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FEDERAL REPUBLIC OF NIGERIA

DRAFT

NATIONAL HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN

2008 to 2012

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FOREWORD

Since the year 2003 Nigeria has embarked on a process of reforming her health sector. The reforms aim at significantly improving the health status of Nigerians and reversing the high prevalence of maternal and child mortality, currently among the worst in the world. A major challenge to the implementation of the reforms and the achievement of the Millennium Development Goals (MDGs) related to neonatal, child and maternal health, and tackling priority diseases such as HIV/AIDS, TB and malaria is the shortage of human resources for health.

The health sector in Nigeria is facing a major human resources for health crisis with the mal-distribution of the available workforce, and the increasing brain drain resulting in shortage of critically needed health professionals. The health sector recognizes that human resources are critical in the provision of quality health care. Evidence points to the fact that areas with lowest concentration of health professionals have the worst health indices in the country. To address the current crisis therefore efforts are being made to re-position the public health sector to work in close collaboration with the private sector and partners to mobilize resources to develop and retain capable and motivated health workers in their right numbers and in their right distribution. This is essential for overcoming bottlenecks to achieving the national health goals.

Inequitable distribution and shortages of health staff are caused by a number of factors including:

- Variations in hiring arrangements as health professionals move from one locations within the country to the other. Hiring arrangements in some states do not favour non-indigenes.
- Mobilisation, allocation, and utilisation of health resources are fragmented among different players. Activities of private sector health providers are poorly coordinated. This affects staff development and utilization.
- There are no standards to guide staffing and their utilization for both the private and public sector. Whilst worker productivity in the public health sector is very low, many private sector health practices on the other hand suffer from poor work quality because of commercial pressures.
- Intakes into training institutions are not informed by projections of staff requirements.

In order to resolve the crisis, the Federal Ministry of Health developed a comprehensive National Human Resources for Health Policy in consultation with all the key stakeholders. The Policy was approved by the National Council of Health last January 2007. This National Human Resources Strategic Plan has been developed as a follow up to the Policy. The strategies and activities in the Plan provides a framework to guide and direct interventions, investments and decision making in the planning, management and development of human resources for health at the federal, state, LGA and institutional levels.

The focus of this HRH Strategic Plan is on developing the most appropriate, feasible and cost effective mix of strategies for ensuring equity in staff distribution and access to quality care irrespective of geographic locations, whilst making health profession more attractive. The

Strategic Plan will be used by all health policy makers and managers at all levels and development partners to mobilize resources to strengthen human resources for health.

I am aware of the enormity of the challenges we are likely to face in the implementation of this Plan, but I am sure that with the collective efforts and sustained support from government, professional associations, development partners and the health workforce we will succeed.

Professor Adenike Grange
Honourable Minister of Health

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I would like to acknowledge with thanks the support given by the Development Partners, Health Professional Associations, Health Workers Unions, Lecturers from Health Training Institutions, Health Managers in the various geo-political zones and the federal level for their immense contributions to the development of this Plan.

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Dr. M. A. Mafe
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EXECUTIVE SUMMARY

Introduction

Human resources management and development pose a major challenge to the implementation of health sector reforms and achievement of the health related Millennium Development Goals in Nigeria. In an attempt to confront the challenges, the Federal Ministry of Health in consultation with stakeholders drafted a comprehensive National Human Resources for Health Policy. The Policy was approved by the National Council on Health in January 2007.

The Human Resources for Health Strategic Plan has been developed to guide the implementation of the HRH Policy at all levels. It provides a framework for resource mobilization based on priority areas for intervention in health workforce planning, management and development.

The Human Resources for Health Strategic Plan set out strategies and options for implementation from 2008 to 2012 to tackle the human resources crisis in the health sector. The overall aim is *to* ***ensure that adequate numbers of skilled and well motivated health workforce are available and equitably distributed to provide quality health services.***

It includes both immediate actions and longer-term processes for achieving six key strategic HRH policy objectives, namely to:

I. Provide a framework for objective analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the country.

II. Rationalise and align supply of health workforce to the priorities of the health sector

III. Apply best practices of human resource for health management and development that promote equitable distribution and retention of the right quality and quantity of health human resource to ensure universal access to quality health services.

IV. Institutionalise performance incentives and management systems that recognize hard work and service in deprived and unpopular locations.

V. Foster collaboration among public sector, non-government providers of health services and other HRH stakeholders

VI. Strengthen the institutional framework for human resources management practices in the health sector.

The Human Resources for Health Strategic Plan examines critical challenges in health workforce planning, management and development in the Nigerian context and their effects on health service delivery in the country. It describes and analyses each of the priority areas outlined in the HRH policy document and proffers solutions as to how these will be addressed.

Human Resources for Health in the country are beset by the following issues and challenges:

a. Shortages, mal-distribution and under-utilization of health professionals, as a result of persistent brain-drain, skewed rural / urban disparity in the distribution of health service providers and inefficiencies in the rational deployment and utilization of staff on the basis of workload.

b. The overall HRH picture in Nigeria is inconsistent and lacks integrity as HR information and data collection are fragmented and incomplete, with various stakeholders collecting and collating bits and pieces in the absence of any common data source or human resource management information system (HRMIS).

c. Production of health professionals are not related to the requirements of the country, as there is no mechanism in place to inform health training institution intake and output targets on the basis of service demand and staffing projections.
d. There are systemic deficiencies in the planning, management, development and administration of the health workforce.

The effects of the challenges above are:

I. Poor availability, distribution and utilization of the health workforce
II. Dysfunctional health management systems
III. De-motivation and high attrition among health professionals
IV. Limited attainment of health sector goals.

Key Policy Objectives and Strategies for Strengthening the HRH Systems

Strategies relating to each of the following five (5) HRH policy objectives are outlined below:

1: Provide a framework for objective analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the country.

Strategies:

1.1 Ensure long, medium and short term plans and projections are in place and up-to-date to guide human resources for health development at federal, state and local government levels
1.2 Strengthen capacity, structures and systems for responsive HRH planning, management & development at all levels
1.3 Establish and strengthen Human Resources Research as a tool for informing improving on health staff management in the public and private sector

2: Rationalise and align supply of health workforce to the priorities of the health sector

Strategies:

2.1 Strengthen health workforce training capacity and output based on service requirements
2.2 Assure quality in Pre-Service training institutions and programmes
2.3 Re-orient postgraduate and post-basic training programmes to the priority needs of the country

3: Apply best practices of human resource for health management and development that promote equitable distribution and retention of the right quality and quantity of health human resource to ensure universal access to quality health services

Strategies:

3.1 Establish mechanisms to strengthen and monitor performances of health workers at all levels
3.2 Recruit, select and deploy staff to reflect organizational objectives

4: Institutionalise performance incentives and management systems that recognize hard work and service in deprived and unpopular locations

Strategies:

4.1 Collaborate with State and Local Governments: cross-state collaboration to encourage implementation, and monitoring of federal government circulars, guidelines, and policies
4.2 Create incentives for health workers with emphasis on those that will attract and retain staff in rural and deprived areas
4.3 Establish systems for effective management of staff performance

4.4 Develop and streamline career pathways for Health Promotion, community health workers, and other health professionals critically needed to foster demand and supply creation in the health sector

5: Foster collaboration among public sector, non-government providers of health services and other HRH stakeholders
Strategies:

5.1 Develop and institutionalize forum for policy review, supervisory and monitoring support framework for public and private practitioners at all levels of health service delivery
5.2 Promote collaboration among stakeholders in public and private institutions to ensure that adequate numbers of quality health staff are available in line with health sector development policies and plans.
5.3 Strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system
5.4 Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship, and post basic training for all health professionals

The strategies are clearly set out in the HRH Strategic Framework along with detailed rationale for their inclusion and the key activities required for their achievement.

Key Assumptions to the Implementation of the Strategies
The successful implementation of this National HRH Strategic Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above strategies, which will be measurable in terms of availability and adherence to prioritized and costed Annual Implementation Plans based on the strategic plan; and prompt allocation, disbursement and utilization of available funding and resource requirements:

a. Government and stakeholder support to strengthen strategic and operational HRH functions and systems at all levels
b. Joint stakeholder commitment towards integrated planning, collaboration and actions for effective service delivery
c. Stakeholders alignment of pre-service training programmes and production capacity with the priority needs of the health sector
d. Availability of adequate resources to provide special incentives to attract and retain health staff at deprived locations..
e. Collaborative public/private partnership at federal, state and local government levels

Year-one of Implementation of the National HRH Strategic Plan
Given the dichotomous relationship between the three tiers of government in health service delivery and the complexity of HRH planning, management and development systems in the country, there are some fundamental issues that need to be addressed during the first year at the different levels:

Communication and Advocacy
The Federal Ministry of Health will work in collaboration with states to organize forums for discussions on human resources for health at the various levels. There will be intense advocacy to all stakeholders including health workers, unions, regulatory bodies, private providers etc on the need for targeted reform in the planning, management and development of human resources for health in the country.

