FEDERAL MINISTRY OF HEALTH

NATIONAL HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN 2021-2025

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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
CSC	Civil Service Commission
DAPs	Departments Agencies and Parastatals
DHPRS	Department of Health Planning Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GAC	Global Affairs Canada
HLMA	Health Labour Market Analysis
HMB	Health Management Board
HRH	Human Resources for Health
JCHEWs	Junior Community Health Extension Workers
LGA	Local Government Area
LGSC	Local Government Service Commission
MDCN	Medical and Dental Council of Nigeria
MOHs	Ministries of Health
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NHRHSP	National Human Resources for Health Strategic Plan
NHWA	National Health Workforce Accounts
NMCN	Nursing and Midwifery Council of Nigeria
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NTDs	Neglected Tropical Diseases
OOPE	Out of Pocket Expenditure
PHC	Primary Health Care
SDGs	Sustainable Development Goals
SMOH	State Ministry of Health
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicators of Staffing Needs

FOREWORD

Development and Management of Human Resources for Health is a cardinal component of the strategy for implementing priority health programmes towards achieving health related Sustainable development Goals (SDGs) in Nigeria. As the pillar of the Health System, the Federal Ministry of Health established a branch in the Department of Health Planning Research and Statistics, to navigate the realms of Human Resource for Health for Health system strengthening.

This branch collaborated with World Health Organisation (WHO) and other stakeholders to develop a National Human Resources for Health Strategic Plan 2021-2025 (NHRHSP) aimed at determining the most appropriate, feasible and cost-effective strategies for ensuring equitable distribution and appropriate mix of health workers for providing qualitative health care delivery services to the Nigerian populace, irrespective of geographical location or socio-economic status. This plan also reflects the priority concerns of the health sector with primary health care as its major focus, ensuring that basic health care is at affordable cost in pursuit of Universal Health Coverage.

As a prelude to developing this document, a joint-Department of Health Planning Research and Statistics and World Health Organisation (WHO) situation analysis was conducted to identify gaps constituting major challenges that militate against national capacity to provide qualitative, equitable, effective and efficient health care. The National Health Act, 2014 (NHAct) prescribes the development of adequate Human Resource for health as prerequisite for a strengthened Health System, the framework for which is the development of the National Human resources for Health Strategic Plan 2021-2025 (NHRHSP).

This National Human Resources for Health Strategic Plan 2021-2025 (NHRHSP) articulates the process of strengthening the systems and structures that facilitate planning, recruitment, distribution, retention and management of health workers in Nigeria. It also serves as a tool for policy makers, health managers, and development partners for resource mobilization and allocation for Human Resources for Health development.

I therefore urge stakeholders in both public and private sectors to cooperate with the Human Resources for Health Branch of the Department of Health Planning Research and Statistics, Federal Ministry of Health (FMoH) for optimal, effective and efficient implementation of this strategic plan towards achieving desired improvement in health outcomes and increase in life expectancy in Nigeria.

Dr. E. Osagie Ehanire, MD, FWACS
Honourable Minister
Federal Ministry of Health
August 2020

ACKNOWLEDGEMENTS

This National Human Resource for Health Policy (NHRHP) and the National Human Resources for Health Strategic Plan (NHRHSP) 2021- 2025 is the product of an extensive, all-inclusive process requiring collaboration and engagements with stakeholders.

The Department of Health Planning Research and Statistics, Federal Ministry of Health (FMOH) through the Human Resources for Health (HRH) Branch coordinated the entire process of development of these documents ensuring their alignment with the National Strategic Health Development Plan II 2018 – 2022

My sincere appreciation goes to the Honourable Minister of Health, Dr. Osagie Ehanire, MD, FWACS and the Honourable Minister of State for Health, Dr. Olorunnimibe Mamora for not only ensuring the required political support but also providing keen technical and professional guidance for the development exercise. I am also grateful to the Permanent Secretary, Abdulazeez Mashi Abdullahi for the administrative support provided for the process. We highly appreciate Global Affairs Canada (GAC) and the World Health Organization (WHO) whose support was vital to the success of the exercise. To all other HRH stakeholders too numerous to mention, I say a big thank you for your invaluable contributions to the preparation of these important documents.

Finally, I want to commend the staff of the Human Resources for Health Branch of my department for their resilience in ensuring timely completion of the development of the National Human Resources for Health Policy (NHRHP)2021-2025 and the National Human Resources for Health Strategic Plan (NHRHSP)2021-2025. I must particularly mention Mr Okechukwu Okwudili, Head Health Systems Support Division. Mr Shakuri Ayinla Kadiri, Head Human Resources for Health Branch and other staff who worked tirelessly to ensure the success of this exercise.

On behalf of the Federal Ministry of Health, I sincerely thank you all.

Dr. Emmanuel C. Meribole
Director, Department of Health Planning Research and Statistics
Federal Ministry of Health , Abuja
August, 2020

EXECUTIVE SUMMARY

The health workforce is the fulcrum on which health system performance relies and is a crucial component in ensuring affordable, accessible, and high-quality health services. The ability for a country to meet its health commitments and goals largely depends on the number, skills, competencies, and availability of health workers and how they are organized and equitably distributed to deliver integrated people-centered health services. Increasingly, most countries are paying attention to policies, plans, and strategies that address health worker needs with an aim of improving health outcomes.

Globally, the needs-based shortage of health care workers is estimated to be about 17.4 million, of which nearly 2.6 million are doctors, almost 9 million are nurses and midwives, with the rest being all other health worker cadres. The largest needs-based shortages of health workers are in South-East Asia at 6.9 million and Africa at 4.2 million. The shortage in absolute terms is highest in South-East Asia due to the large populations of countries in this region, but in relative terms (i.e. taking into account population size) the most severe challenges are in the African Region. The global needs-based shortage of health care workers is projected to be still more than 14.5 million in 2030 just a decline of only 17% according to the World Health Organization.

According to the 2018 Health Workforce Profile, the country has registered a significant increase of health workers in the last five years resulting from increased production capacities from the health training institutions both public and private. However, the percentage increase in the stock of health workers is less than the population growth rate. Nigeria has a total of 74,543 medical doctors' equivalent to 36.3 medical doctors per 100,000 populations (doctor to population ratio of 1: 2753). There were also 301, 579 nurses and midwives equivalent to 88.1 nurses per 100,000 populations (nurses to population ratio of 1: 1,135) and 58.9 midwives per 100,000 population (midwives to population ratio of 1:1,697). There were 9,364 clinical medical specialists licensed in Nigeria and this represents a 31 percent increase from the figure in 2012.

The surgery specialists have the highest number 2,368 (25%) followed by obstetrics and gynecology specialists at 1,238(13%), pediatrics at 1,031 (11%), internal medicine at 1,029 (11%) public health at 916 (10%), pathology at 557 (6%), and ophthalmology at 458 (5%). The country has a total of 4,358 dentists' equivalent to 2.12 dentists per 100,000 populations, 24,668 pharmacists equated to 12 pharmacists per 100,000 members of the population, 5,793 pharmacy technicians which equals to 2.8 pharmacy technicians per 100,000 populations, Community Health Officer (CHO) at 8,533 translating to a density of four CHOs serving 100,000 population, a total of 61,668 Community Health Extension Worker (CHEWs) equated to 30 CHEWs per 100,000 populations and Junior Community Health Extension

Worker (JCHEW) at 46,253 equated at 22.5 CHEWs per 100,000 population (JCHEWs to population ratio of 1:4,436).

Whilst the Federal Ministry of Health has registered remarkable achievements in tackling human resources for health issues, still challenges exist and they are varied from state to state and even geopolitically. The main challenges include uncoordinated HRH practices from various stakeholders leading to inefficiencies, weak human resources for health (HRH) coordination mechanisms, weak human resources for health information systems, weak leadership capacity to provide effective stewardship on HRH issues, maldistribution of health workers at facility levels, and between urban and rural areas and also in the southern and northern parts of the country. Also, the absorption capacity of the public sector is quite low despite the high production of health workers from the health training institutions due to financial constraints. This strategy, therefore, strives to look at innovative strategies to ensure adequate and competent health workers are deployed appropriately to improve health services and outcomes.

The National Human Resources for Health Strategic Plan 2021-2025 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 further guidance and adaptation by the states to ensure the development of the health workforce at sub-national levels, and also inform the development of annual operational plans at all levels of the health system. This 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. The lessons learned from the previous HRH strategy as well as evidence from HRH strengthening programs and research have also been factored in.

The development of this strategic plan was a joint consultative effort of several individuals and institutions led by the Federal Ministry of Health with departments, agencies, and parastatals also playing key roles. Regulatory bodies and councils, 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 UHC aspirations, the strategic plan's interventions are informed by a theory of change (TOC) anchored on three (3) key workforce objectives namely **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 institutionalize HRH units and equip them with qualified, skilled, competent, and motivated staff in their adequate numbers to sustain achievements. This will ensure improved sustainable mechanisms for HRH funding and improve capacity for HRH planning, management, development, coordination, and reporting across all levels. The implementation of responsive HRH management systems at levels of governance and service delivery will be critical. The strategies will include strengthening national and county HRH units to sustain achievements.

Strategic Objective 2: Ensure the production of adequate numbers of qualified health workforce: This objective serves 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 of the faculty will aim to increase student enrolments, improve teaching to ensure qualified competent health workers are produced. The country 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 HRHIS 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 institutionalize the National Health Workforce Accounts will be established to improve the availability, quality, and use of data on the health workforce through monitoring of a set of indicators.

Strategic Objective 4: Optimize the recruitment, utilization, retention, and performance of the available health workforce: This objective will focus on promoting 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 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 2021-2025 is ₦1Billion, with an average of ₦202 million needed per year. Table 14 shows a summary of financing requirements for strategic plan 2020-2025 by strategic objectives. Objective 1 (Strengthen HRH Governance, Stewardship and Accountability) will cost ₦295,770,000 or 29%; Objective 2 (Ensure Production of adequate numbers of qualified Health Workers) will cost ₦200,995,000 or 19.8% while Objective 3 (Ensure the development of monitoring and evaluation for HRH including Systems for HRHIS and Registry will cost ₦333,266,300 or 33%. Objective 4 (Optimize the recruitment, utilization, retention and performance of the available Health workers) will cost ₦157,246,500 or 15.5% while Objective 5 (Strengthen Coordination and Partnership for HRH Agenda) will cost ₦27,158,000 or 2.9%.

CHAPTER 1: INTRODUCTION

1.1 Background

Globally, there is an acute shortage of human resources for health (HRH) and the greatest burden is borne by low-income countries especially in sub-Saharan Africa and some parts of Asia.[1] World Health Organization (WHO) in the Global Strategy on HRH: Workforce 2030, projects that the health workforce in Africa will need to grow the workforce stock by 63% to attain Universal Health Coverage (UHC) by 2030[2].

The 2018 Country Health Workforce Profile reports that Nigeria has a total of 74,543 medical doctors that equates to 36.3 medical doctors per 100,000 members of the population (doctor to population ratio of 1: 2753) based on the projected size of Nigeria population. Also, the Nursing and Midwifery Council of Nigeria (NMCN) licensed a total of 180,709 nurses and 120,870 midwives. This represents an increase of 19% and 17% from the 2012 figure that showed nurses were 148,291 and midwives 101,275 respectively. From 2009 to 2018, the number of nurses and midwives increased at a lower rate (average of 3%) than the population growth of 3.2%. These numbers of nurses and midwives translate to 88.1 nurses per 100,000 population (nurses to population ratio of 1:1135) and 58.9 midwives per 100,000 population (midwives to population ratio of 1:1697) based on the projected population. [3]

The growing population needs health. Disease patterns and emerging conditions necessitate strategies to improve the production, recruitment, and retention of well-trained, competent, and equitably distributed health workers to achieve the Sustainable Development Goals (SDGs) and other national health commitments.

While there is a growing awareness of the importance of ensuring the availability of adequate numbers of qualified, skilled, competent, and motivated health workers; equitably distributed through various initiatives and reforms in the country, significant challenges still exist. They include maldistribution of the available health workers across regions and facility levels, weak human resources information systems for

[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 Healthworkforce Country Profile 2018. Abuja, Federal Republic of Nigeria; 2019.

effective decision making and planning, weak coordination of HRH stakeholders, inadequate financing for the workforce, and weak HRH management and leadership skills.[4] There is, therefore, a need to develop policies and plans that enable HRH production, recruitment, deployment, retention, and management strategies that ensure adequate health workers that can effectively and efficiently respond to the needs of the population.

The country has had several strategies to address HRH issues in a coordinated manner. The first Nigerian National Human Resources for Health Strategic Plan was developed for the period 2008-2012. The second one was for the period 2016-2020 and now the current one is expected to cover the period 2021-2025. It provides a framework that will guide the strategic directions for managing the health workforce for the next five years. While building on the lessons learned from the previous strategies and evidence from HRH strengthening programs, this HRH plan is guided by 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 is a signatory to several regional and global commitments which in essence have shaped this strategy. They include 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, and national policies and commitments

The National HRH Strategic Plan, and global and regional commitments

Nigeria is a signatory to several commitments. This plan for the health sector is equally aligned to the health sector commitments as in the SDGs and the 2018 Astana Declaration on Primary Health Care. The Common African Position (CAP) 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 Human Resources for Health for improved health service delivery in the African Region-2012-2025. Also consulted is the Ouagadougou Declaration on

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

Primary Health Care (2008) that seeks to reactivate the principles of PHC within the context of health systems 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 human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels;
b. to align investment in human resources for health with the current and future needs of the population and of health systems, taking account of the labor 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 human resources for health and
d. to strengthen data on human resources for health, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the global strategy.

The four global HRH strategy components specifically aim to deliver thirteen milestones—seven by 2020 and the remaining 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 with responsibility for development and monitoring of 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 human resources for health 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 sets of objectives to be achieved by countries including Nigeria by 2030 include:

a) Countries will have made progress towards halving inequalities in access to a health worker
b) Countries will have made progress towards improving the course completion rates in medical, nursing, and allied health professionals training institutions
c) Countries will have made progress towards 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, in support of national health employment and economic growth priorities
e) Partners in the Sustainable Development Goals will have made progress to reduce barriers in access to 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 Local government areas aspiration towards achieving UHC. The 2014 Presidential Summit Declaration affirms that UHC is key 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 towards UHC. This act sets the background to earmark adequate public resources to health towards strengthening primary health care through the BHCPF. Fifty percent (50%) of the fund is to be managed by the National Health Insurance Scheme (NHIS) to ensure access to a minimum package of health services for all Nigerians and 45% by the National Primary Healthcare Development Agency (NPHCDA) for primary health-care facility upgrade and maintenance, provision of essential drugs, and deployment of human resources to primary health-care facilities. The Federal Ministry of Health

will manage the remaining 5% for national health emergency and response to epidemics. Counterpart funding from state and local governments is at the core of the National Health Act implementation. Resource mobilization and accountability are key factors for the successful implementation of the National Health Act. Although there is substantial evidence that public financing is key to the achievement of UHC, government expenditure on health has been very low in Nigeria and domestic resource mobilization is weak. It is important to note that if Nigeria truly desires to make progress toward achieving UHC, the need for equitable access to basic health-care services is central. Other important factors include essential medicines and technologies; sustainable financing or funding of health-care 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. It is important that adequate finances, 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) are put in place.

