeholders to facilitate policy dialogue	10	15	20	27	27	27
		Number of state HRH consultations/ policy dialogues/ conferences held.	3	5	8	8	8	8

CHAPTER 4: RESOURCE REQUIREMENTS

This chapter provides an overview of resource (finances) requirements for the planned period, analysis of funds required per strategic objective and financing gap and strategies that the sector will deploy to mobilise additional resources.

4.1 Budget Estimates

The SMoH and SPHCDA are committed to investing in HRH to realise UHC. The total resource requirement estimates for the strategic period 2023-2027 is N185,798,734, an average of N37 Million per year. Table 13 summarises financing requirements for implementing the strategic plan 2023-2027 by strategic objectives and illustrates the distribution of resources across the five thematic objectives. A significant sum, 29% of the total cost, was designated for enhancing the functionality of the HRH Information System. Additionally, 27% of the total cost was allocated to strengthening workforce governance, stewardship, and accountability.

Table 15: Total cost of the State Human Resources For Health Strategic Plan 2023-2027

Strategic objectives	Total Cost per annum					Grand Total (N)	% of Total Cost
	Year 1 Cost (N) 2023	Year 2 Cost (N) 2024	Year 3 Cost (N) 2025	Year 4 Cost (N) 2026	Year 5 Cost (N) 2027		
Obj. 1) Strengthen governance, stewardship, and accountability of the health workforce	12,850,234	9,458,431	9,543,765	9,234,421	9,567,907	50,654,758	27%
Obj. 2) Ensure the production of adequate numbers of qualified health workers	4,950,300	4,243,567	4,987,324	4,453,321	4,234,130	22,868,642	12%
Obj 3. Enhance the functionality of HRH Information System	20,930,500	8,453,231	8,345,621	8,120,000	8,321,223	54,170,575	29%
Obj 4) Optimise the recruitment, utilisation, retention and performance of the available health workforce	10,100,430	5,453,654	5,213,098	5,112,101	5,043,321	30,922,604	17%
Obj 5) Strengthen coordination and partnership for HRH agenda	5,525,000	5,234,289	5,433,000	5,345,101	5,654,765	27,192,155	15%
Total cost (N)	**54,356,464**	**32,843,172**	**33,522,808**	**32,264,944**	**32,821,346**	**185,808,734**	
Total cost (US$) @N460/USD	**117655**	**71089**	**72560**	**69838**	**71042**	**402183**	

4.2 Gaps in Financing

Full implementation of the strategic plan will entail identifying the difference between the resource requirements and the available resource-based budgets to estimate the funding gap. Identifying the funding gap allows potential stakeholders to determine when additional resources are most needed. With the paucity of information on HRH resource availability, determining the strategy's resource deficit was challenging. However, within the implementation period of this strategic plan, HRH resource mapping will be prioritised. HRH resource commitments from the LGAs are to be targeted. Also of interest are the resources available within the private sector and development assistance from donor, bilateral and multilateral organizations and partners.

CHAPTER 5: IMPLEMENTATION FRAMEWORKS/ ARRANGEMENTS

The SMoH and SPHCDA will provide leadership in implementing the strategic plan in collaboration with all stakeholders at the state and LGA levels. The HRH partnership forum will bring together key stakeholders in the health sector, including state health-related sectors, external actors (development partners), non-state actors (implementing partners, private sector), and clients and communities, to achieve priority sector objectives and results. This platform will enable collaboration among health sector partners supporting HRH at different levels. It is, therefore, critical to foster partnerships and networks of stakeholders to harness contributions to the HRH agenda.

5.1 Stakeholder Management

The stakeholder analysis and mapping process has been developed to follow the power, urgency and legitimacy typology ranking. The three attributes define the stakeholder 'salience' as 'the degree to which managers give priority to competing stakeholder claims.

Power (to influence the HRH activities): The extent to which a party has or can gain access to coercive (physical means), utilitarian (material means), or normative (prestige, esteem and social) means to impose their will.

Legitimacy: A generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions.

Urgency: The degree to which stakeholder claims call for 'immediate attention'. The 'degree' depends not just on time sensitivity but also on how 'critical' the relationship is with stakeholders or the importance of their claims.

The more attributes (power, legitimacy, and urgency) a stakeholder is perceived to have, the higher their salience. In other words, the greatest priority will be given to stakeholders who have more power, legitimacy and urgency. Power and legitimacy are interrelated, and the three variables can overlap. Three prime categories of stakeholders are derived for the HRH agenda based on this analysis, which then feeds into the stakeholder management process as outlined below.

Table 16: Stakeholder management process

Red	Definitive stakeholders	Presence of all three attributes (power, legitimacy and urgency), high salience. Managers give immediate priority to these stakeholders.
Yellow	Expectant stakeholders	Two attributes, moderate salience. Rather passive, likely higher-level engagement with these stakeholders. Manage carefully otherwise, frustration could make them "turn red"
Green	Latent stakeholders	One attribute, low salience. Some level of attention and monitoring, otherwise they "go amber"

5.2 Roles of Stakeholders

The strategic plan implementation process will adopt a multisectoral approach, involving different stakeholders, including non-state actors (Civil Society Organizations, Faith-Based Organizations / Non-Governmental Organisations, private sector, development and implementing partners), and state actors (government ministries, departments and agencies) at the federal, state, LGA, and Community levels.

State Actors: The main role of the state actors (state and LGA level actors) is to provide leadership, stewardship and accountability in the health sector. The state government shall formulate policies, develop strategic plans, set sector priorities, regulations and standards. Furthermore, the state government shall provide service delivery guidelines and technical support at the state level, build capacity and manage the state and LGA facilities to provide health services. Improving the population's overall health status and well-being depends on the synergistic functioning of the various sectors in Jigawa State.

Non-State Actors: This category includes the private sector (for-profit and not-for-profit), development and implementing partners. The private sector at all levels supports the health sector in expanding quality care to remote and underserved populations. Even within public service providers, the private sector has a role in providing non-health services. The state HRH fora will provide a platform where such collaboration is promoted. Traditional practitioners will provide complementary services based on locally available interventions, while implementing partners will play a significant role in ensuring that health services are available to the community, especially in hard-to-reach areas. The implementing partners will also provide needed human and monetary resources to implement this strategy.