HRH Divisions
The Federal Ministry of Health as well as its agencies, and State Ministries of Health will establish appropriately mandated and functional HRH Division that will be staffed with officers with the potentials for developing competences in HRH planning, management, training and development. The Divisions will also serve as the Secretariats for the proposed HRH Observatories.

Preparation of HRH Action Plans
Federal Ministry of Health as well as its agencies, and each State will develop its own HRH Strategic Plan linked to the National HRH Strategic Plan with: prioritised and costed annual implementation plans at state level; and a consolidated annual implementation plan and monitoring mechanisms at Federal level

HRH Database
HRH Branch of the Ministry of Health will liaise with states and Regulatory Bodies to develop common systems and data sources for routine HRH information and monitoring & evaluation to enhance evidence-based decision making and inform joint planning and implementation of HRH strategies and interventions..

Pre-service Training
Federal Ministry of Health will facilitate the initiation of discussions among stake holders in deprived zones on sharing of facilities to maximize training intake and output capacity for the production of critically needed professionals in identified states in the locality.

In-service Training
- FMoH will collaborate with SMoHs to provide training in HRH Planning and Strategic HRH Management and Development to HR Managers at federal and state levels.
- Federal, State Ministries of Health and Collaborating Centres will mount training programmes in Health Planning & Management, Health Information Management, Gender and Health Management, and Health Care Financing.

Recruitment
• Federal level in collaboration with underserved states will liaise with NYSC to post all NYSC doctors, midwives and other crucially needed health professionals into specifically identified deprived LGAs.
• States that have “surplus” health workers concentrated in urban locations will be deploy them to deprived areas.
• Under-served states will enter into local bilateral agreements to recruit health workers from other relatively well endowed states.

Retention
• Under-served states will make efforts to improve health workers remuneration and conditions of service.

• Underserved states will design deprived area specific differentiated retention incentive schemes for critically needed health professionals and mobilise resources to fund it.

National and State HRH Observatories
The Federal Ministry of Health and each State Ministry of Health will ensure the setting up of a multi-sectoral steering committee to be responsible for ensuring

- Development of integrated HRH planning
- Monitoring HRH policy implementation and systems development
- Fostering HRH best practices and cross learning at all levels.

Major Accomplishments Envisaged In the First Year
It is expected that implementation of the above strategies will make the health sector especially in the underserved areas more competitive and attractive to health workers. This will ultimately lead to significant improvement in service delivery and better health outcomes in those locations.

Implementation Framework
Leadership
The Federal Ministry of Health will provide strategic oversight and technical support to states to translate the strategies of the 5-year plan into annual implementation plans. At the national level, the proposed high level HR Steering Committee will guide and oversee the implementation and impact measurement & monitoring of the Strategic Plan in line with the National HRH Policy.

LGAs will be expected to develop their own human resource action plans based on their human resource needs and these will inform state level plans. Training institutions will be expected to develop their plans based on their needs and requirements from the state or zone within which they are established. All action plans will be guided by the strategic objectives of this National HRH Strategic Plan.

Resourcing the Implementation of the Plan
Substantial resources will be required to implement the strategies and achieve the overall objectives of the HRH Strategic Plan. There will be need for a sustained commitment and support of the Government, Development Partners, unions, professional associations, health workers and other stakeholders.

The estimated amount required to commence the implementation of the HRH Strategic Plan in 2008 is about Naira N27,789,539,000 as shown in Annex 8 which provides the cost implications for the five – year period (This excludes salaries of health workers already in the system since scales of remunerations vary from one state and local government area to the other).

Monitoring and Evaluation
Effective monitoring and evaluation of the activities and outcomes of the Plan will help to build that evidence-base to ensure that the strategy is achieving its goals. Monitoring the implementation of the HRH Strategic Plan will be done at the federal, state and local government levels. Monitoring and Evaluation Plans will be developed in line with the HRH Strategic Plan and the Annual Implementation plans, in collaboration with the M&E Unit of the FMoH. High-level indicators have been developed for monitoring the implementation of the strategy and more detailed monitoring routines will be developed in Year 1 for use on a monthly, quarterly, biannual and annual basis.

A. INTRODUCTION

The health system in Nigeria has been in persistent decline over the past few years, with resultant poor performance and the enduring burden of disease and poor health indicative of the alarming health status indicators as reported under the 2003 DHS Survey. In response to this level of decline the Government of Nigeria initiated the ongoing process of health sector reform in 2003, in the second tenure of the previous political administration. These reforms are geared towards strengthening the national health system in its mission to deliver effective, efficient, qualitative and affordable health service and thereby improve the health status of Nigerians. This is the health sector's contribution to breaking the vicious cycle of poverty and under-development.

WHO (2006) defines Human Resources for Health as "those who promote and preserve health as well as those who diagnose and treat diseases. Also included are health management and support workers, those who help to make the health system function but who do not provide health services directly" Human resources are the heartbeat of health service delivery. This is evidenced by the fact that health worker numbers and quality are positively associated with immunization coverage, increased outreach of primary health care, and maternal, neonatal and child survival. The health workforce determines health outputs and outcomes, drives health systems performance, and commands the largest share of health budgets.

The major challenge Nigeria faces is how to ensure availability and retention of adequate pool of competent human resources in their right mix to provide health care in areas where their services are in most need. This is a challenge complicated by many global and disease burden issues, such as global changes in health trends, shifts in health needs and demands, declining resources, changes in global economic, political, and technological situations. Additionally, the Health Millennium Development Goals (HMDGs), the global initiatives to fight HIV/AIDS, Tuberculosis and Malaria, and the Polio Eradication Campaign have implications for human resources for health.

Shortages of health workforce are widespread and supply of health care professionals and other service providers are inadequate to meet requirements. Coupled with above the uneven distribution of competent health workforce deprives many groups access to life-saving services, a problem exacerbated by accelerated migration in open labor markets that draw skilled workers away from the poorest communities. Addressing these challenges require inter-sectoral cooperation and action since in many instances the precipitating factors are outside the direct control of the health sector.

Human Resources for Health (HRH) presents one of the biggest reform challenges to the health sector, where there is pressing need to re-organise, align and re-orientate HRH planning, management and development systems and functions across all three tiers of government to ensure efficiency and effectiveness in the overall health service delivery system. This Strategic Human Resources for Health Plan sets out clear strategies and actions to improve and strengthen HRH in Nigeria over the period 2008 to 2012. This is essential for driving the implementation of the National Human Resources for Health Policy that was approved by the National Council on Health (NCH) in January 2007, in the context of the ongoing health sector reform programme. It presents a framework to guide, prioritize and direct various interventions and investments to support improvements in health system performance as well as inform and enhance decision-making in the planning, management and development of HRH at all levels.

This National HRH Strategy document has been developed to guide the implementation the National HRH Policy. A Technical Working Group made up of staff of the HRH Branch of the

FMOH, the NPHCDA, some lecturers from universities and a private medical practitioner was constituted to do extensive desk review of the national HRH policy and other existing health and related policy documents in the country. The group also did extensive consultations with a broad spectrum of stakeholders in HRH within the 6 geo-political zones of the country with the aim of ensuring that the HRH Strategies are aligned with the current national HRH policy directions, are realistic and can be implemented.

It is expected that the successful implementation of this strategic HRH framework will result in the: equitable distribution of health professionals; production and supply of health workers will be tailored to the requirements of the health sector; all Nigerians, especially the poor will have access to quality health care; and there will be significant improvements in the health status of all.

B SITUATIONAL / ENVIRONMENTAL ANALYSIS

B .1 Global Challenges in Human Resources for Health Planning, Management and Development

Human resources for health planning, management and development, particularly in sub Saharan Africa, have been strewn with crisis. Investments in the production and training of the much needed professionals do not seem to match requirement and therefore does not make the expected impact. A number of other factors have also been assigned to the low level of health worker concentration in areas where their services are needed in Africa. Notable among the factors are massive brain drain among health professionals, internal mal-distribution of those available, public-private dichotomy in distribution of services and utilization of skilled health manpower, unclear career pathways that make some professionals abandon the health professions for others.

