YOBE STATE PHC HRH STRATEGIC PLAN (2021-2031)

JULY 2022

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Glossary of Terms

APER	Annual Performance Evaluation Report
Aux Nurse	Auxiliary Nurse
BEmONC	Basic Emergency Obstetric and Newborn Care
B-IG	Basic Immunization Guide
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CSE	Comprehensive Sexuality Education
DHIS 2	District Health Information Software 2
DHT	Dental Health Technician
DRF	Drug Revolving Fund
EHO	Environmental Health Officer
ENCC	Essential Newborn Care Course
FP Tech	Family Planning Technology
HCT	HIV Counselling and Testing
H. Asst	Health Assistant
H. Attd	Health Attendant
HTIs	Health Training Institutions
IMCI Plus	Integrated Management of Childhood Illnesses Plus
IPC	Infection Prevention and Control
IYCF	Infant and Young Child Feeding
JCHEW	Junior Community Health Extension Worker
KPI	Key Performance Indicators
Lab. Pers.	Laboratory Personnel
BMGF	Bill and Melinda Gates Foundation
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
GAVI	Global Alliance Vaccine Initiative
HCW	Health Care Workers
HRH	Human Resource for Health

KII	Key Informant Interview
LEMCHIC	Local Government Emergency Maternal Child Health Intervention Centre
MEAL	Monitoring, Evaluation and Learning
NEMCHIC	National Emergency Maternal and Child Health Intervention Centre
NPHCDA	National Primary Health Care Development Agency
NHREC	National Health Research Ethics Committee
PEA	Political Economy Analysis
PHC	Primary Health Care
RMNCAH+N	Reproductive, Maternal, Neonatal, Child and Adolescent Health + Nutrition
SBA	Skilled Birth Attendant
SEMCHIC	State Emergency Maternal Child Health Intervention Centers
SPHCB	State Primary Health Care Board
WHS	Ward Health System Strategy
YSPHCB	Yobe State Primary Health Care Board

Acknowledgments

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Foreword

By ……..

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Executive Summary

Yobe State has faced severe disruption of its health service as a result of the Boko Haram insurgency. Population migration and transport restrictions have substantially impacted access

to health provision. The human resource for health capability of the state has been severely diminished through the outward migration of (especially non-indigenous) health workers and the suspension of programmes providing external technical assistance. The political will of the Yobe State government to strengthen health provision — through lifting a moratorium on recruitment and providing incentives for retention and support of staff — has supported a recovery of health systems functionality. Policies of free-drug provision and decentralized drug supply appear to have been protective to the operation of the health system. Community resources and cohesion have been significant assets in combatting the impacts of the insurgency on service utilization and quality. Staff commitment and motivation — particularly amongst staff indigenous to the state — has protected health care quality and enabled flexibility of human resource deployment.

Yobe State PHC HRH Specific Strategic Plan has been designed to run from 2021-2030 to provide the blueprint needed to guide its PHC programmes and an attempt to address the intrinsic weaknesses and challenges, such as inadequate skilled health care providers; gross underfunding; poor coverage of high impact, life-saving, and cost-effective interventions; poorly maintained, ageing and dilapidated infrastructure and medical equipment; inadequate drugs and commodities; and limited community participation. These constitute some of the factors that continue to obstruct effective and efficient delivery of healthcare services to the people of Yobe state. These challenges necessitated the development of the Yobe State PHC HRH Strategic Plan 2021-2030, which will continue to invest in strengthening the PHC system.

Yobe State PHC HRH Strategic Plan 2021-2030 has been developed to improve access to healthcare services at the community level. This PHC HRH Strategic with attention given to expansion and scale-up of the essential health care service package, which comprises of Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition-(RMNCAH+N) related programmes; Control of communicable diseases (including malaria, tuberculosis, HIV/AIDS, hepatitis and neglected tropical diseases); Control of non-communicable diseases (including mental health, oral health, eye care, and care of the elderly); Protection from public health emergencies and risks); Management of environmental health (water and sanitation, food safety, snakebites and chemical programmes); Emergency medical services; and health promotion and education activities modeled towards enlightenment and creating demand for improved health care services delivery in the state. The opportunities that the strategic plan aims to take advantage of, and the threats that the plan is likely to face during its implementation were identified and factored into development of important activities as required according to the strategies adopted.

Yobe State specific strategic plan provides for the establishment and strengthening of the PHC health care financing, human resources for health, health governance and information systems.

It also focuses on promoting partnerships of relevant stakeholders in the PHC system to increase participation and ownership through strengthening of structures that will serve as the foundation and broad-based support required to ensure effective delivery of quality health care services at the PHCs across the state. The context, goals, strategic objectives, priority interventions, and key activities required to deliver improved performance of the PHC system and equitable health outcomes for the teeming state's population are well articulated in the plan.

The estimated cost of the plan is one billion, twenty million, nine hundred and seventeen thousand four hundred and fifteen naira only (N1, 020,917,415.00) for the 10-year period. Total cost of the strategic plan takes into consideration the cost of programmes management activities to be carried out and the health system inputs that are required to be in place to achieve the desired coverage targets and impact goals. It is therefore expected that with adequate financial, human and material resources, essential health care services in the PHC health systems would improve quality of health care across the PHCs and to all people in Yobe state.

Chapter 1. Introduction

1.1 Background

Primary Health Care (PHC) is the frontline of the health care that serves as the first point of community entry into the health care system. A strong accessible PHC system improves population health outcomes while also delivering cost-effective care. A strong PHC system is necessary to achieve SDG 3 which is to "*ensure healthy lives and promote well-being for all at all ages*" this can be done by addressing maternal and child mortality rates, epidemics, premature mortality, ensuring access to quality sexual and reproductive health care services, etc.

PHCs are universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level contact of the individual and community in the national health system, thus bringing health care as close as possible to where people live and work and contribute the first element of a continuing health care process".3 It is essentially aimed to promote health, to cure diseases and to rehabilitate. Nigeria is one of the few countries in the developing world to have systematically decentralized the delivery of basic health and education services to locally elected governments

An effective primary care system is critical for any country, developed or developing, to maximize outcomes and minimize costs.8, 9 Accurate and relevant data gathering, and information processing are necessary for any field of endeavor whether in health care or any other field. It has long been recognized that clients in primary health care in Yobe are different from those in other types of care. For example, the predictive values of symptoms may be quite different in different settings and clinical evidence derived from other settings may have limited applicability to primary health care and delivery. This is due not only to differences in the prevalence of specific diseases, but also to the fact that patients in primary care have many problems and the clinician must prioritize the diagnosis and management of all these together over time, often in a setting where continuity of care plays a crucial role.

This '*whole-of-society*' approach to health includes components of comprehensive and affordable health service provision to the populace, enabling multi-sectoral policies, and targeted actions to address the wide socio-economic determinants of health and the empowerment of individuals, families, and the community in actively participating in improving their health status emphasize the need for an effective and efficient primary health care system in Yobe State.

A state-specific strategic plan for PHC HRH based on the state's characteristics and gaps was necessary to fulfill the PHC HRH national objectives. To assist in the development of a 10-year state-specific PHC HRH plan that will address the maternal and child mortality rates, epidemics, and premature mortality in these states, the NPHCDA/NEMCHIC performed a PHC HRH profile exercise in 2021 in ten pilot states.

The Yobe State-specific PHC HRH strategic plan (for 2021 to 2030) lays out the state's long-term course for enhancing PHC HRH systems and structures.

[1] Business Bliss Consultants FZE. (November 2018). Concept of primary health care in Nigeria. https://nursinganswers.net/essays/concept-of-primary-health-care-in-Nigeria.php?vref=1

1.2 Rationale for the Yobe HRH strategy

A strategy is a road map for accomplishing specific objective; it aids people, groups, and even entire systems in cooperating to reduce issues through coordinated and efficient means. By 2030, Yobe State is committed to developing a strong PHC workforce that will provide community-based, high-quality healthcare services that are equitable, affordable, and accessible. Yobe state developed its PHC HRH strategic plan to accomplish this.

The Yobe state strategic plan will act as a road map for the state as it works toward its HRH goals. The vision, purpose, and goals of the state are outlined in this strategic document, along with interventions, actions, targets, and key performance indicators, which are grouped into six priority categories. The timelines for achieving the goals and keeping track of success using preset indicators will be outlined in this approach. This strategic plan will also direct HRH finance and costing, particularly for the deployment of HRH in Primary Health Care services.

1.3 Policy context

To make sure the Yobe state strategic plan has a strong foundation and takes into account prior PHC and/or HRH policies and strategies and uses these learnings to improve the plan, primary health care (PHC) and human resource for health (HRH) policy documents at the global, national, and state levels were reviewed and linked to the plan.

National Strategic Health Development Plan II (2018 – 2022)

The National Strategic Health Development Plan (NSHDP) II, 2018–2022, tries to solve the first plans' shortcomings while building on the most important lessons learned from the first plan. The NSHDP II specifies the requirement for government at the Tertiary, Secondary, and Primary Health Care levels to develop a workforce plan with the overall objective of providing universal access to basic health care for every family through skilled and supported health workers, recognizing HRH as the cornerstone of the health system. In line with this idea, the Yobe HRH strategy covers HRH at all levels of healthcare.

National HRH Strategic Plan (2016 – 2020)

The National HRH Strategic Plan offers direction for addressing important issues related to planning, production, training and development, management, utilization, motivation, retention, financing, monitoring, and evaluation of HR within the health sector as described in the National HRH Policy 2015. It is meant to act as a tool for the country's many HRH stakeholders to be coordinated and integrated. The National HRH Strategic Plan's vision, guiding principles, framework, and objectives serves as the foundation for the Yobe HRH strategy.