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

The National Health Act (NHAct) provides a framework for the regulation, development, and management of a health system as well as standards for offering health services to all Nigerians. The Act provides for the development of policies and guidelines for monitoring of HRH provision, distribution, development, management, and utilization in the country. The developed policies should ensure the facilitation of adequate distribution of human resources, provision of well trained and skilled workforce to meet population health needs, effective and efficient utilization, management of human resources while upholding the rights and obligations of health care personnel at all levels. The HRH strategic directions and priorities of the National HRH strategic plan are aligned to the NHAct 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 to strengthen Nigeria’s health system particularly the primary health care to deliver effective, efficient, equitable, accessible, acceptable, and

comprehensive health care 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 utilization of evidence-based planning and projection of the HRH, including medium and long-term planning for health.
b) Improving the production of HRH, including the training of specialized 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 both 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 that the health workforce registry becomes functional and efficient
h) Developing and implementing mechanisms to minimize rivalries between professional health workers and also minimize industrial unrest (strikes)
i) Developing and implementing measures to address the post-graduate specialty training challenges in health care
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 Basic Health Care Provision Fund (BHCPF) for the development of human resources for Primary Health Care
l) Effective management of 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 primary care.

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

The second NSHDP II provides the health sector medium-term roadmap to move the country towards the accomplishment of National Health Policy goals and objectives. NSHDP II will guide national and subnational governments on the health sector priorities. Additionally, it recognizes 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 the size, distribution, and skill-mix of its health workforce. Therefore, it commits to have the right number, skill mix of competent, motivated, productive, and equitably distributed health workforce for provision of optimal and quality health care 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 HRH agenda
- Ensuring the production of adequate numbers of qualified health workers
- Ensuring the development of monitoring and evaluation for HRH including systems for HRHIS and registry
- 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 recognizes 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 human resources for health structures to facilitate effective planning, production, recruitment, management, development, and retention of

health workers at all levels of care. It emphasizes the importance of collaboration between governments, the private sector, and all other actors in ensuring efficient utilization 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 they are needed.

1.3 The National HRH Strategic Plan (2021-2025) Development Process

The development of the NHRHSP was participatory and evidence-based through inclusive consultations with stakeholders to ensure commitment, ownership, and accountability. A technical working group (TWG) of forty-one (41) members was constituted and officially inaugurated on 20th March 2020 by the health sector leadership. Their mandate was to guide the development process of the plan. They were drawn from different ministries, departments, and parastatals (MDAs) including the Federal Ministry of Finance, Federal Ministry of Education, Office of the Head of the Civil Service of the Federation, Federal Civil Service Commission, NPHCDA, Nigeria Centre for Disease Control (NCDC), the 14 professional regulatory bodies, health professional associations, the private sector, and development partners. The TWG had several meetings and workshops before a national validation meeting by the DPRS and HRH focal persons of the 36 States and the FCT on 18th November 2020.

CHAPTER 2: SITUATION ANALYSIS

This chapter summarizes the situation analysis based on the health labor market analysis (HLMA) in Nigeria. A detailed HRH situation analysis, informed by the policy levers of the health labor market analysis, was conducted in 2020.

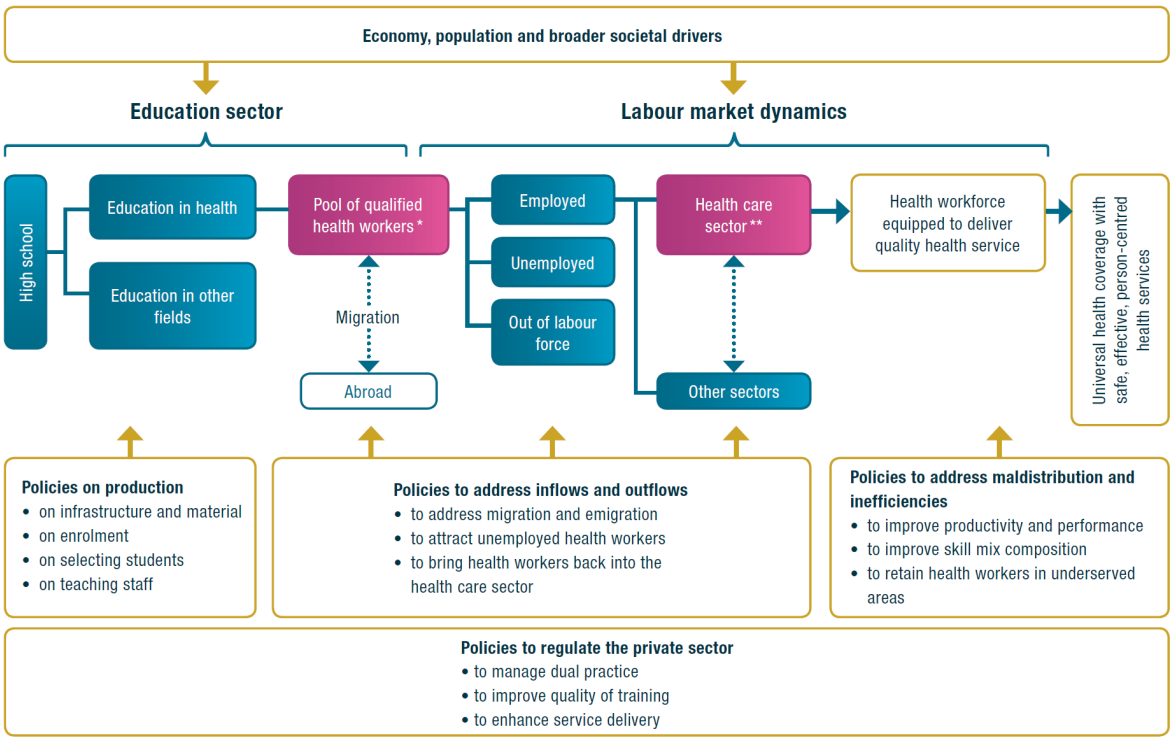


Figure 1: Policy levers to shape health labor market

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*

The health labor market framework was adopted to provide an overview of health labor market dynamics and contributions of health workforce policies to the attainment of equitable access to quality health services and UHC. The HLMA being a dynamic and complex system generated the 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 both 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 through to the pool of active skilled health workforce equipped to deliver quality health services where they are needed.

2.1. Health systems organization and service delivery structure

The organization of the health service delivery in Nigeria is shown in Figure 2.

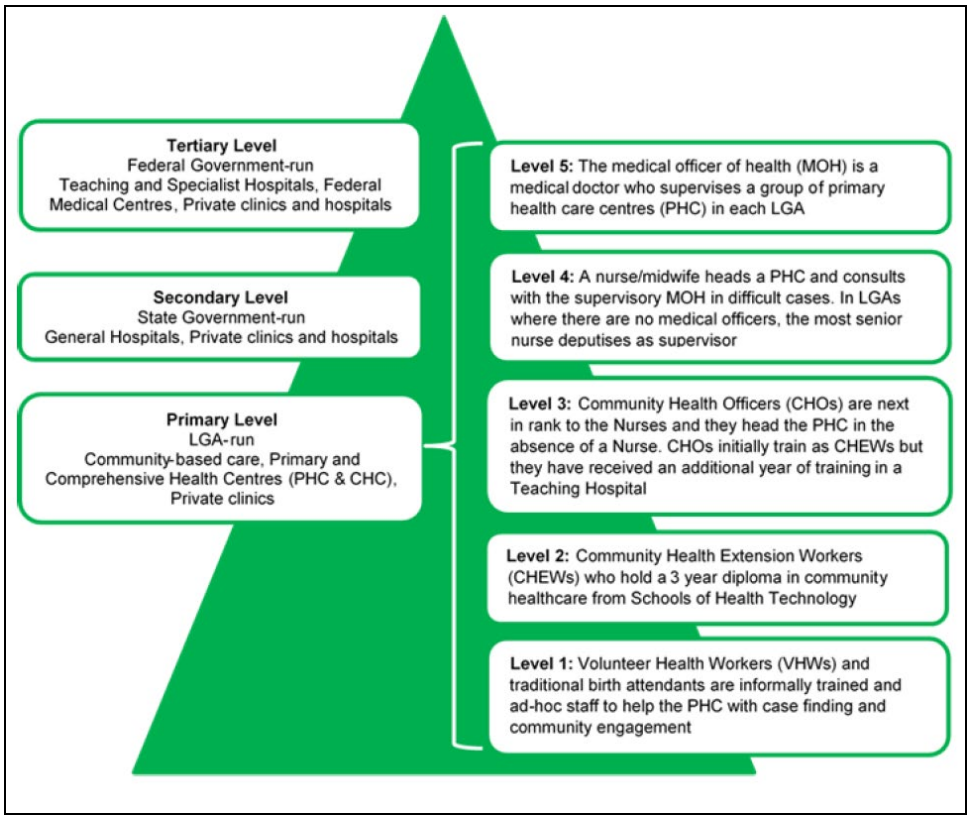


Figure 2: Organization of service delivery.

Source: NSHDP II

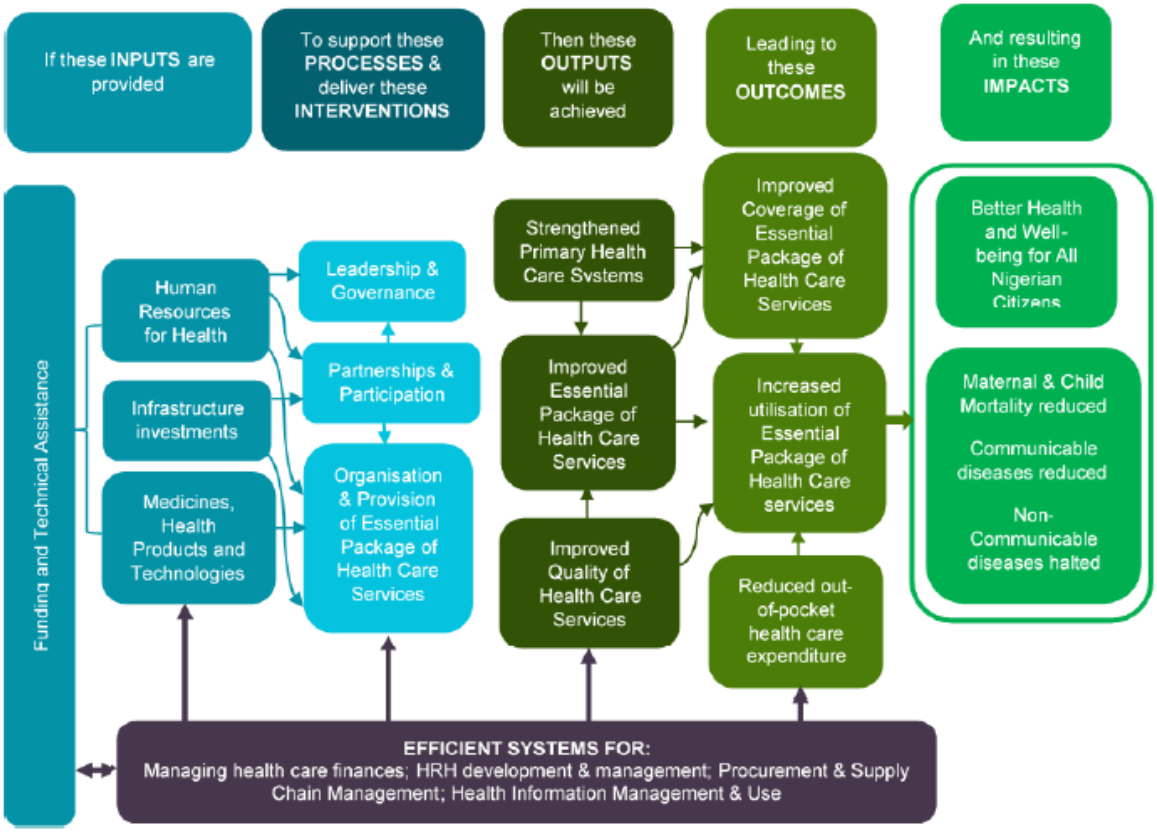
All the three tiers of government share responsibilities of providing health services. The Federal Government is largely responsible for providing policy guidance, planning, and technical assistance for coordination of the state-level implementation of the National Health Policy and establishing health management information systems. Also, the Federal government is responsible for disease surveillance, drug regulation, vaccine management, and regulation of the training of health professionals. Federal Government is also responsible for the management of most teaching and specialist hospitals as well as some medical centers. Several states and private entities also manage some tertiary level health facilities in the country.

The states operate the secondary health facilities (general hospitals) and in some cases tertiary hospitals, as well as some primary health care facilities. The training of nurses, midwives, health technicians, and the provision of technical assistance to local government health programs and facilities are also the responsibility of the state authorities.

The 774 local government areas oversee the operations of PHC facilities within their geographic areas. This includes the provision of basic health services, health promotion, and community health hygiene and sanitation. The health system comprises the private health sector, (profit and non-profit) as well as traditional and spiritual healers.

2.2. Overview of HRH management in Nigeria

Health workforce governance or stewardship capacity at national, state, and LGA levels are considered fundamental to steer the health workforce agenda in Nigeria for effective service delivery. A functional health system is essential for Nigeria to deliver UHC and ensure that Nigeria achieves SDG health targets. The essence of



the HRH in achieving the health sector goal is recognized in the NSHDP II (figure 3).

Different stakeholders have a role to play in HRH governance within the health sector. These include Ministries of Education, Finance, Agriculture, and even Environment. Other agencies include the Civil Service Commission (CSC), Local and state governments, regulatory bodies, professional associations, trade unions, academia, and development partners. The HRH has a role to coordinate the stakeholders to achieve their mandate.

Strengthening HRH governance at the federal and state level is critical if Nigeria is to effectively work on the attainment of UHC and SDGs. Two obstacles that hinder strengthening HRH are governance capacities and insufficient investments. It is essential to have a well-functioning HRH unit with the requisite number of qualified staff and teams who can effectively perform their tasks within the health system. Management of the health workforce is improved and better health services are developed when the teams can fulfill their mandate effectively.