Table 17: Stakeholder mapping and their expectations

Stakeholder	Stakeholder expectations of HRH unit	HRH unit's expectations of the stakeholder	Classification	Stakeholder management strategy
FMoH	HRH unit is to provide policy direction on HRH Ensure that mechanisms are in place for effective management of the health workforce management in the state	Effective policy direction and technical support Support the unit to carry out HRH functions effectively		Continuous engagement
SMoH	HRH unit is to lead HRH development and reporting in the state effectively Ensure that mechanisms are in place for effective management of the health workforce in the state Leadership from HRH unit in terms of information and capacity development	SMOH reports all HRH development and activities at the state level to the HRH unit		Continuous engagement
NPHCDA	Leadership from the HRH unit in terms of information and capacity development and information exchange	NPHCDA reports all HRH development and activities happening under NPHCDA to the HRH unit regularly		Continuous engagement
SPHCDA	Leadership from HRH unit in terms of information and capacity development.	SPHCDA reports all HRH development and activities at state level to the HRH unit		Continuous engagement
LGHA	Leadership from HRH unit in terms of information and capacity building	LGHA to report all HRH development and activities at LGA level to the HRH unit		Continuous engagement
Community	Leadership of community structure in terms of information building	Community to cooperate and give feedback.		Continuous engagement
State Ministry of Finance	To ensure that money budgeted for HRH development is released and on time To ensure transparency and accountability	To make its plans and intentions on spending very clear and on time through its Annual operational plan and memos		Continuous engagement

Stakeholder	Stakeholder expectations of HRH unit	HRH unit's expectations of the stakeholder	Classification	Stakeholder management strategy
State Ministry of Education	To cooperate in all matters related to the production of health workers	To continually engage the Ministry of Education on what needs to be done by MoH on this matter of health worker production		Continuous engagement
Professional Association	To give information to HRH unit continuously in all matters related to HRH development	Feedback from HRH branch in all matters related to HRH management in the state		Continuous engagement
Professional regulatory bodies	Continuous information exchange with HRH unit	Feedback expected from HRH unit on all issues related to HRH development in the state		Continuous engagement
Health Training Institutions	To give information continuously on training developments in the institutions through responsible regulatory bodies and SMoH HRH unit	To give feedback to training institutions through the responsible regulatory bodies and SMOH HRH unit		Continuous engagement through the state MOH HRH unit
Private Health Sector actors	To give information related to HRH development in the private sector through the responsible HRH unit at the state level	To give feedback to the private sector through the responsible HRH unit in the state MOH.		Engagement through the state MOH HRH unit
MDAs	Co-operation on activities of mutual benefit and adherence to terms of mutual agreements Accurate presentation of information provided on health matters/HRH Providing access to updated documents that need HRH intervention Timely, accurate, up-to-date and reliable legal information Timely transmission of information as may be required.	Co-operation on activities of mutual benefit and adherence to terms of mutual agreements Consumer of HRH services Feedback on HRH services Joint resource mobilisation		Continuous engagement and discourse on matters of HRH collaboration, policy and accountability Proper and accountable use of resources Timely, updated, relevant, reliable and consolidated HRH information Collaboration, participation and support in mutually beneficial activities

Stakeholder	Stakeholder expectations of HRH unit	HRH unit's expectations of the stakeholder	Classification	Stakeholder management strategy
Development partners	Efficient, transparent and accountable use of resources Collaboration and participation in mutually beneficial activities	Financial, technical and structural support towards building sustainable HRH agenda Feedback on partnership Collaboration, participation and support in mutually beneficial activities		Continuous engagement and discourse on HRH issues, collaboration, policy and accountability Proper and accountable use of resources by providing timely feedback on the implementation of donor-funded programmes

CHAPTER 6: MONITORING, EVALUATION AND REPORTING

6.1 Overview of the State HRH Strategic Plan Monitoring, Evaluation and Reporting

This chapter highlights the monitoring and evaluation (M&E) framework for ensuring the implementation of this HRH strategic plan. The purpose of Monitoring, Evaluation and Reporting is to ensure that the Strategic Plan implementation is according to schedule and in the event of any deviation, appropriate and timely action is taken. The Monitoring, Evaluation and Reporting process will be undertaken at local government units, MDAs and state levels. It will also aim to assess the achievement of strategic objectives, generate information to support decision-making for the HRH management and make recommendations on future performance improvement areas. Local government units, states, MDAs, SPHCDA and SMOH together with collaborating and implementing partners will be involved in monitoring and tracking the progress of the HRH activities. Implementing the Strategic Plan will be closely monitored to ensure its accomplishment. Monitoring, follow-up and control systems will be established at all levels. These will include review meetings, regular review of the budget systems and development of progress reports.

Tracking implementation of the strategic plan

Quarterly review meetings will be held between the HRH units, DPRS and HRH forums to review the implementation of the Annual operational plan that comes out of this strategic plan. The input of these HRH quarterly meetings will be the output from the meetings with DPRS and health programmes. During these meetings, the HRH focal persons will provide progress reports indicating overall progress made on key strategic objectives. The nature and scope of reporting will include progress made against the strategic plan; causes of deviation from the strategic plan, if any; areas of difficulties and suggested solutions to problems that may adversely affect implementation; and corrective measures to be undertaken.

The strategic plan encompasses more than simply achieving or implementing the objectives. Monitoring, Evaluation and Reporting provide the backup necessary to achieve the set objectives. During the formulation of the strategic plan, the implementation indicators and projections are sometimes based on past experiences. These, however, may change during the implementation, and thus, a management control system will be necessary to ensure the strategic plan stays on course. Monitoring will involve routine data collection and analysis on the progress of the strategic plan implementation. The results from the analysis will then be used to inform decision-making,

including taking corrective action where deviations in implementation have been noted. The Monitoring and Evaluation at State, MDAs and LGA levels will coordinate collecting monitoring and evaluation data, analysis and reporting. It will provide technical support and facilitate monitoring and evaluation capacity building in liaison with the HRH branches and units.

The Monitoring and Evaluation teams will take full responsibility for overseeing the implementation of the strategic plan over the entire implementation period (2023 – 2027) by providing a report on the annual operational plan, which is an offshoot of this plan. They will continuously monitor and evaluate all strategies, activities and outcomes to advise HRH units on the implementation status and offer feasible policy and strategy alternatives. This will be done quarterly and will inform the updates to the HRH forum. The HRH units will be required to keep records of the lessons learnt during the implementation of the Strategic Plan and, to the largest extent possible, ensure this information is available in real-time. A system of disseminating the lessons learnt to users will be developed as part of the Monitoring and Evaluation Strategy. The Monitoring and Evaluation teams, as part of its overall Monitoring and Evaluation mandate, will monitor the documentation and implementation of lessons learnt. Annual health worker and customer satisfaction surveys will be undertaken to gauge the achievement of the set objectives.

The Strategic Plan will be evaluated during and after implementation to gauge the extent of achievement of the intended results. The evaluation will be carried out using relevance, efficiency, effectiveness, sustainability and impact measures. Annual and mid-term reviews will also be carried out. The implementation matrix will help track and monitor progress in implementing the Strategic Plan.

