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Introduction

Background and Rationale

- Maternal, newborn and child mortality rates remain persistently high in Nigeria, limiting the achievement of the SDG 3[1]
- The NPHCDA[2] through NEMCHIC[3] seeks to improve suboptimal MNCH[4] outcomes in the country by optimizing the availability of quality RMNCAH+N[5] services at PHC facilities
- To achieve this, NEMCHIC conducted a National PHC HRH Profiling and PEA across 10 BMGF States to identify and address gaps

Scope

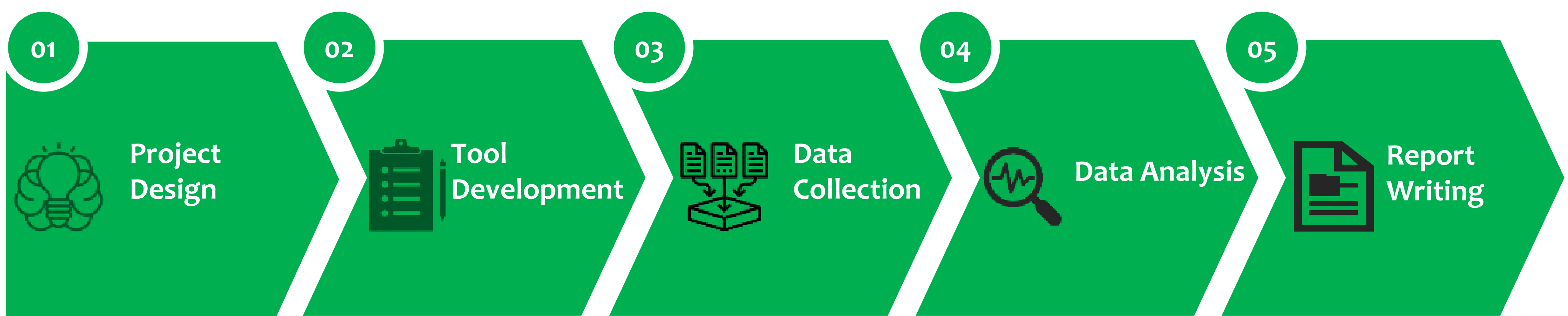
- The assessment entailed:
  - Profiling the health workforce in the primary healthcare facilities across the 10 BMGF states, to identify HRH gaps
  - Conducting a Political Economy Analysis (PEA) to understand the HRH political and economic landscape in the 10 BMGF states

The broad objectives of the assessment were to:

1. Determine the gaps in size, skill mix, and distribution of the HRH disaggregated by cadre, gender and PHCs in the 10 states
2. Ascertain the quality of the existing workforce by cadre across the PHCs and LGAs in the states
3. Assess the state's HRH production capacity
4. Identify actors and Institutions involved in PHC HRH decision-making

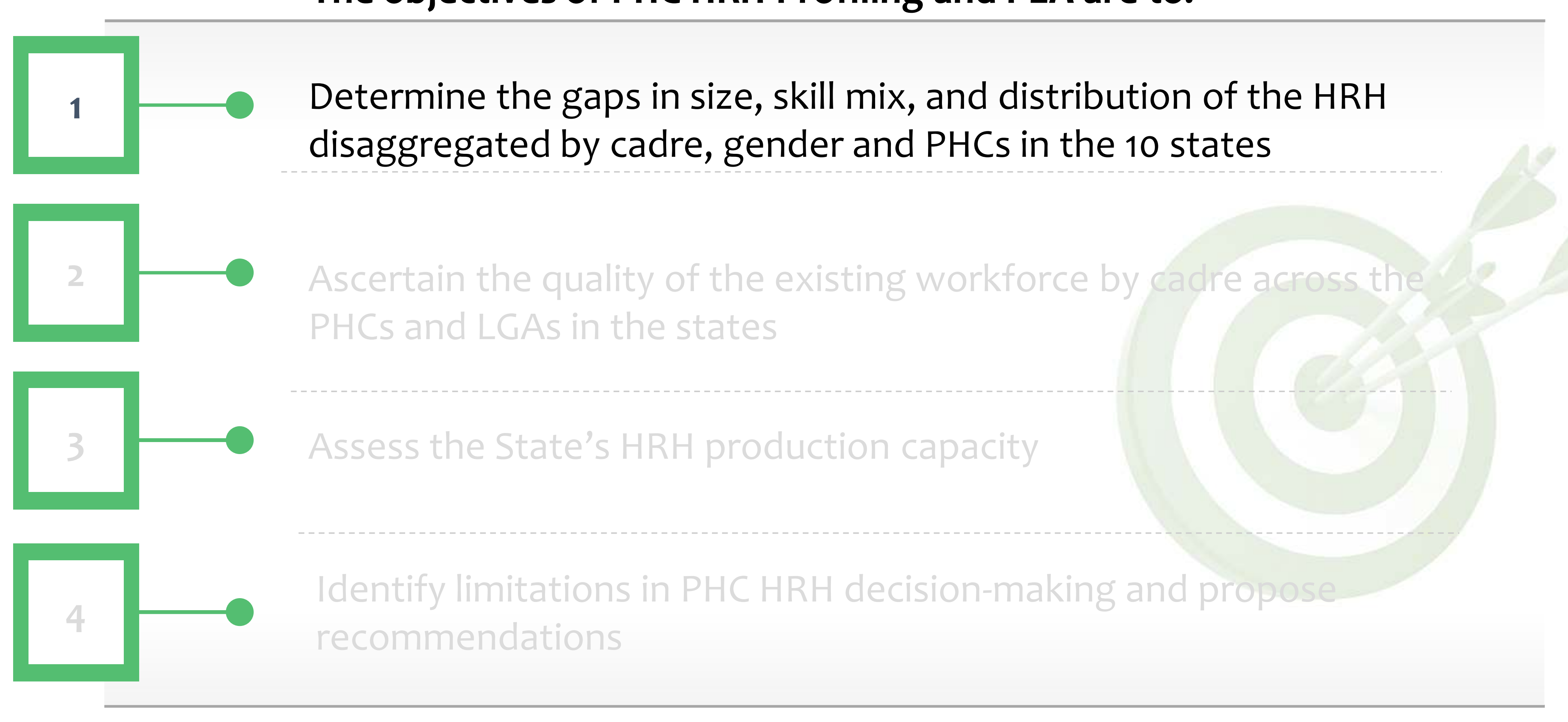
1: SGD 3: Ensure healthy lives and promote well-being for all at all ages by 2030 2: NPHCDA: National Primary Health Care Agency 3: NEMCHIC: National Emergency Maternal and Child Intervention Center 4: MNCH: Maternal, newborn and child health 5: RMNCAH+N: Reproductive, Maternal, Neonatal, Child and Adolescent Health + Nutrition