Reaching Every Ward with Skilled Birth Attendants (REWSBA) 2021

The REWSBA is a set of implementation guidelines aimed at reducing the alarmingly high rates of maternal mortality in Nigeria by guaranteeing that all wards in the country have licensed medical personnel (in particular, skilled birth attendants) who are capable of handling straightforward maternal cases. The five steps of the REWSBA strategy execution are to mobilize, train, deploy, equip, support, and retain SBA.

The National Primary Health Care Under One Roof (PHCUOR) Policy 2011

The PHCUOR policy reform aims to address important stewardship and governance, since they are the most difficult components the Nigerian health services delivery system has ever faced and because they are the major factors in the underperformance of the entire national health sector. In order to decrease fragmentation in the management and service delivery of Primary Health Care, the PHCUOR seeks to consolidate all PHC services under a single body. The National Health Act of 2014 and the Sustainable Development Goal 3 (SDG3) to attain Universal Health Coverage are in accordance with this. Through the Basic Health Care Provision Fund, the Nigerian National Health Act (NHAct 2014) legally makes financial resources for PHC available. There is a great opportunity to support significant advances in PHC as decision-makers adopt the National Health Act and the PHCUOR reform recommendations for

the integrated administration of primary-level health care. The PHCUOR guiding principles, guide the Yobe HRH strategy.

1.3.2 Links to State Policy and Strategy Documents

Minimum Service Package (MSP) for Yobe State

The Yobe State Costed Minimum Service Package (MSP), based on the guiding principles of effectiveness, efficiency, and equity, was developed to revitalize and enhance the Primary Health Care System as a component of an integrated network of care. The objective of this document was to create and estimate the cost of the ideal PHC service delivery model for Yobe State.

Yobe State Primary Health Care Under One Roof (PHCUOR) Policy

Yobe State has participated actively in the revision of PHCUOR policy. The State scored 97 percent on the PHCUOR policy reform implementation in 2022, placing it first in the NPHCDA and partners' evaluation of the PHCUOR scorecard.

1.4 The Strategic Plan Development Process

The preparation of the Yobe State PHC HRH 10-year strategic plan began in March 2022 with an onboarding meeting with the State, during which stakeholders were informed of the need for the State to develop a PHC HRH strategic plan that would lead the State in tackling its specific PHC HRH concerns.

A HRH profile was conducted in Yobe in order to identify the causes of the HRH deficits. This required gathering data on health care workers (HCWs) and conducting Key Informant Interviews (KIIs) with key stakeholders. After the data collection was concluded, a report detailing the results of the gap analysis was developed, verified with Yobe State stakeholders, and disseminated.

A Technical Working Group (TWG) was composed of representatives from the Yobe State Primary Health Care Board, the Departments of Planning and Human Resource, the State Emergency Maternal Child Health Intervention Center, the State Ministry of Health, LGA Monitoring and Evaluation Officers, and Partners, among others. A workshop was conducted from May 16th to May 20th, 2022, to produce the draft Yobe State PHC HRH 10-year strategic plan. Following this, a smaller group comprised of a few members of the TWG and other stakeholders was established to evaluate the proposed strategic plan in depth.

Chapter 2. Yobe State Profile

2.1 Geographical information, demographic profile, Socio-economic profile, and Political information.

Figure 1: Map of Yobe state in the North-Eastern part of Nigeria

2.1.1 Geographical information

Yobe, named after the river Yobe, was carved out of the former Borno State on August 27, 1991, by the then Federal Military Administration headed by General Ibrahim Badamasi Babangida. It was the result of years of labor by many individuals whose goal was to assure fast and sustained socioeconomic growth across the regions and towns that now comprise the state.

The political organization of Yobe is comprised of 17 Local Government Areas and 178 political wards. It has fourteen emirate councils. Its capital is Damaturu.

2.1.2 Demographic profile

According to the 2006 national population estimate, Yobe state population is projected at 4,025,606 people in 2022. There are several cultural and ethnic groups which includes Manga/Kanuri, Fulani, Bolewa, Karai-Karai, Ngamo, Ngizim, Bade, Maga, and Babur.

2.1.3 Socio-economic profile

Yobe is blessed with vast agricultural land that supports farming activities (pastural, fishing, and crops) that provides a means of livelihood for most people in the state. With support from successive administrations,

Yobe's Agric sector has been transformed in many ways over the years. There is also a vast deposition of solid minerals (iron ore, lime stone and potash etc). The state also has some tourist and historic attractions which includes the famous Dufuna Canoe, a historic artefact that was carbon-dated to have existed for over 8,500 years.

2.1.4 Political information

Politically, Yobe state is split into three geopolitical zones: Zone A includes Damaturu, Gujba, Gulani, Tarmuwa, Bursari, Gaidam, and Yunusari; Zone B includes Potiskum, Fika, Fune, and Nangere; and Zone C includes Bade, Jakusko, Karasuwa, Nguru, Yusufari, and Machina LGAs. This brings the total number of LGAs in the state to 17.

2.2 Current Health Profile

2.2.1 Health system profile

Health System Governance

Primary Health Care (PHC) services are provided and administered by the Yobe State Primary Health Care Board (YSPHCB). The SMOH is provides policy-direction and stewardship to the YSPHCB.

The government, personal out-of-pocket expenses, donor funds, the private sector, and health insurance premiums, funds health care services in Yobe State. Due the Yobe State government political will and commitment, health budgetary provision increased from 8 percent in 2009 to 11 percent in 2022[1].

Physical structures

The health sector of Yobe State provides primary, secondary, and tertiary levels of care. Primary health care services are primarily preventive, promotive, protective, curative, restorative, and rehabilitative, whereas secondary health care services provide secondary healthcare services. The tertiary health care provide specialized curative and reparative care. There are more than 517 primary care facilities, 18 secondary care facilities, and 8 tertiary care facilities. Despite the tremendous improvement in Yobe State's health care delivery system through upgrade of both primary and secondary facilities, there is still inadequate skilled human resource.

2.2.2 Status of PHC Implementation

The Midwives Service Scheme (MSS) was launched by the NPHCDA in December 2009 to address the HRH needs in rural primary health care (PHC). This was done based on the evidence that when the number of mid- wives increases, services utilization increases, women's satisfaction with care received increases, and maternal and newborn mortality decrease. To do this, three categories of midwives were recruited as part of the MSS: the newly graduated, the unemployed, and the retired. They were posted

[2]Nigeria | PHCPI (improvingphc.org)
[3] Health Financing Decisions: Use of Sub-National Health Accounts in Yobe State - HSDF
Antenatal Care Services Utilization in Yobe State, Nigeria: Examining Predictors and Barriers - PMC (nih.gov)

to selected PHCs in rural communities. The YSPHCB was responsible for the implementation of MSS, here responsibility for monthly remuneration, provision of basic health insurance coverage and midwifery kits for the mid-wives was provided by the federal government through NPHCDA.

Since the establishment of primary healthcare board in 2010, the state government has recruited over 1000 PHC workers including midwives. The state has also established a school of midwifery with basic and community midwifery programs. Based on the needs of more mixed health workers at PHC level, the state government upgraded the school of health technology to college of health sciences with full accreditation of about 5-6 courses in 2020.

2.2.3 Yobe State Health Burden

Yobe State has a maternal death rate of 1,549 per 100,000 live births, which is over three times the national average of 512 per 100,000 live births.

According to the 2016-17 MICS, Yobe state neonatal death rate was 59 per 1000 live births, the infant mortality rate was 100 per 1000 live births, the child mortality rate was 52 per 1000 children surviving to reach one year of age, and the under-five mortality rate was 150 per 1000 live births. While the 2021 MICS survey shows that neonatal death rate was 10 per 1000 live births, under-5 mortality was 52 per 1000 live births.

2.3 Yobe State PHC HRH situation

2.3.1 Background

The utilization of data for evidence-based decision-making is essential for designing strategies/policies; thus, we must comprehend the present Yobe HRH scenario, especially at the PHC level, in order to use this information to make informed judgments. Yobe State performed a PHC HRH profile and PEA exercise in 2021 to comprehend the barriers to the provision and accessibility of primary health care services. In this instance, the WHO HRH conceptual framework was adapted in the PHC HRH profiling exercise across the recommended HRH thematic areas, including policy, planning, financing, education, recruitment, distribution, training and retention, incentives, migration, and the delivery of priority health programs/services.

Individual HRH data were gathered at the level of the health institution, whereas administrative HRH statistics were acquired at the State level. In addition, HRH production data was gathered from Health Training Institutions and Regulatory authorities. The qualitative analysis was undertaken in order to comprehend the causes of the discovered HRH gaps as well as the institutions and players engaged in PHC HRH decision-making.

2.3.2 PHC HRH profiling and PEA Methodology

The HRH profiling exercise was conducted by NEMCHIC employing a five-step strategy: project design, tool creation, data gathering, data analysis, and report writing. Administrative officials, account officers at the State level, all PHC healthcare personnel at all facilities, administrative officers at health training institutes (HTI) and regulatory agencies provided quantitative information. We gathered qualitative data from important stakeholders at the national, state, HTI, and regulatory levels.

Project Design

NEMCHIC designed the project concept and selected research locations, engaged national and State stakeholders, classified States by HRH status, and advocated for States' approval.