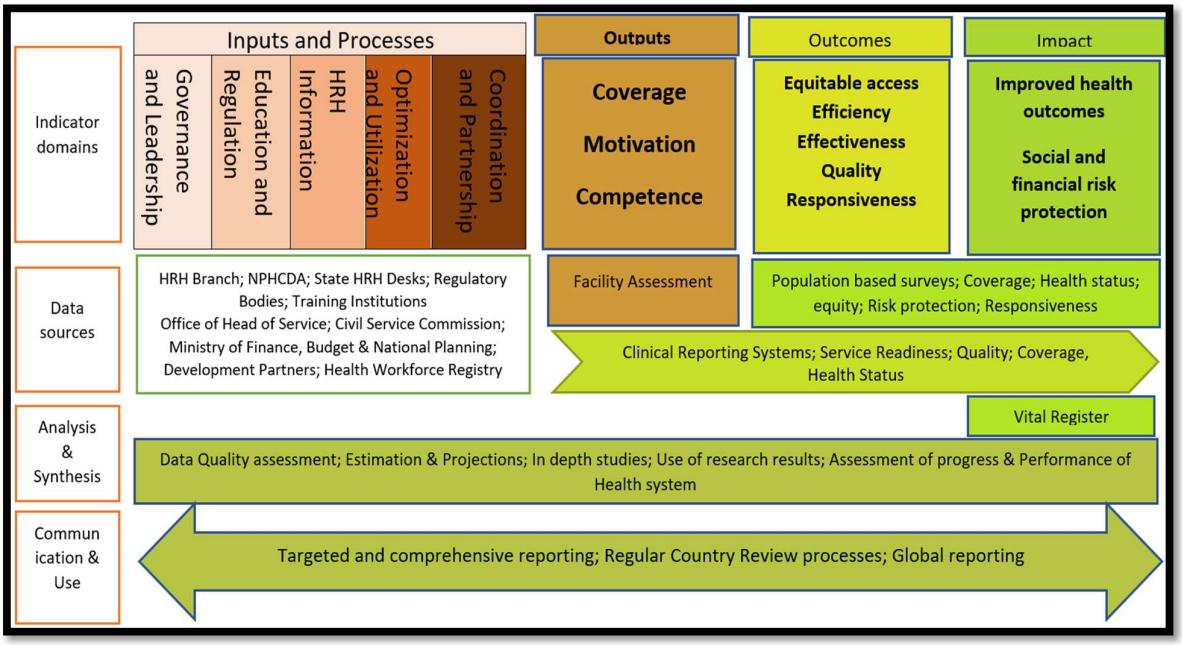
The operationalisation of this Strategic Plan commences with the development of the annual operational plan. Semi-annually, an assessment of whether results produced by the implemented activities were those forecasted as outcomes and whether they were achieved to the expected performance standards/measures needs to be conducted. This will be based on the key performance indicators. A description of the baseline data and target for these indicators is in section 3.4 (Tables 8-12). Using a tool, the HRH units are to assess the implementation of the strategic plan by highlighting the five strategic objectives, the interventions towards implementation of the strategic objectives, the time frame within which the activities were to be implemented and any variances that may be noted in the implementation of the plan.

Table 18: Indicative template for semi-annual review of the State HRH Strategic Plan

Strategic focus	Strategic intervention	Interventions	Time Frame	Status	Variance & why	Responsibility	Improvement Programm(s)

6.2: Monitoring and Evaluation framework for the State HRH Strategic Plan 2023-2027

Figure 11: Summary of State HRH Strategic Plan 2023-2027 Monitoring and Evaluation framework



Successful State HRH Strategic Plan 2023-2027 implementation calls for a robust Monitoring and Evaluation Plan. The State HRH Strategic Plan 2023-2027 Monitoring and Evaluation framework was adapted from the NSHDP II Monitoring and Evaluation framework. It is a management tool for promoting efficiency, effectiveness, accountability and transparency towards achieving the State HRH Strategic Plan 2023-2027 goals and objectives. It outlines various roles and responsibilities regarding M&E, organising plans for data collection, data quality, analysis and use. The following steps were taken in developing the Monitoring and Evaluation Framework and Plan for the State HRH Strategic Plan 2023 - 2027:

- Determine the purposes of the monitoring and evaluation mechanisms and assessment of the information needs
- Ensure all interventions have clearly defined objectives, outputs and indicators.
- Establish coordinated and common reporting tools
- Determine methods for obtaining information on indicators
- Assign responsibilities for information gathering
- Determine time frame and frequency of data collection, and allocate resources
- Establish mechanisms for sharing information and incorporating results into prevention and response planning.

The State HRH Strategic Plan 2023-2027 Framework tests the assumptions in the theory of change (Figure 11) and traces the necessary results chains to deliver the targets set out in the State HRH Strategic Plan 2023-2027.

6.3 Purpose of State HRH Strategic Plan 2023-2027 Monitoring and Evaluation Plan

The main purpose of this Monitoring and Evaluation Plan is to track the progress and effect corrective measures where necessary, thereby allowing all stakeholders and implementers in the health sector to work effectively and efficiently through clearly defined roles and responsibilities. This will also enable achieving the goals and objectives of State HRH Strategic Plan 2023-2027 within its stipulated timeframe. The Monitoring and Evaluation Plan provides a tool to track and report Jigawa State's progress towards global health reporting requirements and global commitments such as SDGs. It is a common framework for tracking and reporting progress against the compact agreements made nationally. The Monitoring and Evaluation Plan enables and guides the tracking of the health workforce status in the state and her contribution to the Regional and Global HRH Agenda. Specifically, the Monitoring and Evaluation plan

- Serves as a guide in determining the processes to be undertaken to track progress made within the State HRH Strategic Plan 2023-2027 period with regard to national and international indicators.
- Provides an opportunity to make corrections in implementing State HRH Strategic Plan 2023-2027 through regular monitoring.
- Provides evidence for informed decisions regarding programme management and service delivery.

- Ensures the most effective and efficient use of resources.
- Evaluates the extent to which the interventions have had the desired impact.
- Serves as a tool that communicates stakeholders' various roles and responsibilities regarding monitoring and evaluation of State HRH Strategic Plan 2023-2027.
- Gives a systematic arrangement for quality data collection, collation, analysis and use.
- Figures out specific strategies and tools to stimulate informed decision-making.
- Organises the various Monitoring and Evaluation activities that must take place for Monitoring and Evaluation to be truly successful in the health sector.
- Engages relevant stakeholders in the health sector to ensure Monitoring and Evaluation integration into all programmes.

6.4 State HRH Strategic Plan 2023-2027 Core Indicators

Data for tracking and evaluating State HRH Strategic Plan 2023-2027 implementation will be drawn from administrative and programme reports, facility assessments and population-based surveys. Table 17 lists the sources and tools for data collection for tracking State HRH Strategic Plan 2023-2027 implementation. The results of the interventions will be communicated using existing channels targeting a diverse audience and multiple stakeholder groups. These indicators track HRH coverage, motivation and competence of the health workforce. Table 18 presents strategies to address common data limitations that may influence effective monitoring of the State HRH Strategic Plan 2023-2027 implementation.