Factors often cited by health professionals especially from the public sector for migrating or leaving their professions include:

I. Poor conditions of service and demoralizing work environments, non availability of relevant equipment and logistics, and lack of incentives for hard work,
II. Unclear career pathways and sometimes absence of, or inadequate career counseling facilities thus making staff take career decisions that may not meet their aspirations.
III. Delays in promotion, poor placement after training and inadequate opportunities for professional advancement.
IV. Many African countries have civil service structures and regulations that make health professionals feel that management positions are more rewarding and prestigious than progressing along traditional health professional career pathways..
V. Inadequate HR planning at the various levels and this is compounded by the non-availability of reliable, complete and up to date baseline data and information on staff for decisions making and target setting
VI. Staff distribution in many developing countries is skewed towards urban areas because the development agenda of governments do not create platforms for equitable distribution of social amenities.

In addition to above, specifically in Nigeria

I. Mal-distribution between states is fuelled largely by variations in hiring arrangements as health professionals move from one locations to the other. Hiring arrangements in some states do not favour non-indigenes.

II. Mobilisation, allocation, and utilisation of health resources are fragmented among different players. Activities of private sector health providers are poorly coordinated. This affects staff development and utilization.
III. There are no standards to guide staffing and their utilization for both the private and public sector. Whilst worker productivity in the public health sector is very low, many private sector health practices on the other hand suffer from poor work quality because of commercial pressures.

Nigeria is in the process of aligning its national human resources for health management and development systems and practices to the objectives of the on-going health sector reforms programme. The public health sector is in the process of re-positioning itself to work in close collaboration with the private sector to formulate relevant HRH policies and strategies and together mobilize resources. It is anticipated that this will help to develop and retain capable and motivated health workers in their right numbers and in their right distribution that is essential for overcoming bottlenecks to achieving the national health goals.

B.2. Nigeria Health Sector Strategies, Mission Statement and Goals

The health sector strategies and goals are well articulated in the National Health Policy (2004) and other Health Sector Reform documents.

The health sector strategic thrusts are summarised as:

I. Improving the Stewardship Role of Government
II. Strengthening the National Health System and its management
III. Reducing the Disease Burden
IV. Improving Availability of Health Resources and their Management
V. Improving Access to Quality Health Services
VI. Improving Consumer Awareness and Community Involvement
VII. Promoting Effective Public/Private Partnerships and Coordination

The cross-cutting issues for driving the implementation of the strategies above are:

- Communication Strategy for HSR Advocacy
- HSR Monitoring and Evaluation
- Structure and Management of the Reform Process

The vision of the health sector is to: reduce morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases and containing emerging and re-emerging diseases; meet global targets on elimination and eradication of diseases; and significantly increase life expectancy and quality of life of Nigerians.

The mission is to develop and implement appropriate policies and programmes, and undertake necessary actions to strengthen the national health system to deliver effective, quality and affordable services to Nigerians.

The goal is to strengthen the national health system to provide effective, efficient, quality; accessible and affordable health services and to improve the health status of Nigerians through the achievement of health related Millennium Development Goals.

B3 Summary of the Demographic, Socio-Economic Indices and Current Health Status / System in Nigeria

Nigeria is made up of 36 states and a Federal Capital Territory (FCT), which are grouped into six geopolitical regions: North Central, North East, North West, South East, South South, and South West. There are also 774 constitutionally recognized Local Government Areas (LGAs) in the country.

The population of Nigeria by the 2006 census was 140,003,542. The population of Nigeria is predominantly rural; approximately one-third live in urban areas. The Total Fertility Rate by the 2003 NDHS is 5.7. Life expectancy is 44 years and 45 percent of the population is under 15 years of age (UN 2004).

The GDP in 2006 and 2007 are 6.9 and 5.3% respectively. Petroleum plays a large role in the Nigerian economy, accounting for 40% of the GDP. However, due to crumbling infrastructure, corruption, and ongoing civil strife in the Niger-Delta- its main oil producing region- oil production and export is not at 100% capacity.

The health sector is characterized by wide regional disparities in status, service delivery, and resource availability. More health services are located in the southern states than in the north. The health sector has deteriorated despite Nigeria's high number of medical personnel per capita.

Health service provision in Nigeria includes a wide range of providers in both the public and private sectors, such as public facilities managed by federal, state, and local governments, private for-profit providers, NGOs, community-based and faith-based organizations, and traditional care givers (WHO 2002).

Nigeria is a federation with three tiers of government - federal, state, and local – and responsibility for health service provision in the public sector is based on these three tiers. The levels of care in the public sector are:

Primary: Facilities at this level form the entry point of the community into the health care system. They include health centers and clinics, dispensaries, and health posts, providing general preventive, curative, promotive, and pre-referral care to the population as the entry point of the health care system. Primary facilities are typically staffed by nurses, community health workers, community health extension workers (CHEWs), junior CHEWs, and environmental health officers. LGAs are mandated by the constitution to finance and manage primary health care.

The national health policy regards primary health care as the framework to achieve improved health for the population. The national health policy document requires that a comprehensive health care system delivered through the primary health centers should include maternal and child health care, including family planning services.

Secondary: These facilities including general hospitals and they provide general medical and laboratory services, as well as specialized health services, such as surgery, pediatrics, obstetrics and gynecology to patients referred from the primary health care level. Medical officers, nurses, midwives, laboratory and pharmacy specialists, and community health officers typically staff general hospitals.

Primary and secondary level of care is also provided by the largely unregulated private health sector.

Tertiary: Tertiary level facilities form the highest level of health care in the country and include specialist and teaching hospitals and federal medical centers (FMCs)**.** They treat patients referred from the primary and secondary level and have special expertise and full-fledged technological capacity that enable them to serve as resource centers for knowledge generation and diffusion. Each state has at least one tertiary facility.

Health status

Improvements in key health indicators have been slow and Nigeria ranks among the countries with the highest child and maternal mortality: the under-five mortality rate is 201 per 1,000 live births (DHS 2004); maternal mortality ratio is estimated at 800 per 100,000 live births (WHO/UNICEF 2004).

Among the major contributors to the disease burden of the country are malaria, tuberculosis (TB), and HIV/AIDS. Malaria is a major health and developmental problem in Nigeria, with a prevalence of 919 per 100,000 population (WHO 2002). The HIV/AIDS epidemic has unfolded on a large scale in Nigeria: adult prevalence is 3.9 percent and nearly 2.9 million people are living with the virus (UNAIDS 2006). Tuberculosis cases have increased dramatically with the onset of HIV/AIDS in the country, with an estimated prevalence of 546 cases per 100,000 population in 2004.

There are great disparities in health status and access to health care among different population groups in Nigeria. For example, the under-five mortality rate in rural areas is estimated at 243 per 1,000 live births, compared to 153 per 1,000 in urban areas (DHS 2004). While 59 percent of women in urban areas deliver with a doctor, nurse, or midwife, only 26 percent of women in rural areas do so (DHS 2004). Unlike most of Sub-Saharan Africa, rural areas in Nigeria have a higher HIV/AIDS prevalence than urban areas (UNAIDS 2004). Furthermore, there are wide variations in health status and access to care among the six geo-political regions of the country, with indicators generally worse in the North than in the South (MDG Report 2004).

C.1 Human Resources in the Nigerian Health Sector

Nigeria has one of the largest stocks of human resources for health in Africa comparable only to Egypt and South Africa. There are about 39,210 doctors and 124,629 nurses registered in the country, which translates into about 30 doctors and 100 nurses per 100,000 populations (Table 2.1). This compares to a Sub-Sahara African average of 15 doctors and 72 nurses per 100,000 populations (WHO 2006).

The figures presented in Table 2.1 are for some health professional categories registered by Nigeria's professional medical/health regulatory bodies as in 2006. They include health workers in both the private and public health sectors, and, very likely, health professionals who are not practising in the country or may not be practising health care at all.