Tool development

NEMCHIC created a standardized PHC HRH profile instrument by modifying comparable global and national HRH profiling instruments. The standardized National PHC HRH Profiling tool was designed to collect HRH information on three levels; the first level – Individual HRH information including name, date of birth, gender, marital status, citizenship, contact information and next-of-kin details, educational background details, professional license information, employment information, training; the second level – HRH group information including name, date of birth, gender, marital status, citizenship, contact information and next-of-kin details; and the third level the second level consists of information at the state level, such as attrition statistics, absorption data, research and information systems, and funding; third level – Health training institution and regulatory body production, health training institution regulation

Data collection

Data collectors and supervisors were recruited, trained, and deployed to collect both quantitative and qualitative key information indicators (KIIs). Data collectors also received supportive supervision, and random data quality checks were undertaken.

Data analysis

The obtained quantitative data was cleaned and analyzed, the audio recordings from the interviews were transcribed, the transcripts were cleaned and coded using the Dedoose software, and extracts from the coded transcripts were compiled and used for content analysis and extraction.

Report Writing

The Yobe State PHC HRH profiling report was developed by NPHCDA, the report was then validated and disseminated to State stakeholders.

2.3.3 PHC HRH profiling and PEA exercise objectives

The Objectives of the HRH situation analysis were to:

1. Determine the gaps in size, skill mix, and distribution of the HRH disaggregated by cadre, gender and PHCs in the state
2. Ascertain the quality of the existing health workforce by cadre across the PHCs and LGAs in the state
3. Assess the state’s HRH production capacity
4. Identify actors and institutions involved in PHC HRH decision-making

2.3.4 Yobe State PHC HRH profiling and Political Economy Analysis (PEA) exercise findings

Yobe State PHC facilities and HCW profile

Figure 2 below shows the distribution of HCWs across LGAs and health facility types. 3,815 HCWs were profiled, health post having the most facilities and a high proportion of HCWs are found in primary health care centers and HRH are disproportionately distributed across the 17 LGAs with Fune and Tarmua LGA having the highest and lowest number of healthcare workers respectively.

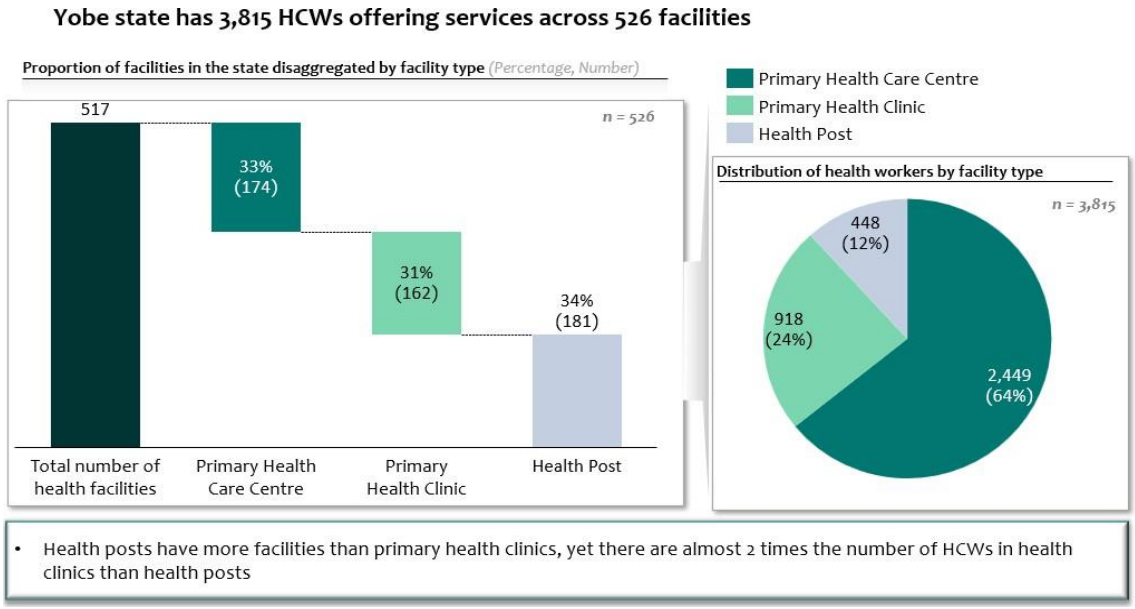

Figure 2: Distribution of HCW disaggregated by LGA and health facility type

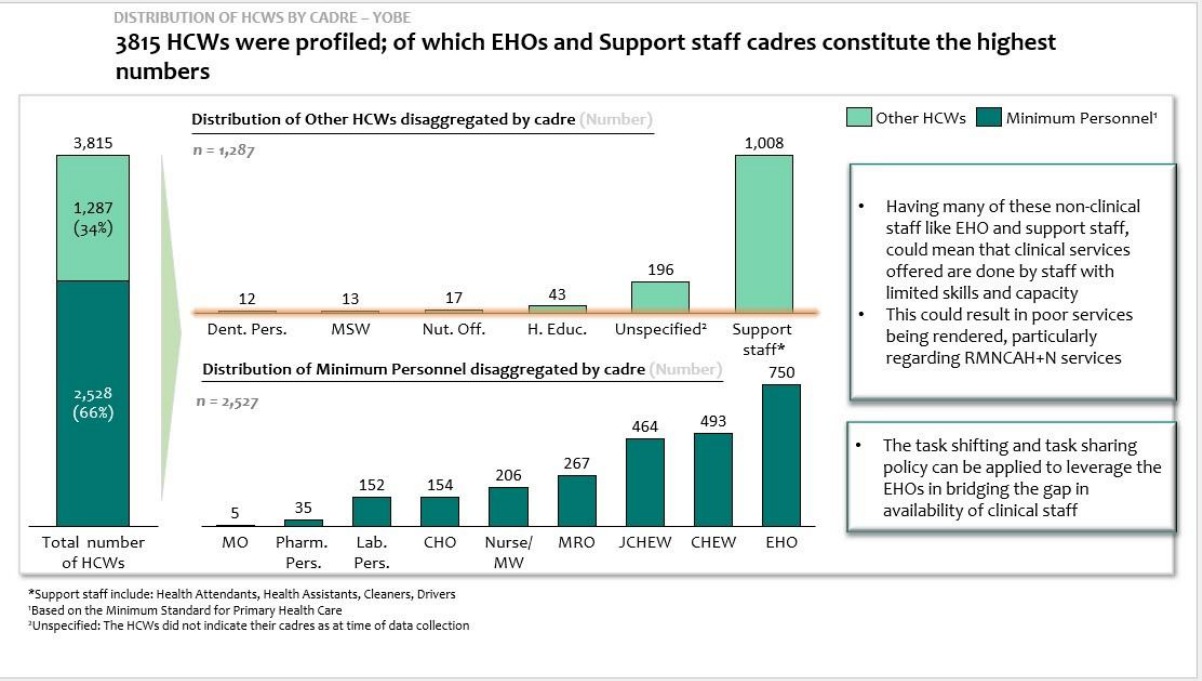

Figure 3: Distribution of HCW disaggregated by a cadre

Of the 3,815 MSP personnel profiled HCWs, support staff and CHEWs and JCHEWs accounts for about 66% of the HRH in Yobe State.

Health workforce distribution across health facility type in the LGAs

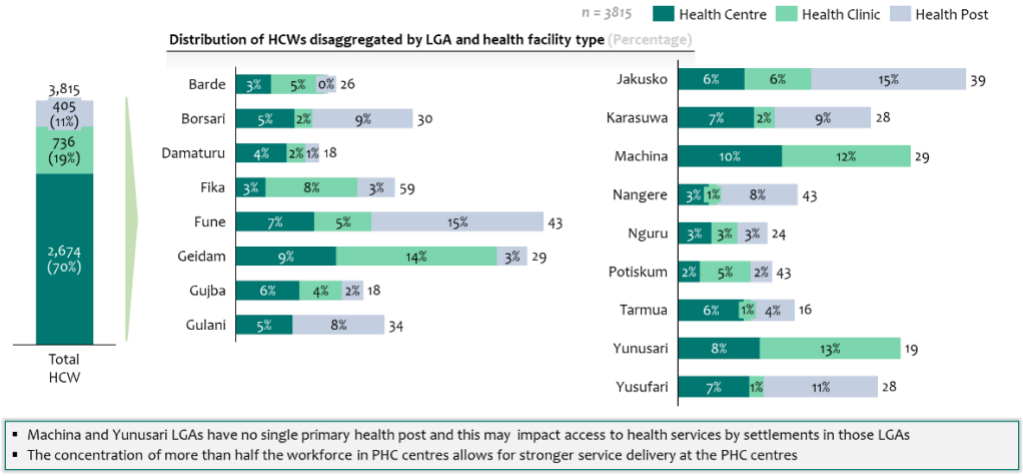

Figure 4. Distribution of HCWs across health facility types in the LGAs

The figure 4 above shows the distribution of HCWs across LGAs and health facility type. The 3,815 profiled HRH are disproportionately distributed across the 17 LGAs. About 2 of the 17 LGAs do not have any health posts, and this may have a negative impact on access to healthcare for the hard-to-reach communities.