The Monitoring and Evaluation teams will take full responsibility for overseeing the implementation of the Strategic Plan over the entire implementation period. They will continuously monitor and evaluate all strategies, activities and outcomes to advise the HRH units on the implementation status and offer feasible policy and strategy alternatives. This will be done quarterly using the Annual Operational Plans, which are expected to be developed as part of the build-up to the budget processes, and the same will inform the updates to the HRH forum. The HRH unit will be required to keep records of the lessons learnt during the implementation of the Strategic Plan and, to the largest extent possible, ensure this information is available in real-time. A system of disseminating the lessons learnt to users will be developed as part of the Monitoring and Evaluation Strategy. The Monitoring and Evaluation teams, as part of their overall Monitoring and Evaluation mandate, will monitor the documentation and implementation of lessons learnt. Annual health

worker and customer satisfaction surveys will be undertaken to gauge the achievement of the set objectives.

The Strategic Plan will be evaluated during and after implementation to gauge the extent of achievement of the intended results. The evaluation will use relevance, efficiency, effectiveness, sustainability and impact measures. Annual reviews and mid-term reviews will also be carried out. Table 19 draws from tables 10-14 to illustrate the indicators that will help track and monitor progress in implementing the Strategic Plan.

Table 19: Indicators to be tracked in monitoring State HRH Strategic Plan 2023-2027

Focus one: HRH Leadership and Governance
Strategic Objective: **Strengthen HRH governance, stewardship, and accountability**
• Number of LGAs with functional HRH units
• Number of LGAs with HRH planning budget lines in the Health sector budgets
• Number of LGAs implementing HRH policies and strategic plans
• Number of LGAs that have a harmonised costed HRH Annual Operational Plans
• Number of LGAs submitting annual HRH reports
• Number of LGAs with funding for HRH development utilising PPP
Focus two: HRH Education and Regulation
Strategic Objective: **Ensure the production of adequate numbers of qualified health workforce**
• Percentage of health training institutions fully accredited by the relevant regulatory bodies
• Number of LGAs with health worker matching identified needs
• Number of new HRH training initiatives being actively implemented
• Number of LGAs implementing evidence-based gender-sensitive strategies to inform enrolment, retention and management of health workers
• Number of LGAs with appropriate skill-mix of HRH at all levels of care based on evidence
Focus three: HRH monitoring, evaluation and research
Strategic Objective: **Ensure the development of monitoring and evaluation for HRH, including systems for HRH Information System and Registry**
• Numbers of LGAs with functional and updated workforce registries linked to SHWR
• Percentage of state MDAs and LGAs regularly updating HRH information in the SHWR
• Number of annual HRH profiles published at state levels
• Percentage of HRH research projects conducted based on state priorities
• Percentage of state-focused research outputs that informed decisions to improve HRH development, planning and management at state levels
Focus four: HRH management
Strategic Objective: **Optimise the recruitment, utilization, retention and performance of the available health workforce**
• Number of LGAs implementing evidence-based health workers retention policy and/or strategies
• Number of LGAs with competency-based job descriptions for health workers
• Number of LGAs implementing performance management systems based on HRH priorities and appropriate job descriptions
• Number of LGAs implementing adapted TSTS policy
Focus five: HRH Coordination and Partnership
Strategic Objective: **Strengthen coordination and partnership for HRH**
• Number of LGAs with validated joint annual PPP HRH plan
• Number of LGAs with functional mechanisms for coordination of stakeholders to facilitate policy dialogue

- Number of state HRH consultations/ policy dialogues/ conferences held

6.5 Sources and Data Collection Methods for The State HRH Strategic Plan 2023-2027

Table 20: Sources, methods and limitations for data collection on the State HRH Strategic Plan

Data source or tool	Information provided	Data collection methods	Type	Limitations
Supportive supervision checklists	Facility-based data on inputs, provider competency and quality of services	Facility visits and checklist	Routine	Variable coverage and limited completeness
Nominal role	Aggregate data on the stock of health workers by cadre, location, etc.	HRH units/ desk officers at MDAs, SMoH, SPHCDA etc.	Periodic	Variable coverage and limited completeness
Facility surveys	HRH skill mix at service delivery points, workload, service utilization records	Survey instruments	Annual Periodic	Quality of data and inadequate dissemination
Health Workforce Registry	Data on HRH, including availability, skill mix, distribution etc.	HRH branch/units/ desk officers at MDAs, SMoH, SPHCDA etc.	Periodic	Inadequate update/ integrity
State government gazettes, audit reports and notifications	Employment into the public sector, HRH management guidelines (attraction, recruitment, deployment, retention and attrition)	Executive orders, SEC conclusions, Administrative Statistics reports and circulars, Acts of the National and State Assembly, White paper	Periodic	Variable timeliness and limited dissemination
Training Institutions	Information on enrollment processes, enrollees, graduates, curriculum, procedures, accreditation status, tutor–to–student ratio	Supportive and mentoring visits and checklist, reports from professional regulatory bodies	Periodic	Variable timeliness, validity, reliability, inadequate dissemination and domestication
Development Partners	Information on technical and financial support to the State health sector	Programme/project reports	Routine	Variable timeliness and limited dissemination

Table 21: Data Quality issues and suggested actions

Data Quality Issues	Actions Taken or Planned to Address this Limitation
Data Inconsistency Data are inconsistent when the value of the data is not the same across applications and systems e.g., contradictions in the numerical count of midwives in Dutse LGA	The use of data definitions, extensive training, standardised data collection (procedures, rules, edits, and process) and integrated/interfaced systems will facilitate consistency
Reliability issues, validity of data, timeliness, reliability, precision.	Regular training and step-down training of data generators on data capturing tools (DCTs). Intensive supportive supervision and spot checks to improve field data management systems via on-site support and mentoring Data auditing and Data Quality Assurance- Monthly/quarterly DQA will also be conducted by the state and documented in the DQA checklists, and the health facility staff designated to the data entry should be notified Conducting routine data verification and validation processes. Review the availability and completeness of all indicator source documents for the selected reporting period. Verify reported results (monthly data validation) - Recount the reported numbers from available source documents, compare the verified counts to the site-reported numbers, and identify reasons for differences. Cross-check reported results with other data sources: Perform cross-checks of the verified report totals with other data- sources (e.g., inventory records, register, etc.). Regular feedback for data quality improvement – State and LGA, including Monitoring and Evaluation coordination meetings monthly or quarterly, will be put in place to address data quality issues, and discrepancies noticed. The National Monitoring and Evaluation team will do quarterly feedback to MDAs and LGAs.
Timeliness issues Data may not be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.	Advocacy visits for fund release to enable studies to be conducted at the appropriate time spot and to analyse data and provide feedback to the relevant stakeholders
Data Accessibility issues Data may not be easily available to stakeholders	Establish data ownership and guidelines for who may access data and/or systems. The amount of accessible data may be increased through system interfaces and systems integration. Access to complete, current data will better ensure accurate analysis. Otherwise, results and conclusions may be inaccurate or inappropriate
Data incomprehensiveness All required data items may not be captured	Clarify how the data will be used and identify end-users to ensure complete data are collected for the survey. Ensure that the entire scope of the data is collected and document intentional limitations
Data not precise The study/survey's purpose, the question to be answered, or the aim for collecting the data element must be clarified to ensure data precision.	To collect data precisely enough for the study, define acceptable values or value ranges for each data item
Data Inaccuracy	Ensure accuracy involves appropriate training and timely and appropriate communication of data definitions to those who collect data.