The HRH Profiling and PEA exercise was conducted using a five-step approach

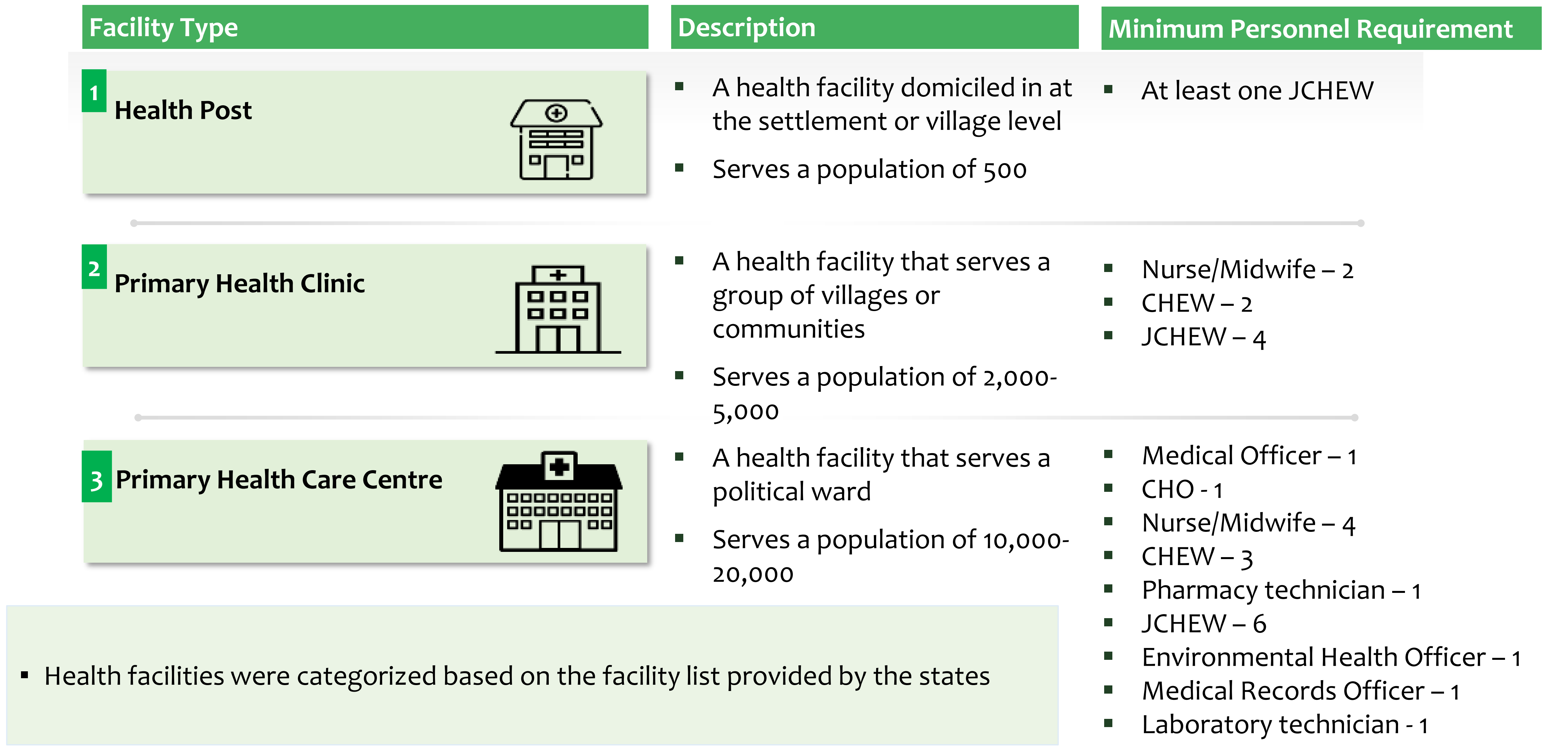


01 Project Design	02 Tool Development	03 Data Collection	04 Data Analysis	05 Report Writing
▪ Stakeholder engagement at National, State and LGA levels to obtain buy-in and approval ▪ States' categorization by status of HRH profiling, HRH tools/database availability, and existence of a functional SEMCHIC or HRH working group.	▪ Development of a draft National PHC HRH Profiling tool with all stakeholders ▪ Tool pretesting and refining across all 10 states ▪ Tool validation and adoption with feedback from all stakeholders ▪ Tool linked to an Excel-based tool for data aggregation	▪ Data collectors and supervisors engaged, trained and deployed ▪ Quantitative and qualitative data collected across all 25 LGAs ▪ Supervision and spot-check verification conducted during data collection	▪ Cleaned and analyzed quantitative data from the Excel-based tool ▪ Cleaned, transcribed, coded and analyzed audio recordings of 13 key informant interviews as qualitative data	▪ Synthesized findings from analyzed data (quant and qual) ▪ Drew insights from data and validated data with stakeholders ▪ Developed HRH Profiling and PEA report detailing findings and recommendations

Findings from this profiling exercise will be discussed across the four objectives



For reference, we used the Minimum Service Package guidelines to categorize the Health facility types in Niger State



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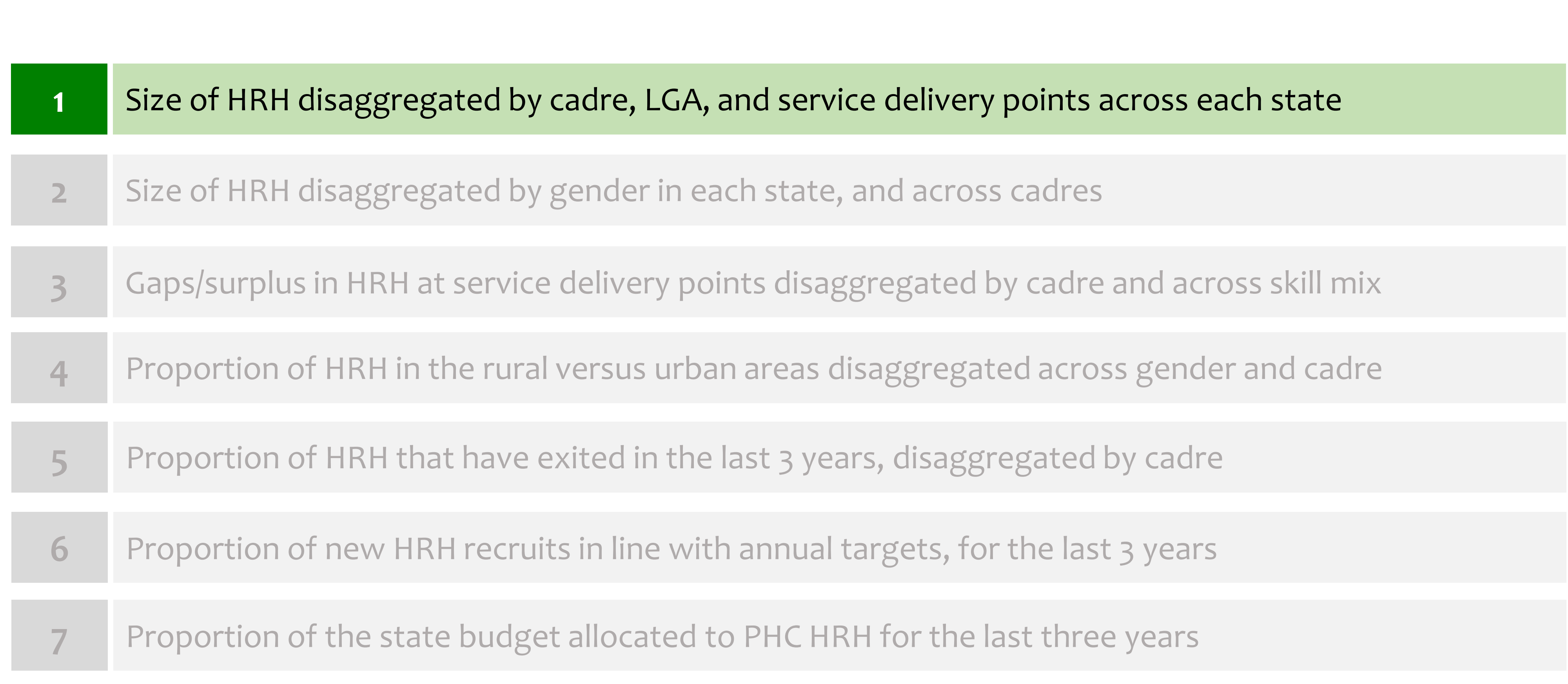