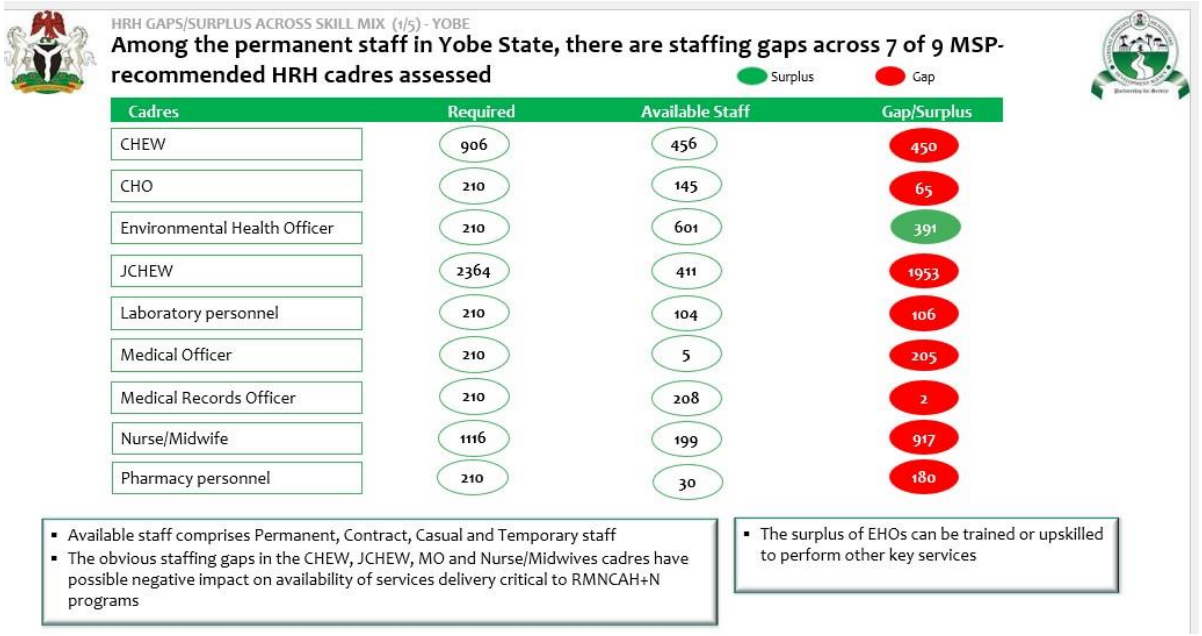

Figure 5: HRH gap/surplus skill mix

Gaps/Surplus in the PHC facilities

Based on the National Minimum Standards for PHC in Nigeria, it is recommended that a total of 1 HRH in the Health Post, 12 HRH – eight (8) clinical and four (4) support staff in the PHC clinics and 24 HRH – nineteen (19) clinical and five (5) support staff in PHC centers, are required to deliver minimum services at the PHC facilities. Findings from the figure below shows a gross gap in the healthcare workers cadres as all nine (9) cadres having gaps and only the EHO cadre having a surplus supply of HCWs.

There are significant staffing gaps across all the MSP recommended cadres, The most significant gap can be seen in the JCHEW cadre. It is also important to note that out of the 210 required Medical Officers there are only 5 available Medical Officers who were profiled as providing services in the State's PHC facilities.

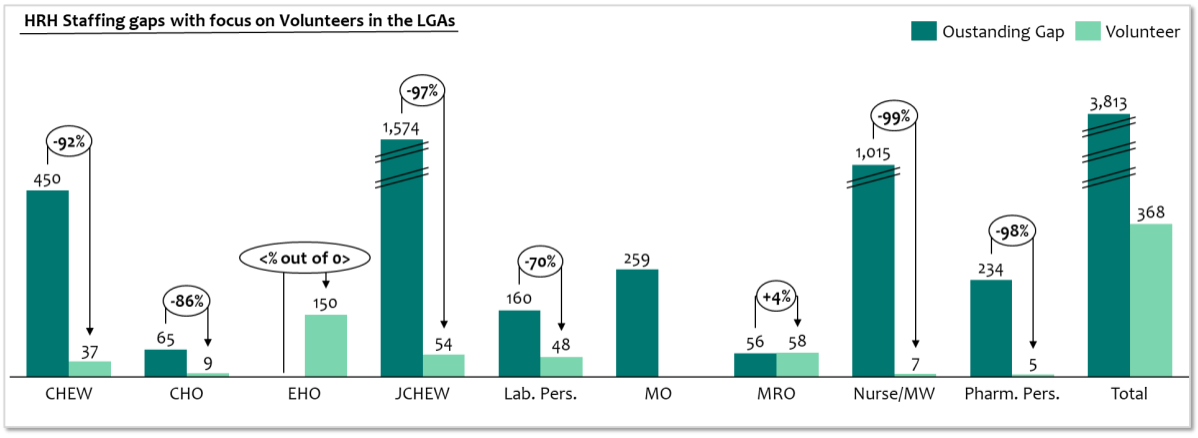

Figure 1. Staffing gaps with focus on Volunteers

The diagram above demonstrates the staffing shortages that occur when volunteers are included in the PHC HRH. Despite the fact that available volunteers complement staffing deficiencies and service delivery across all essential HRH cadres, huge staffing gaps remain. A dependence on volunteers for employees might result in high turnover, jeopardizing the supply of services over the long run.

HRH size and distribution by cadre across the Health Posts

According to the MSP, a health post is needed to have one JCHEW in order to deliver services, as seen in Figure 7. However, 61 percent of health posts do not satisfy this standard, which may restrict access to excellent treatment in Yobe State's difficult-to-reach communities where health posts are the only point of access to healthcare.

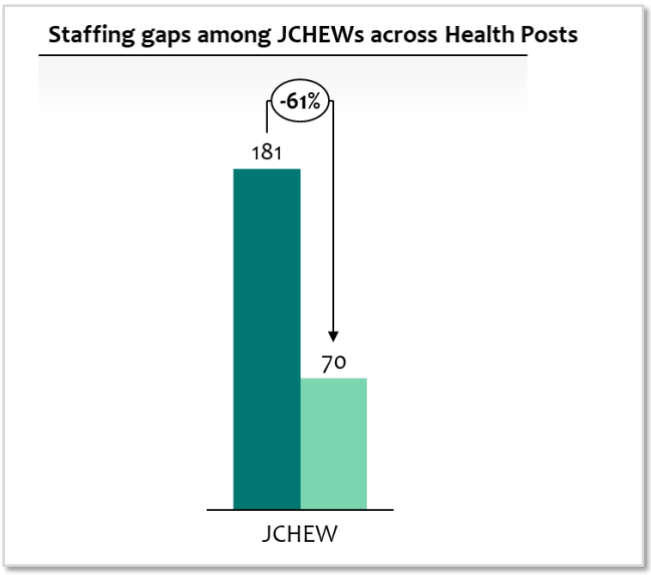

Figure 7: Distribution of HRH by Cadre across all Health Post

HRH size and distribution by cadre across primary health clinics

Eight (8) HCWs, consisting of two Nurse/Midwives, two CHEWs, and four JCHEWs, are needed to offer services in basic healthcare clinics. As seen in Figure 8, PHC clinics had the greatest manpower shortage in the Nurse/Midwife cadre; this is a cause for worry for Yobe given the crucial role Nurses/midwives play in providing MNCH.