6.6 Interventions and Indicator Matrix

Table 22: Strategic Objective one Indicator Matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2023	2024	2025	2026	2027
Intervention 1.1.1: Institutionalise the HRH units and equip them with qualified, skilled, competent, and motivated staff in adequate numbers	• Number of LGAs with functional HRH units as evidenced by submission of monthly reports	State	Input	Annual Report	Annual	SMoH SPHCDA	27	27	27	27	27	27
	• Number of LGAs with HRH planning budget lines	State	Input	Annual report	Annual	SMoH SPHCDA	0	5	10	15	20	27
Intervention 1.1.2: Improve capacity for HRH planning and reporting functions at the state and LGA levels	• Number of LGAs implementing HRH policies and strategic plans	State	Input	Annual Report	Annual	SMoH SPHCDA	0	13	27	27	27	27
	• Number of LGAs that have harmonised costed HRH Annual Operational Plans	State	Output	Annual Report	Annual	SMoH SPHCDA	0	10	25	27	27	27
	• Number of LGAs submitting annual HRH reports	State	Output	Annual Report	Annual	SMoH SPHCDA	27	27	27	27	27	27
Intervention 1.1.3: Strengthen sustainable mechanisms for funding HRH planning adequately at State and LGA levels	• Number of LGAs with funding for HRH development utilising PPP	State	Output	Annual Report	Annual	SMoH SPHCDA	0	14	27	27	27	27

Table 23: Strategic Objective two Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2023	2024	2025	2026	2027
Intervention 2.1.1. Strengthen the quality assurance process for HRH training institutions.	• Percentage of health training institutions fully accredited by the relevant regulatory bodies	State	Output	Accreditation Report	Annual	SMOH SPHCDA	23	50	75	85	95	100
Intervention 2.1.2. Strengthen the linkage between HRH training institutions, regulatory bodies and other stakeholders to ensure alignment between health workforce production and needs	• Number of LGAs with health worker production matching identified needs	State	Output	Annual Report	Annual	SMOH SPHCDA	0	5	10	20	27	27
	• Number of new HRH training initiatives being actively implemented	State	Output	Annual Report	Annual	SMOH SPHCDA	2	3	4	5	6	7
Intervention 2.1.3. Improve production of health workforce taking into account gender dynamics and skill mix for service delivery.	• Number of LGAs implementing evidence-based gender-sensitive strategies to inform	State	Output	Annual Report	Annual	SMOH SPHCDA	3	10	15	17	22	27

	enrolment, retention and management of health workers											
	• Number of LGAs with appropriate skill-mix of HRH at all levels of care based on evidence	State	Output	Annual Report	Annual	SMOH SPHCDA	5	10	15	20	27	27

Table 24: Strategic Objective three Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2023	2024	2025	2026	2027
Intervention 3.1.1 Strengthen HRH Information System at the state and LGA levels	Numbers of LGAs with functional and updated workforce registries linked to SHWR.	State	Output	LGA HWR	Quarterly	SMOH SPHCDA	21	25	27	27	27	27
	Percentage of state MDAs and LGAs regularly updating HRH information in the SHWR	State	Output	Activity report	Quarterly	SMOH SPHCDA	100	100	100	100	100	100
Intervention 3.1.2 Establish mechanisms for annual HRH data reviews and reporting for evidence and decision making at the state and LGA levels	Number of annual HRH profiles published at the state and LGA levels	State	Output	Activity report	Annually	SMOH SPHCDA	0	5	15	20	25	27
Intervention 3.1.3 Improve HRH research for data-driven decision making	Percentage of HRH research conducted based on state priorities	State	Output	Research report	Annually	SMOH SPHCDA	33	50	70	80	100	100
	Percentage of state-focused research outputs that informed decisions to improve HRH development, planning	State	Output	Activity report	Annually	SMOH SPHCDA	33	50	70	80	100	100

	and management at state levels											

Table 25: Strategic Objective four Indicator matrix

Strategic Interventions	Indicator	Indicator type	Indicator level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2023	2024	2025	2026	2027
Intervention 4.1.1 Promote evidence-based recruitment, deployment and retention of health workers at all levels of care	Number of LGAs implementing the health workers retention policy	State	Output	Annual Report	Annual	SMOH SPHCDA	5	10	15	20	27	27
Intervention 4.1.2 Improve HRH performance management systems at the state and LGA levels	Percentage of LGAs with a competency-based job description for health workers	State	Output	Annual Report	Quarterly	SMOH SPHCDA	0	1	5	10	15	27
	Number of LGAs implementing performance management systems based on health priorities and appropriate job descriptions	State	Output	Annual Report	Annual	SMOH SPHCDA	0	10	15	27	27	27
Intervention 4.1.3 Strengthen the task shifting and task sharing implementation with required guidelines	Number of LGAs implementing task shifting task sharing policy	State	Output	Annual Report	Annual	SMOH SPHCDA	27	27	27	27	27	27

Table 26: Strategic Objective five Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2023	2024	2025	2026	2027
Intervention 5.1.1 Strengthen partnership for HRH programmes and activities	• Number of LGAs with validated joint annual PPP HRH plan	State	Output	Annual Report	Annual	SMOH SPHCDA	0	5	8	13	20	27
Intervention 5.1.2 Strengthen coordination of stakeholders (public, private, regulatory, professional associations, and development partners at all levels)	• Number of LGAs with functional mechanisms for coordinating stakeholders to facilitate policy dialogue	State	Output	Meeting report	Quarterly	SMOH SPHCDA	0	5	10	15	20	27

6.7 Implementation Arrangements for the Monitoring and Evaluation Plan

Data Management

Data flow will be aligned with the existing state data management systems. Data collection for tracking the progress of the plan will be based on specific indicators for this Monitor and Evaluation Plan:

Data collection refers to the process of gathering data that is generated from various activities relevant to the State HRH Strategic Plan 2023-2027 and its Monitor and Evaluation Framework. This involves obtaining data from original sources and using tools (paper or electronic) to collate, analyse, and report the data. Data can be collected using questionnaires, interviews, observations, and existing records.

Data collation is the process of combining data into summarised (often standardised) formats. This can be done electronically or manually and at different levels (MDAs and LGAs).

Data analysis is the review and manipulation of data depending on the type of data and the purpose. This might include applying statistical methods, selecting or discarding certain subsets based on specific criteria, other techniques. Data analysis enables data users to understand or interpret the results and use them for decision-making (data use).