The structure of the HRH units in the states is generally weak. In addition to the weak capacity for HRH planning and the unit being resource-constrained, they cannot influence policy directions. This is because they tend to operate only at administrative or operational levels rather than at the strategic level. Indeed, most of the units are only able to carry out specific activities when a development partner provides funds.

Figure 3: NSHDP II Theory of change

Analysis of the functions indicates that the HRH units are directly responsible for five functions. They mainly undertake policy and plan development, and implementation; management of HRH Information systems; HRH research and documentation, as well as monitoring and evaluation.

Personnel management which includes recruitment and performance management is coordinated by the CSC whilst every department in the Ministry of Health coordinates training and development of its staff. Table 1 shows the seven HRH management functions and the five being currently handled by the HRH branch in the FMOH.

Table 1: Seven HRH functions showing the five being handled by the HRH branch

HRH Governance: Level	Policy Development	Plan Development & Implementation	Personnel management	Training & Development	HRH info. Systems	Research, studies, and documents	HRH M&E
Ministry	Minister FMOH	Minister FMOH	Chairman CSC	Minister FMOH	Minister FMOH	Minister FMOH	Minister FMOH
Department	D, HPRS	D, HPRS	Recruitment and Promotion	Each Dept takes charge	D, HPRS	D, HPRS	D, HPRS
Division	HSS	HSS			HSS	HSS	HSS
Branch	HRH	HRH			HRH	HRH	HRH

2.3 Disease burden trends in Nigeria and their implication on HRH

To address the country's disease burden, adequate human resources are required if access and coverage have to be achieved at all levels of care across the country. According to the 2018 Global Burden of Disease study, Nigeria has made progress in some health indicators although the country is still undergoing an epidemiological transition and communicable diseases still constitute the bulk of the disease burden. 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 (NTDs) in Africa and accounts 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 airways 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 2: 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 followed by neonatal disorders, HIV/AIDS, malaria, diarrhoeal diseases, and tuberculosis as provided in table 2.

2.4 Health workforce stock

Table 3:Stock of health workers in Nigeria (Credit: HWP 2018)

Health workforce category	Stock	Per 100,000	Per population
Medical officers	74, 543	36.3	1:2753
Nurses Midwives	301,579	88.1	1: 1135
Dentists	4,358	2.12	1: 47,170
Pharmacists	24,668	12	1:8,333
Pharmacy technicians	5,793	2.8	1:35,485
Community Health Officers	8,533	4	1:24,091
Community Health Extension Workers	61,668	30	1:3,333
Junior Community Health Extension Workers	46,253	22.5	1:4,436
Alternative Medicine Practitioners	32	0.02	1:5,000,000
Environmental Health Practitioners	14,645	7	1:14,286
Health Information Managers	34,393	17	1:5,882
Radiologists	2,516	1.2	1: 83,000
Optometry	5,371	2.6	1: 37,000
Medical Laboratory Practice	71,269	34.8	1:2873
Medical Rehabilitation Therapist staff	5,462	2.7	1:37,000
Public Analyst	922	0.45	1: 222,222

Chartered Chemists	2,854	1.4	1:71,429

The country has experienced a significant increase in health workers in the last five years resulting from increased production capacities from the health training institutions both public and private. According to the Nigeria Health Workforce Country Profile 2018 (see table 3), Nigeria has a total of 74,543 medical doctors equivalent to 36.3 medical doctors per 100,000 populations (doctor to population ratio of 1: 2753). There are also 301, 579 nurses and midwives equivalent to 88.1 nurses per 100,000 populations (nurses to population ratio of 1: 1,135) and 58.9 midwives per 100,000 population (midwives to population ratio of 1:1,697). Further statistics indicate that 9,364 clinical medical specialists are working across Nigeria and this represents a 31 percent increase from the figure in 2012. The surgery specialists have the highest number 2,368 (25%) followed by obstetrics & gynaecology 1,238(13%), paediatrics 1,031 (11%), internal medicine 1,029 (11%) public health 916 (10%), pathology 557 (6%) and ophthalmologists at 458 (5%).The country has a total of 4,358 dentists' equivalent to 2.12 dentists per 100,000 populations; 24,668 pharmacists or 12 pharmacists per 100,000 members of the population; 5,793 pharmacy technicians which is equal to 2.8 pharmacy technicians per 100,000 populations; Community Health Officers (CHOs) at 8,533 translating to a density of 4 CHOs serving 100,000 population; a total of 61,668 Community Health Extension Worker (CHEWs) which is equal to 30 CHEWs per

100,000 populations and Junior Community Health Extension Worker (JCHEW) at 46,253 or 22.5 CHEWs per 100,000 population (JCHEWs to population ratio of

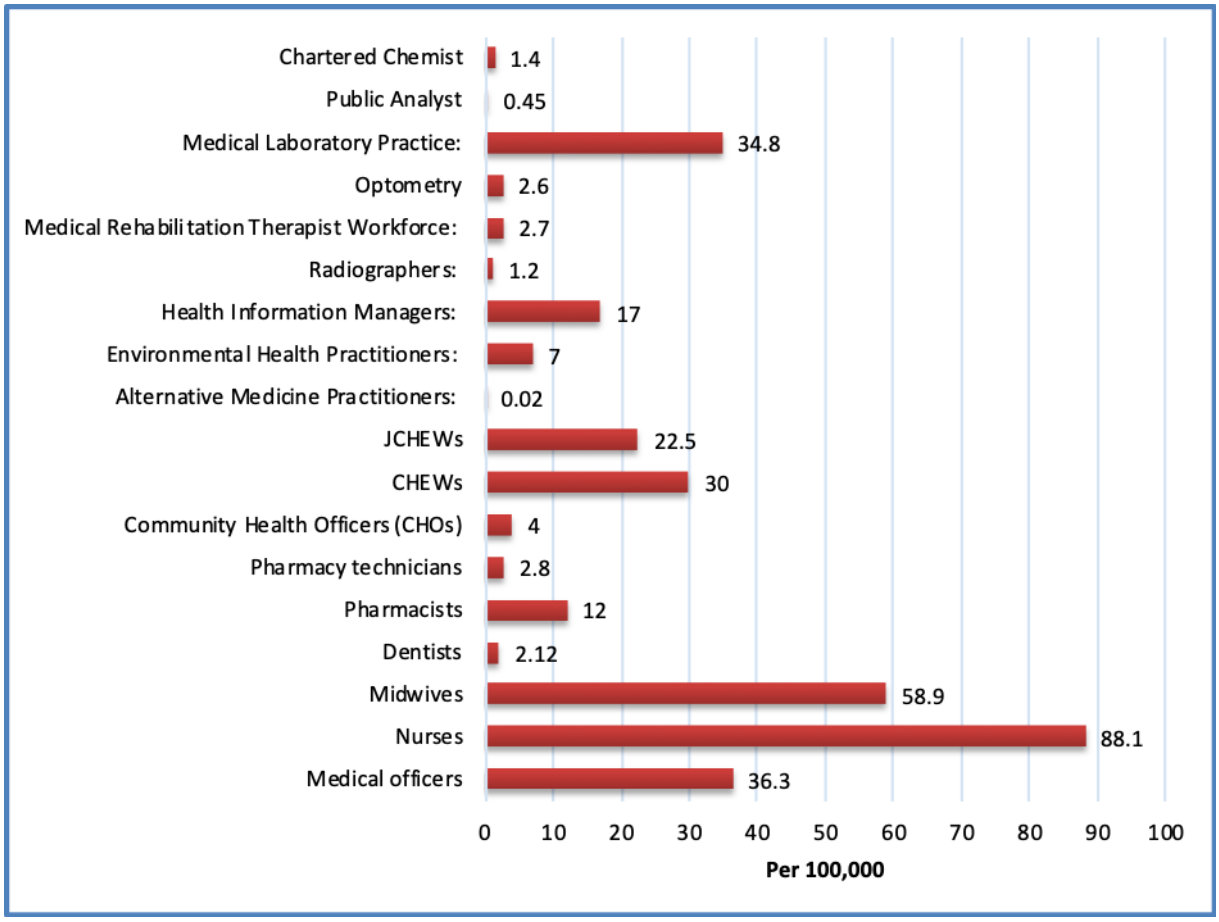


Figure 4: Selected health care cadre density per 100,000 populations

1:4,436). Figure 5 provides selected health care cadres density per 100,000 populations.

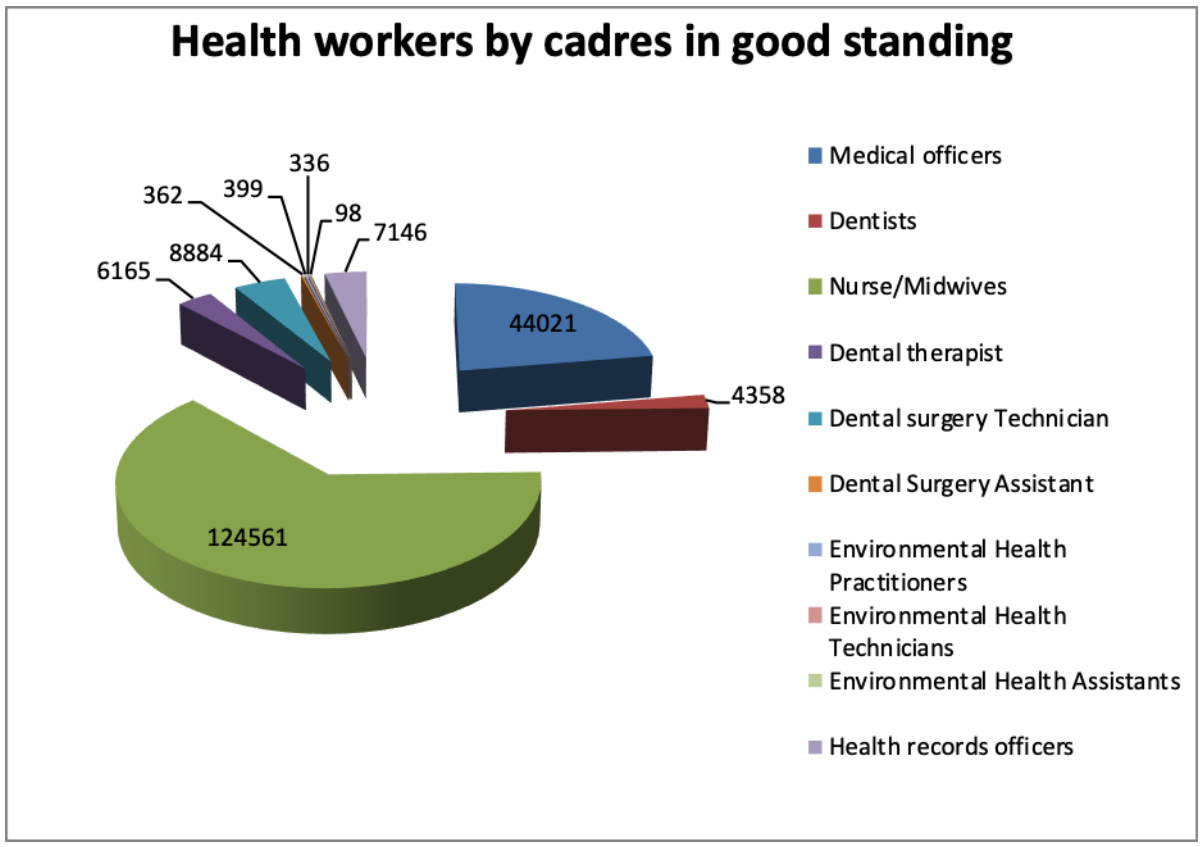


Figure 5: Health workers in good standing in selected cadres

A total of 74.543 medical doctors were registered with the Medical and Dental Council of Nigeria (MDCN) in 2018. However, only 44021 (59%) of the registered medical officers were in good standing**.** There were a total of 4,358 dentists registered with MDCN but only 3,198 registered dentists were in good standing. The Nursing and Midwifery Council of Nigeria (NMCN) registered a total of 180,709 nurses and 120,870 midwives in 2018. Only 124,561 registered nurses and midwives were in good standing having renewed their annual practicing licenses with the NMCN. This implies that several health workers remain untracked. This gap could be attributed to many reasons including attrition, slow absorption of health workers into active service, health workers practicing invalidly, and probably health workers in positions of administration roles who see no need for renewing their licenses. This is, therefore, a good reason for collaboration between the ministries of health and regulatory bodies to ensure a functional information system to track health workers and ensure compliance by practicing health workers. Ministries of Health and relevant regulatory councils should investigate the gap between health workers' registration and retention to rule out non-compliance. Figure 6 provides a summary of selected cadres in good standing with their regulatory councils.

The gender distribution shows a variable picture across all cadres as presented in table 4.

Table 4: Selected cadres by gender

Cadres	Males	Percentage	Females	Percentage
Medical officers	28,613	65%	15,407	35%
Dentists	1,791	56%	1,407	44%
Nurse/midwife	16,193	13%	108,368	87%
Dental therapist	3,252	53%	2,913	47%
Environmental health practitioners	192	48%	207	52%
Health records officers	3,644	51%	3,502	49%

2.5 Health Workforce Attrition

Attrition in the public sector is mainly due to several reasons including retirement, death, dismissal, and voluntary resignation due to internal or external migration. Other reasons include lack of access to professional development and further education for those in rural areas, weak regulatory environments, inadequate supervision, and heavy workloads amongst others. Measuring attrition and identifying determinants should be an integral part of managing health workers but this is often ignored in favor of reporting health outcomes and process indicators such as the number of health workers recruited and trained. Attrition that leads to disruption in the continuity of care and retraining costs can undermine the health services. In addition to challenges related to internal mobility and inequities, Nigeria is also one of the several major health workforce exporting countries in Africa. This trend in migration contributes to shortages of experienced and specialized health professionals. Figure 7 shows the migration trend of some cadres as presented in HWP 2018.