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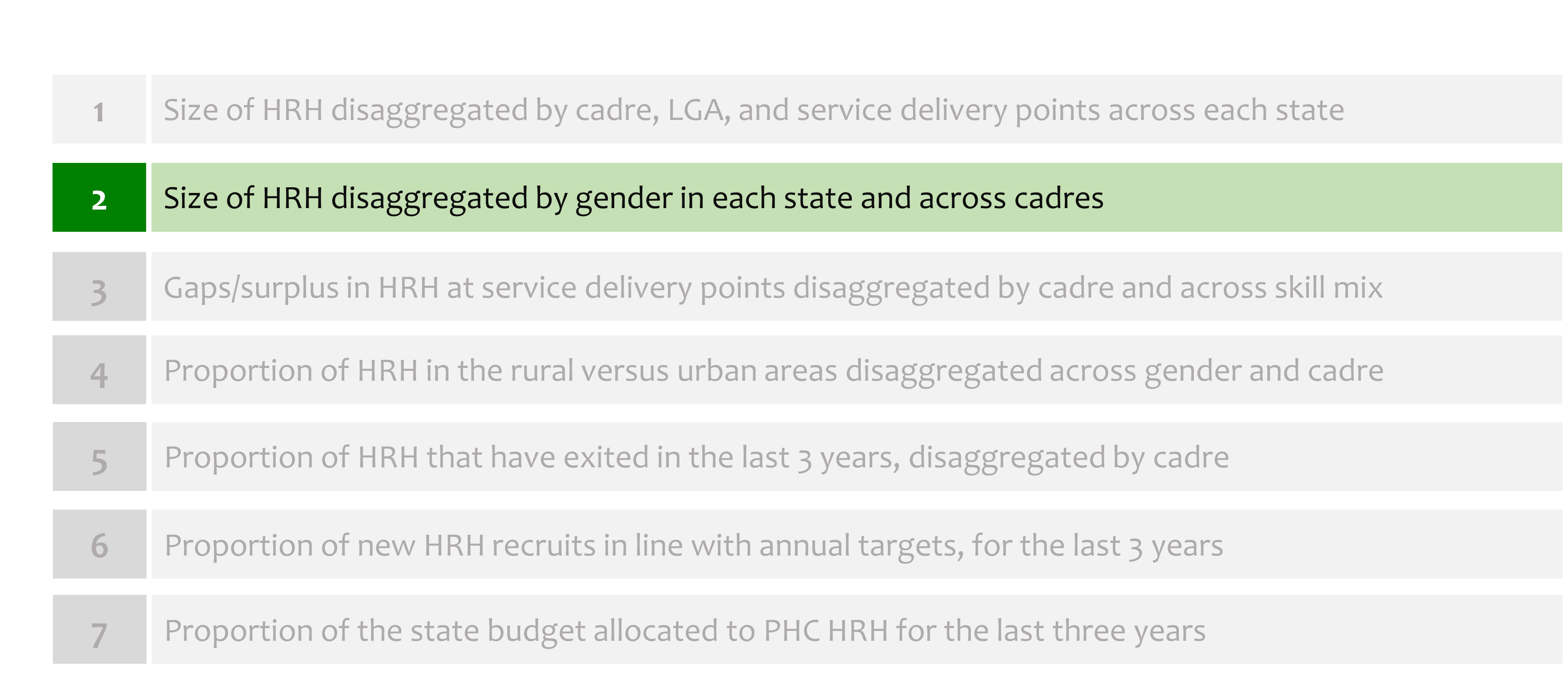

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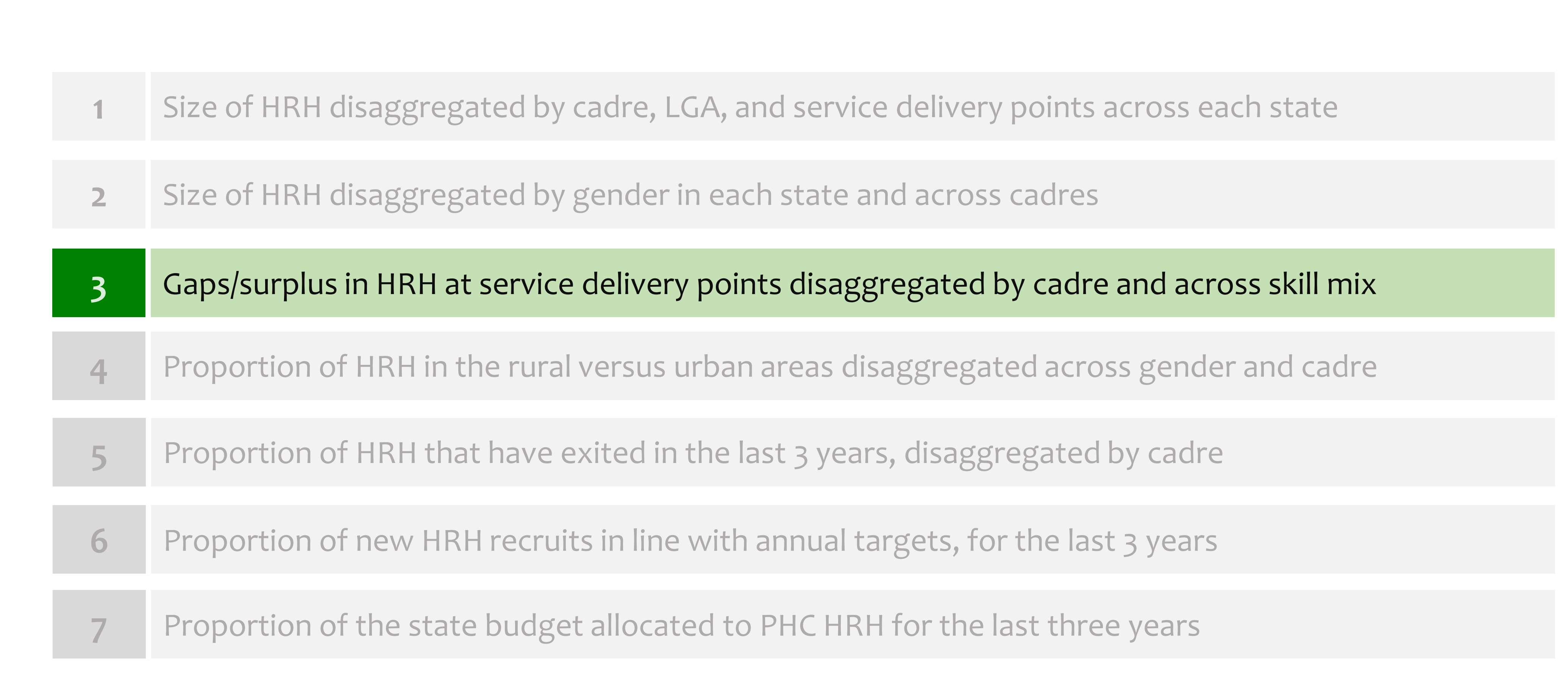

Using the PHC Minimum Standard Personnel (MSP) requirements, staffing gaps were observed on available permanent staff across all 10 HRH cadres in Niger

Surplus Gap *n = 3559*

Cadres	Required	Available Staff	Gap/Surplus
CHEW	3281	1795	1486
CHO	469	183	486
Environmental Health Officer	469	135	334
JCHEW	10310	813	9497
Laboratory Personnel	469	330	139
Medical Officer	469	3	464
Medical Records Officer	469	75	394
Pharmacy Personnel	469	15	454
Nurse/Midwife	3750	106	3644