Table 1: Number of some Categories of Health Workers Per 100,000 Population in Nigeria 2006

Staff Type	Number of Staff	No. of Staff/100,000 population
Doctors	39,210	30
Nurses	124,629	100
Midwives	88796	68
Dentists	2,773	2
Pharmacists	12,072	11
Medical Lab. Scientists	12,860	12
Community Health Practitioners	117,568	19
Physiotherapists	769	0.62
Radiographers	519	0.42
Health Record Officers	820	0.66
Environmental Health Officers	3441	3
Dental Therapists	872	0.69

Doctors and dentists include 2,968 and 215 expatriates respectively. This suggests that there are considerable numbers of expatriates providing medical care support in the country.

C.2. Current Human Resources Policies and Plans

Empirical evidences indicate that both the Federal and most State Ministries of Health do not have structures and capacities to facilitate the development and implementation of cohesive and integrated HRH plans. Very few State Ministries of Health have evidence of routinely planning for human resources for health. Staff management responsibilities and functions are centralized in offices such as the Head of Civil Service, the Civil Service Commission, or Health/Hospital Management Boards.

Intakes into health training institutions are not influenced by evidence-based predetermined staff requirements. Consequently, many of the health training institutions over-produce some cadres of staff who do not readily find employment within the state yet are not employed by other states where needs exist. At the same time, there is gross under-production of other cadres who are critically needed in the states.

C.3 Pre-service Training Capacity

In 2002 / 03 Nigeria had the capacity to produce approximately 2,000 doctors, 5,500 nurses and 800 pharmacists (FMOH, 2003). There are 20 fully and 3 partially accredited medical schools spread throughout the country; about 5 additional ones have been proposed. About 33 states in the federation have approved nursing training schools, with some states having as many as 5. Some states do not have any midwifery training institution.

Some states are better endowed with institutions that train various categories of health professionals than others. The less endowed states such as Jigawa and Gombe are disadvantaged in attracting adequate numbers of critically needed health professionals. Considering the large capital outlay required in setting up and operationalising training institutions, the short term solution should not be replication of programmes in all states. There is need for every state to regularly assess its critical human resources for health requirements, and rationalization of the use of existing training institutions, with provision of adequate resources to enable them cater for clearly defined needs of clusters of states.

Government is the main financier of health training all over the country.

In recent times, newly graduated doctors, pharmacists, physiotherapists, and medical laboratory scientists do not readily get accredited facilities to enable them do their internship. Some have to wait for as long as two years before they can get placement. In the heat of the frustration some are noted to have abandoned their professions altogether and looked for something else to do.

C.4. Health Worker Distribution

Fig. 1: Zonal Distribution of some Key Health Professionals

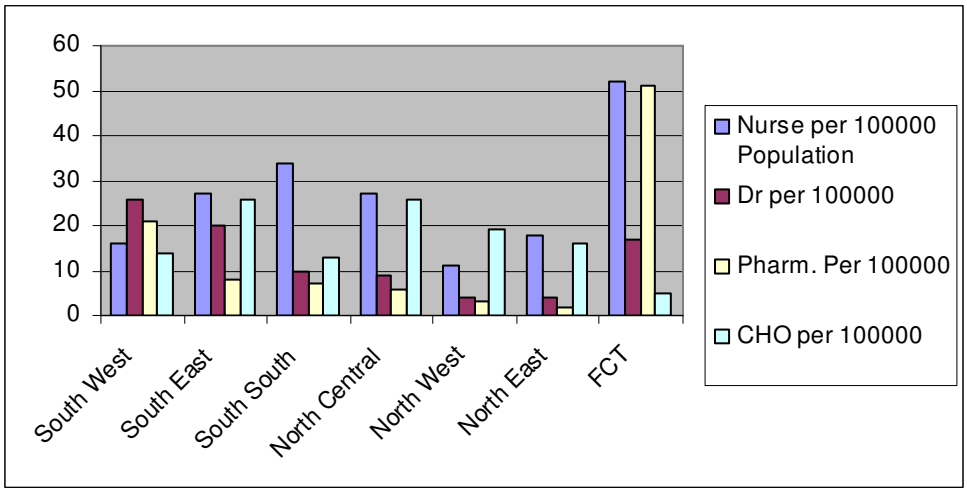


Figure 1 above shows that availability of various staff category per 100,000 population vary from one zone to the other. Whilst the national average for doctor per 100,000 population is estimated at 12, some zones notably North West and North East have as low as 4. Whereas the national nurse/midwife per 100,000 population stands at 21, the South West, North West and North East zones have 16, 11, 18 respectively. This suggests that any strategy to ensure equitable distribution of doctors and nurse-midwives must be sensitive to the needs of the affected zones.

Records available lump doctors and dentists, as well as nurses and midwives respectively together. This does not bring out clearly the distribution and availability of some very essential cadres. In some states midwifery training is a requirement for employment into the public sector for all registered nurses. It is however difficult to differentiate between nurses who have had additional professional training in midwifery and are practicing as such from those who are still engaged in general nursing.

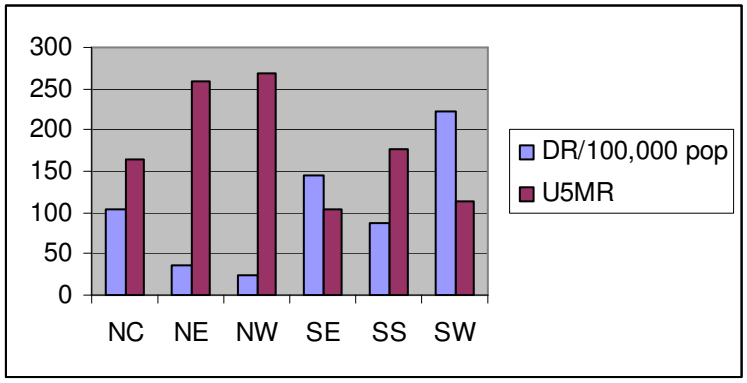
There are very low numbers of some members of the medical care team such as radiographers and medical laboratory scientists in some states. The discontinuation of the diploma in

radiography programme and the subsequent closure of schools are likely to worsen the situation if intakes into the degree programmes are not increased. The implementation of the ward minimum service package in primary health centres require that every PHC facility designated should have a laboratory technician. There are however no records on available laboratory technicians.

There is evidence of rural/urban disparities in the distribution of health staff. Some states are better endowed with health professionals than others. Some states are however noted for having rules and regulations that unfairly discriminate even against essential and critically needed health professionals that are not indigenes.(detailed breakdown of state by state distribution is in annex 3)

Processes and procedures for recruitment of health professionals tend to be cumbersome in many states. Remuneration packages for health professionals vary a great deal between federal and states and also among states. The result is that health professionals tend to gravitate into federal facilities and states where better remunerations are offered. Private providers (except faith based ones) mainly operate in urban settings where income levels are generally high and clients are perceived to have the ability to pay for services rendered. Resultantly there is poor access to qualified and competent health professionals for people living in rural and deprived areas that bear a greater portion of the disease burden.

Figure 2: Doctor Population Density in Relation to Under – 5 Mortality Rates in the Geo-Political Zones



Adapted from the NDHS Report (2003)

Zones and for that matter states with very poor health indices also have very low doctor density per hundred thousand population. For instance, North East and North West zones have the highest under-fives mortality rates of 260 and 269 with a corresponding low doctor density per 100,000 population of only 4 each. Conversely, in South West and South East zones, under-five mortality rates are 103 and 113, with doctor per 100,000 population of 26 and 20 respectively. The comparison does not however suggest that the mortality rates in the southern states are within acceptable limits.

In an human resources for health situation assessment carried out jointly by FMoH and Nigeria Action Committee on AIDS(NACA) and Partners for Health Reforms plus (PHRplus) in 2006, it was reported that on average there is 1doctor for every 4 primary health facilities. There are about an average of 5 doctors per general hospital (secondary level) facility, while a tertiary hospital has an average of 62 doctors. Also there are about 3 nurses/midwives per primary health facility, and a laboratory worker in only half of the facilities. The staffing pattern may be influenced by the type of services that are provided at each of the levels. However, in some rural states it is rare to

find midwives in primary facilities. If the high neonatal mortality rates are to be reduced effectively, there is need to ensure equity in the distribution and deployment of adequate numbers of midwives with competence in life saving in communities.

Within states also, disparity in the distribution of health professionals between urban and rural deprived locations prevail.

The priority for human resources for health development should be improved planning and management at both strategic and operational levels to ensure even and consistent production and deployment of critically needed staff.