6.8 Data Quality Management

Quality assurance, which forms the bedrock of good systems should be incorporated at the levels of data collection, collation, analysis and reporting. The following weaknesses in data management should always be watched out for:

- Non-availability of standardised or updated data reporting tools
- Low reporting rates from the private health sector
- Significant data quality gaps as measured through Data Quality Assurance
- Delayed and incomplete financial data reporting
- Inadequate number and capacity of Monitoring and Evaluation and HRH Information System Officers
- Data governance gaps
- Multiple vertical and fragmented reporting systems
- Inadequate capacity and practice in data analysis, synthesis, dissemination and use at all levels
- Lack of linkages between civil and vital registration and HRH Information System

These gaps will be addressed effectively to meet the State HRH Strategic Plan 2023-2027 vision of a competent, gender-responsive and motivated Health Workforce to attain UHC. Identifying and managing potential risks to the quality of data collected and information used is of utmost importance to successfully implement State HRH Strategic Plan 2023-2027. Strategies to address common limitations in data management are outlined in tables 18 and 19 of this Monitoring and Evaluation Plan.

Capacity building at all levels on data analysis and information use is a critical gap which SMoH will address urgently. Technical factors (data-collection tools, processes, and IT devices), and organisational and behavioural factors will be addressed to ensure sustainable production and use of good quality information.

To enhance evidence-based decision-making, comprehensive data analysis and synthesis will be conducted. All relevant data will be synthesised, employing specified parameters (disaggregation) where applicable, and analysed for utilisation across different sector levels. The outcomes will be consolidated into a cohesive assessment of the health situation and trends. Key sector performance indicators and targets will be utilised to evaluate progress and performance.

Basic indicator information shall be presented as the state's average achievement obtained from collating all the available information from all the LGAs into the state-level figures. Sub analyses of the indicator information shall be carried out to provide information on the impact of the intervention.

As part of our Monitoring and Evaluation activities, regular internal Data Quality Assurance exercises will be conducted to maintain consistent high quality of reported programme data. The data management and quality assurance system will encompass the following components:

- Internal Data Quality Assurance check at the level of data collection
- External Data Quality Assurance check conducted by the DPRS in the SMoH, SPHCDA and implementing partners
- Regular feedback for quality improvement

Regular data records review and periodic Data Quality Assurance processes are necessary core Monitoring and Evaluation routine activities designed to consistently ensure the quality of reported programme data before reporting to the next level in the data flow. Identifying and accounting for biases due to incomplete reporting, inaccuracies and non-representativeness is essential and will greatly enhance the credibility of the results. This involves a multi-step process including: (i)

Assessment of the completeness of reports; (ii) Accuracy of coverage estimates from reported data; (iii) Systematic analysis of survey-based indicator values; and (v) Adjustments of the indicator values, using transparent and well-documented methods. The Data Quality Assurance should be done regularly, and the results should be published at all levels.

6.9 HRH Data Governance Arrangements

This is a statutory function of the SMoH and SPHCDA with laid down processes and practices. The relevant departments have their monitoring teams, who routinely conduct monitoring missions to agencies, parastatals and institutions to assess the progress, quality and standards of the health workforce against the plans and indicators projected. The HRH units at the SMoH and SPHCDA levels are ideally responsible for supervising and monitoring the progress of the development of tools and LGA-level implementation of HRH policies and plans.

This is seldom done due to financial and logistical challenges. Monitoring, follow-up and control systems need to be institutionalised at all levels. These will include periodic review meetings, regular review of the budget systems and development of progress reports.

6.10 Monitoring, Review and Evaluation State HRH Strategic Plan 2023-2027 Implementation

The State HRH Strategic Plan 2023-2027 implementation will be routinely monitored, reviewed and evaluated to track progress in achieving the set objectives and targets. The purpose of the State HRH Strategic Plan 2023-2027 evaluations is to improve the effectiveness of the State HRH Strategic Plan 2023-2027 and/or to inform programming decisions. The structure of the evaluation process is to track results against indicators across the "Results Chain" or Theory of Change, with the emphasis placed on tracking outputs, outcomes and impacts of various interventions. Occasionally, evaluations will be conducted by respective MDAs, in collaboration with development partners, relevant stakeholders, or jointly with independent consultants to determine issues relating to relevance, effectiveness, efficiency, Value-for-Money, impact and sustainability of service delivery in line with the Development Assistance Committee criteria for evaluation.

This Monitoring and Evaluation Plan has made provision for routine monitoring of the Core Indicators through Joint Annual Reviews, a Mid-Term Review and an End-Term Evaluation of this plan. However, reviews will not be limited to these baselines, mid- and/or end-term evaluations. Evaluation findings will be disaggregated by gender, age, or other important characteristics that will inform

equity.