- Huge staffing gaps existing in the Nurse/Midwife, CHEW, and JCHEW cadres that are critical to the provision of RMNCAH+N services, may bear possible negative impact on the availability of MNCH service delivery in the State
- To bridge the gaps, the State could consider more employment on a long-term scale OR upskilling other HCW cadres to perform these essential services in the interim

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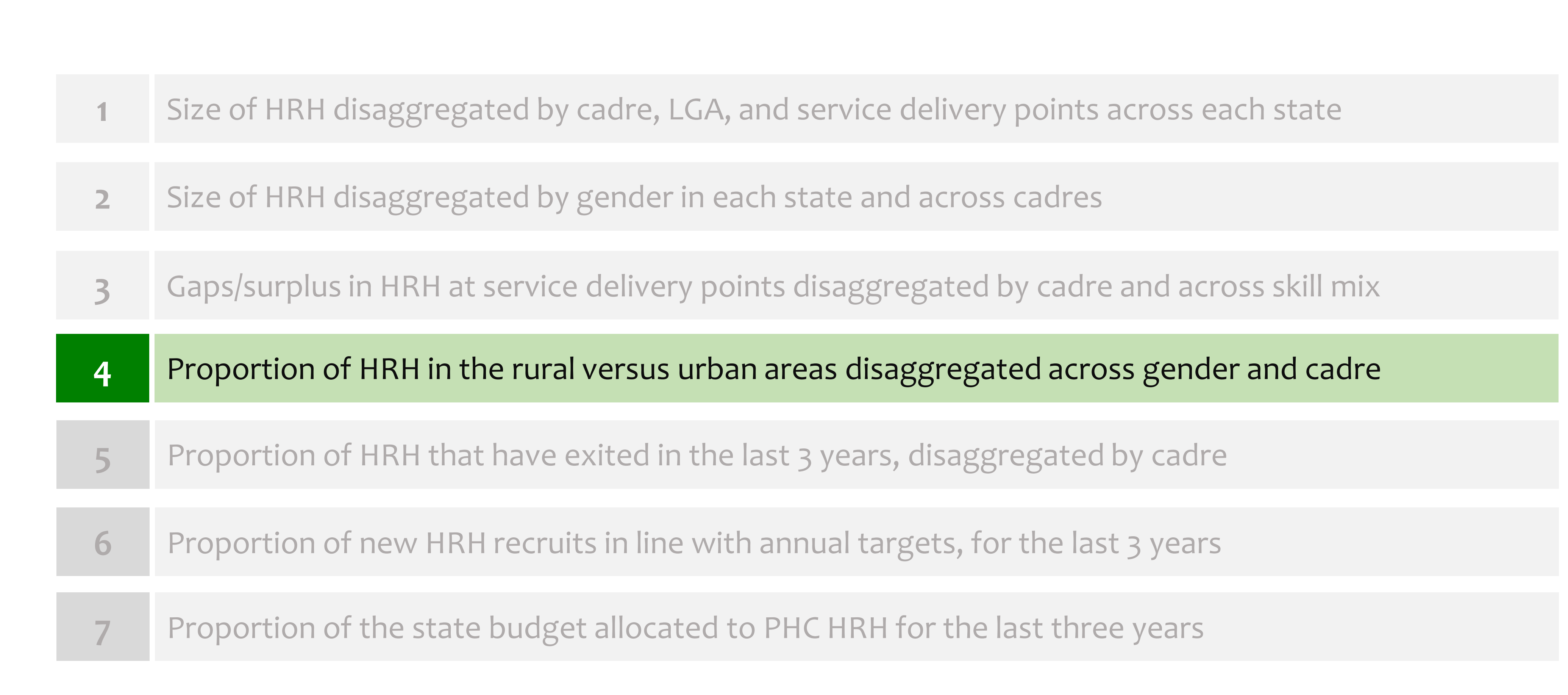

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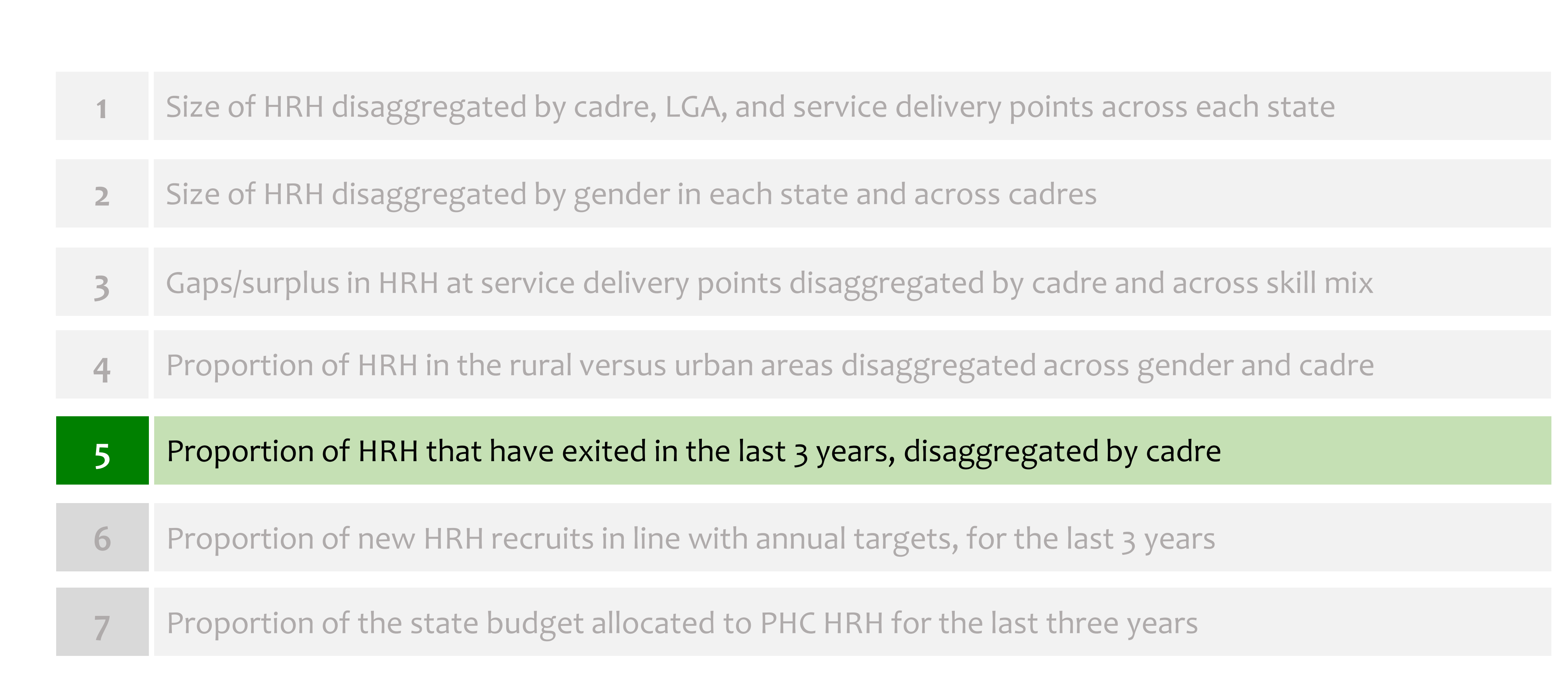