C.5. Workloads and Health Worker Utilisation

In a recent assessment of workloads of health workers and their utilization in tertiary health institutions, general hospitals and PHC facilities in nine selected states variations in workloads were found to be prominent from one level of care to the other. For instance, nursing staff in some tertiary health institutions were found to be heavily overloaded with work, whilst their counterparts in the general hospitals had very little to do. The use of workloads as a way of rationalizing staff deployment and utilisation will be a useful approach to maximizing utilization of available staff and minimizing inefficiencies.

The constitutional arrangement whereby each level of the three tiers of government owns health facilities and therefore, staff hiring and management is divided along those lines makes it nearly impossible to redistribute staff across the levels of service delivery on the basis of workloads.

C.6. Remuneration and Fringe Benefits

There are gross disparities and distortions in remuneration packages and schemes of service for health workers at different levels in the public sector especially for nurses and midwives. The disparities are more pronounced between staff on federal payrolls and their colleagues in the states and worse in the local government systems.

Schemes of service and post qualification classification systems are also too rigid to allow for the changing requirements in the health sector. For instance Health Education and Health Promotion are of high importance in the creation of demand for health services and community mobilisation for health. Thus it is important that, technical expertise is developed for all levels. However, existing schemes of service are not attractive enough for highly qualified personnel with expertise in that field. There is need to rationalize remunerations across levels and make salaries comparable for analogous grades and backgrounds.

C.7. Wastage analysis – Nurses, Doctors, Pharmacists, Others

The health sector losses its staff mainly due to retirement, resignation, migration and death.

C.7.1 Brain Drain

A significant number of Nigerian health professionals migrate to Europe and USA in search of better remuneration, better facilities, and better working environments. Within the country health professionals are moving away from the sector to other more attractive sectors.

Table 2: Nigerian Doctors Registered with the American Medical Association By Specialty – 2003

Specialty	Number	Percentage
Internal Medicine and sub specialties	1269	44
Surgery and surgical sub specialties	332	12
Family/General Practice	281	10
Paediatrics	427	15
Psychiatry	187	7
Obstetrics and Gynaecology	161	6
Pathology/Oncology	90	3
Radiology	35	1
Preventive Medicine	32	1
Others	41	1
Total	**2855**	**100**

Source: American Medical Association

The loss to migration of Nigerian nurses has also accelerated in recent years. This is evident in the number of letters of verifications received from other countries on nurses who had applied for employment in those destinations.

Table 3: Requests for Verification on Nurses Seeking Employment Outside Nigeria in the Last Three Years

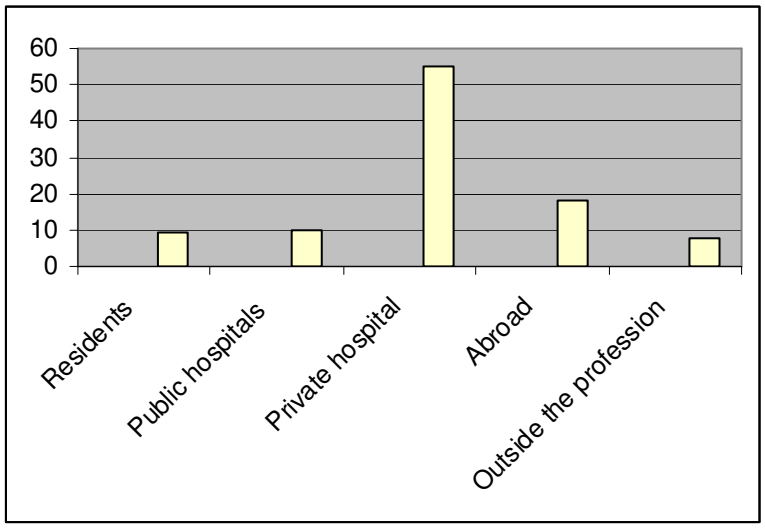
Country	Year 2004	Year 2005	Year 2006*
United Kingdom	2500	2600	750
USA	2100	2050	650
Ireland	750	855	450
Australia	55	60	75
Canada	50	60	12
British Columbia	10	11	3
New Zealand	20	21	5
South Africa	15	16	6
Ghana	8	10	7
Botswana	4	5	10
Prince Ward Island	5	7	9
Total	**5619**	**5772**	**1967**

* *Covers only 1st half year.*

Source: Nursing and Midwifery Council of Nigeria

It should be noted that verification can only be used as proxy indicator since some applicants who may have intentions to travel do not end up doing so at the end of it all. However, there may be a lot more who left and for whom no verifications were elicited. Also there are those who might have left health care delivery into other professions within the country.

Figure 3: Registered Nigerian Doctors and their Distribution.



Source: Human Resources for Health in Nigeria: Implications for Systems Performance and Pro-Poor Care .Assessment Report 2003.

About 26% of Nigerian Doctors are either working abroad or have changed professions and are in other jobs regarded as more financially rewarding.

Majority of Doctors in-country are working in the private sector. This calls for closer collaboration between the public and private sector to ensure equitable coverage of their services throughout the country. There is also the need to ensure continuous quality of health care irrespective of who is providing the services.

The World Health Report (2006) also indicates that about 12% of doctors trained in Nigeria are working in OECD countries alone. It is likely that a greater number of the migrant doctors may not be practicing in their field of training and for that matter, are not registered as such. The cost to Nigeria of each skilled doctor who emigrates is estimated to be about US$184,000 (UNCTAD).

Table 4: HRH Stock Increase from New Graduates and Attrition Rates in the Public Sector

Staff Category	Increase from New Graduates (%)	Attrition Rate (%)
Doctors	16.50	2.34
Nurses and Midwives	1.14	1.43
Laboratory Staff	3.42	1.26
Pharmacists and technicians	3.56	2.16
CHO/CHEWs	3.25	1.44

Source: NACA and PHRplus 2006

About an average of 2,500 doctors, 5,500 nurses and 800 pharmacists graduate and enter the health sector every year.

Except for nurses and midwives, there appears to be a positive net gain when rate of inflow of fresh graduates are compared with attrition rates. However it should be noted that medical schools are now using indexing in their admission processes and this has drastically affected intakes into the schools. A drastic reduction of inflows of new doctors will be obvious in about 5 years when there will be a marked population increase and development of new health facilities.

On average, annual attrition due to all factors among doctors is about 2.4%; nurses and midwives 1.4%; pharmacists and technicians 2.2%; laboratory staff 1.3%; CHO/CHEW 1.5%. Attrition in rural areas is higher than in urban areas. Doctors, nurses and midwives working at the primary level have higher attrition rates than those working at the secondary or tertiary level.

C.8 Nigerian Health Sector and HRH Challenges

The Nigeria health sector faces the following intricate human resource challenges, characteristic of health systems in many developing countries:

a. Weak strategic human resources planning, management & development capacity and systems, with resultant poor planning of staffing needs and utilization at both federal and state levels. This is exacerbated by the non-availability of functional, dedicated and appropriately staffed strategic human resources for health divisions within Federal and State Ministries of Health.

Accurate and up to date comprehensive data are relevant for human resources planning and key decision making on staff. However, data on health staff are scattered, incomplete and lack integrity since various stakeholders collect and collate bits and pieces without recourse to any standard. Further, no operational research is carried out on relevant contemporary human resources planning, management and development issues in order to elicit evidence for decision making. Neither are there any mechanisms at any level for monitoring and evaluating staff deployment and utilization in the service delivery areas.

b. There are systemic deficiencies in the planning, management and administration of available personnel. The intensity of human resource challenges vary from one location and level to the other. The common strands are:

I. Shortage of professional staff in the north and over supply in the south
II. Distribution of health workers is skewed toward urban centres with acute shortages in rural locations.
III. There is poor utilization of health professionals across the public private sector divide resulting in duplication of functions in some locations where other areas are poorly covered by skilled personnel
IV. There is apparent gross unemployment and under-employment among health professionals and technicians in the country
V. Attrition of health professionals is becoming excessive
VI. Low level and discrepancies in salaries and other conditions of service for health professionals working at different levels and between states
VII. Absence of effective staff performance management 'building-blocks' such as up-to-date job descriptions, objectives, targets, supportive supervision, appraisal mechanisms, etc, resulting in low productivity of health workers
VIII. Poor interpersonal relations and inter-professional friction among health workers
IX. Staff recruitment regulations in some states with shortages of critically needed health staff that discriminate against non-indigenes (contract versus pensionable appointment for staff)

X. Cultural preferences for acceptability of health worker services
XI. Poor work environment including dilapidated structures, inadequate and outdated equipment and cumbersome work flows.
XII. Lack of protective, safety equipment and logistics for staff.

c. Misalignment of pre-service production and training programmes to health priorities and policies with main challenges being:

I. Disjoint between human resources skills requirements, service gaps and production output.
II. Absence of systematic in-service training and poorly coordinated continuing education programmes resulting in inadequate training with low coverage of staff and ambivalent quality of performance
III. Poor infrastructural facilities for effective teaching and learning including inadequate classroom space in some cases, and audio visual equipment
IV. Lack of incentives for teachers who have very limited opportunities for additional work and hence extra income.