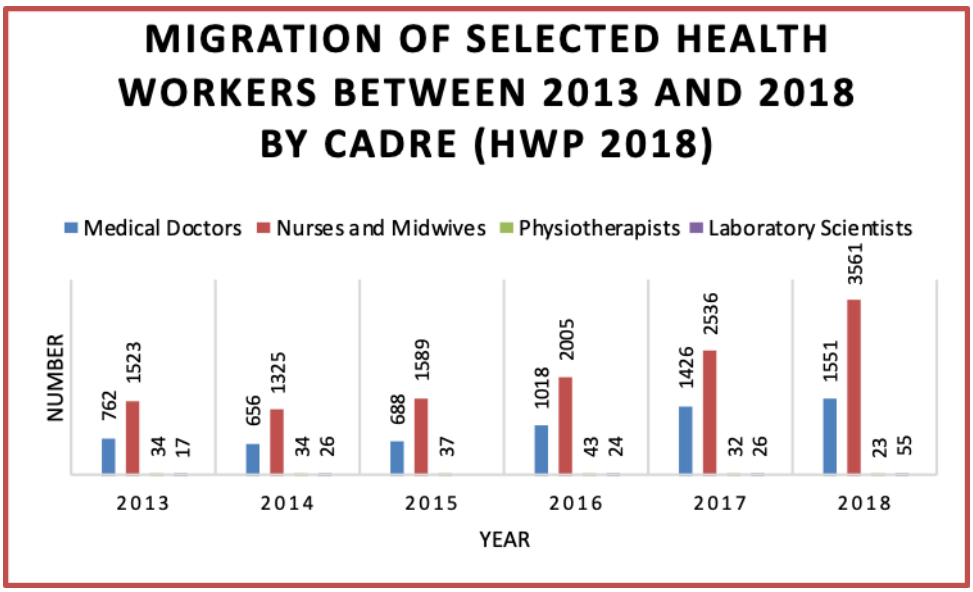


Figure 6: Trends in External Migration between 2013 and 2018

2.6 Health workforce financing

The weaknesses in financing for the health workforce include weak institutional structure and inconsistent policy implementation as well as low government investment in health. The implementation of specific HRH planning, management, and development activities in the health budgets, outside of salaries and related entitlements, is sub-optimal mainly due to the lack of sufficient funds. In most states, there are no dedicated budget lines for the aforementioned activities. Where budget lines exist, they are often not released. The financing of human resources for health is done through several modes.

Assessing HRH financing only from the standpoint of the public sector health budget often undervalues the volume of public financing for HRH. Notwithstanding, government spending on HRH via allocations to the health sector has seen an increase in the annual health budget, either at the Federal or State level. The budget is largely expended on the recurrent expenditure of which the greater ration is spent on salaries and allowances of health workers.

Private sector financing for HRH also occurs through multiple mechanisms. For example, international donors (bilateral and multilateral agencies,) provide funds for HRH development through their health-focused interventions. It is indeed recognized that a growing number of international development programs and partners earmark funds to support various HRH components. Examples of such partners are the WHO, Global Affairs Canada (GAC), UKAid, USAID, and the Global Fund. These funds are, however, channeled through direct implementation of programs in the HRH thematic areas. These expenditures are not routinely captured in the MoH budgets. Thus, it is difficult to ascertain the volume of these non-public donor financing initiatives.

Taking into account 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 arising from the weak implementation of in-service training and continuous professional development programs. These constitute a significant but unrecognizable part of the financing for HRH.

2.7 Health workforce education

According to the 2018 Nigeria Health Workforce Country Profile, the country has 38 medical schools with 89 percent (34) having full accreditation and the remaining having partial accreditation. Seventy-one percent (71%) of medical training schools are in the southern part of the country. The South-West geopolitical region has 11 medical schools. Ondo and Oyo States both have one school each. Ekiti, Lagos, and Ogun states have two medicals schools each while Osun State has three schools. The South-South geopolitical region has 9 medical schools. Akwa Ibom, Bayelsa, Cross River, and Delta States have one school each; Rivers has two schools while Edo has three medical schools. The South-Eastern geopolitical region has 7 medical schools. Abia, Ebonyi, and Imo states have one school each while Anambra and Enugu States have two medical schools each. There are 10 states in Nigeria without any accredited medical school and they are predominantly in the northern parts of the country. The states are Adamawa, Bauchi, Taraba, and the Yobe States in the North-East geopolitical zone; Jigawa, Kebbi, Katsina, and the Zamfara States in the North-West geopolitical zone as well as Niger and Kogi States in the North Central geopolitical zone. The North-Central geopolitical zone has 13 percent (5) of the medical schools in the country. These include 1 medical school each in Benue, Kwara, Nasarawa, Plateau States, and the FCT. The North-West geopolitical zone has four medical schools, including two in Kaduna State and one each in Kano and Sokoto states. The North-East geopolitical zone has just two medical schools in Borno and Gombe states.

The country has a total of 262 nursing, midwifery, and community midwifery training institutions (see table 5 for categories and numbers). 171 of the schools offer basic and post-basic nursing courses, 83 offer basic or post-basic midwifery training courses, and 8 offer community midwifery courses.

Table 5:Ten states with 50% of all NMTIs

State	Number of institutions
1. Edo	18
2. Kaduna	16
3. Enugu	15
4. Lagos	14
5. Anambra	13
6. Oyo	13
7. Kano	11
8. Osun	11
9. Cross River	10
10. Imo	10
Total	**131**

Of the 262 training institutions, 99 have full accreditation while 147 have provisional accreditation. Some 16 existing schools have lost accreditation due to non-compliance with the regulatory requirements. Ten states account for 50 percent of the 262 nursing, midwifery, and community midwifery training institutions with 8 of them situated in the Southern part of the country and two in the Northern part. Edo State has 18 institutions, Kaduna State has 16, and Enugu State has 15. Lagos state has a total of 14 schools, Anambra and Oyo have 13 schools each, Kano and Osun have 11 schools each while Cross River and Imo States have 10 schools each. The following 8 states of Adamawa, Bauchi, Borno, Kano, Katsina, Sokoto, Yobe, and Zamfara all offer community midwifery programs. It is estimated that if Nigeria schools operate at maximum capacity, then approximately 11,990 nurses, midwives, and community midwives could be produced annually.

Category of training offered	Number	Accreditation status
Basic and Post-basic Nursing	171	99 with full accreditation; 147 with provisional accreditation and 16 not accredited
Basic and Post-basic Midwifery	83	
Community midwifery	8	

Table 6: Nursing and Midwifery Training Institutions and accreditation status

There are nine accredited dental schools in Nigeria as shown in the Health workforce profile 2018. Seven are in the southern part of the country. They include two in Lagos State and one each in Edo, Enugu, Rivers, Osun and Oyo States. One school each, in Borno and Kano states, exists in the northern part of the country with all the schools having an annual production capacity of 185 dentists. In a nutshell, the country has several training institutions for the various cadres. The health institutions are regulated and coordinated by multiple organizations including the Ministry of Education, Ministry of Health, National Universities Commission, and fourteen Health Professional Councils.

2.8 Health workforce performance and productivity

The implementation of performance management in the health workforce is essential to improving accountability, efficiency, productivity, and quality of care. The federal, state and LGAs have instituted 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 to be 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. States and 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 the civil servants thus the need for domesticating the forms to the health sector needs.

Nigeria adopts both financial and non-financial incentives for motivating health workers. The SMoHs have not developed a set of indicators or systems to specifically measure or compare the performance of workers in the health sector. At the organization level, organization performance monitoring and management are also not well 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, unfavorable 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 with regards to 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, job enhancement, and enlargement are sparingly implemented although evidence suggests that these play a key role in health worker retention.

2.9 Human resource for health information systems

Nigeria has made remarkable strides towards establishing human resources for health information systems and registry. A reliable human resources information system ensures real-time information on health care 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.

A National Health Workforce Registry (NHWR) Platform has been established with support from Global Affairs Canada and the WHO. The established NHWR Platform is electronic and web-enabled and considered the single and authoritative source of information on HRH in the country. The NHWR platform is a multi-site system with one system instance in one central server and the system houses all submitting entities - the Federal Ministry of Health and its departments, agencies, and parastatals (DAPs), state ministries of health and its DAPs, regulatory bodies and the private sector. Validated health workforce information is collated, aggregated, and centralized using a bottom-up process; from sub-national levels, regulatory bodies, and training institutions to the national level. The validated HRH data flow process from sub-national levels to the national level relies on data submitting health entities. These submitting health entities are health bodies that are authorities for HRH information in their respective administrative levels. The registry currently has health workforce information for 11 states – Abia, Adamawa, Anambra, Bauchi, Borno, Cross River, Edo, Niger, Osun, Sokoto, and Yobe States. A handbook of the registry that contains an implementation guide, standard operating procedure, and basic user training manual, was also developed with support from Global Affairs Canada and WHO to sustain the functionality of the registry.

The management of human resource information in the country operates through a combination of paper-based nominal rolls with multiple forms and electronic systems. There are limitations of the use of this data and information systems due to non-timely receipts of this data to the centralized systems leading to irregular updates. There is a lack of a unitary framework for HRH information flow with the most needed information not readily available. The country is in the process of strengthening this progressively through the National Health Workforce Accounts (NHWA) to support tracking of HRH policy performance towards universal health coverage.

2.10 HRH recruitment and management

The CSC has the authority for the recruitment of all civil servants into the public service including senior cadres of health workers. This function is conducted in collaboration with other agencies outside the health sector. For primary health care, the NPHCDA at the national level, Primary Health Care Development Boards/ Agencies at the state level, and Local Government Service Commissions at the LGA level manage the recruitment of selected health care worker cadres.

Decisions on recruitments are often not based on evidence but perceived needs, and occasionally, norms. Registers and staff records are all updated through periodic staffing returns from the facilities. The mechanisms for recruitment vary from state to state. The processes of recruitment also vary usually in response to vacancies arising from health worker attrition.

The MoHs 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 sanctioned posts. On approval, the CSC, LGSC, and Hospitals Management Board can initiate and implement the recruitment process based on guidelines. The advertisements are publicized in the government gazettes or major dailies. The recruitment process is conducted by the appointing authorities with the participation of representatives/directors of the requesting health departments. Usually, there are three to six months or longer between the sourcing and issuing of appointment letters before recruited officers are officially absorbed in 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 and state compounds the problem further. The absence of health workforce projections is mostly due to evidence-based staffing norms, standards of care, and essential service packages for secondary and tertiary levels of care.

The lingering embargo on recruitment in some states, despite severe shortages across the country, has placed serious limitations on the capacity of the health sector

to absorb the load of fresh graduates produced from the health training institutions. This is further increasing the workloads on existing staff and impacting negatively on the quality of care and health indices.

The distribution process of health workers is usually based on the availability of new staff or vacancies resulting from staff attrition. The distribution is based on urgency or how severe the situation per state. Several agencies are involved in the process just like most of the other HRH practices. The various departments and services take responsibility for the redistribution of their staff to where they are needed most. 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 labor market especially when attrition rates are high. The use of evidence-based models like the Workload Indicators of Staffing Need (WISN) is only used in a few states. As a result, the patterns of distribution of the health workers in the country show maldistribution in the states and across the regions. There are imbalances between the rural and urban areas and even between facilities and within the departments of a facility.

The disparities in remuneration between the federal and state levels in the health sector increase 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, implementation of vertical health programs like HIV/AIDS, malaria, tuberculosis, and maternal and child health, by development partners, also pose significant threats to the health worker availability. These programs pay comparatively higher packages further fuelling the disparities in distribution between departments.

2.11 Health workforce governance and leadership

Leadership and governance focus on the role of government in health and its relation with 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. Human resource for health management and development is still an evolving function in many countries including Nigeria. The systems, structures, and

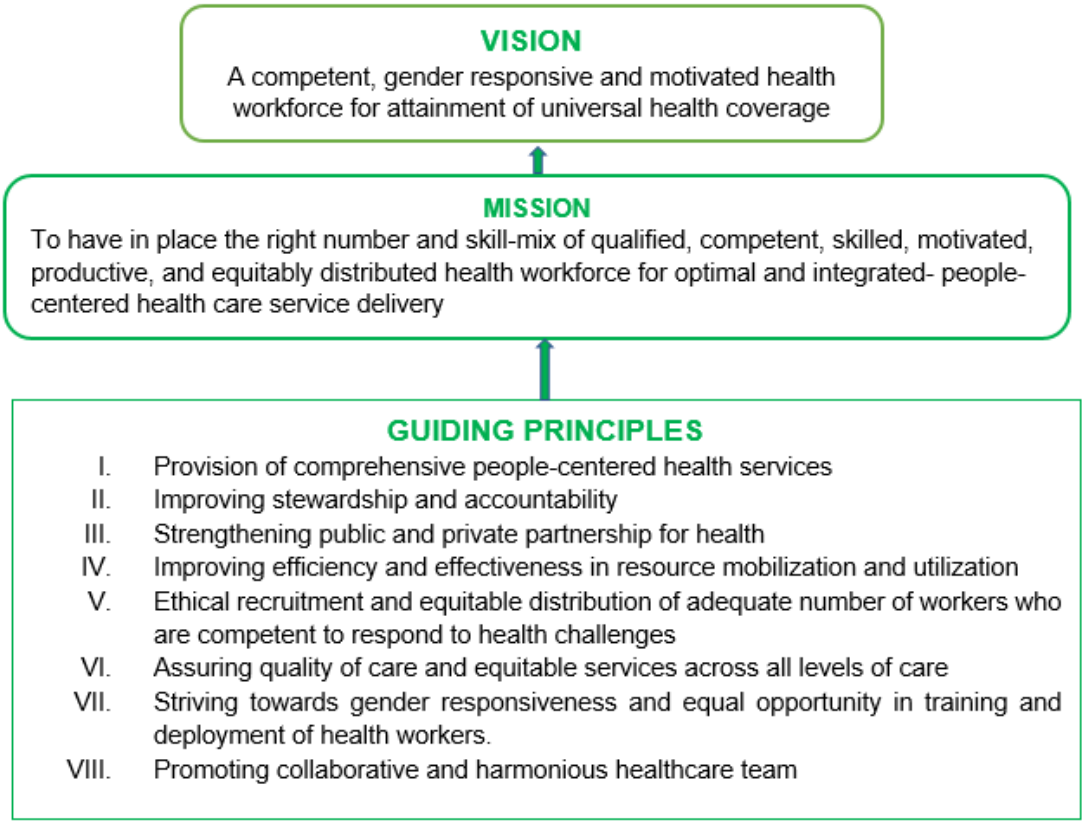
practices are in varying stages in the states. The responsibility of overall strategic leadership, governance, and oversight, including policy formulation and enforcement of guidelines for HRH, rests with the MOH. The responsibilities are co-shared among several institutions within and outside the health sector each having its responsibility performed autonomously.

HRH is coordinated within the DHPRS collaboratively with other institutions within and outside the health sector. The HRH work should impact the different departments of service delivery like reproductive, maternal, new-born, child, adolescent health, and nutrition (RMNCAH+N), communicable, and non-communicable diseases amongst others.

Available evidence suggests that most states have established HRH branches/units with focal persons that are at various levels of functionality. These offices are inadequately staffed, funded, and thus weak in capacity thereby hindering the day to day running of HRH operations. Their activities include HRH administration, information management, and technical HRH functions.