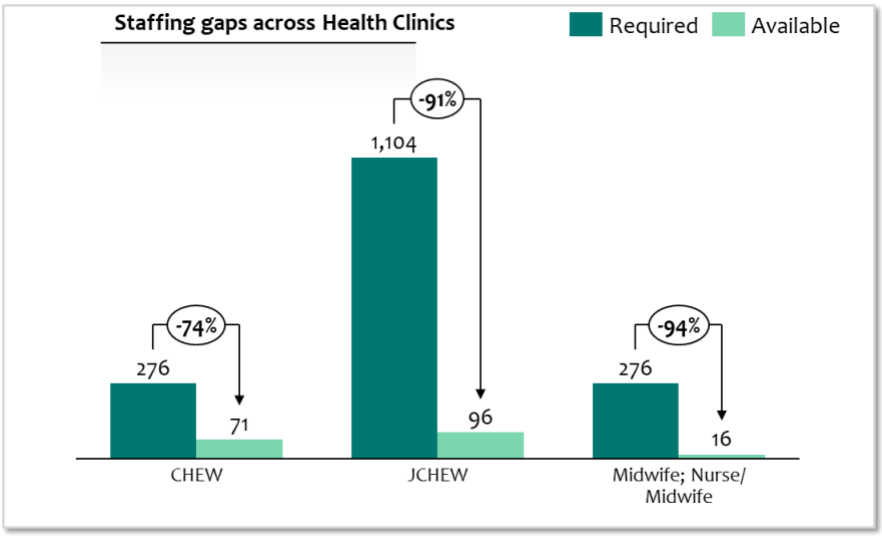

Figure 8: Distribution of HRH by Cadre across all Health clinic

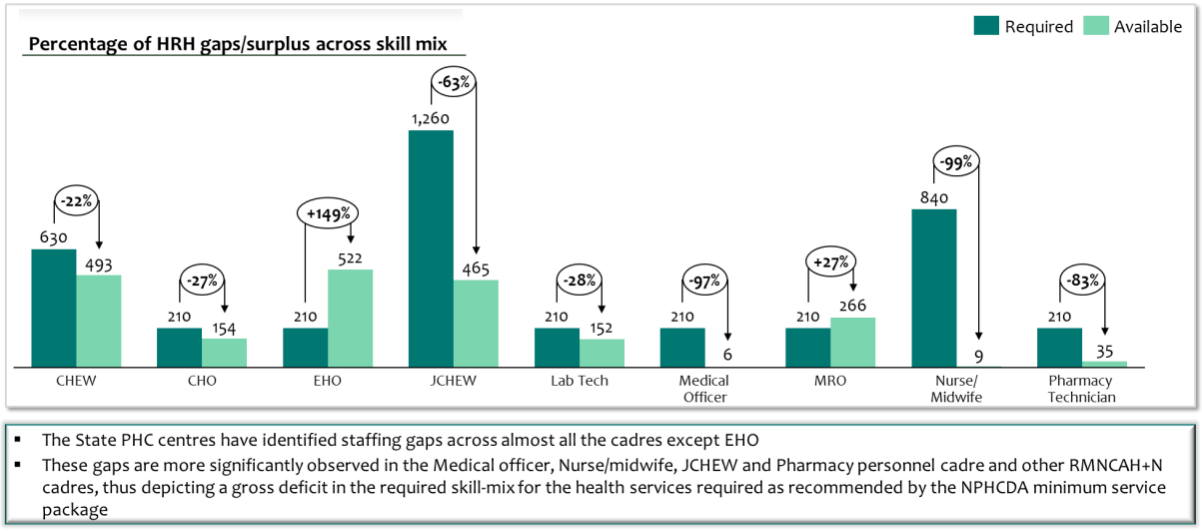

Figure 9: Distribution of HRH by Cadre across all Health center

HRH size and distribution by cadre across the PHC centers

In addition, according to the minimum staffing requirements, nine HRH cadres (one medical officer, one CHO, four nurse/midwife, three CHEW, one pharmacy personnel, six JCHEWs, one EHO, one MRO, and one laboratory personnel) are required to provide services in PHC centers. As illustrated in figure 7, there are personnel shortages in eight of the nine essential HRH cadre. The cadres with the largest staffing deficits were Medical Officer, JCHEW, and Nurse/midwife, with 97 percent, 63 percent, and 99 percent vacancies, respectively.

Distribution of trained HRH across the rural and urban LGAs

Figure 10 below shows the distribution of HRH in the rural and urban areas. About 62% of the HCWs work in the rural areas while 38% work in the urban areas. Despite having more HCWs in the rural areas, the healthcare worker to one LGA ratio is much lower in the rural areas. This implies that the healthcare workers are more concentrated in the urban areas.

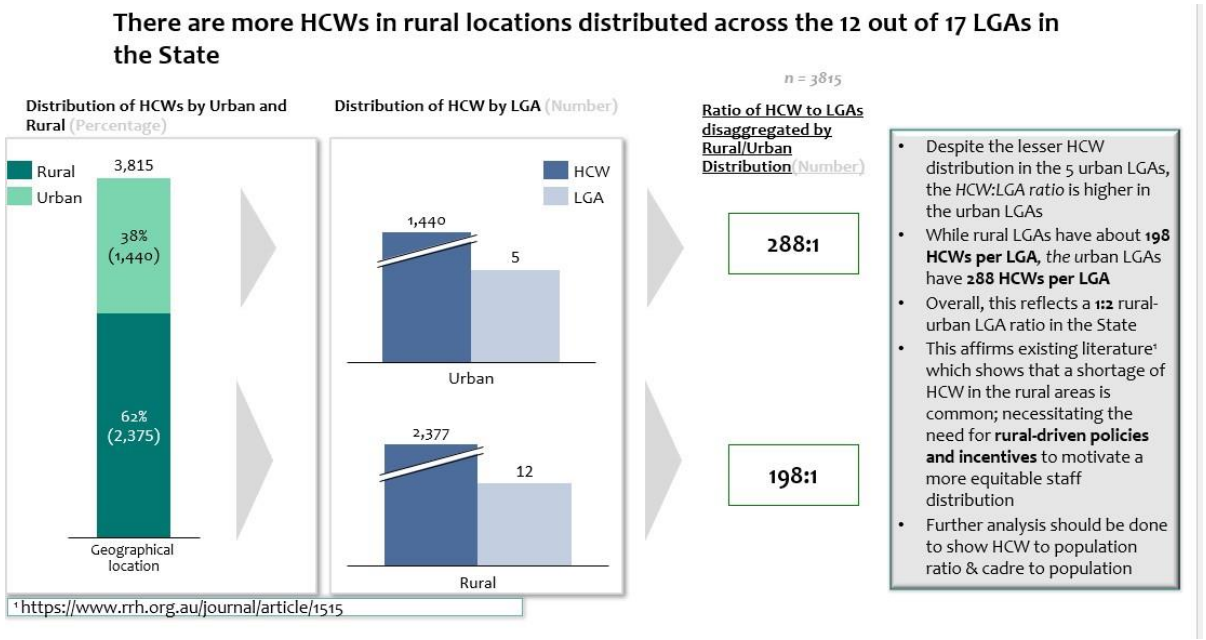

Figure 10: Distribution of HRH the rural versus urban areas and by LGA

Of the 1,440 urban healthcare workers profiled in Yobe State, 55% of them are female while 45% are male.

PHC HRH training and development

The acquired data were reviewed based on NPHCDA guidelines for in-service training for HRH cadres in the MSP. According to this suggestion, the majority of HRH have not undergone these trainings during the last two years.