The resultant deficiencies of the above are:

I. Lack of motivation leading to frustrations among staff and peripheral managers.
II. Lack of efficient systems for assessing performance and training needs of staff.
III. Excellent skills and hard work do not seem to be rewarded resulting in high attrition of skilled staff.
IV. Poor and uneven distribution of skilled staff across the country.

In summary the HRH challenges facing the country include: inappropriate policies and poor human resources management and development practices; inappropriate or inadequate training with curricula that are not needs-based; poor access to information and knowledge resources; inadequate numbers and skills of health workers; uneven distribution of workers at different levels of service delivery, poor motivation resulting in low morale; unsafe conditions in the workplace; Unclear career pathways and structures, unattractive conditions of service and remunerations; lack of supportive supervision; lack of integration of services between the public and private sectors. All these have resulted in poor commitment to work and high attrition of health workers.

C. Current Initiatives to Resolve the Human Resource Crisis

Human Resources for Health is being given the much needed attention in Nigeria in recent times. A number of activities have been initiated which eventually will lead to improvement in human resources management systems, procedures and practices in the health sector of the country. Key initiatives taken so far include:

C.1. Revision of the National Health Policy

In the revised national health policy, strategies are in place to motivate and retain health workers. These are aimed at:

I. Ensuring equitable distribution of human resources for health care delivery between urban and rural areas including difficult terrains such as mountainous, riverine, and hard-to-reach areas in the country;
II. Promoting collaboration among human resource managers at the tertiary, secondary, and primary levels, and with private health institutions including compliance with approved guidelines on health human resources;

III. Ensuring the right quantity and quality of staff at all levels in line with health sector development plans, and creating conducive atmosphere that encourages health workers to serve anywhere in Nigeria, and to contain brain drain;
IV. Pursuing the training of specialized manpower in areas of national priority, and bonding of government-sponsored beneficiaries in line with the appropriate policies;
V. Ensuring that professionally-trained health human resources managers are responsible for human resources for health development units, and all staff continuously trained in health human resources management;
VI. HRH recruiting agencies from other countries shall register with the FMOH and operate within the provision of memoranda of understanding with the Federal Ministry of Health and regulatory bodies; and
VII. Deliberate efforts on the part of the Ministries of Health to offer additional incentives to encourage skilled Nigerians working abroad to return and provide health services.

C.2. The Health Sector Reform

I. The Health Sector Reform document also highlighted some critical issues relating to HRH, and proposes strategies to address them. The issues include:
II. Poor condition of service resulting in de-motivation of professional staff.
III. Inadequate and inappropriate mix of personnel that affects the quality of health care.
IV. Poor funding and implementation of training and development of health personnel contributing to attrition and brain drain syndrome.
V. The lack of performance-based national strategy for human resources that affects health workers, and the overall performance of the health system.

C.3. The Health Bill

The National Health Act when passed will address issues of human resources management within the national health system in order to:

I. Ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements including prescribing re-certification programmes through a system of continuing professional development.
II. Identify shortages of key skills, expertise and competencies within the national health system and empower the FMOH to prescribe strategies which are not in conflict with other legislation, for the recruitment of health care personnel from other countries; and training of health care providers to make up for the deficit.
III. Ensure adequate human resources planning, development and management structures at national, state and local government levels.

"*FMOH ensures the definition and clarification of roles and functions of the Federal Ministry of Health, State Ministries of Health and Local Government Health Authorities with regard to the planning, production, and management of human resources".*

C.4. The National Health Insurance Scheme (NHIS)

The NHIS is being implemented through extensive public-private partnership involving health facilities at primary, secondary, and tertiary levels. In order to meet selection criteria health facilities must adhere to established standards regarding work protocols, equipment, and clinical practice. These are contributing to:

I. Improved job satisfaction for health workers due to availability of needed equipment, and better work environment.
II. Employment opportunities for health managers and health workers.

C.5. National Human Resources for Health Programme

The HRH Branch within the FMOH was created in the early 1990s but was given greater push by issues raised in the 2006 World Health Report, with focus on the global human resources for health crisis. The report suggests that the crisis is critical in developing countries including Nigeria. In addition, the health workforce was the focus of the World Health Day 2006. These gave impetus to the strengthening of the HRH Branch, which has recorded some modest achievements since 2006.

A HRH situational analysis was conducted to determine the state of health workers, and managerial structures in public and private health institutions nation wide, and to offer evidence based policy guidance. Findings from the study led to:

I. Development of the National HRH Policy.
II. An assessment of workloads of health workers using the Workload Indicator of Staffing Needs (WISN) approach,
III. Development of National HRH Strategic Plan
IV. On-going efforts to establish HRH Units in state ministries of health.
V. Initiation of the development of the updated comprehensive National HRH Information System. It is expected that data on health training institutions, the availability of all categories of health workers including specialists, their distribution, and proportion employed will be collected continuously and analysed to inform strategic level decisions on the workforce.

C.6. Training and Development

In an attempt to deal with the HRH crisis, capacity building is given serious attention. This includes:

I. Training and retraining of primary health care workers.
II. Re-engineering the Collaborating Centres for Training in Health Planning and Management, Health Information Management, and Gender in Health Management Studies.
III. Compulsory continuing professional development for health workers.
IV. Life Saving Skills training for doctors and nurses/midwives.
V. Integrating health services management in the training of health care workers.
VI. Reviewing training curricula of health care workers to reflect prevailing health care trends.

C.7. Motivating Health Workers

Efforts to motivate and retain health care professionals include:
I. special salary scale for health professionals; and
II. preferential entry point for health professionals in the public sector

C.8. Improving Availability of HRH in Difficult Terrains

Initiatives to attract and retain health professionals into difficult terrains include:

I. Nursing and Midwifery Council's one year compulsory community midwifery service.
II. NYSC posting of medical personnel to rural areas.
III. Hardship and deprived area allowance for rural posting.
IV. Loan scheme to encourage establishment of practices in rural areas.

Most of the initiatives enumerated above are being implemented in a slow, disjointed and fragmented fashion without coordination mainly owing to the fact that responsibility for health staff management and development is divided among the three tiers of government. States and LGAs have the ultimate responsibilities to train, hire, manage and develop their health workforce based on their perceived needs, prevailing local laws and regulations. Further, current initiatives for motivating health staff lay too much emphasis on financial rewards as opposed to effective leadership, transparency and other non-financial incentives..

GUIDING PRINICIPLES, POLICY OBJECTIVES

AND HUMAN RESOURCES FOR HEALTH

STRATEGIC FRAMEWORK

D. Guiding Principles for the HRH Strategic Plan

The overall mission of the Nigeria health sector is to develop and implement appropriate policies and programmes, and undertake necessary actions to strengthen the National Health System to deliver effective, quality and affordable services to Nigerians. The goal is to strengthen the national health system to provide effective, efficient, quality; accessible and affordable health services and to improve the health status of Nigerians through the achievement of health related Millennium Development Goals

The principles underpinning the HRH Strategic Plan are contained in the National Human Resources for Health policy, which recognises the rights of the populace to quality health care provided by a pool of skilled and competent health workers in their right mix.

The guiding principles of this strategic HRH plan are:

1. Improving on access
2. Improving stewardship and accountability
3. Strengthening public and private partnership for health.
4. Improving efficiency and effectiveness in resource mobilisation and allocation.
5. Producing adequate number of workers who are community focused and are adequately prepared to respond to health challenges they are confronted with currently.
6. Assuring quality of care

E. Human Resources for Health Objectives and Strategies

The ultimate aim of the strategic HRH plan is to ensure that all the people living in Nigeria, especially the poor, irrespective of their locations, have access to quality health care. The HRH Strategic Plan outlines long-term processes and immediate actions to achieve the following key HRH policy objectives:

I. Provide a framework for objective analysis and implementation and monitoring of measures aimed at addressing the HRH crisis in the country.
II. Rationalise and align supply of health workforce to the priorities of the health sector
III. Apply best practices of human resource for health management and development that promote equitable distribution and retention of the right quality and quantity of health human resource to ensure universal access to quality health services.
IV. Institutionalise performance incentives and management systems that recognize hard work and service in deprived and unpopular locations.
V. Foster collaboration among public sector, non-government providers of health services and other HRH stakeholders
VI. Strengthen the institutional framework for human resources management practices in the health sector.