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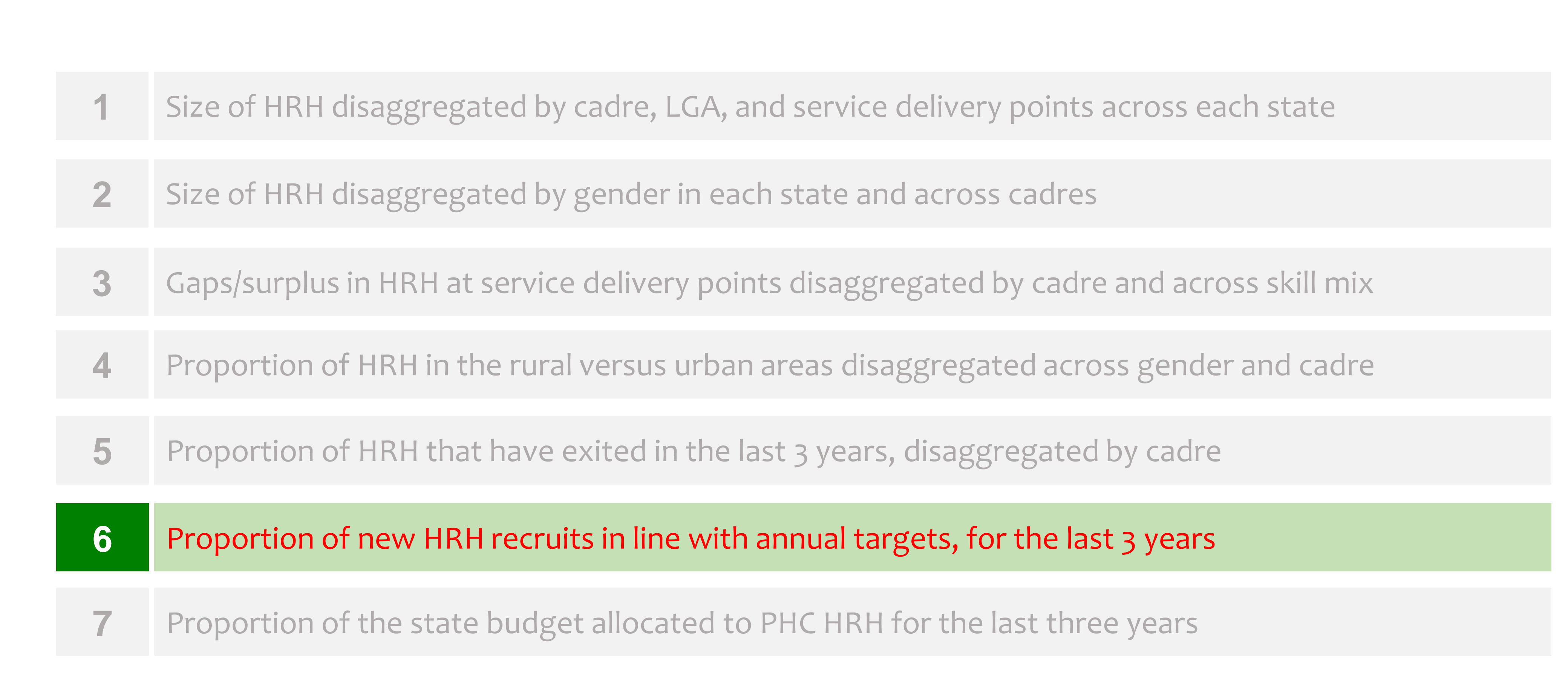

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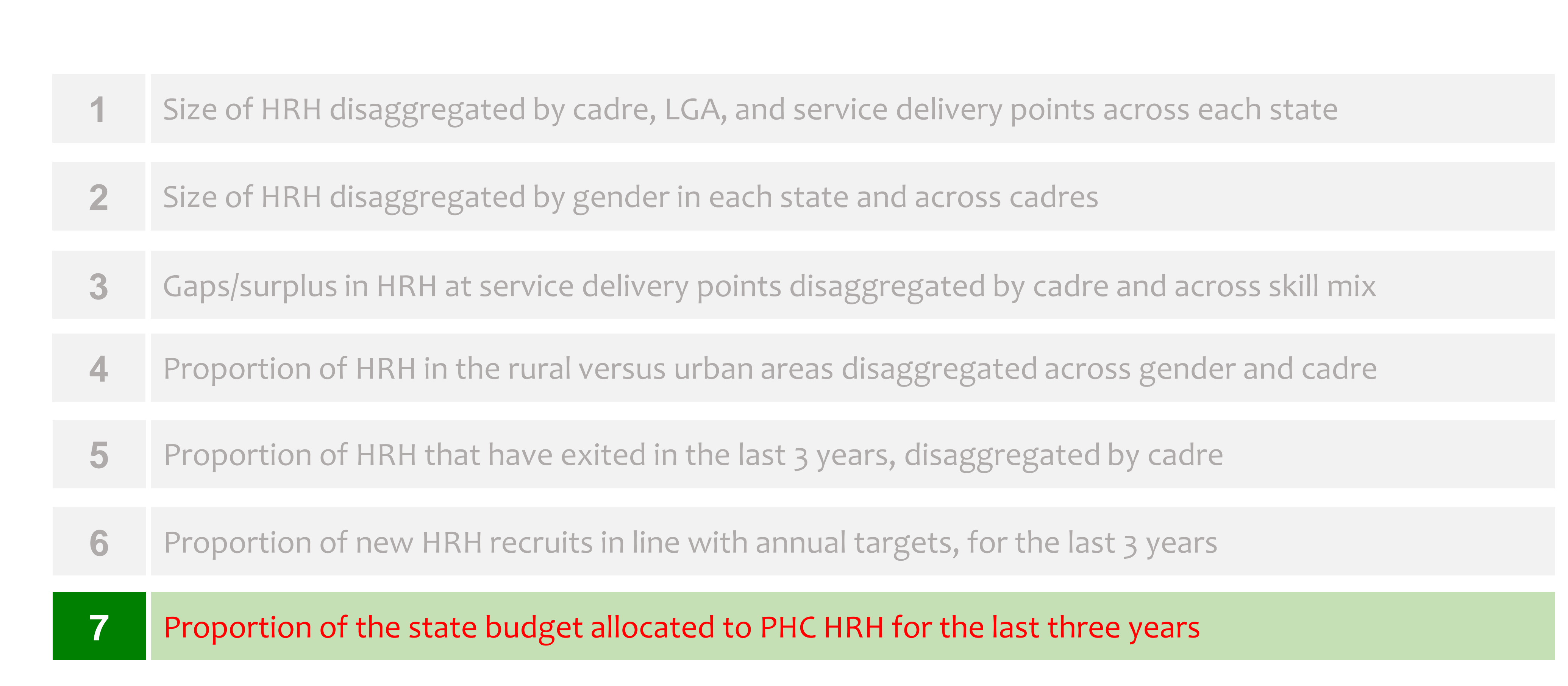
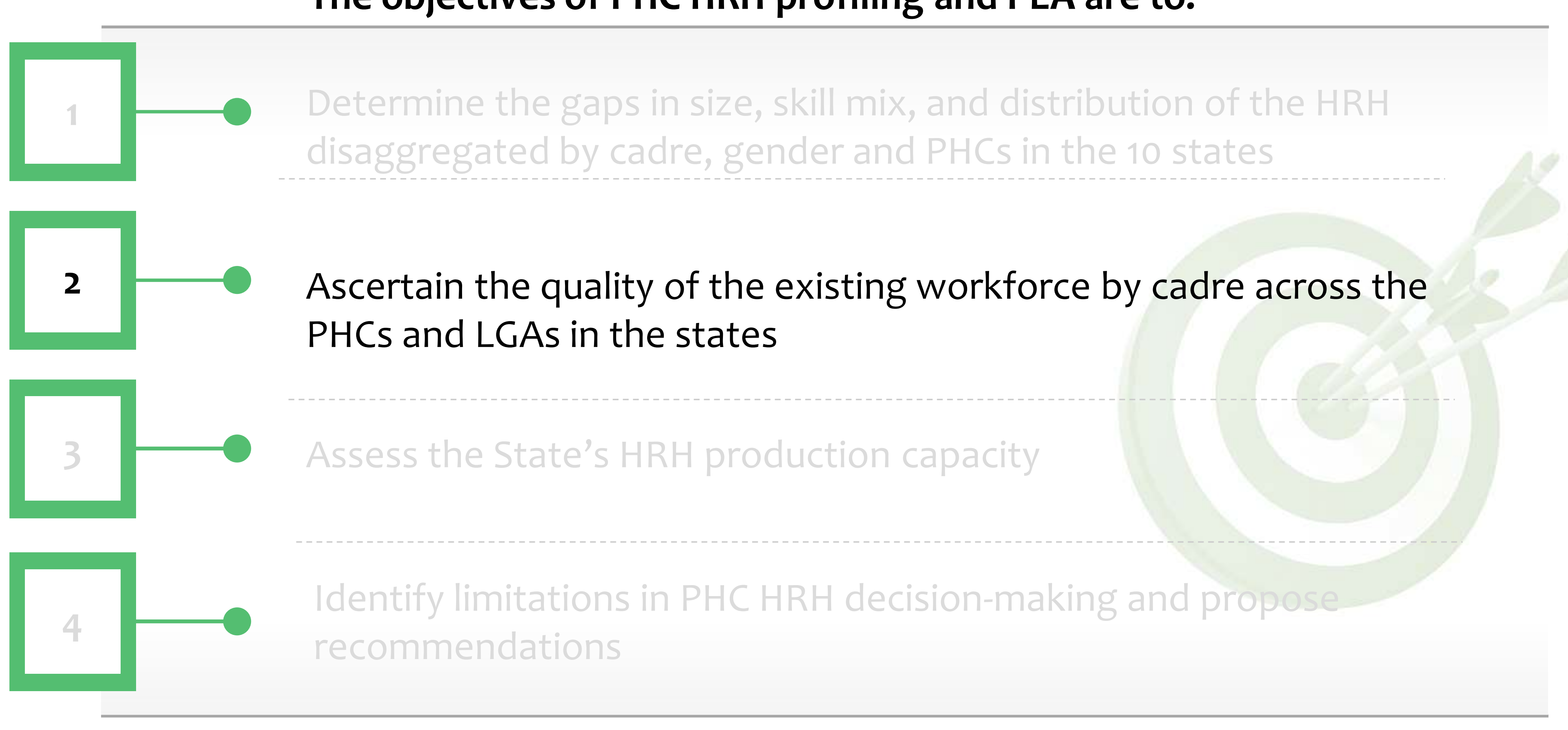