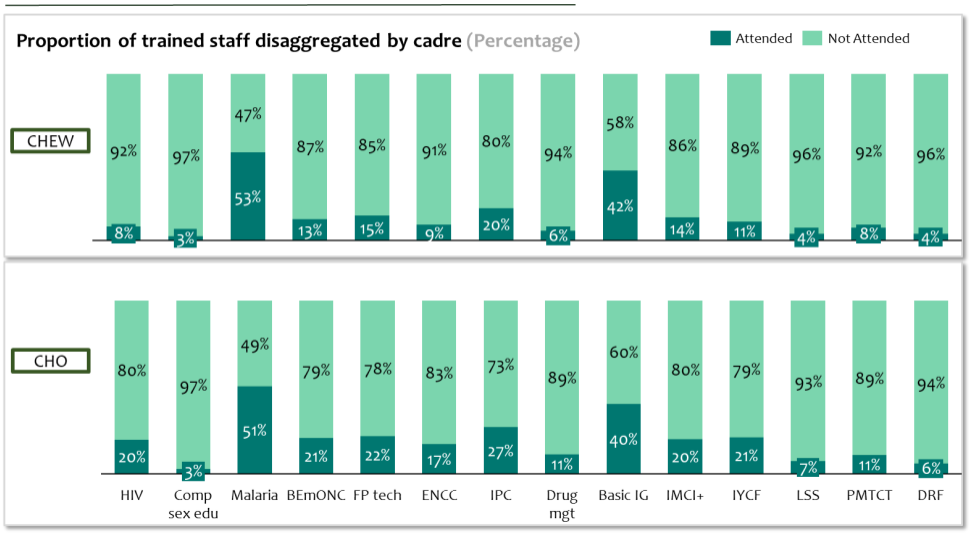

Figure 2. PHC HRH in-service training

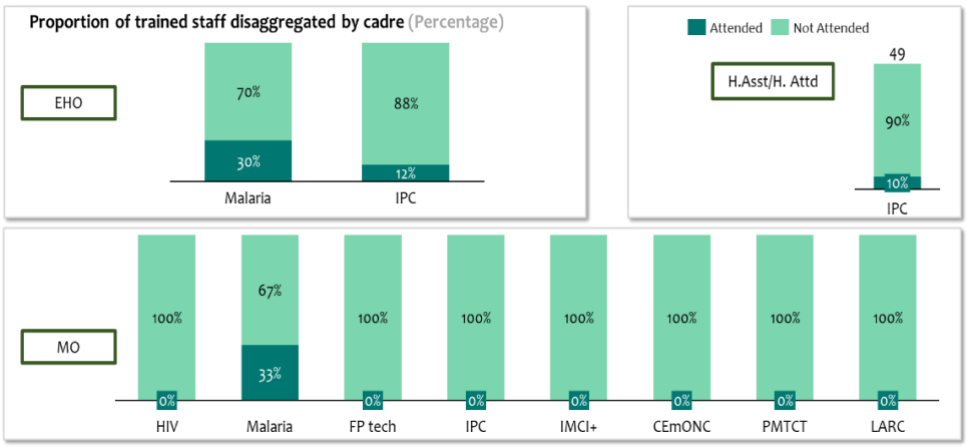

Figure 12. PHC HRH in-service training

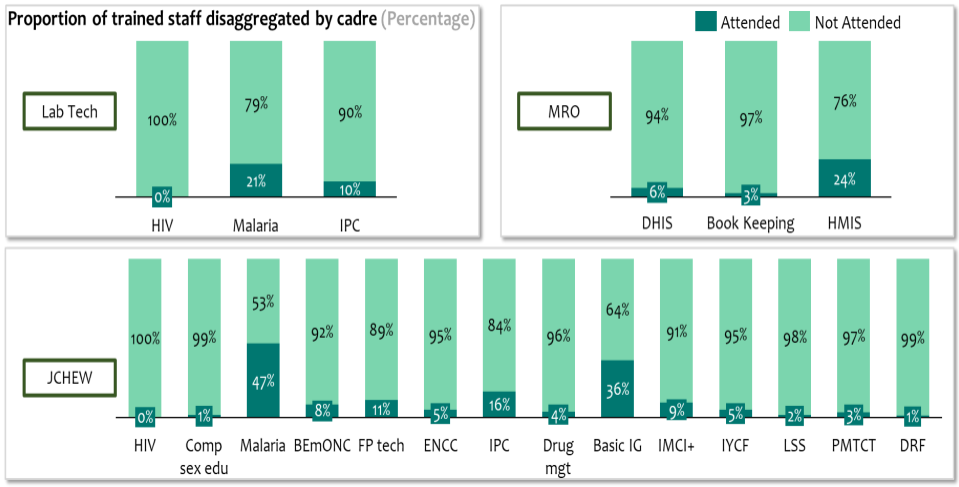

Figure 13. PHC HRH in-service training

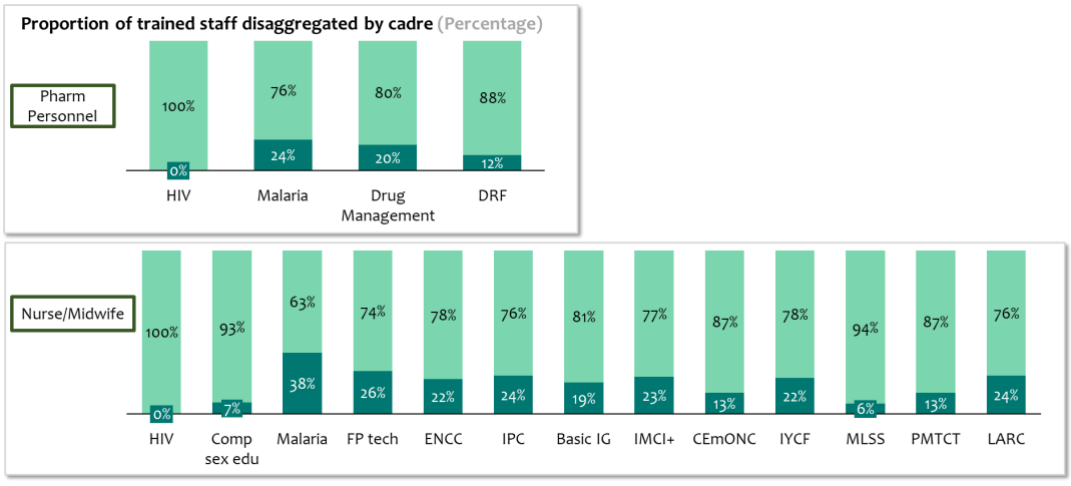

Figure 14. PHC HRH in-service training

The PEA reveals the existence of an in-service training plan that guides trainee selection based on profession/cadre and needs assessment. However, it remained unclear if this timetable being followed.

The YSPHCB shall implement in-service training, retraining, and continual professional development programs as a prerequisite for performance assessments and promotions. This will support a culture of

health professionals developing their knowledge and skills to meet the health needs and requirements of the people they serve and to be prepared with enough and appropriate knowledge to respond to changing health demands and emerging health trends. A compilation of training needs and requirements will also provide the YSPHCB with adequate information to support the allocation of resources to in-service training and continuous professional development.

HRH policy and planning

The Yobe state government has human resource policy in place which the HTIs leverage on the health and education policy for HRH production. Although the Yobe State demand-supply relationship for HRH production has not met its needs, effort is being put by the government, HTIs and regulatory agencies to fulfill the State's needs on HRH.

Production, Recruitment, and deployment

The YSPHCB collaborates with the LG to evaluate the need for HCWs and with the State government to authorize the recruitment of HCWs. The state government allows the urgent recruitment of technical personnel to fill a facility's vacancy based on assessed requirements and the yearly budget. Recruitment of PHC HRH at the LGA level is the responsibility of the PHCB in collaboration with the Ministry of LG and chieftaincy Affairs. The annual production of HRH are carried out by Health Training Institutions (HTIs).

The results of the profile and PEA exercise indicate inadequate skilled personnel throughout the system, particularly midwives and nurses. There is a disparity in the distribution of HCWs between rural and urban LGAs; hence, the YSPHCB must engage 13,384 HRH to meet the PHC HRH shortfall in the state. The State government, YSPHCB, and the HTIs must align their plans based on a gap analysis; this will allow HTIs to change their enrollment goals in order to enhance the mixed number of trained HRH available for recruitment and fair redistribution/deployment among LGAs.

Supervision and Performance management

The YSPHCB establishes standards for supervision and performance monitoring, and the conduct of supervisory visits is carried out by the State and LGA teams. However, the PEA exercise revealed a weakness in documentation of performance reward/sanction mechanisms, as well as insufficient funding for the conduct of supportive supervision. The YSPHCB should strengthen performance-based incentive and punishment system for the PHC HRH.

Staff compensation

The SPHCB in collaboration with Ministry of local government and chieftaincy affairs should improve rural-driven incentives to encourage HRH in providing services in rural LGAs.

HRH Research

There is weak continuous operational research activities on HRH in Yobe to guide policy formulation and innovation. The insufficient support in HRH planning, development, and management results in resource allocation for HRH that is neither evidence-based nor data-driven. The YSPHCB must strengthen and institutionalize operational research into HRH in order to stay abreast of best practices in HRH management to ensure that policy and strategy formulation and development are evidence-based.

HRH information system

The YPHCB manage the HRH Information System (HRHIS). Findings from the profiling and PEA exercise shows that data was usually not easily obtained/collected from officers and there are usually push backs to data sharing.

HRH financing

The YSPHCB receives its funding from state and local government councils in addition to funds for flag-off programs, from national and development partners.

For HRH financing, the YSPHCB and ministry of local government and chieftaincy affairs pays monthly salary of all PHC workers alongside facility-hired/engaged skilled manpower through the basic healthcare provision fund, equity, as well as the state contributory healthcare management agency (state health insurance).

[1] Nigeria | PHCPI (improvingphc.org)

Chapter 4. Yobe State PHC HRH Strategic Plan 2021- 2031

The YSPHCB is dedicated to ensure the availability of a sufficient number of skilled health professionals who are equitably distributed, adequately motivated, and capable of providing qualitative

and cost-effective services to the communities. Vision and mission statements are required to guarantee consensus on the organization's general objectives. The strategic plan includes the PHC HRH vision, goal, priority areas, strategic objectives, interventions, activities, and key performance indicators of the state. The YSPHCB formulated a vision and objective for the advancement of PHC HRH.

The primary objective of this PHC HRH Strategic Plan is to provide an appropriate supply, distribution, mix, and combination of HRH to allow the achievement of the greatest possible health outcomes in the State. This deployment of tactics will concentrate on the following six subject areas:

1. Human Resources for Health Size and Distribution
2. Human Resources for Health Production
3. Human Resources for Health Retention, motivation, and performance development
4. Human Resources for Health Information Systems
5. Human Resources Leadership and Governance
6. Human Resources for Health Financing

4.1 Vision

National PHC HRH SF vision

"Increase availability of a resilient PHC health workforce at the primary healthcare facilities"

Yobe state PHC HRH SP vision

"A responsive PHC system that ensures availability of qualitative health workforce in the required size, at the PHC facilities in the state"

4.2 Mission

Yobe state HRH SP mission

"To develop and implement strategies towards developing competent, equitable and motivated healthcare workers that will provide qualitative PHC services in the state PHC system."

4.3 Guiding Principles of Mission

1. Increase availability and access to health care services by ensuring basic health care packages are available at the PHC level
2. Provide comprehensive and quality health services with an emphasis on RMNCAH+N services
3. Increase motivation of the health workforce to provide quality health care services
4. Improve stewardship and accountability for HRH development
5. Strengthen partnerships and collaboration across sectors and with the international community
6. Facilitate financial and political commitments to HRH strengthening
7. Promote data collection, data sharing, and the use of HRH data for research and evidence-based decision-making.

4.4 Goal

Yobe PHC HRH Goal

"To improve access to quality health services at the PHC level by ensuring competent, motivated and skilled HCWs are available in adequate numbers, and equitably distributed by gender, cadre, and geographical location by the year 2032."

4.4 Guiding Principles of Goal

1. Ensure that basic healthcare packages are accessible at the PHC levels.
2. Increase access to and availability of health care services.
3. Encourage the health workforce to deliver high-quality healthcare services.
4. Strengthen partnerships and collaboration across sectors and with the international community.
5. Increase stewardship and accountability for HRH development.
6. Encourage political and financial support for HRH strengthening
7. Encourage the gathering, sharing, and use of HRH data for analysis and reasoned decision-making.

4.5 Strategic objectives, interventions

Strategic Objective 1: Increase the number of health workers in line with the staffing requirements of the MSP for each health facility type.

Rationale:

The use of evidence-based planning and decision-making is necessary for achieving the objective of enhancing the availability and accessibility of RMNCAH+N services. The September 2021 HRH profile conducted in Yobe will be used to provide information on the state's HRH situation. It is necessary to establish proper personnel distribution, since this will affect the fair allocation and deployment of HRH across LGAs.

Interventions

1. Identify HCW staffing requirements by gender, cadre, and catchment area.

Activities

1. Use the findings from 2021 PHC HRH profiling to determine the gaps

Intervention 2

Engage/recruit qualified healthcare workers based on identified needs.

Rationale:

Setting need objectives based on staffing requirements will ensure that the emphasis is not only on expanding numbers, but also on obtaining the necessary skill mix; in this case, cadre critical to the delivery of RMNCAH+N services should be emphasized.

Activities

1. Recruit/engage skilled HCWs to fill 50% of the identified gaps (4,175) by 2032.

Strategic Objective 2: Ensure equitable distribution of PHC HCWs

Rationale:

To ensure that engaged/recruited personnel are equitably distributed within the PHC system.