CHAPTER 3: STRATEGIC DIRECTION

3.1. Vision of National HRH Strategic Plan 2021-2025



3.2. Theory of Change

To achieve **positive health outcomes for the Nigerian population** in the context of UHC and SDGs, the health system will perform optimally by being **equitable and accessible**; **efficient and effective** of **high quality, and responsive**. To make health service in Nigeria equitable, accessible, efficient, effective, of high quality, three workforce objectives need to be achieved in the five years - **coverage** of the population

by the workforce (including ensuring that the citizen has access to the health worker s/he needs physically and through social protection); the **motivation** of the workforce; and improved c**ompetence** of the workforce. To achieve these objectives, the following actions will have to be undertaken (at the minimum) as part of strengthening the HRH pillar of the health system. They include:

- All actions that will ensure numeric adequacy of health workforce for the Nigerian Health System

- All actions to achieve an effective skill mix of the Nigerian health workforce
- All actions that will ensure that the right health workers are available to the Nigerian wherever s/he lives and whatever his/her economic status.
- All actions that will ensure that the Nigerian health worker is satisfactorily remunerated and they work in a satisfactory work environment
- All actions to ensure that the health system supports the health worker to perform optimally
- All actions to ensure that the Nigerian health worker acquires the skill appropriate for his/her work
- All actions that will ensure that appropriate training and learning are available to the Nigerian worker inclusive of appropriate orientation and curriculum as well as continuous learning.
- Effective leadership of HRH in Nigeria at national and sub-national levels including effective financing, monitoring, evaluation, learning, and innovation

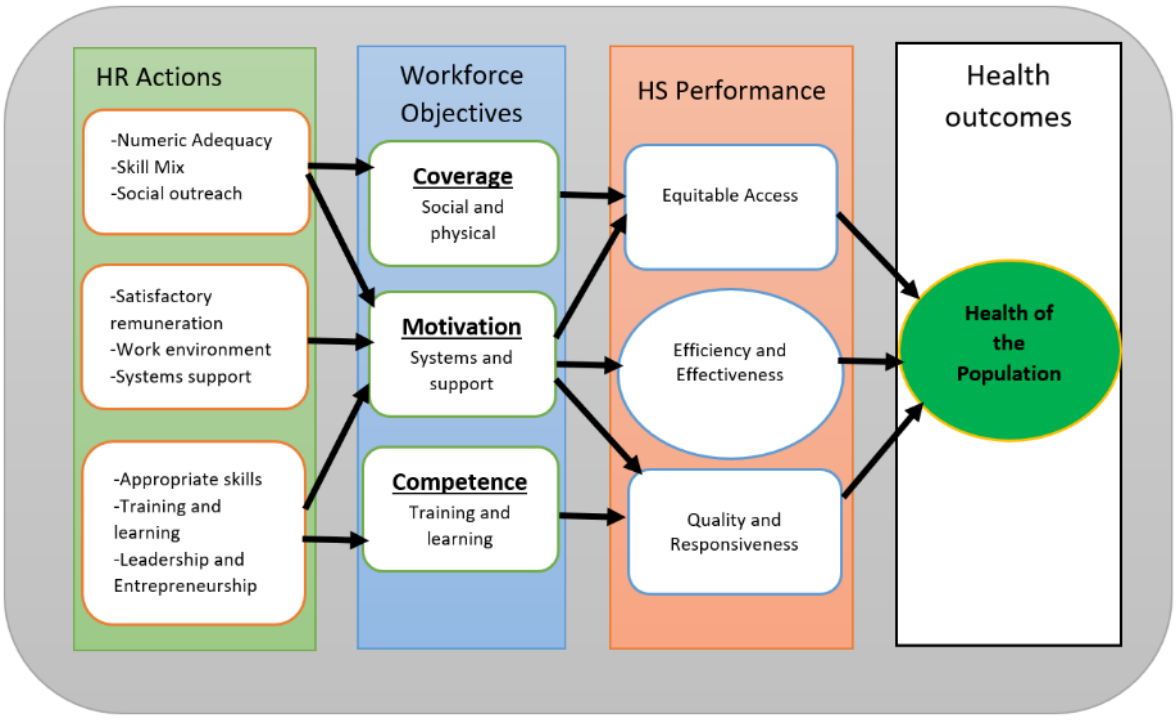


Figure 7: Theory of Change (Credit: USAID/WHO HSS Assesment manual 2007

3.3. The strategic framework

Figure 9 presents the pillars on which this plan rests. It shows the clear linkage between HRHSP 2021-2025 and NSHDP 2018- 2022 and HRH policy 2020.

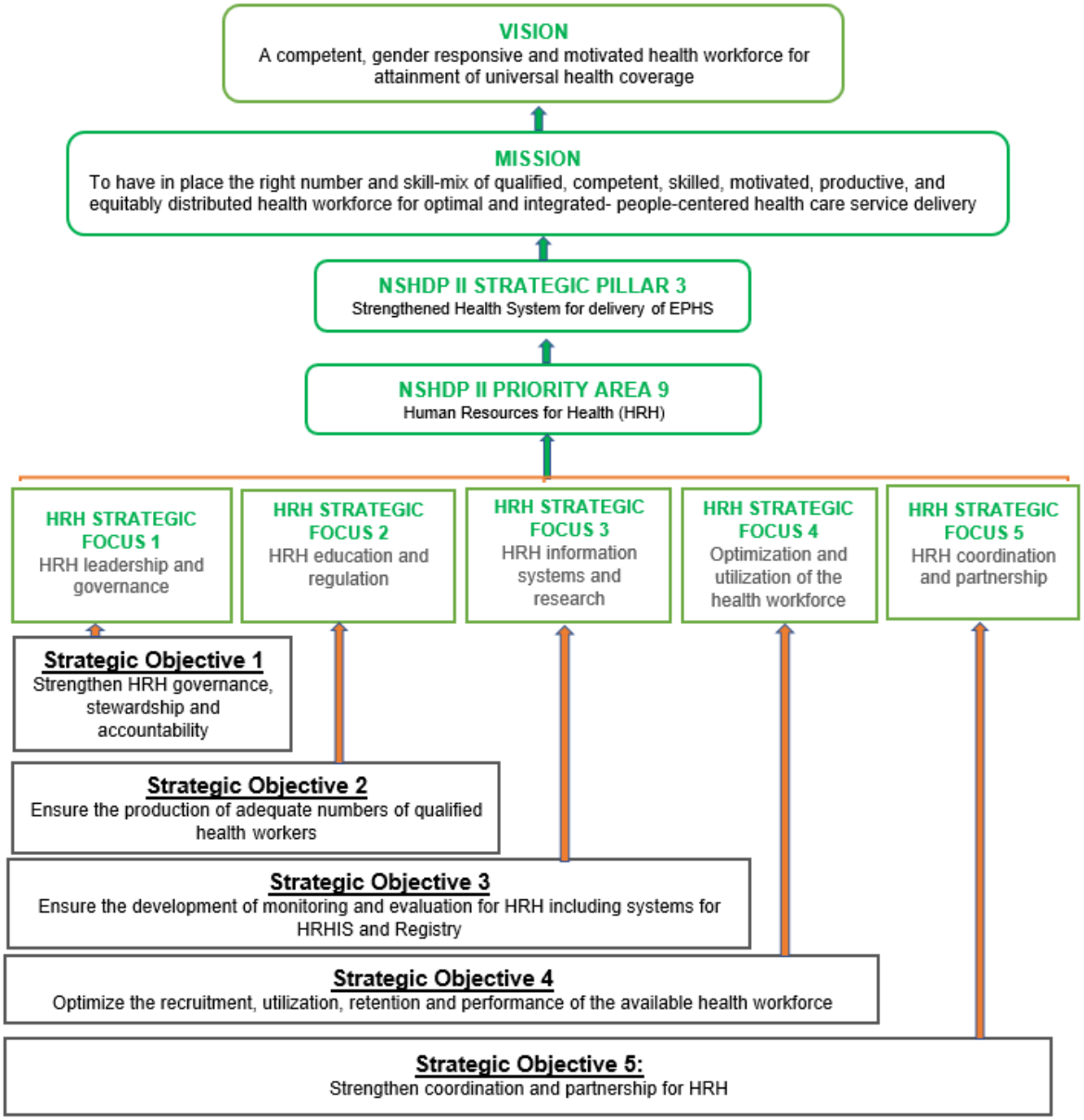


Figure 8: 2021-2025 HRH Strategic framework

The HRH strategic plan 2021-2025 has five strategic objectives. They include (1) strengthening HRH governance, stewardship, and accountability, (2) Ensure the production of adequate numbers of qualified health workforce (3) Enhance the functionality of the Human Resources for Health Information System (HRHIS), (4) Optimize the recruitment, utilization, retention, and performance of the available health workforce and (5) Strengthen coordination and partnership for HRH at state and federal

levels. 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 7: Strategic Objective one

Strategic objective 1: Strengthen HRH governance, stewardship, and accountability ***Outcome: HRH structures made functional at Federal and state levels***								
Strategic Intervention(S1)	**Specific Activity**	**Key Performance Indicator(s)**	**Baseline**	**Annual targets**				
				2021	**2022**	**2023**	**2024**	**2025**
Intervention 1.1.1: Institutionalize the HRH units and equip them with qualified, skilled, competent, and motivated staff in their adequate numbers	1.1.1.1: Support the strengthening of HRH units at all levels 1.1.1.2: Advocate for increased funding to strengthen the HRH unit 1.1.1.3: Develop an investment case for financial sustainability for HRH in collaboration with other Ministries 1.1.1.4: Strengthen institutional leadership and governance capacities of the HRH units	• Number of States with functional HRH units • Number of states with HRH planning budget lines in the Health sector budgets	**34** **18**	**36** **23**	**37** **26**	**37** **29**	**37** **32**	**37** **37**
Intervention 1.1.2: Improve capacity for HRH planning and reporting functions at all levels	1.1.2.1: Formulate a comprehensive HRH policy at federal and State levels 1.1.2.2: Develop/update comprehensive and costed HRH strategic plans at all levels 1.1.2.3: Develop evidence based, costed and prioritized HRH annual operational plans 1.1.2.4: Conduct periodic reviews (joint annual reviews, mid-term review and end-term review) of implementation of the HRH strategic plans 1.1.2.5: Develop annual HRH reports and federal and State levels	• Number of States implementing HRH policies and strategic plans • Number of States that have harmonized annual HRH Operational Plans • Percentage of states submitting annual HRH reports	**18** **2** **0%**	**23** **23** **20%**	**28** **28** **50%**	**33** **33** **70%**	**37** **37** **100%**	**37** **37** **100%**
Intervention 1.1.3. Strengthen sustainable mechanisms for funding HRH planning adequately at National and sub-national level	1.1.3.1. Institute PPP mechanism for funding HRH planning 1.1.3.2. Advocate for sustained financing from the Ministries of Health, SPHCDA (BHCPF) in collaboration with other line ministries, partners, and stakeholders	• Percentage of states with funding for HRH development utilizing PPP	**0%**	**20%**	**30%**	**55%**	**65%**	**80%**

Table 8: Strategic Objective two

Objective 2: Ensure the production of adequate numbers of the qualified health workforce *Outcome: Improved access to adequate and qualified health workforce*								
Strategic Intervention(S1)	**Specific Activity**	**Key Performance Indicator(s)**	**Baseline**	**Annual targets**				
				2021	**2022**	**2023**	**2024**	**2025**
Intervention 2.1.1. Strengthen the quality assurance process for HRH training institutions.	2.1.1.1. Advocate to owners of training institutions for increase of human resources for health in their right skill mix 2.1.1.2. Strengthen the capacity of regulatory bodies to perform their roles of HRH accreditation and regulation at all levels. 2.1.1.3. Develop, Review and Revise training curricula in line with emerging health needs 2.1.1.4. Scale-up continuing professional development (CPD) programmes targeting HRH trainers and practitioners	Percentage of health training institutions accredited by the relevant regulatory bodies	**55%**	**65%**	**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	2.1.2.1. Establish and institutionalize platforms for alignment between HRH Training Institutions, Regulatory bodies, community leaders, policy makers, legislators and other stakeholders. 2.1.2.2. Develop/implement other pre-service and in-service training programmes as appropriate, including community midwifery, community nursing, and programmes by collaborative institutions	Percentage of States with health worker production matching identified needs Number of new HRH training initiatives being actively implemented	**0%** **2**	**15%** **2**	**20%** **4**	**35%** **5**	**50%** **6**	**60%** **6**
Intervention 2.1.3. Improve production of health workforce taking into account gender dynamics and skill mix for service delivery.	2.1.3.1. Promote gender sensitivity in the production of HRH through informed enrollment, retention and management strategies 2.1.3.2. Promote evidence-based HRH distribution based on skill-mix informed by primary, secondary and tertiary healthcare needs as well as population dynamics	Number of States implementing evidence-based gender-sensitive strategies to inform enrolment, retention and management of health workers Number of states with appropriate skill-mix of HRH at all levels of care based on evidence	**9** **0**	**10** **10**	**12** **15**	**15** **20**	**17** **25**	**20** **30**

Table 9: Strategic Objective three

Objective 3: Ensure the development of monitoring and evaluation for HRH including systems for HRHIS and Registry *Outcome: Reliable and quality health workforce data available at all levels.*								
Strategic Intervention(SI)	**Specific Activity**	**Key Performance Indicator(s)**	**Baseline**	**Annual targets**				
				2021	**2022**	**2023**	**2024**	**2025**
3.1.1. Strengthen HRHIS at all levels	3.1.1.1. Establish/strengthen National Health Workforce Registry (NHWR) at all levels 3.1.1.2. Strengthen data management and evidence use mechanisms for the HRHIS	Number of states with health workforce registries linked to the NHWR Percentage of federal DAPs and states regularly updating HRH information in the NHWR	**21** **0%**	**25** **40%**	**31** **60%**	**37** **100%**	**37** **100%**	**37** **100%**
3.1.2. Establish mechanisms for HRH data reviews and reporting for evidence- based decision making at the Federal, and State levels	3.1.2.1. Establish/ strengthen the National HRH observatory to lead institutionalization of the National Health Workforce Accounts reporting 3.1.2.2 Strengthen evidence generation using the health labour market analysis framework. 3.1.2.2. Conduct biannual HRH data reviews to assess functionality and utilization of HRH data as well as publish annual HRH profiles	Number of annual HRH profiles published at national and state levels	**0**	**5**	**15**	**26**	**33**	**38**
3.1.3. Improve HRH research for data-driven decision making	3.1.3.1. Develop HRH research framework 3.1.3.2. Conduct operational research that provides information to improve HRH development, planning and management	Percentage of HRH researches conducted based on national priorities Percentage of research used to inform decisions to improve HRH development, planning and management at national and state levels	**0%** **0%**	**10%** **10%**	**20%** **20%**	**40%** **30%**	**70%** **50%**	**90%** **60%**