Figure 12: Key assumptions underpinning the Monitoring and Evaluation process

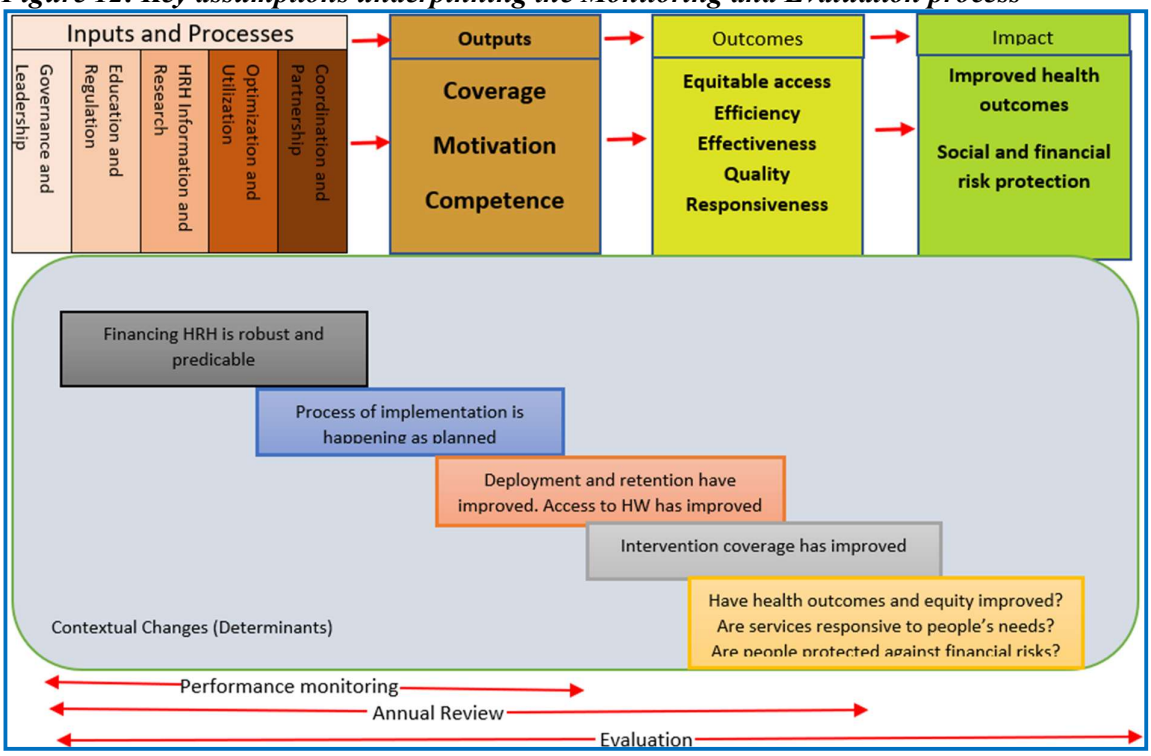


Table 27: Methodology and frequency of carrying out Monitoring and Evaluation

Methodology	Frequency	Output	Focus	Level of monitorng and review
Performance Monitoring	Quarterly	Quarterly progress reports; transmitted to next higher level of supervision	A review of progress against targets and planned activities.	Inputs, process, output and outcome
Joint Annual Review	Annually	Annual progress reports transmitted to next higher level of supervision	Done jointly with development partners, key stakeholders and planning entities to review progress against set targets outcomes in line with IHP+ guidelines	Inputs, process, output and outcome
Mid Term Review	Mid-way in the implementation of the State HRH Strategic Plan 2023-2027	Midterm Review Report	Done by sector to review progress against planned impact	Input, process, output, outcome and impact levels
End Term Evaluation	At the end of State HRH Strategic Plan 2023-2027	End Term Evaluation Report	Independent review of progress against planned impact	Input, process, output, outcome and impact levels

CHAPTER 7: RISK MANAGEMENT

A proactive approach to strategic risk management is essential in anticipating and mitigating potential risks that could impede the realisation of specific attainable targets, strategic themes, and general objectives of the strategic plan. These have been classified as strategic, operational, reputation, supervisory or compliance and financial risks.

i. Strategic risk: is the prospective adverse impact arising from poor strategic decisions, improper implementation of decisions; or lack of responsiveness to changes in the operational environment. Strategic risk encompasses the risk of; choosing and continuing to follow sub optimal strategies to meet objectives; not executing the strategies successfully; and treating the functions as usual risks differently from expected.

ii. **Operational risk:** This is the risk of loss from inadequate or failed processes, people, systems or external events including weak governance and even IT risks.

iii. **Reputational risk** which is the risk of damage to the image of the HRH office. Failure to do what the office is mandated to do.

iv. **Supervisory/compliance risk**: failure to act in accordance with internal policies or prescribed best practices can lead to mistrust from stakeholders.

v. **Financial risk** would emanate from failure to either mobilise adequate funds or lack of prudence in financial resource utilisation and encompasses:

a) Credit risk: The risk of loss from the governments at all levels or partners not meeting their obligations as anticipated.

b) Liquidity risk: Risk of being unable to meet cash flow obligations as anticipated.

For each risk, appropriate mitigation measures have been determined, and the mitigation measures have subsequently informed the implementation as well as the M & E framework.

Table 28: Risk analysis

Classification	Anticipated Risk	Mitigation Measures
Strategic Risks	Failure to realise HRH's mandate	Develop operational plans to guide the realisation of the State HRH Strategic Plan Align the vision, mission and strategic objectives to SHSDP II and other health documents Implement the strategic plan and put in place a Monitoring and Evaluation framework to ensure timely progress tracking
	Strategic scope	Regularly review strategic objectives with a view to realigning them with changes in the operational environment, health needs and actual performance results
	Failure of staff and other stakeholders to buy into the vision and strategy	Stakeholder inclusion and participation in the visioning and strategic planning/ annual operational planning processes to ensure understanding and embracing of the vision and strategy
Operational Risks	Lack of stakeholder good will	Comprehensive stakeholder analysis and mapping to inform targeted stakeholder management in order to enhance and sustain stakeholders' goodwill Effective and continuous stakeholder engagement through the quarterly HRH forum meetings
	Inadequate human, physical and other resources.	Lobby for funds for hiring additional competent staff in the HRH units Retain, retrain and motivate current staff Acquire more physical assets such as computers and office space Mobilise financial resources to support the HRH agenda
	Low awareness of HRH roles, achievements and services to SMoH	Ensure visibility through targeted information sharing/dissemination of results anchored on clear communication
	Changes in the systems	Responding rapidly to changes/trends by embracing change
	Bureaucratic red tape and slow decision making	Enhance stakeholder management strategies
	Ineffective Performance Appraisal System (APER)	Continuous review and revision of the performance appraisal tool Ensure all HRH fully optimised its APER by developing and cascading targets in line with Strategic Plan and undertaking continuous reviews
	Inaccurate data, data manipulation, mismatch of data, system/ human errors of the HRIS/ Registry	Set up a system for validating information collected from the various sources Install and update logical access controls at the various levels
	Staff challenges, including high employee turnover, loss of specialised staff, skills gaps and low motivation/morale	Staff motivation Staff sensitisation on policies and procedures Development and implementation of appropriate HRH policies Effective succession planning Training and development Communication and teamwork Ensure optimal staffing levels with the required competencies
Reputational Risk	Stakeholders misunderstanding the mandate of HRH units leading to unrealistic expectations	Awareness creation on mandate and planned services Continuous engagement and management of the stakeholders
Compliance Risks	Noncompliance with policy requirements	Regular review of strategies and operations against core mandate Aligning all HRH activities with health programmes Intensive risk-based approach to Monitoring and Evaluation in collaboration with the Monitoring and Evaluation team at SMoH and SPHCDA

Classification	Anticipated Risk	Mitigation Measures
Financial Risks	Inadequate financial resources and overreliance on donor funding	Use policy guidelines in the proper budgeting and development of resource mobilisation strategy through initiatives like diversification of financial streams
	Inadequate and inequitable resource allocation	Prioritisation of resource allocation on the basis of the implementation matrix Continuous review of the plan to ensure resource allocation for prioritised activities
	Non allocation of funds and failure to release allocated HRH funds	Lobbying for funds through proper planning for expenditure and implementation Continuous M&E of annual work plans

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ANNEX 1: PARTICIPANTS AT THE DOMESTICATION WORKSHOP

S/N	Name	Organization
1	Dr Kabir Ibrahim Aliyu	JPHCDA
2	Dr Umar Namadi Abdullahi	JSMoH
3	Dr Nura Awaisu	JSMoH
4	Dr Usman Abba Ahmed	JSMoH
5	Malam Kabiru Usman	College of Nursing and Midwifery
6	Yusuf Bashir	JSPHCDA
7	Muhammed Ali	JICHMA
8	Lawan S. Yakubu	JICHMA
9	Sadiq Muhammed Gana	Office of the Head of Civil Service
10	Dako Hadiza Jummai	FMoH
11	Shamsudeen Aliy Saad	NPHCDA
12	Abdulkadir Yakubu	JSPHCDA
13	Isyaku S. Shehu	SMOH
14	Abdullahi Ibrahim	SMOH
15	Ya'u Sani Usman	JSPHCDA
16	Dr Abimbola Olaniran	KIT