Intervention 3

Ensure re-distribution of existing healthcare workers across health facilities in the state based on identified staffing needs.

Activities

1. Re-distribute existing HCWs based on the workload, catchment area, gender, skill mix and state staffing needs/gaps.
2. Deploy newly recruited HCWs to health facilities based on gender, workload skill mixes and catchment area

Strategic Objective 3: Strengthen HTIs to produce all cadres of healthcare workers to ensure there is adequate supply to meet staffing requirements of the MSP.

Rationale:

To ensure that there are enough HRH to recruit and absorb into the health workforce it is important to ensure that qualified health care workers are being produced to match the demand. This is specifically notable for CHEWs, JCHEWs, nurses/midwives etc. To close this gap, the training capacity and accreditation status of the HTIs need to be expanded and reviewed for strengthening. Furthermore, training programs should continuously be adjusted to meet health challenges.

Intervention 1

Increase HRH production from the HTIs through improved infrastructure, training materials, qualified tutors etc.

Activities

1. Develop and disseminate advocacy kit to all relevant stakeholders on the need to provide adequate infrastructure, equipment and teachers towards increasing production capacity Increase trainer to trainee ratio.
2. Develop and disseminate advocacy kit.
3. Transfer the excess EHOs to the Ministry of Environment.
4. Collaborate with the SMOH, HTIs and regulatory bodies to increase enrolment target of HRH cadres based on identified gaps.
5. Strengthen the existing CME team (in all health professional and regulatory bodies) to develop and implement CME plan for the PHC HRH
6. Develop and disseminate advocacy kit to CME points- based license renewal for PHC HCW

Intervention 2

Improve the quality assurance for HCW training in the HTIs.

Activities

1. Collaborate with SMOH to conduct regular supervision of accredited health institutions to ensure functionality based on standards, and update list of HTIs in Yobe

Intervention 3

Ensure alignment between health training institutions, regulatory bodies, and HRH leadership in the states to ensure HRH production based on needs.

Activities

1. SMOH to ensure regular coordination meetings between YSPHCB, HTIs and regulatory bodies for effective regulation.

Intervention 4

Ensure gender equity in HRH production for all cadres.

Activities

1. Develop and disseminate advocacy kit to ensure a gender responsive enrolment of potential HRH.

Strategic Objective 4: Continuously motivate and improve the performance of the HCWs towards ensuring retention in the PHC system**.**

Rationale:

HCW motivation is an important factor in increasing productivity and efficiency, reducing medical errors and increasing the delivery of quality health services.

Intervention 1

Strengthen and institutionalize mechanisms for enhancing in-service training for HCWs based on current health sector needs to enhance on-the-job performance and capacity.

Activities

1. Review and update APER forms to ensure its functionality
2. Implement reward systems for improved performance and productivity
3. Conduct orientation exercise for newly recruited HCWs to adequately function in the health facilities.
4. Adapt/adopt standardized national RMNCAH+N clinical mentoring and training guideline.
5. Conduct informal in-service training (workshops, refresher trainings, LSS training to upskill CHEWs to SBAs) for existing health care workers.
6. Provide enabling environment for existing HCWs to enroll for formal training.
7. Conduct quarterly and monthly supportive supervision at the state and LGA levels respectively, to ensure optimal service delivery.

Intervention 2

Define and institutionalize HRH performance-based management systems at the administrative, community and facility levels.

Activities

1. Develop and implement performance-based management plan (detailing reward and sanction mechanism) for the PHC workforce.
2. Establish incentives for HCWs particularly for those in the rural areas (eg rural posting allowances, accommodation)

Strategic Objective 5: Strengthen PHC HRH information systems to facilitate effective HRH planning and management.

Rationale:

The need for the collection of quality data, needed evidence- and needs-based decisions making which has been made impossible by the lack of a comprehensive Human Resource for Health Information System (HRHIS).

Intervention 1

Develop and sustain a functional HRH Information System across the state and LGA levels.

Activities

1. Provision of hardware and software for the HRH information system.
2. Advocate to the NPHCDA to finalize the development of HRHIS for the state.
3. Quarterly update of HRH information system with HCWs' profiles.
4. Yearly update of HRH information system with health training institution and regulatory bodies data.

Intervention 2

Ensure the conduct of HRH research through optimal monitoring and evaluation measures.

Activities

1. Systematically analysis the HRHIS to identify issues for an informed decision and research formulation.

Strategic Objective 6: Strengthen leadership, governance, and coordination of the PHC HRH across all levels.

Rationale:

To ensure that the activity of the state is in line with the National PHC HRH goal effective oversight, coalition-building, regulation, and accountability. The NPHCDA is tasked with the responsibility of strengthening its capacity to effectively plan and manage the workforce at various levels. Doing so requires investments in the leadership and management capacity at all levels of the health management cadres and in health facilities. This is to ensure that responsible personnel have the tools and knowledge necessary to make evidence-based decisions affecting the health workforce at all levels. Additionally, critical investments should be made in the regulatory bodies and agencies that ensure the quality of health workforce training and service provision, to provide increased capacity of health managers for leadership, management, and advocacy of the health system.

Intervention 1

Strengthen Enhance responsiveness of HRH policies and plans to the need of the populace.

Activities

1. Conduct workshop for the review of policy and guidelines that will serve the need of HRH workforce in Yobe state
2. Conduct stakeholder's sensitization on HRH policies and guidelines.

Intervention 2

Strengthen the capacity of the administrators, managers and supervisors for data-based HRH planning and management at all levels.

Activities

1. Identify and assign responsibilities to HRH department of SPHCB
2. Conduct capacity building of the State PHC HRH TWG to provide oversight for the implementation of the PHC HRH plan including utilizing the quarterly report from the HRHIS.
3. Conduct workshop for administrators, managers and supervisors on effective HRH planning and management at all levels (state, LGA and HFs).
4. Develop PHC plans based on the State's PHC HRH Strategic plan.
5. Conduct three-yearly review of the PHC HRH strategic plan for progress in achievement of milestones.

Intervention 3

Institutionalize structures for HRH reporting and reviews for evidence-based decision-making

Activities

1. Establish reporting channel from facilities up to the SPHCB
2. Conduct biannual HRH planning and management meeting, and proffer solutions based on review reports from the HRHIS.
3. Conduct biannual HRH Stakeholders workshop to present findings and proffer solutions to the YSPHCB leadership and obtain buy-in for implementation.

Strategic Objective 7: Enhance adequate HRH financing for efficient implementation of HRH activities.

Rationale:

Several studies have pointed out that policymakers should view funding human resources for health (HRH) as an investment rather than an expense. The potential for a return on HRH investment is high, and it also has a positive impact on economic growth and social development.

Intervention 1

Enhance funding for PHC HRH development.

Activities

1. Conduct advocacy to all relevant stakeholders (state and donors) to increase financing for HRH activities in the plan.

2. Conduct fund pooling and additional resource mapping to assess potential health, social, and economic gains of HRH investments.

Intervention 2

Improve accountability for HRH financing.

Activities

1. Develop a responsive and effective accountability mechanism for the PHC HRH financing.
2. Implement the developed accountability mechanism.
3. Provision of funds to support reward for best performing HCWs.

Chapter 5. Monitoring and Evaluation Plan

For the PHC HRH strategic plan to be implemented effectively and move forward, a monitoring and evaluation approach is required. This plan describes the resources available to carry out each strategic aim under the six priority areas, the established indicators for each intervention, the agency, organization, or person in charge of ensuring that each activity is carried out, as well as the resources required to achieve each strategic aim. Objectives, baselines, assumptions, risks, timelines, and targets have all been set for each intervention or activity.

5.1 Coordination Structures

The Yobe State PHC HRH Strategic Plan 2021–2030 will be implemented, monitored, and coordinated by the YSPHCB in collaboration with the Local Government Area Authorities. The National Primary Health Care Development Agency, HTIs and other stakeholders would support the system. The HRH Desk Officer will have a direct role in the YSPHCB's overall coordination and monitoring of the plan through the Directorates of Health Planning, Research, and Statistics. With input from the relevant stakeholders, the Department of Health Planning, Research, and Statistics (DHPRS) will establish any new procedures for consultation and oversight that may be required. Partner and donor organizations will be asked to support the Yobe State PHC HRH strategic plan 2022– 2032 by coordinating and aligning their actions with the plan's timelines and YSPHCB's priorities.

5.2 Monitoring and Evaluation systems and structures

As part of the overall M&E system, data for the KPIs recommended for the Yobe State PHC HRH strategic plan 2022-2032 will be gathered. The following are crucial data sources for the monitoring and evaluation of the implementation plan:

5.2.1 Assumptions and Risks

Assumptions and risks were defined to itemize structures, resources and weaknesses that would aid or impede the success of the activities in the implementation of the plan. The Results Framework in Annex (ii) provides the assumptions and risks for the Yobe State PHC HRH SP 2022-2032.

5.2.2 Indicators

Indicators have been defined to measure success in implementing this plan. Reports generated by the HRH desk officer in the DHPRS will be evaluated. The Results Framework in Annex (ii) provides the indicators for the Yobe State PHC HRH SP 2022-2032.

5.2.4 Reporting

The Yobe PHC HRHSP 2022–2032 objectives will be reported on utilizing the routine information reporting systems from the PHCB, both those already in place and those that will be put in place as part of the implementation of this plan. The HRH desk officer will make sure that the reporting systems are suitable for informing about implementation progress. Quarterly updates on the HRH TWG's progress will be sent to partners and stakeholders in HRH dept. These reports will identify problem areas and make recommendations on how to fix them.