Table 10: Strategic Objective four

Objective 4: Optimize the recruitment, utilization, retention and performance of the available health workforce *Outcome: Adequately recruited, deployed, motivated and productive health workers*								
Strategic Intervention(SI)	**Specific Activity**	**Key Performance Indicator(s)**	**Baseline**	**Annual targets**				
				2021	**2022**	**2023**	**2024**	**2025**
4.1.1. Promote evidence-based recruitment, deployment and retention of health workers at all levels of care	4.1.1.1. Advocate for the implementation of safety guidelines and insurance policies for health workforce (private and public) 4.1.1.2. Strengthen the implementation of the Patients' Bill of Right to enhance oversight of the private sector 4.1.1.3. Strengthen effective recruitment, deployment and retention policies and practices to promote rational utilization of health workers	•Number of states implementing evidence-based the health workers retention policy and/or strategies	**9**	**12**	**17**	**22**	**27**	**30**
4.1.2. Improve HRH performance management systems at all levels	4.1.2.1. Review and implement existing HRH recruitment and deployment policies/guidelines to promote gender and social inclusion, as well as equity 4.1.2.2. Establish/strengthen performance-based management systems 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	• Number of states with competency-based job description for health workers • Number of states implementing performance management systems based on health and HRH priorities	**0** **0**	**1** **35**	**5** **65**	**10** **70**	**15** **80**	**25** **85**
4.1.3 Strengthen the task shifting and task sharing implementation with required guidelines	4.1.3.1 Adapt and Implement the national Task Shifting and Task Sharing (TSTS) policy in response to state specific HR needs 4.1.3.2 Develop and implement a costed framework for TSTS based on evidence 4.1.3.3. Conduct periodic reviews to assess level of implementation of the TSTS policy 4.1.3.4 Institute mechanisms for continuous supportive supervision at all levels	Number of States implementing adapted TSTS policy	**24**	**27**	**30**	**32**	**34**	**36**

Table 11: Strategic Objective five

Objective 5: Strengthen coordination and partnership for HRH *Outcome: Institutionalized HRH coordination and partnership mechanisms*								
Strategic Intervention(SI)	**Specific Activity**	**Key Performance Indicator(s)**	**Baseline**	**Annual targets**				
				2021	**2022**	**2023**	**2024**	**2025**
5.1.1.Strengthen partnership for HRH programs	5.1.1.1. Update database of stakeholders and partners implementing HRH programs at all levels 5.1.1.2. Strengthen public/private partnerships to ensure coherence and support for HRH plans.	• Number of states with validated joint annual PPP HRH plan	0	5	8	13	20	25
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 (National Health Observatory and HRH TWG) at all levels	• Number of States with functional mechanisms for coordination of stakeholders in order to facilitate policy dialogue • Number of national HRH consultations/ policy dialogues/ conferences held	0 0	5 1	8 2	13 2	20 2	25 2

CHAPTER 4: RESOURCE REQUIREMENTS

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

4.1. Budget estimates

The Federal and State Ministries of Health are committed to invest in HRH to realize UHC. The total resource requirement estimates for the strategic period 2021-2025 is ₦1Billion, an average of ₦202 million per year. Table 14 shows a summary of financing requirements for strategic plan 2020-2025 by strategic objectives. Resource distribution across the five thematic objectives, planned investments to enhance the functionality of Human Resources for Health Information System (HRHIS) accounts for 33% of the Total Cost. Likewise, ₦295million, 29% of the Total Cost was allocated to strengthening workforce governance, stewardship, and accountability.

Table 12: Total Cost of the NHRHSP 2021 - 2025

Strategic Objectives	Total Cost Per annum					Grand Total (₦)	% of Total Cost
	YEAR 1 Cost (₦) (2021)	YEAR 2 Cost (₦) (2022)	YEAR 3 Cost (₦) (2023)	YEAR 4 Cost (₦) (2024)	YEAR 5 Cost (₦) (2025)		
Strengthen HRH governance, stewardship and accountability	**79,111,000**	**69,077,000**	**46,344,000**	**46,469,000**	**54,769,000**	**295,770,000**	**29%**
Ensure the production of adequate numbers of qualified health workers	**40,199,160**	**40,199,160**	**40,199,160**	**40,199,160**	**40,199,160**	**200,995,800**	**20%**
Ensure the development of monitoring and evaluation for HRH including systems for HRHIS and Registry	**280,570,300**	**11,734,000**	**17,494,000**	**11,734,000**	**11,734,000**	**333,266,300**	**33%**
Optimize the recruitment, utilization, retention and performance of the available health workforce	**125,136,000**	**7,025,000**	**7,025,000**	**11,035,500**	**7,025,000**	**157,246,500**	**16%**
Strengthen coordination and partnership for HRH agenda	**5,782,000**	**5,344,000**	**5,344,000**	**5,344,000**	**5,344,000**	**27,158,000**	**3%**
Total Cost (₦)	**530,798,460**	**33,379,160**	**116,406,160**	**114,781,660**	**119,071,160**	**1,014,436,600**	
Total Cost (in US$)	**$1,396,838**	**$ 350,998**	**$ 306,332**	**$ 302,057**	**$ 313,345**	**$ 2,669,570**	

4.2. Gaps in Financing

The difference between the resource requirements and the available resource-based budgets provides a measure of the gap in funding which exists if the Strategic plan is to be fully implemented. The identification of the funding gap provides an opportunity for potential stakeholders to see when additional resources will be most useful. With the paucity of the information on HRH resources availability, determining the resource deficit for the strategy was challenging. However, within the implementation period, HRH resource mapping has been prioritised. HRH resource commitments from Federal, States including FCT and Local Government are to be targeted. Also of interest, are the resources available within the private sector and developments assistance from donor, bilateral and multilateral organizations and partners.

CHAPTER 5: IMPLEMENTATION FRAMEWORKS/ ARRANGEMENTS

The Federal and State Ministries of Health will provide leadership in the implementation of the strategic plan in collaboration with all stakeholders at national and state levels. Stakeholders in the health sector will include state health-related sectors, external actors (development partners), non-state actors (implementing partners, private sector) and clients/community through the HRH partnership forum that brings together all key partners in the health sector supporting HRH at different levels to work in collaboration to achieve priority sector objectives and results.

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.

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 stakeholder or the importance of their claim.

Legitimacy: A generalized 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.

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 HRH agenda based on this analysis, which then feed into the stakeholder management process as outlined below.

Table 13: 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 Organizations, private sector, development and Implementing partners), and state actors (government Ministries, Departments and Agencies) at the federal and state levels.

State Actors: The main role of the state actors (both federal and state) is to provide leadership, stewardship and accountability in the health sector. The federal and state governments shall formulate policies, developing strategic plans, setting sector priorities, regulation, setting standards, providing service delivery guidelines, provision of technical support to the state level, capacity and managing the federal facilities and state facilities to provide health services. Improving the overall health status and well-being of the population depends on the synergistic functioning of the various sectors in Nigeria.

Non-State Actors: This category includes private sector (for-profit and not-for-profit), development partners and implementing partners. The private sector at all levels provides significant support to 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 federal and state HRH forums will provide a platform where such collaboration is promoted. Traditional practitioners

provide complementary services based on locally available interventions while implementing partners have played 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 14: Stakeholder mapping and their expectations

Stakeholder	Stakeholder expectation of HRH branch	HRH unit's expectations of the stakeholder	Classification	Stakeholder management strategy
FMoH	HRH branch to effectively lead HRH development and reporting in Nigeria	Effective funding		Continuous engagement
HoS	Ensure that mechanisms are in place for effective management of Health workforce management in Nigeria	Support the branch to carry out HRH functions effectively		Continuous engagement
SMOH	Leadership from HRH branch in terms of information and capacity development	SMOH reports all HRH development and activities at subnational level to the HRH branch		Continuous engagement
NPHCDA	Leadership from HRH branch in terms of information and capacity development and information exchange	NPHCDA reports all HRH development and activities happening under NPHCDA to the HRH branch continuously		Continuous engagement
SPHCDA	To cooperate with the state HRH unit in all aspects related to HRH development in the state	To have information from HRH branch on HRH continuously through the HRH branch in the stater		Engage through the state MOH HRH Unit
Federal Ministry of Finance	To ensure that money budgeted for HRH development is released and on time	To make its plans and intentions on spending very clear and on time through its Annual Operational Plan (AOP) and memos		Continuous engagement
Federal Ministry of Education	To cooperate in all matters related to production of HW	To continually engage MOE on what needs to be done by MOE on this matter of HW production		Continuous engagement
Professional Association	To give information to HRH continuously in all matters related to HRH development	Feedback from HRH branch in all matters related to HRH management in the country		Continuous engagement
Professional	Continuous information	Feedback expected from		Continuous engagement

regulatory bodies	exchange with HRH branch	HRH branch on all issues related to HRH development in Nigeria		
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		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
DAPs	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 Feedback on HRH services Joint resource mobilization		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
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 implementation of donor funded programs

CHAPTER 6: MONITORING, EVALUATION AND REPORTING

6.1. Overview of the NHRHSP monitoring, evaluation and reporting

The implementation of 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. Quarterly review meetings will be held between the HRH units, DPRS and HRH forums to review the implementation of the AOP that come out of this strategic plan. 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 Plan; causes of deviation from Plan, if any; areas of difficulties and suggested solutions to problems that may adversely affect implementation; and corrective measures to be undertaken. The input of these HRH quarterly meetings will be the output from the meetings with DPRS and health programmes.

The Strategic Plan alone does not mean the achievement or implementation of the objectives. Monitoring, Evaluation and Reporting provides the back-up necessary to ensure that the set objectives are achieved. During the formulation of the Strategic Plan, the implementation indicators and projections are sometimes based on past experiences. These however, may change in the course of the implementation and thus a management control system will be necessary to ensure the 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 FMoH, State, DAP and LGA levels will coordinate collection of M&E data, analysis and reporting. It will provide technical support and facilitate M&E 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 Plan over the entire Strategic Planning period by providing

report on the AOP which is an offshoot of this plan. They will continuously monitor and evaluate all strategies, activities and outcomes with a view to advising HRH Branch/units on the implementation status as well as offer feasible policy and strategy alternatives. This will be done on quarterly basis and the same will inform the updates to the HRH forum. The HRH units/branches will be required to keep records of the lessons learnt during implementation of the Plan and to the largest extent possible ensure this information is available on real-time basis. A system of disseminating the lessons learnt to users will be developed as part of the M&E Strategy. The M&E teams, as part of its overall M&E 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 reviews and mid-term review will also be carried out. The implementation matrix will help track and monitor progress in the implementation of the Plan.

The operationalization of this Starategic Plan commences with the development of Annual Operatonal Plans. 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 summary of the baseline data, and target for these indicators are in section 3.4 (Tables 9-13). 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.

Strategic Focus	Strategic Intervention	Interventions	Time Frame	Status	Variance & Why	Responsibility	Improvement Program(s)

Table 15: Indicative template for semi-annual review of the NHRHSP

6.2. Monitoring and Evaluation framework for NHRHSP 2021-2025

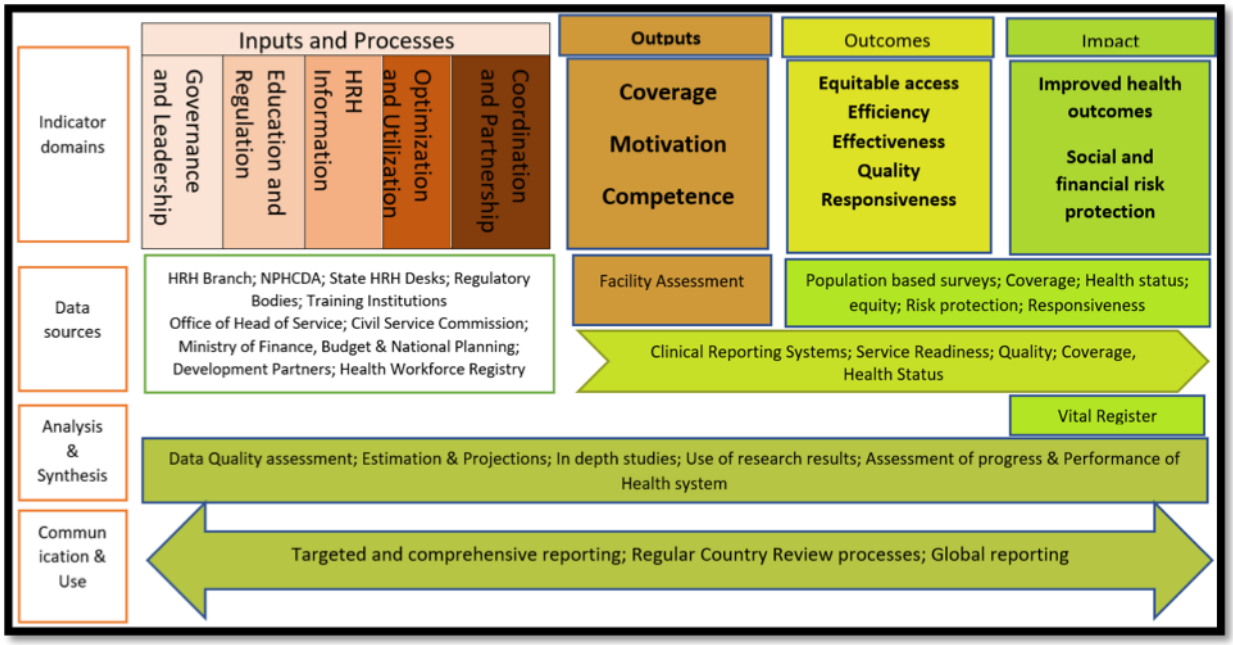


Figure 9: Summary of NHRHSP 2021-2025 M&E framework

Successful implementation of the NHRHSP 2021-2025 calls for a robust M&E Plan. The NHRHSP 2021-2025 M&E Framework was adapted from the NSHDP II M&E framework. It serves as a management tool for promoting efficiency, effectiveness, accountability and transparency towards achieving the NHRHSP 2021-2025 goals and objectives. It outlines various roles and responsibilities regarding the M&E, organizing plans for data collection, data quality, analysis and use.

The following steps were taken in developing the M&E Framework and Plan for the NHRHSP 2021-2025:

- 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; and
- Establish mechanisms for sharing information and incorporating results into prevention and response planning.

The NHRHSP 2021-2025 Framework tests the assumptions in the theory of change (Figure 7) and traces results chains that are necessary to deliver the targets set out in the NHRHSP 2021-2025.