Findings from this profiling exercise will be discussed across the four objectives

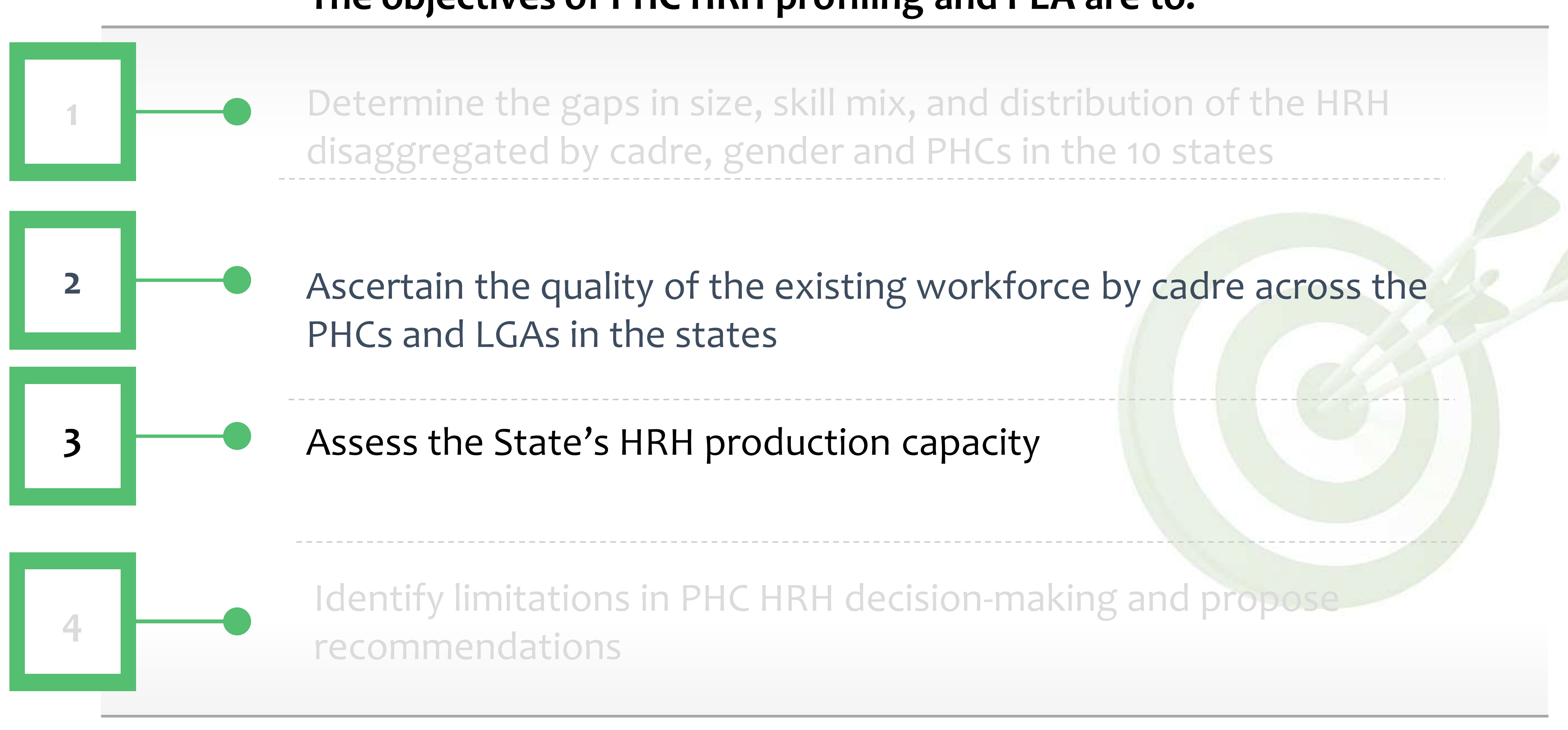


In-service training of the PHC HRH cadres were analyzed by NPHCDA's recommendation for trainings

X — Required training

	HIV	Comp Sex Edu.	Malaria	BEmONC	ENCC	FP Tech	IPC	Drug Mgt.	DHIS 2	Bookkeeping	Basic Immunization Guide	IMCI+	HMIS	CEmONC	IYCF	MLSS	LSS	PMTCT	DRF	LARC	Total
CHEW	X	X	X	X	X	X	X	X			X	X			X		X	X	X		14
CHO	X	X	X	X	X	X	X	X			X	X			X		X	X	X		14
EHO			X			`	X														2
H. Asst/H. Attd							X														1
JCHEW	X	X	X	X	X	X	X	X			X	X			X		X	X	X		14
Lab Tech	X		X				X														3
MO	X		X			X	X					X		X				X		X	8
MRO									X	X			X								3
Nurse/Midwife	X	X	X		X	X	X				X	X		X	X	X		X		X	13
Pharmacy Tech.	X		X					X											X		4