Chapter 6. Estimated Costing for Implementing the Yobe State PHC HRH Strategic Plan

The Yobe State Primary Health Care Human Resources for Health Strategic Plan (2022 – 2032) is comprehensive and will require extensive resources to be sourced and deployed for its implementation over the ten-year plan period (2022- 2032). The wide spectrum of resources needed would be in the categories of human (skilled health workers); material (equipment, information communication technology, etc.) and financial (funds from various budgetary and non-budgetary sources). Hence, YSPHCB will require active resource mobilization for the implementation of this plan.

The estimated budget for the Yobe State PHC HRH Strategic plan 2022- 2032 is One Billion, twenty million, nine hundred and seventeen thousand, four hundred and fifteen naira **(₦1,020,917,415.00** only (see table below).

YOBE STATE MINISTRY OF FINANCE, BUDGET AND PLANNING 2021 ANN AOP		
PROJECTED EXPENDITURE BY PRIORITY AREA		
PRIORITY AREA	BUDGET (NAIRA)	PROJECTION
HRH SIZE AND DISTRIBUTION	28,254,515.00	3%
HRH PRODUCTION	1,960,000.00	0%
HRH RETENTION, MOTIVATION AND PERFORMANCE DEVELOPMENT	63,591,000.00	6%
HRH INFORMATION SYSTEM	15,451,000.00	2%
LEADERSHIP AND GOVERNANCE	893,068,500.00	87%
HRH FINANCING	18,592,400.00	2%
Grand Total	1,020,917,415.00	100%

Table 1. PHC HRH Costing plan

Chapter 7. Conclusion

The Yobe State PHC HRH Strategic Plan, which was recently developed, serves as guidance for the Yobe State administration for HRH issues relevant to the PHC services. In order to fulfill the specified PHC HRH targets, the National Primary Health Care Development Authority (NPHCDA) will need to see to it that the strategic plan document is distributed to all levels of government and stakeholders,

including His Excellency the Executive Governor of Yobe state. A few crucial elements must be present for this strategy plan to be successful. They include dependable leadership, strong teamwork, yearly work plans that are founded on facts and consider costs, and, ultimately, workable monitoring and evaluation procedures that are supported by observable indications.

Annex i. Strategic objectives, activities, responsible stakeholders, and timelines

Priority areas	Strategic objectives	Intervention	Activities	Responsible	Timelines
HRH size and distribution	Increase the number of employed healthcare workers and ensure equitable distribution by facility type	Identify HCW staffing requirements by gender, cadre, and geography	▪ Conduct annual HRH recruitment with emphasis on recruiting female HRH ▪ Recruited HRH should be deployed in the LGAs based on staffing needs here LGAs with the lowest HRH should be prioritized.	▪	
		Recruit qualified healthcare workers based on identified needs	▪ Conduct annual HRH recruitment of Nurse/Midwife, CHEWs, JCHEWs, and Medical Officers yearly	▪	
	Ensure equitable distribution of PHC HCWs	Define and implement equitable healthcare worker distribution and re-distribution strategy based on staffing needs	▪ Deploy recruited HRH to the LGAs based on their needs	▪	
HRH production	Strengthen production of all healthcare worker cadres to ensure a demand-supply link, based on state-specific healthcare worker needs	Increase HRH production training capacity in line infrastructure, trainers, etc.	▪ Increase enrollment target to match the HRH gap ▪ Increase trainer to trainee ratio ▪ Increase infrastructure capacity ▪ Develop and employ strategies to increase	▪	

			student retention and reduce drop-out		
		Improve the quality assurance for training health training institutions	▪ Establishment of structures for new health training institutions ▪ Accreditation of programs and courses ▪ Accreditation of health training institutions ▪ Recruitment of teachers to deliver the programs and courses ▪ Retrain existing HTI faculty staff	▪	
		Ensure alignment between health training institutions, regulatory bodies, and HRH leadership in the states to ensure HRH production is in line with HRH needs	▪ The YSPHCDA will share the HRH gaps with the HTIs and ensure enrollment targets are in line with the gap analysis ▪ The regulatory bodies should ensure that the process of acquiring/renewing license is short and affordable	▪	
		Ensure gender equity in HRH production for all cadres	▪ Conduct advocacy campaigns to increase enrollment of female students	▪	
HRH retention, motivation, and performance development	Continuously motivate and improve the performance of the HCWs towards ensuring retention in the PHC system	Define and institutionalize HRH performance management systems at the administrative and community level	▪ Review and update APER forms to ensure its functionality ▪ Implement reward systems for improved performance and productivity	▪	
		Establish and institutionalize mechanisms for enhancing in-service training for HCWs based on current health sector needs, to enhance their on-	▪ Cost in-service training for Yobe PHC HRH ▪ Include funding for in-service training in the workplan	▪	

		the-job performance and capacity			
		Develop incentives for the PHC workforce with a focus on healthcare workers deployed to rural and HTR areas	▪ Deploy incentives to HCW that currently provide health services in hard-to-reach areas ▪ Conduct a salary revision of HCWs in LGAs	▪	
HRH Information system	Strengthen PHC HRH information systems to facilitate effective HRH planning and management	Develop and sustain a functional HRH Information System across the national and state levels	▪ Joint HRH planning and management meetings ▪ Development of a HRHIS with regular updates ▪ Training of HRH desk officer and M&E officers	▪	
		Institutionalize structures for HRH reporting and reviews for evidence-based decision making	▪ Review of HRH policies and plans with feedback from all stakeholders including the Yobe public and PHC HRH	▪	
		Ensure the conduct of HRH research through optimal monitoring and evaluation measures	▪ Periodically conduct a HRH gap analysis, this will ensure that policies and plans are tailored to the state's current HRH situation	▪	
Leadership and Governance	Strengthen leadership, governance, and coordination of the PHC HRH across all levels	Strengthen the capacity of HRH structures in the states for effective HRH planning, management, and development	▪ Identify HRH directorates/leaders essential to effective workforce planning and management ▪ Conduct capacity building sessions of the identified HRH directorates/leaders	▪	
		Enhance the capacity of the administrators, managers, and supervisors for HRH planning and management at all levels	▪ Conduct leadership and management capacity building sessions for the managers and supervisors at all levels	▪	

		Strengthen the function of HRH administrative bodies to ensure evidence-based HRH planning and management	▪ Train M & E officers to manage HRHIS	▪	
		Enhance responsiveness of HRH policies and plans to the need of the populace	▪ Use the Yobe gap analysis report to inform HRH policies and planning	▪	
		Strengthen communication of HRH information across all levels	▪ Set up a data repository, here data on HRH policy, HRH gap, HCW exit, HRH financing, etc should be made available to essential stakeholders on request	▪	
HRH financing	Enhance adequate HRH financing for efficient implementation of HRH activities	Enhance funding for HRH development	▪ Use the Yobe gap analysis report to inform health budgeting this will ensure evidence-based budgeting ▪ Create a technical advisory group (TAG) to develop and pilot a specific research methodology to assess potential health, social, and economic gains of HRH investments	▪	
		Improve accountability for HRH financing	▪ A focal person should be assigned responsibility for ensuring proper HRH budgeting and timely fund release for HRH activities ▪ Develop and institutionalize the use of tools, templates, and processes for financial accountability ▪ Ensure accrual accounting is central to the whole health system to provide an accurate financial picture.	▪	

			▪ Reduce tolerance of corruption by setting up checks and balance monitoring system		

Annex ii. Outcomes, indicators, baseline, targets, and means of verification

Outcomes	**Indicators**	**Baseline**	**Target**	**Means of verification**
Increased number of employed healthcare workers and ensure equitable distribution by facility type	▪ Proportion of health facilities that have the appropriate skill mix of healthcare workers by facility type based on WHS recommendations			
Equitable distribution of PHC HCWs	▪ Proportion of health facilities with an equitably distributed (gender, geographical location, etc) health workforce			
Strengthened production of all healthcare worker cadres to ensure a demand-supply link, based on state-specific healthcare worker needs	▪ Proportion of health training institutions that are accredited by the relevant regulatory institutions based on the PHC HRH needs ▪ Proportion of health training institutions that meet the trainee to trainer ratio recommended by the regulatory bodies			

Increased HCW performance and increased HCW retention	▪ Implementation of rural-driven incentives ▪ Implementation of reward-sanction mechanism ▪ Percentage reduction in attrition rate among PHC health workers in the PHC facilities ▪ Number of in-service training, refresher training, and supportive supervision conducted			
Strengthened PHC HRH information systems	▪ Existence and use of a functional and updated HRHIS ▪ Annual HRH review report based on the HRHIS			
Strengthened leadership, governance, and coordination of the PHC HRH across all levels	▪ Implementation of the Yobe PHC HRH strategic plan			
Adequate HRH financing for efficient implementation of HRH activities	▪ Proportion allocated to PHC HRH in the state health budget ▪ Percentage of allocated HRH funds released for HRH development activities			

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1. WHO Global Strategy on HRH; Workforce 2030
2. National Health Policy (2016)
3. National Strategic Health Development Plan II (2018 – 2022)
4. National HRH Strategic Plan (2016 – 2020)
5. Reaching Every Ward with Skilled Birth Attendants (REWSBA) 2021
6. The National Primary Health Care Under One Roof (PHCUOR) Policy 2011

List of contributorsz

Participant	Designation	Organization

List of Validation Meeting Participants XXX

Participant	Designation	Organization