6.3. Purpose of NHRHSP 2021-2025 M&E Plan

The main purpose of this M&E 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 in order to achieve the goals and objectives of NHRHSP 2021-2025 within its stipulated timeframe. The M&E Plan provides a tool to track and report Nigeria'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 M&E Plan enables and guides the tracking of the health workforce status in Nigeria and her contribution to Regional and Global HRH Agenda. Specifically, the M&E plan

- Serves as a guide in determining the processes to be undertaken to track progress made within the NHRHSP 2021-2025 period with regard to national and international indicators.
- Provides opportunity to make corrections in the implementation of NHRHSP 2021-2025 through regular monitoring
- Provides evidence for informed decisions regarding programs management and service delivery.
- Ensures 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 the various roles and responsibilities of stakeholders regarding monitoring and evaluation of NHRHSP 2021-2025.
- Gives systematic arrangement for quality data collection, collation, analysis and use.
- Figures out specific strategies and tools to stimulate informed decision making.
- Organizes the various M&E activities that must take place for M&E to be truly successful in the health sector.
- Engages relevant stakeholders in the health sector to ensure M&E integration into all programmes.

6.4. NHRHSP 2021-2025 Core Indicators

Data for tracking and evaluating NHRHSP 2021-2025 implementation will be drawn from administrative and programme reports, facility assessments and population-based surveys. Table 19 lists the sources and tools for data collection for tracking NHRHSP 2021-2025 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 20 presents strategies to address common data limitations that may impinge effective monitoring of the NHRHSP 2021-2025 implementation.

The Monitoring and Evaluation teams will take full responsibility for overseeing the implementation of the Plan over the entire Strategic Planning period. They will continuously monitor and evaluate all strategies, activities and outcomes with a view to advising HRH branch on the implementation status as well as offer feasible policy and strategy alternatives. This will be done on quarterly basis using the AOPs 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 branch will be required to keep records of the lessons learnt during implementation of the Plan and, to the largest extent possible, ensure this information is available on real-time basis. A system of disseminating the lessons learnt to users will be developed as part of the M&E Strategy. The M&E teams, as part of their overall M&E 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 reviews and mid-term review will also be carried out. The implementation matrix will help track and monitor progress in the implementation of the Plan.

Table 16: Indicators to be tracked in monitoring NHRHSP 2021-2025

Focus one: HRH Leadership and Governance
Strategic Objective: **Strengthen HRH governance, stewardship, and accountability**
• Number of States with functional HRH units
• Number of states with HRH planning budget lines in the hHealth sector budgets
• Number of States implementing HRH policies and strategic plans
• Number of States that have harmonized annual HRH Operational Plans
• Percentage of states submitting annual HRH reports
• Percentage of states with funding for HRH development utilizing PPP
Focus two: HRH Education and Regulation
Strategic Objective: **Ensure the production of adequate numbers of qualified health workforce**
• Percentage of health training institutions accredited by the relevant regulatory bodies
• Percentage of States with health worker production matching identified needs
• Number of new HRH training initiatives being actively implemented
• Number of States implementing evidence-based gender-sensitive strategies to inform enrolment, retention and management of health workers
• Number of states 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 HRHIS and Registry**
• Number of states with health workforce registries linked to the NHWR
• Percentage of federal DAPs and states regularly updating HRH information in the NHWR
• Number of annual HRH profiles published at national and state levels
• Proportion of HRH researches conducted based on national priorities
• Proportion of research used to inform decisions to improve HRH development, planning and management at national and state levels
Focus four: HRH management
Strategic Objective: **Optimize the recruitment, utilization, retention and performance of the available health workforce**
• Number of states implementing evidence-based the health workers retention policy and/or strategies
• Number of states with competency-based job description for health workers
• Number of states implementing performance management systems based on health and HRH priorities
• Number of States implementing adapted TSTS policy
Focus five: HRH Coordination and Partnership
Strategic Objective: **Strengthen coordination and partnership for HRH**
• Number of states with validated joint annual PPP HRH plan
• Number of States with functional mechanisms for coordination of stakeholders in order to

facilitate policy dialogue

Data Quality Issues	Actions Taken or Planned to Address this Limitation

• Number of national HRH consultations/ policy dialogues/ conferences held

6.5. Sources and data collection methods for the NHRHSP 2021-2025

Table 17: Sources, methods and limitations for data collection on NHRHSP

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 stock of health workers by cadre, location etc. fo	HRH branch/units/ desk officers at FMOH, Federal 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 human resources for health including availability, skill mix, distribution etc.	HRH branch/units/ desk officers at FMOH, Federal MDAs, SMoH, SPHCDA etc.	Periodic	Inadequate 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 State health sector	Programme/project reports	Routine	Variable timeliness and limited dissemination

Table 18: Data Quality issues and suggested suggested actions

Data Inconsistency Data are inconsistent when the value of the data is not the same across applications and systems such as contradictions in numerical count of Midwives in Cross River Health Service	The use of data definitions, extensive training, standardized 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 trainings 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- 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 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 number; 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 M&E coordination meetings monthly or quarterly will be put in place to address data quality issues and discrepancies noticed. A quarterly feedback to MDAs and LGAs will be done by the National M&E team.
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 analyze 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 integration of systems. 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 precise 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 19: Strategic Objective one Indicator Matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2021	2022	2023	2024	2025
Intervention 1.1.1: Institutionalize the HRH units and equip them with qualified, skilled, competent, and motivated staff in their adequate numbers	Number of States with functional HRH units	National	Input	Annual Report	Annual	FMOH	34	36	37	37	37	37
	• Number of states with HRH planning budget lines in the Health sector budgets	National	Input	Annual report	Annual	FMOH	18	23	26	29	32	37
Intervention 1.1.2: Improve capacity for HRH planning and reporting functions at all levels	• Number of States implementing HRH policies and strategic plans	National	Input	Annual Report	Annual	FMOH	18	23	28	33	37	37
	• Number of States that have harmonized HRH Annual Operational Plans	National	Output	Annual Report	Annual	FMOH	2	23	28	33	37	37
	• Percentage of states submitting annual HRH reports	National	Output	Annual Report	Annual	FMOH	0%	20%	50%	70%	100%	100%
Intervention 1.1.3: Strengthen sustainable mechanisms for funding HRH planning adequately at National and sub-national level	• Percentage of states with funding for HRH development utilizing PPP	National	Output	Annual Report	Annual	FMOH	0%	20%	30%	55%	65%	80%

Table 20: Strategic Objective two Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2021	2022	2023	2024	2025
Intervention 2.1.1. Strengthen the quality assurance process for HRH training institutions.	• Percentage of health training institutions accredited by the relevant regulatory bodies	National	Output	Accreditation Report	Annual	FMOH	55%	65	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	• Percentage of States with health worker production matching identified needs	National	Output	Annual Report	Annual	FMOH	0%	15%	20%	35%	50%	60%
	• Number of new HRH training initiatives being actively implemented	National	Output	Annual Report	Annual	FMOH	2	2	4	5	6	6
Intervention 2.1.3. Improve production of health workforce taking into account gender dynamics and skill mix for service delivery.	• Number of States implementing evidence-based gender-sensitive strategies to inform enrolment, retention and management of health workers	National	Output	Annual Report	Annual	FMOH	9	10	12	15	17	20
	• Number of states with appropriate skill-mix of HRH at all levels of care based on evidence	National	Output	Annual Report	Annual	FMOH	0	10	15	20	25	30

Table 21: Strategic Objective three Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2021	2022	2023	2024	2025
Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2021	2022	2023	2024	2025
	• Percentage of federal DAPs and states regularly updating HRH information in the NHWR	National	Output	Activity report	Quarterly	FMOH	0%	40	60	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 national and state levels	National	Output	Activity report	Annually	FMOH	0	5	15	26	33	38
Intervention 3.1.3 Improve HRH research for data-driven decision making	• Percentage of HRH researches conducted based on national priorities	National	Output	Research report	Annually	FMOH	0%	10%	20%	40%	70%	90%
	• Percentage of research used to inform decisions to improve HRH development, planning and management at national and state levels	National	Output	Activity report	Annually	FMOH	0%	10%	20%	30%	50%	60%

Intervention 4.1.1 Promote evidence-based recruitment, deployment and retention of HWs at all levels of care	• Number of states implementing the health workers retention policy	National	Output	Annual Report	Annual	FMOH	9	12	17	22	27	30
Intervention 4.1.2 Improve HRH performance management systems at all levels	• Percentage of states with a competency-based job description for health workers	National	Output	Annual Report	Quarterly	FMOH	0	1	5	10	15	25
	• Number of states implementing performance management systems based on appropriate job description	National	Output	Annual Report	Annual	FMOH	0	35	65	70	80	85
Intervention 4.1.3 Strengthen the task shifting and task sharing implementation with required guidelines	• Number of States implementing adapted TSTS policy	National	Output	Annual Report	Annual	FMOH	24	27	30	32	34	36

Table 22: Strategic Objective four Indicator matrix

Table 23: Strategic Objective five Indicator matrix

Strategic Interventions	Indicator	Indicator Type	Indicator Level	Data Source	Freq. of collection	Organization Responsible	Baseline	Milestones/Target				
								2021	2022	2023	2024	2025
Intervention 5.1.1 Strengthen partnership for HRH programs and activities	• Number of states with validated joint annual PPP HRH plan	National	Output	Annual Report	Annual	FMOH	0	5	8	13	20	25
Intervention 5.1.2 Strengthen coordination of stakeholders (public, private, regulatory, professional associations and development partners) at all levels	• Number of States with functional mechanisms for coordination of stakeholders in order to facilitate policy dialogue	National	Output	Meeting report	Quarterly	FMOH	0	5	8	13	20	25
	• Number of national HRH consultations/ policy dialogues/ conferences held	National	Output	Meeting Report	Quarterly	FMOH	0	1	2	2	2	2

6.7. Implementation Arrangements for the M&E Plan

6.7.1. Data Management

Data flow will be aligned with the existing national data management systems. Data collection for tracking the progress of the plan will be based on the specific indicators. For purposes of this M&E Plan:

Data collection refers to the process of gathering data that are generated from various activities relevant to the NHRHSP 2021-2025 and its M&E Framework. This involves obtaining data from original sources and using tools (paper or electronic) to collate, analyze, and report the data. Data can be collected using questionnaires, interviews, observations, and existing records.

Data collation is the process of combining data into summarized (often standardized) formats. This can be done electronically or manually and at a different level (MDA and States).

Data analysis is the review and manipulation of data depending on the type of data and the purpose. This might include application of 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**).

6.7.2. 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 standardized or updated data reporting tools
- Low reporting rates from the private health sector
- Significant data quality gaps as measured through DQAs
- Delayed and incomplete financial data reporting
- Inadequate number and capacity of M&E and HRHIS 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 HRHIS

These gaps will be addressed effectively in order to meet the NHRHSP 2021-2025 vision of a competent, gender responsive and motivated Health Workforce for attainment of UHC. Identifying and managing potential risks to the quality of data collected and information used is of utmost importance to the successful implementation of NHRHSP 2021-2025. Strategies to address common limitations in data management are outlined in tables 19 and 20 of this M&E Plan.

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

Data analysis and synthesis will be done to enhance evidence-based decision-making. All relevant data will be synthesized based on determined parameters (disaggregated) where applicable and analyzed for use at various levels of the sector. The results obtained will be summarized into a consistent assessment of the health situation and trends, using key sector performance indicators and targets to assess progress and performance.

Basic indicator information shall be presented as the national average achievement obtained from collating all the available information from all reporting units into the state level figures and thereafter consolidate the national figures.

Sub analyses of the indicator information shall be carried out to provide information on the impact of multi-dimensional poverty on actual coverage, health status and financial risk protection achievements. This shall enable better targeting of strategies to address the multi- dimensional poverty issues impacting on the results being sought.

Routine internal data quality assurance exercises will be carried out as part of M&E routine activities so as to consistently ensure the quality of program data reported. The quality assurance system and data management will include:

- Internal Data Quality Assurance check at the level of data collection
- External Data Quality Assurance check conducted by the D(H)PRS in the FMOH and implementing partners
- Regular feedback for quality improvement

Regular data records review and periodic DQA processes are necessary core M&E

routine activities designed to consistently ensure the quality of reported program 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 DQA should be done on a regular basis and the results should be published at all levels.

6.7.3. HRH Data Governance Arrangements

This is a statutory function of the FMoH 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 branch at the FMoH level is ideally responsible for supervising and monitoring progress of the development of tools and state level implementation of HRH policies and plans. This is seldom done due to financial and logistical challenges

Monitoring, follow-up and control systems needs to be institutionalized at all levels. These will include periodic review meetings, regular review of the budget systems and development of progress reports.

6.7.4. Monitoring and Reviewing NHRHSP2021-2025 Implementation

The implementation of the NHRHSP 2021-2025 will be routinely monitored, reviewed and evaluated to track progress in achieving the set objectives and targets. The purpose of the NHRHSP 2021-2025 **evaluations** is to improve the effectiveness of the NHRHSP `P2021-2025 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 emphasis being 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 (VfM), impact and sustainability of service delivery in line with the Development Assistance Committee (DAC) criteria for evaluation.

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

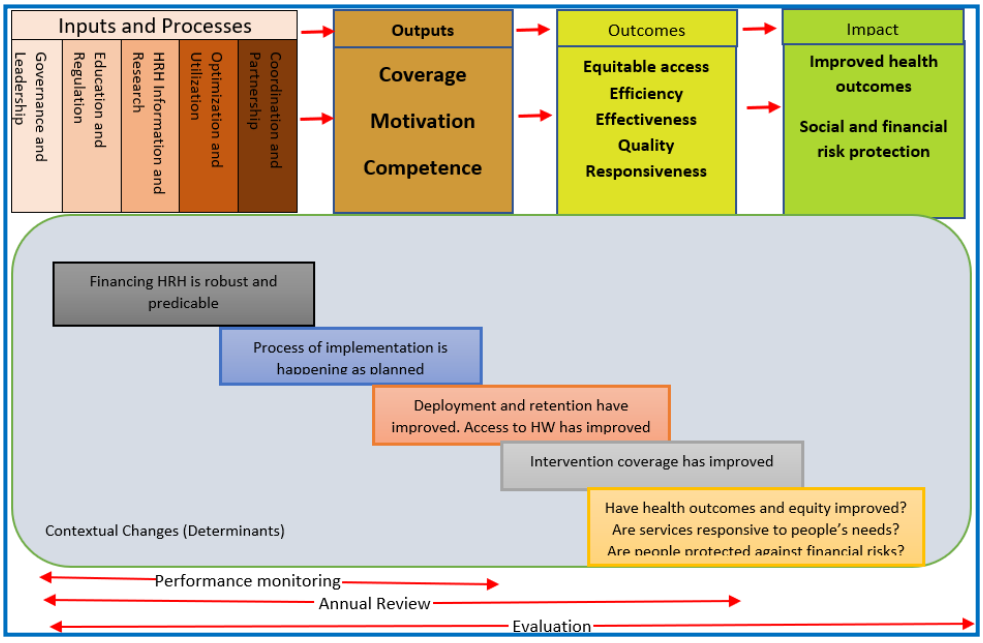


Figure 10: Key assumptions underpinning the M&E process

Table 24: Methodology and frequency of carrying out M&E

Methodology	Frequency	Output	Focus	Level of monitoring 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 implmentation of the NHRHSP 2021-2025	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 NHRHSP 2021-2025	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 realization 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 and weak governance and even IT risks.