Findings from this profiling exercise will be discussed across the four objectives



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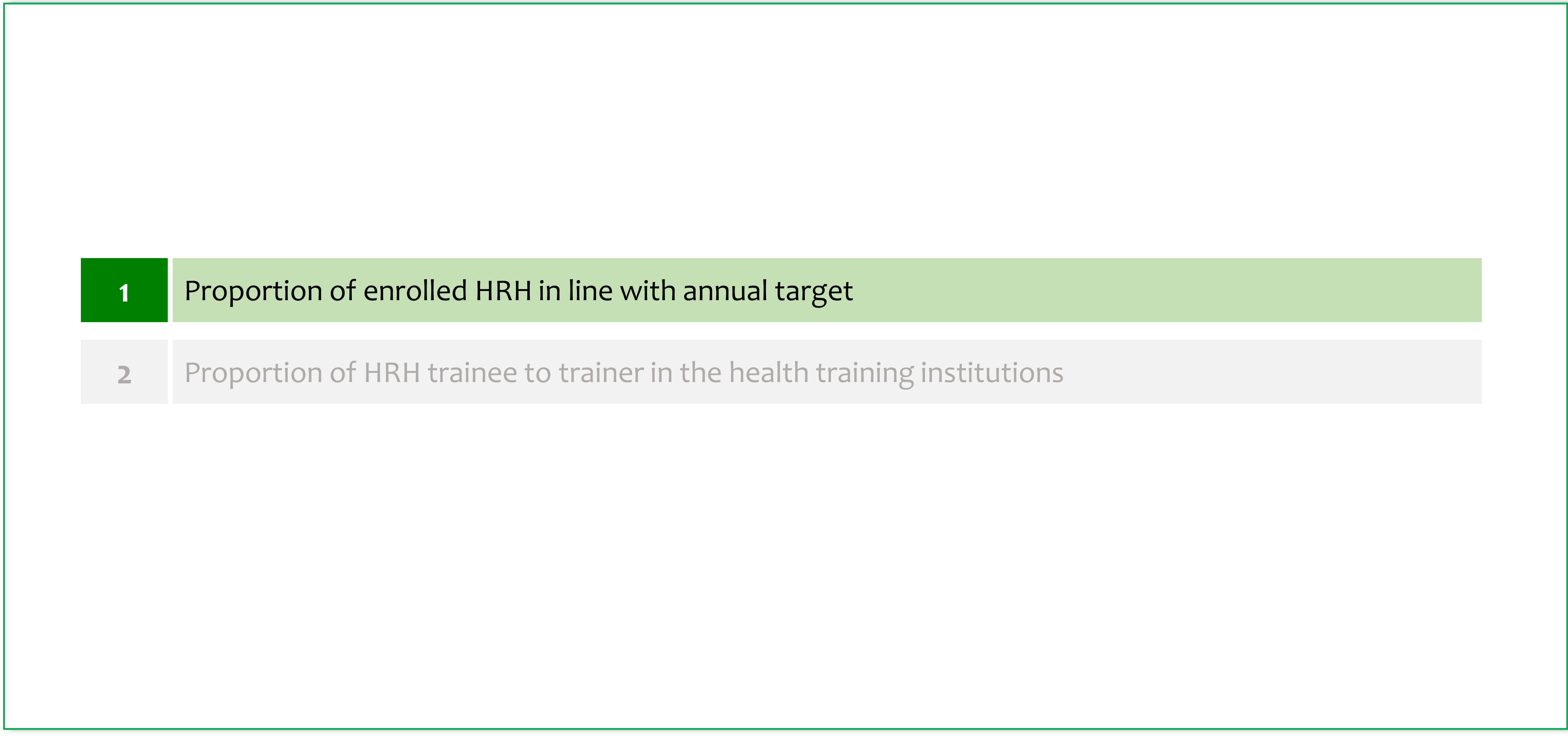

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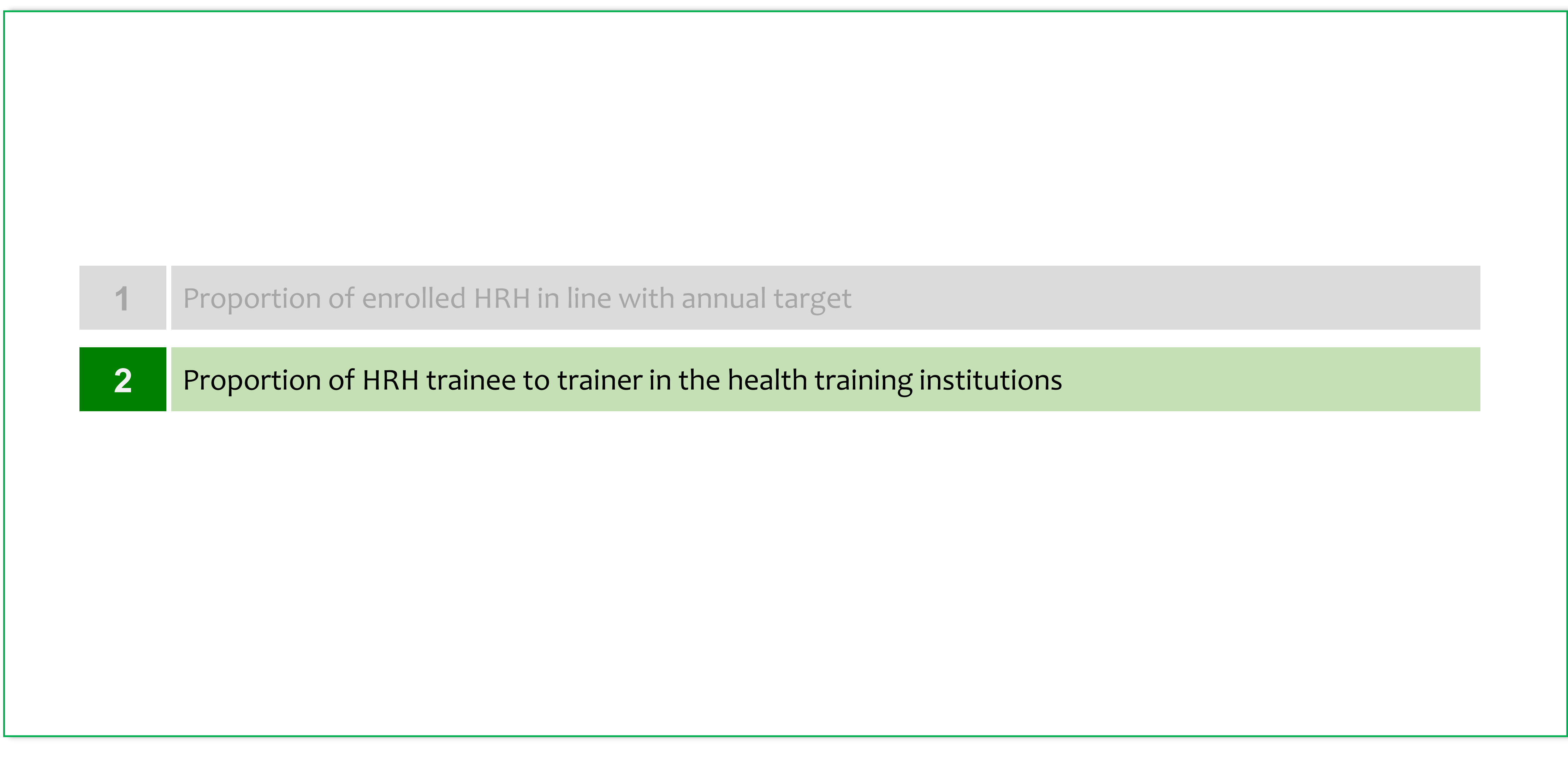