A number of strategies and activities have been outlined for implementation within the planned period. The activities are not arranged in any order of priority and many of them are expected to be implemented concurrently at the different levels. The following are the policy objectives with their corresponding key Strategies and actions to drive implementation:

Policy Objective 1.0 Provide a framework for objective analysis and implementation and monitoring of measures aimed at addressing the HRH crisis in the country.

Strategy 1.1: Ensuring that long, medium and short term plans and projections are in place and up-to-date to guide human resources for health development at federal, state and local government levels

Rationale

Current initiatives in HR planning for the health sector have been patchy, poorly coordinated and not institutionalised across states, and at the federal level. This has resulted in over-production of some cadres and under-production of others that are critically needed. From the outset there is a pressing need to assess the existing health sector workforce, and to determine workloads, staffing patterns and skills at all levels. The availability of accurate and up-to-date information and baseline data on staffing levels, staffing patterns and skill mix at federal, state, local and facility level are therefore essential to determine recommendations for staffing standards and norms and revised staffing levels on the basis of service delivery needs and gaps

There is therefore a need to institutionalise human resources planning at all levels and to use the plans as tools in rationalizing production, distribution and utilization of health workforce in the country. HR Planning should be based on acceptable standards, procedures and guidelines.

Activities

a. Develop, introduce and utilize staffing norms based on workload to guide planning
b. Use service availability to determine staffing needs instead of the traditional professional category or physical norms e.g. bed states
c. Provide guidance for distribution of staff based on the health sector priorities, the Millennium Development Goals, health worker population ratios, variation in population densities and other demographic and socio-economic indices as well as other essential health needs assessment
d. Provide appropriate coordinating mechanisms towards mutual consistency in human resources for health planning and budgeting among the Ministries of Health, Finance, Education, Office of Head of Civil Service, Planning Commission, Regulatory Bodies, Private Sector Providers, NGOs in health, and other institutions
e. Provide the necessary framework for integrating the processes of health infrastructure planning, human resources planning and health technology planning to minimize mismatches
f. Set up effective structural and technical capacity, both within and outside the Federal and State Ministries of Health and Local Government Health Departments for human resources policy, planning and management

Strategy 1.2: Strengthen capacity, structures and systems for responsive HRH planning, management & development at all levels

A Review existing HRH planning, management and development capacity, systems and structures at all levels across the sector

B Establish and support appropriate HRH structures both within and outside the Federal and State Ministries of Health and Local Government Health Departments for human resources policy, planning and management

C Review and refine the functions, mandates and responsibilities of regulatory and professional bodies

D Develop, prioritise and implement a capacity development plan to improve HRH strategic and operational planning capability, as well as HRH management & development capacity and systems strengthening at all levels

E Establish a high-level HRH coordinating mechanism / technical working group encompassing human resources for health planning, management, development & financing, with representation from Ministries of Health, Finance, Education, Office of Head of Civil Service, Planning Commission, Regulatory Bodies, Private Sector Providers, NGOs in health, and other institutions

F Establish the necessary policy framework for integrating the processes of health infrastructure planning, human resources planning and health technology planning to minimize mismatches

Strategy 1.3: Establish and strengthen Human Resources Research as a tool for informing and improving on HRH policy and implementation in the public and private sector

Rationale

Human resources research in the health sector is rudimentary. There is the need for evidence to guide decisions on the most important resource in health care – the workforce. Whilst some evidence can be deduced from routine data collected at the various levels, it is imperative that specific investigations are conducted periodically to gather evidence on issues that can not be gleaned from data available.

Activities

A Develop a HRH Research Plan focussing on operations research and HRH areas for further study, for inclusion in HRH Annual Implementation Plans in line with the proposed allocation at least 1% of HRH programme budget towards HRH research activities

B Identify priority HRH related operations research areas to determine lessons learned and to inform HRH policy and programme development

C Commission, conduct and supervise regular HRH related operational research studies, includingI labour market supply studies, workforce utilization, retention, worker motivation, etc.

C Disseminate and utilize research findings to inform HRH policy and implementation recommendations, including improvements in workforce availability, skill mix, productivity, utilization and motivation

Policy Objective 2.0 Rationalise and align supply of health workforce to the priorities of the health sector

Strategy 2.1: **Strengthen health workforce training capacity and output based on service requirements**

Rationale

Currently, intakes into health training institutions are not related to requirements of the country. There is gross inequity in the distribution of some critically needed health professionals across states. An option for addressing the shortfall at a minimum cost can be arranging to train such needed staff in an existing institution in another state within the same geo-political zone other than developing the infrastructure for starting similar training from scratch. Such arrangements could improve the availability of midwives in under-served locations in the country.

For instance, whilst maternal mortality rates are high in some states, conversely few midwives are available in those locations. There is the need to vary intake into training institutions on the basis of requirements.

Activities

a. Designate zonal training sites for defined programmes such as midwifery within geo-political zones to maximize their use
b. Collaborate in designating, refurbishing and equipping zonal colleges to cater for the special training needs of states within the zones in medical, paramedical, nursing, and midwifery education
c. Train and retrain administrators and tutors in designated zonal institutions
d. Develop acceptable arrangement for admissions based on predetermined requirements of each state and LGA
e. Set up and strengthen training institutions for production of health care providers in states based on need
f. Sponsor candidates and bond them to return to serve for an agreed period after training.
g. Develop relevant training programmes and practices for the production of adequate numbers of community health oriented professionals based on national priorities

Strategy 2.2: Assuring Quality in Pre-Service Training Institutions and Programmes

Rationale

Training of health professionals does not reflect the prevailing challenges in the Nigerian health care environment. Pre-service training is expected to provide trainees the opportunities to acquire competences in a way that guarantees conformance to standards of practice. The acquisition of relevant competences will be better enhanced if mechanisms are established that continuously assure quality in teaching and learning.

Activities
To meet national needs:

a. Periodically review training curricula and programmes
b. Continuously review assessments conducted by training institutions to meet accreditation and professional requirements

c. Establish quality assurance units and education review units in all training institutions
d. Reward training Institutions with high quality standards and innovations
e. Establish incentives and upgrading structures for academic staff regularly so as to ensure their retention
f. Provide adequate infrastructure, teaching and learning materials, and financial support for training institutions
g. Promote horizontal communication and cooperation among accreditation bodies

Policy Objective 3.0 Apply best practices of human resource for health management and development that promote equitable distribution and retention of the right quality and quantity of human resource to ensure universal access to quality health services.

Strategy 3.1: Establishing mechanisms to strengthen and monitor performances of health workers at all levels.

Rationale

Empirical evidence and anecdotal information point to substandard performances of health professionals at all levels all over the country. This situation has resulted in poor quality of health care and therefore clients do not get value for their money. In order to win back the confidence of the people and increase demand for health services, there is need to improve on staff performances and by extension the quality of services provided in health facilities at all levels irrespective of geographic locations.

Activities

a. Strengthen regulatory bodies to enable them establish professional standards
b. Set up structures and monitoring systems in the geo-political zones to effectively monitor professional practices
c. Institutionalise structured in-service training on policy development and analysis for strategic level managers at all levels
d. Develop and provide job descriptions and specifications for all categories of health workers
e. Support formulation of policies and analysis of key management positions
f. Strengthen continuing professional development of health staff
g. Develop systems for managing performances of staff and the health team in both public and private facilities to ensure achievement of health sector goals
h. Strengthen supportive supervision of all cadres of health workers

Strategy 3.2: Re-orienting postgraduate and post-basic training programmes to the priority needs of the country

Rationale

Postgraduate and post-basic training programmes have not focused on the priority needs of the health sector and the need for community-oriented specialization. The effect is the under-production and mal-distribution of specialists in critical areas and needs.

Activities

a. Provide sponsorships for trainees/residents in needed specialties to attract them to such specializations and bond them to return to serve after training
b. Conduct appropriate periodic specialist needs assessments for postgraduate and post basic training programmes in the country and using these as basis for admissions

c. Provide sponsorships and incentives for doctors and other eligible professionals who want to undertake postgraduate degree in public health for the provision of community health practice in the country
d. Set criteria for special bridging programmes of training to allow desirous technical grade health workers to attain professional qualifications with relative ease
e. Work with the Collaborating Centres to develop programmes for continuous professional development of Managers for the health sector.