ANNEX 2: PARTICIPANTS AT THE VALIDATION WORKSHOP

S/N	Name	Organization
1	Aminu Danmalam	NTLCFP
2	Pharmacist Jaafar Magaji	PSN
3	Abubakar Hamza Dahiru	SMoH
4	Yusuf Bashir	JSPHCDA
5	Surajo Sulyman	College of Health Science & Technology, Jahun
6	Musa Yayandi	College of Nursing and Midwifery, B/Kudu
7	Ya'u Sani Usman	JSPHCDA
8	Musa Nababa	JSPHCDA
9	Kamal Yusuf	NSP
10	Abdu Usman	SMoH
11	Mohammed Yahaya	AMLSN
12	Usman Mohammed Madaki	SMoH
13	Abdullahi Sarki Suleiman	JICOPH
14	Kafayat Alausa Yetunde	SMoH
15	Lawan S. Yakubu	JICHMA
16	Nura Awaisu	SMoH
17	Dauda Mohammed	SMoH
18	Kabiru Hassan	SMoH
19	Aliyu Usman Turaki	SMoH
20	Shamsudeen Sani	FCDO-Lafiya
21	Dr Abdurrahman S. Usman	NMA
22	Sadiq Mohammed Gana	OHOs
23	Shafiu Dahiru G.	CIHP
24	Musa Muazu	JICOPH/CSO
25	Pharmacist Rabiu Yakubu	SMoH
26	Hamisu Adamu	SMoH
27	Dr Shehu Sambo	JSPHCDA

S/N	Name	Organization
28	Dr Usman Abba Ahmed	SMoH
29	Abdullahi Ibrahim	SMoH
30	Musa Muhammed Makwayi	WDC Rep
31	Dr Zubair Usman	DDHS
32	Dr Bello M	WHO
33	Aminu Adamu Ringim	Budget and Planning
34	Ya'u Adamu Jahun	SMoH
35	Dr Abimbola Olaniran	Global Fund _KIT
36	Sakinat A. Suleiman	VILDEV/CSO
37	Rabiu Inuwa Adnan	SMoH

ANNEX 3: STATE HRHSP 2023-2027 COST SUMMARY

OBJECTIVES & STRATEGIES	TOTAL COST PER ANNUM					GRAND TOTAL (₦)	% OF TOTAL COST
	YEAR 1 COST (₦) (2023)	YEAR 2 COST (₦) (2024)	YEAR 3 COST (₦) (2025)	YEAR 4 COST (₦) (2026)	YEAR 5 COST (₦) (2027)		
Obj. 1) Strengthen governance, stewardship and accountability of the health workforce	**12,850,234**	**9,458,431**	**9,543,765**	**9,234,421**	**9,567,907**	**50,654,758**	
Strategy 1.1.1: Institutionalise the HRH units and equip them with qualified, skilled, competent and motivated staff in their adequate numbers	5,037,494	4,958,615	4,299,226	4,237,833	4,765,846	23,298,014	
Strategy 1.1.2: Improve capacity for HRH planning and reporting functions at all levels	2,125,883	1,323,480	1,478,766	1,467,750	1,367,526	7,763,405	**27%**
Strategy 1.1.3: Strengthen sustainable mechanisms for funding HRH planning adequately at state and LGA levels	3,445,348	1,341,119	2,007,205	1,948,287	1,623,678	10,365,637	
Strategies 1.1.4: Strengthen mechanisms for HRH oversight on the private health sector	2,241,509	1,835,217	1,758,568	1,580,551	1,811,857	9,227,702	
Obj. 2) Ensure the production of	**4,950,300**	**4,243,567**	**4,987,324**	**4,453,321**	**4,234,130**	**22,868,642**	

OBJECTIVES & STRATEGIES	TOTAL COST PER ANNUM					GRAND TOTAL (₦)	% OF TOTAL COST
	YEAR 1 COST (₦) (2023)	YEAR 2 COST (₦) (2024)	YEAR 3 COST (₦) (2025)	YEAR 4 COST (₦) (2026)	YEAR 5 COST (₦) (2027)		
adequate numbers of qualified health workers							
Strategy 2.1.1: Strengthen the quality assurance process for HRH training institutions.	4,752,288	4,067,780	4,787,668	4,275,438	4,064,434	21,947,608	
Strategy 2.1.2.: Scale up production of the health workforce to match demands/needs	124,401	112,562	125,170	111,798	106,417	580,348.	**12%**
Strategy 2.1.3: Improve production of health workforce taking into account gender dynamics and skill mix for service delivery.	73,611	63,225	74,486	66,085	63,279	340,686	
Obj. 3) Enhance the functionality of Human Resources for Health Information System	**20,930,500**	**8,453,231**	**8,345,621**	**8,120,000**	**8,321,223**	**54,170,575**	
Strategy 3.1.1.: Strengthen HRH Information System at all levels	17,057,974	8,162,804	8,151,118	7,800,256	7,995,534	49,167,686	**29%**
Strategy 3.1.2: Establish mechanisms	369,895	290,427	194,503	319,744	325,689	1,500,258	

OBJECTIVES & STRATEGIES	TOTAL COST PER ANNUM					GRAND TOTAL (₦)	% OF TOTAL COST
	YEAR 1 COST (₦) (2023)	YEAR 2 COST (₦) (2024)	YEAR 3 COST (₦) (2025)	YEAR 4 COST (₦) (2026)	YEAR 5 COST (₦) (2027)		
for annual HRH data reviews and reporting for evidence and decision making at the State and LGA levels							
Strategy 3.1.3: Improve HRH research for data-driven decision making.	3,502,631	-	-	-	-	3,502,631	
Obj. 4) Optimise the recruitment, utilisation, retention and performance of the available health workforce	**10,100,430**	**5,453,654**	**5,213,098**	**5,112,101**	**5,043,321**	**30,922,604**	
Strategy 4.1.1: Promote evidence-based recruitment, deployment and retention of health workers at all levels of care	4,442,305	4,362,923	4,170,478	4,466,485	4,042,676	21,484,867	**17%**
Strategy 4.1.2.: Improve HRH performance management systems at all levels	5,658,125	1,090,731	1,042,620	645,616	1,000,645	9,437,737	
Obj. 5) Strengthen coordination and partnership for HRH agenda	**5,525,000**	**5,234,289**	**5,433,000**	**5,345,101**	**5,654,765**	**27,192,155**	

OBJECTIVES & STRATEGIES	TOTAL COST PER ANNUM					GRAND TOTAL (₦)	% OF TOTAL COST
	YEAR 1 COST (₦) (2023)	YEAR 2 COST (₦) (2024)	YEAR 3 COST (₦) (2025)	YEAR 4 COST (₦) (2026)	YEAR 5 COST (₦) (2027)		
Strategies 5.1.1: Strengthen partnership for HRH programs and activities	1,675,377	1,286,591	1,339,594	1,313,838	1,389,895	7,005,295	
Strategies 5.1.2: Strengthen coordination of stakeholders (public, private, regulatory, professional associations and development partners) at all levels	3,849,623	3,947,698	4,093,406	4,031,263	4,264,870	20,186,860.	**15%**
Total Cost (₦)	**54,356,464**	**32,843,172**	**33,522,808**	**32,264,944**	**32,821,346**	**185,808,734**	
Total cost (US$) @N460/USD	**117655**	**71089**	**72560**	**69838**	**71042**	**402183**	