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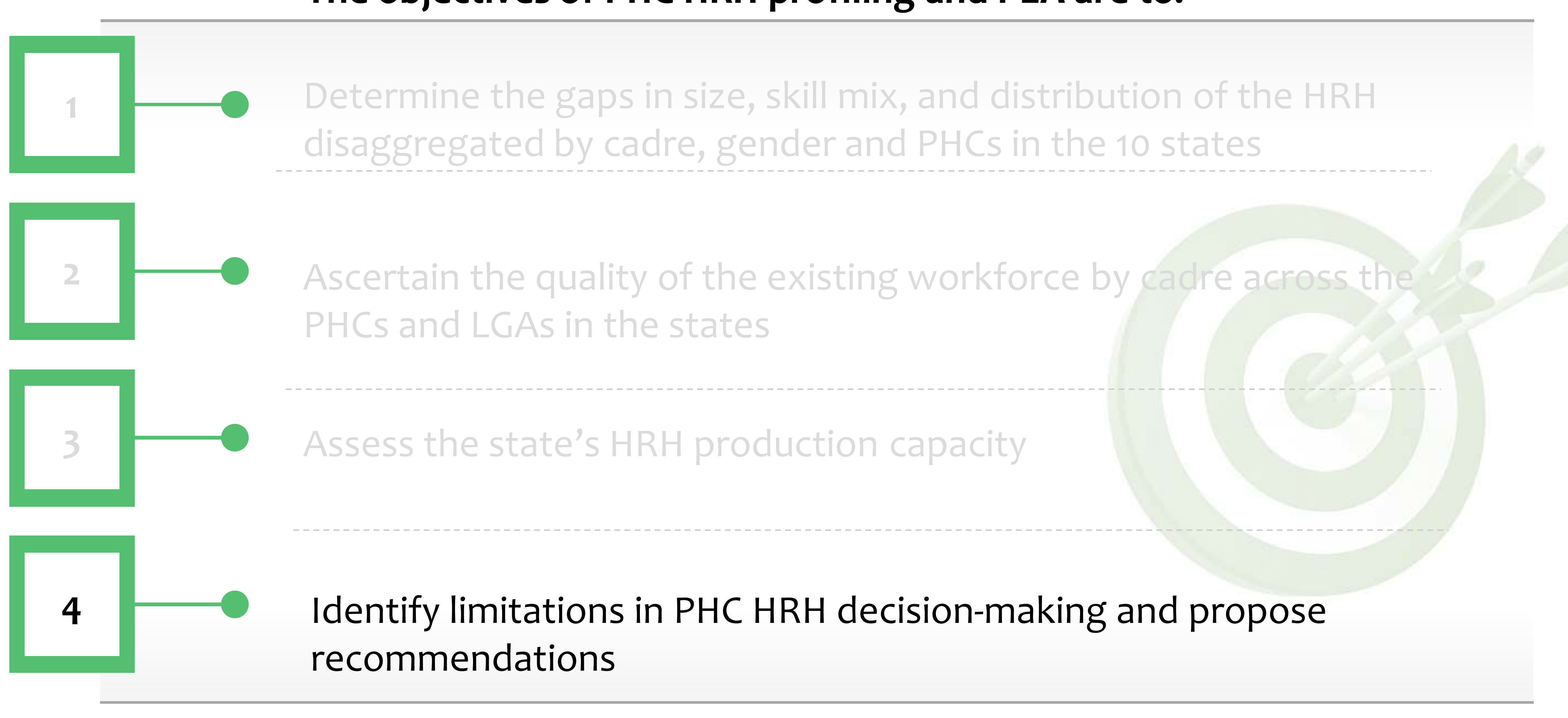

Based on findings, we identified overarching issues with PHC HRH with their corresponding recommendation (1/2)

HRH dimension	Issues identified	Recommendations
1 Planning	▪ Unavailability of the strategic plan to the HTIs ▪ Absence of a link between demand and supply for HRH production	▪ Make the strategy for production available ▪ Ensure there is a link between HRH production demand and supply
2 Financing	▪ Shortage of funds for PHC HRH operations and HTI operations (capital projects)	▪ Budget allocation (approval/release) of funds for financing PHC HRH operations
3 Recruitment/deployment	▪ Embargo on recruitment since 2011 – some facilities are completely manned by volunteers ▪ Overworked HCWs due to embargo on recruitment and continuous exits	▪ Raise recruitment embargo and recruit qualified HCWs to fill identified gaps
4 Working condition/incentives/motivation	▪ Dilapidated facilities that are inconducive for working/service delivery	▪ State government need to revitalize the physical working conditions of the dilapidated facilities
	▪ Lack of rural posting allowance to motivate HCWs to work in deprived areas	▪ Government(State/LGA) should approve and implement rural posting allowance at the LGA level
	▪ Lack of PPEs in the facilities to protect the HCWs	▪ Release funds for the procurement of PPEs to protect HCWs
5 Exit management	▪ Many HCWs retire at the same time because recruitment was done once	▪ Recruit HCWs in phases
	▪ There is no transition plan to replace the exited HCW	▪ Ensure exiting HCWs are replaced immediately

Based on findings, we identified overarching issues with PHC HRH with their corresponding recommendation (2/2)

HRH dimension	Issues identified	Recommendations
6 In-service training	▪ Limited in-service trainings	▪ Conduct frequent in-service trainings based on capacity needs of the HCWs
7 Supervision/performance development and monitoring	▪ Limited funding and logistics to conduct supervision as monthly and quarterly	▪ State government should ensure approval for HRH activities are given as at when due
	▪ High truancy in terms of service delivery	▪ Ensure sanctioning of HCWs that are absent and unaccounted for
	▪ Inadequate use of APER forms as HCWs wait till the end of the year and rush through the filling process to submit	▪ Develop and implement schedule for performance management
	▪ Lack of tangible rewards aside verbal and written recognition	▪ State government should approve and implement rewards for outstanding HCWs
8 Institutional information	▪ Limited control of HCWs at the NSPHCDA due to LGA autonomy	▪ Complete the transfer of LGA HCWs to the Agency based on the PHCUOR policy
9 Overarching issues	▪ High truancy level is also high – unaccounted absenteeism	▪ NSPHCDA should leverage their control post PHCUOR to keep HCWs accountable for providing services in PHC facilities

Based on findings, we proposed recommendations to address HRH gaps in Niger state

Immediate, mid- and long-term implementation plan

Immediate term

0 – 6 months

- Redistribute HCWs based on identified gaps and the MSP, to ensure equitable access to healthcare at the community level
- Adapt the national training recommendations
- Implement adapted training schedule
- Ensure NSPHCDA leads recruitment of the HRH
- Distribute recruited HRH based on the identified gaps
- Upskill CHEWs, JCHEWs to provide RMNCAH+N services in line with the Task shifting/Task sharing policy
- Develop and implement rural posting incentives for HCWs
- State governments should always approve funds for HRH operations on time to ensure optimal implementation of the AOP

Mid term

7 – 24 months

- Recruit 50% of the 13,384 HRH to address the identified staffing gaps
- Collaborate with the health training institutions to convert surplus EHOs to CHEWs
- Conduct a salary comparison assessment and upgrade PHC HRH salaries based on the state's economy

Long term plan

25 – 36 months

- Recruit 100% of the 13,384 HRH to address the identified staffing gaps
- Work with HTIs and regulatory bodies to produce sufficient HRH that can potentially be absorbed into the PHC system
- Routinely update the HRH database

Questions and Answer Session

Any questions?