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

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

v. **Financial risk** would emanate from failure to either mobilize adequate funds or lack of prudence in financial resource utilization 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 25: Risk analysis

Classification	Anticipated Risk	Mitigation Measures
Strategic Risks	Failure to realize HRH's mandate	• Develop operational plans to guide realization of the HRHSP • Aligning the vision, mission and strategic objectives to • to NHSDP III 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 stakeholder good will • 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/branches • Retain, retrain and motivate current staff • Acquire more physical assets such as computers &office space • Mobilize financial resources to support the HRH agenda
	Low awareness of HRH roles, achievements and services to MoH	• 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 optimized 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 specialized staff, skills gaps and low motivation/morale	• Staff motivation • Staff sensitization 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 branch/offices leading to unrealistic expectations	• Awareness creation on mandate and plans • 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 M & E in collaboration with the M&E team at FMoH and states
Financial Risks	Inadequate financial resources and over reliance on donor funding	• Use policy guidelines in the Proper budgeting and development of resource mobilization strategy through initiatives like • diversification of financial streams
	Inadequate and inequitable resource allocation	• Prioritization of resource allocation on the basis of the • implementation matrix • Continuous review of the Plan to ensure resource • allocation for prioritized 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: NATIONAL HRH TECHNICAL WORKING GROUP MEMBERS

S/N	NAME	ORGANISATION	DESIGNATION
1.	Dr. Emmanuel Meribole	FMoH	Director, Health Planning, Research and Statistics (Previous)
2.	Dr. Ngozi Azodoh	FMoH	Director, Health Planning, Research and Statistics (Current)
3.	Shakuri Kadiri	DHPRS, FMoH	Deputy Director, Head/HRH
4.	Barr, Nna Ogbonna	DHPRS FMoH	Head NGO DHPRS
5.	Dr. Sunny Okoroafor	WHO	NPO HSS/HRH
6.	Oluseyi Olujimi	The Carter Center	M&E Officer
7.	Ifeyinwa Onwudinjo	NPHCDA	Deputy Director (HRH)
8.	Aduagba.U. Bolaji	DHPRS FMoH	Chief Scientific
9.	Olugbenga Olubayode	DHPRS FMoH	SPPO/HRH
10.	Adijat Elijah	FMoH	Program officer
11.	Helen Oduntan	NBTE	Director Monotechnic Prog
12.	Oluseyi Abejide	Save The Children	Advocacy Manager
13.	Francis Duru	MSH GF- RSSH	Senior Meal Advisor
14.	Ikechebelu Adaobi	DHPRS /M&E	Scientific officer
15.	Dr. Oyeniyi Samuel	FMoH /DFH	Deputy Director
16.	Akinwunmi Akintan	NCDC	HRM (NCDC)
17.	Gbebikan Adewunmi	Dental Therapist Reg Board of Nig	Snr, Ex. Officer PRS HRH
18.	Dr. Blessing.G. Ebitodaghe	Nig, Center for Disease Control	Research Trainig & Knowledge Managent
19.	Michael Ojo Rita Ejemeare	ICCON	Assit, Director Corporate and Protocol
20.	Anajoku Kesiena joyce	Fed Civil Service Commission	Senior Admin Officer
21.	Dr. Adaeze Okonkwo	DSP	Assistant Director
22.	Dako Hadiza	FMoH	CPPO HRH
23.	Kazim Efobi Chigozie	FMoH	SSO HRH
24.	Bosun Fasulu	FMoH	PAO HRH
25.	Ali Ahmed Gubio	FMoH	SO SP
26.	Dr. Akin Oyemakinde	MNCH2	STA
27.	Mrs. Ismail Fatima	Nursing Div. FMoH	Nursing Officer
28.	Dr. Nneka Orji Achugo	FMoH	TA -HMSH
29.	Olu Adeboyejo Yetunde	SAO FMOH	SAO
30.	Pharm Ibrahim Babashehu Ahmed	PCN	DPRS
31.	Adeoye Elizabeth	FME	Deputy Director
32.	Dr. Babatunde Adelekan	UNFPA	NPA
33.	Olawale Ayoade	FMoH	PEO II
34.	Ajala Yunusa	FMOH	HEO

ANNEX 2: PARTICIPANTS AT NATIONAL VALIDATION

NAME	ORGANIZATION	DESIGNATION
1. Dr Ngozi Azodoh	FMoH	Director, Health Planning, Research and Statistics
2. Bilyaminu Aliyu	Borno	DPRS
3. Jimin Simon	Benue	DPRS
4. Amusa T. Ayodele	Oyo	Rep. DPRS
5. Solomon Angyu Daudu	Taraba	DPRS
6. Ibrahim Z. Bakut	Kaduna	DPRS
7. Dr. Stephen John	Adamawa	DPRS
8. Yusuf H. Abubakar	Jigawa	DPRS
9. Olomiete A. Beatrice	Bayelsa	DPRS
10. Bawale Muhammed	Kebbi	DPRS
11. Auwal Muhammad M.	Sokoto	Rep. DPRS
12. Dr. Chika Nwawkwo	Ebonyi	Rep. DPRS
13. Bitrus B. Ngaruru	Yobe	Rep. DPRS
14. Nura AbdulKadir	Zamfara	Rep. DPRS
15. Ajayi Balogun	Ekiti	DPRS
16. Dr. Peter Inyang	Akwa Ibom	DPRS
17. Aiyedogbon Johnson	Kogi	DPRS
18. Oguejiofor Anna	Enugu	DPRS
19. Felicie Ayila Torunese	Kwara	Rep. DPRS
20. Dr. O. J. Kusimo	Ogun	DPRS
21. Dr.Ejiro Ogheneaga	Delta	DPRS
22. Pharm Hamza T. Yahaya	Niger	DPRS
23. Abdu Usman	Gombe	DPRS
24. Dr. Angela O. Ifeanacho	Abia	DPRS
25. Nwafor Chibuzor	Anambra	DPRS
26. Jibrin Habu	Kano	DPRS
27. Dashe N. Rimmon	Plateau	DPRS
28. Dr. Isiaka A. Adekunle	Osun	DPRS
29. Dr. Ibrahim S. A	FCT	DPRS
30. Dr. Akanle Olufunke	MRTRBN	Registrar
31. Gbebikan Adewunmi J.	DTRBN	Rep Registrar
32. Abdulsalam A. Duro	IPAN	Rep. Registrar
33. Sani Umaru	HRORBN	Rep. Registrar
34. Ruth Atuluku	MDCN	Rep. Registrar

35. Michael Ojo Rita	ICCON	Rep. Registrar
36. Ejimofor Malachy	RRBN	Rep. Registrar
37. Dr. Akinwale Akinlabi	MLSCN	Rep. Registrar
38. Daramola Adeola	EHORECON	Rep. Registrar
39. Garba Danlami	EHORECON	Rep. Registrar
40. Hassan Yusuf	PCN	Rep. Registrar
41. Anthony Ekaba	ODORBN	Rep. Registrar
42. Nwajuaku Kosy	ODORBN	Rep. Registrar
43. Idris Ahmad Bappah	DTRBN	Rep. Registrar
44. S.B. Ogundele	CHPRBN	Rep. Registrar
45. Aransiola A. Modupe	Kwara	HRH FP
46. Olatunji Ojo Adenike	Ekiti	HRH FP
47. Adelowo B. Tinuola	Oyo	HRH FP
48. Bashir Mohammed	Borno	HRH FP
49. Oyigbenu Naomi Eyimeshi	Nassarawa	HRH FP
50. Joshua Abigail	Bayelsa	HRH FP
51. Okoro Onyebuchi	Enugu	HRH FP
52. Haruna Adamu	Kaduna	HRH FP
53. Garkumyetiya R. Umar	Taraba	HRH FP
54. Muhammad Awwal Umar	Sokoto	HRH FP
55. Emmanuel Y. Zira	Adamawa	HRH FP
56. Anweh Stephanie	Benue	HRH FP
57. Bala Isah Kamba	Kebbi	HRH FP
58. Uguru Samuel C.	Ebonyi	HRH FP
59. Abdulhamid Gambo	Yobe	HRH FP
60. Mustapha Bello	Zamfara	HRH FP
61. Godwin Archibong	Akwa-Ibom	HRH FP
62. Muhd Ahmad Umar	Gombe	HRH FP
63. Akande M. David	Kogi	HRH FP
64. Olatunji Mary A.	Ogun	HRH FP
65. Usman Abubakar	Jigawa	HRH FP
66. Akingboye Motunrayo	Ondo	HRH FP
67. Ozigbo Collins	Anambra	HRH FP
68. Chimerizim Anyaogu Grace	Abia	HRH FP
69. Haruna Adamu	Kano	HRH FP
70. Dr. Olajumoke Oyenuga	Lagos	HRH FP
71. Ekpeka Abraham Pius	Edo	HRH FP
72. Obiazor Nkiruka	Delta	HRH FP

73. Pam Victoria M.	Plateau	HRH FP
74. Ochia Hilary Odili	Rivers	HRH FP
75. Mbagwu Clifford	Fct	HRH FP
76. Kosamat Y. Adebisi	Osun	HRH FP
77. Inegbeboh Jude		HRH & Capacity Building Advisor
78. Sunny O. Philips	USAID	Technical Lead HSS
79. Dr. Chukwu Chidera	Lafiya Project	Project Officer
80. Okwudili O.	FMOH	Head, HSS
81. S. A. Kadiri	FMOH	Head, HRH
82. Ikechebelu Adaobi	FMOH	SO1
83. Kasim Efobi Chigozie	FMOH	SSO
84. Fatima Tayo A. Ismail	FMOH Nur Div	ACNO
85. Ajala Yunusa	FMOH	HEO
86. Olawale Ayoade	FMOH	PEO
87. Okoedoh Justina . O.	FMOH	SO 1
88. John Okobia	FMOH	ACAO
89. Sanni Adeniyi O.A.	FMOH	Director
90. Aduagba U. Bolaji	FMOH	CSO
91. Dr. Sunny Okoroafor	WHO	NPO HSS/HRH – Technical Assistance
92. Dr. Mollent Okech		Consultant
93. Dr. David Olayemi		Consultant
94. Dr. Emeka Nsofor		Consultant

ANNEX 4: NATIONAL HRHSP 2021-2025 COST SUMMARY

OBJECTIVES & STRATEGIES	TOTAL COST PER ANNUM					GRAND TOTAL (₦)	% OF TOTAL COST
	YEAR 1 COST (₦) (2021)	YEAR 2 COST (₦) (2022)	YEAR 3 COST (₦) (2023)	YEAR 4 COST (₦) (2024)	YEAR 5 COST (₦) (2025)		
Obj. 1) Strengthen governance, stewardship and accountability of the health workforce	**79,111,000**	**69,077,000**	**46,344,000**	**46,469,000**	**54,769,000**	**295,770,000**	
Strategies 1.1.1: Institutionalize the HRH units and equip them with qualified, skilled, competent and motivated staff in their adequate numbers	24,867,000	28,908,000	6,300,000	6,300,000	15,850,000	82,225,000	
Strategies 1.1.2: Improve capacity for HRH planning and reporting functions at all levels	6,925,000	2,350,000	2,325,000	2,350,000	2,100,000	16,050,000	**29%**
Strategies 1.1.3: Strengthen sustainable mechanisms for funding HRH planning adequately at National and subnational levels	15,050,000	9,800,000	9,750,000	9,800,000	9,300,000	53,700,000	
Strategies 1.1.4: Strengthen mechanisms for HRH oversight on the private health sector	32,269,000	28,019,000	27,969,000	28,019,000	27,519,000	143,795,000	
Obj. 2) Ensure the production of adequate numbers of qualified health workers	**40,199,160**	**40,199,160**	**40,199,160**	**40,199,160**	**40,199,160**	**200,995,800**	
Strategies 2.1.1: Strengthen the quality assurance process for HRH training institutions.	38,593,160	38,593,160	38,593,160	38,593,160	38,593,160	192,965,800	
Strategies 2.1.2.: Scale up production of the health workforce to match demands/needs	1,008,000	1,008,000	1,008,000	1,008,000	1,008,000	5,040,000	**20%**
Strategies 2.1.3: Improve production of health workforce taking into account gender dynamics and skill mix for service delivery.	598,000	598,000	598,000	598,000	598,000	2,990,000	
Obj. 3) Enhance the functionality of Human Resources for Health Information System (HRHIS)	**280,570,300**	**11,734,000**	**17,494,000**	**11,734,000**	**11,734,000**	**333,266,300**	
Strategies 3.1.1.: Strengthen HRHIS at all levels	220,432,800	11,326,000	17,086,000	11,326,000	11,326,000	271,496,800	
Strategies 3.1.2: Establish mechanisms for annual HRH data reviews and reporting for evidence and decision making at the Federal, State and LGA levels	4,789,500	408,000	408,000	408,000	408,000	16,421,500	**33%**
Strategies 3.1.3: Improve HRH research for data-driven decision making.	45,348,000	-	-	-	-	45,348,000	
Obj. 4) Optimize the recruitment, utilization, retention and performance of the available health workforce	**125,136,000**	**7,025,000**	**7,025,000**	**11,035,500**	**7,025,000**	**157,246,500**	
Strategies 4.1.1: Promote evidence-based recruitment, deployment and retention of health workers at all levels of care	54,998,500	5,625,000	5,625,000	9,635,500	5,625,000	81,509,000	**16%**
Strategies 4.1.2.: Improve HRH performance management systems at all levels	70,137,500	1,400,000	1,400,000	1,400,000	1,400,000	75,737,500	
Obj. 5) Strengthen coordination and partnership for HRH agenda	**5,782,000**	**5,344,000**	**5,344,000**	**5,344,000**	**5,344,000**	**27,158,000**	
Strategies 5.1.1: Strengthen partnership for HRH programs and activities	1,752,000	1,314,000	1,314,000	1,314,000	1,314,000	7,008,000	**3%**
Strategies 5.1.2: Strengthen coordination of stakeholders (public, private, regulatory, professional associations and development partners) at all levels	4,030,000	4,030,000	4,030,000	4,030,000	4,030,000	20,150,000	
Total Cost (₦)	**530,798,460**	**33,379,160**	**116,406,160**	**114,781,660**	**119,071,160**	**1,014,436,600**	
Total Cost (in US$)	**$1,396,838**	**$350,998**	**$ 306,332**	**$ 302,057**	**$ 313,345**	**$ 2,669,570**	


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