Strategy 3.3: Recruiting, selecting and deploying staff to reflect organizational objectives

Rationale
Recruitment, selection, and distribution of health workers are often not based on need and are thus inappropriate and lopsided. These result in some services being rendered by people without required competences or non-availability of services to those in critical need.

Activities

a. Create conducive environment to attract, induce, and retain health workers to serve in difficult terrain and areas where their services are in most need.
b. Provide induction and relevant orientation to all new entrants into the health sector within the first three months of their appointments.
c. Promote the use of non-discriminatory appointment policies especially for critically needed professionals.
d. Recruit retired health professionals in maternity care to undertake services in rural areas: for example, in their rural areas of origin
e. Establish mechanisms for effective collaboration between public and private sectors
f. Encourage skilled Nigerians working abroad to return and contribute to the Nigerian Health Care System based on well-determined HRH needs.
g. Strengthen Health Promotion Units with provision of adequate and competent staff to support demand creation.
h. Re-distribute health staff on the basis of workloads, norms and human resources development plans
i. Redeploy CHEWS extensively to work with communities in line with their training
j. Liaise with relevant authorities for the deployment of NYSC appropriate health professionals to PHC facilities as first contact.
k. Use HR plans as bases for efficient staff utilisation and monitoring across health facilities at all levels.
l. Design and implement integrated support supervisory arrangements.
m. Develop emergency staff with necessary logistics to support the referral arrangements.
n. Recruit Medical Officers of Health (with community health experience) for effective implementation and supervision of primary health care services.
o. Provide appropriate incentives for private health providers to set up practices in underserved areas.
p. Divide each LGA into community nursing/midwifery areas and assigning community nursing and midwifery personnel (or in their absence retrained CHEWs) specifically to each one of them.
q. Develop health systems that make community/rural health workers rise to the top of their specialty practices in primary health care/community health services without having to move into secondary or tertiary health facility
r. At all levels provide patent medicine vendors opportunities (training and other) to improve their performance – in line with the Patent Medicine Vendors' policy

4.0 Institutionalise performance incentives and management systems that recognize hard work and service in deprived and unpopular locations.

Strategy 4.1. ***Collaborating with states and local governments: cross-state collaboration to encourage implementation, and monitoring of federal government circulars, guidelines, and policies***

Rationale
There is often a disjoint between federal government policies, circulars and directives and state level actions or priorities. Also, there is minimal information sharing or flow among contiguous states on national HRH and health priorities. These affect staff morale and commitment resulting in inefficient staff utilization and poor service delivery in areas of needs,

Activities
a. Organise annual stakeholders' consultative forum to discuss critical HRH issues at national, zonal state and local government level.
b. Establish monitoring indicators to measure HRH performance at all level.
c. Conduct periodic monitoring of implementation of HRH strategic plan at all levels

Strategy 4.2. Creating incentives for health workers with emphasis on those that will attract and retain staff in rural and deprived areas.

Rationale
The bulk of national health priority issues are mostly in rural and deprived areas, where HRH availability is severely limited. The results are poor services and inability of the system to achieve the health-related MDGs. There is need to create the conditions that will pull staff with the relevant competences to willingly locate into areas where their services are in most need.

Activities
a. Establish special programmes for recruiting and deploying HRH from areas of abundance to areas of scarcity.
b. Implement systems to address staff concerns and problems
c. Provide appropriate incentives, including financial that encourage private providers to set up practices in underserved areas and meet all laid down conditions for establishing such private practices.
d. Design incentive packages to attract and retain health staff with rare skills in deprived and hard-to-reach areas.
e. Provide incentives and establish motivational mechanisms to encourage health professionals remain in the country to deliver health care.
f. Provide differential remuneration for community health professionals and technical staff to encourage them to take up jobs in under-served and rural areas.
g. Establish systems for recognising and rewarding initiatives, quality of service, and hard work in every public and private health care facility.

Strategy 4.3. ***Establishing systems for effective management of staff performance***

Rationale
Staff management systems in the health sector are inefficient and ineffective. Current appraisal systems are largely subjective and perfunctory. For performance of HR systems to be effective, there is need to set up evidence-based structures for managing staff.

Activities
a. Establish norms and staffing standards to guide recruitment and posting of health professionals.
b. Design performance management systems for health services managers and health teams
c. Review, in consultation with states and local governments, schemes of service, salary scales, and other emoluments in the public health sector to ensure harmony in salaries at all levels and to boost the morale of staff.

Strategy 4.4. ***Developing and streamlining career pathways for Health Promotion, community health workers, and other health professionals critically needed to foster demand and supply creation in the health sector.***

Rationale
Lack of clarity of career pathways has created distortions in schemes of service for many health professionals. This has resulted in stagnation in career advancement for staff, disillusionment, inter-cadre wrangling and brain drain. Also there is difficulty in attracting and retaining quality staff.

Activity
a. Streamline career progression and development within the sector to outline causes of stress arising from work-life linkages
b. Review and develop courses for in-service training at the universities and other educational institutions that offer relevant programmes to health staff.
c. Establish career progression schemes, and support career counselling, mentoring and coaching, and mainstream staff mentoring as part of responsibilities of health managers at all levels.
d. Adhere to promotion schedules on merit for all categories of staff at the various levels.
e. Promote equitable access to career development opportunities.

5.0 Foster collaboration among public sector, non-government providers of health services and other HRH stakeholders

Strategy 5.1 ***Developing and institutionalising forum for policy review, supervisory and monitoring support framework for public and private practitioners at all levels of health service delivery.***

Rationale
Supervision and monitoring of public and private health practice is viewed as invasive with punitive intentions due to poor communication and collaboration between government regulatory agencies, and health care providers. The involvement of private providers in policy development and planning would promote compliance to professional regulations, standards, and best practices.

Activities

a. Organise regular workshops and forums for HRH stakeholders to discuss reports from observatories and HRH researches in order to foster collaboration among relevant agencies, states, LGAs, private, and non- governmental organisations.
b. Establish mechanisms for Involving relevant stakeholders in HRH activities from planning, through implementation, monitoring, and evaluation.
c. Establish systems for structured support and supervision of health professionals at federal, state and local government, and private health facilities.
d. Establish mechanism for private sector providers to strengthen, update, identify, and deploy human resources in line with government policies.
e. Strengthen collaboration between HRH Divisions and professional regulatory bodies at all levels.

Strategy 5.2 ***Promoting collaboration among stakeholders in public and private institutions to ensure that adequate numbers of quality health staff are available in line with health sector development policies and plans***

Rationale

Excess human capacity in the private sector is untapped by the public sector due to constraints of work environment and remuneration. Establishing mechanisms to enable health professionals engage in extra/intra-mural practices based on skill demand and personal aspiration would make the services of health workers available in areas of need.

Activities

a. Develop and strengthen mechanisms and guidelines for extra/intra-mural practice.
b. Create incentives to encourage specialists in private and public practice to operate in public health facilities especially where such skills are not readily available.
c. Pool resources of private and public health providers for effective health care in rural communities.
d. Renegotiate terms of employment in the public sector to allow flexible work hours, and alternate work schedules for health workers (full time, part time etc.).
e. Strengthen public institutions in respect of adequate numbers of skilled personnel
f. Establish technical groups, comprising officers from public and private health care providers to develop, disseminate, and enforce staffing standards and norms for different levels of health facilities.
g. Support "Private-not-for-Profit" institutions to provide services in areas where other health providers are lacking or inadequate.

Strategy 5.3. Strengthening communication, cooperation and collaboration

between health professional associations and regulatory bodies on professional issues that have significant implications for the health system

Rationale

Health professional associations and regulatory agencies tend to focus on their special areas, limiting understanding of issues within the larger health care system. This results in loss of synergy, and perpetuates intra and inter-cadre rivalry. Strengthening collaboration between regulatory bodies and associations would enhance role definition, complementarities, and standards.

Activities

a. Collaborate with professional associations, regulatory authorities and other HRH stakeholders to develop concise job descriptions for all categories of health workers with clear delineation of roles and responsibilities.

b. Create structures to promote teamwork, multidisciplinary collaboration, and understanding of professional roles and responsibilities at all levels

c. Establish multidisciplinary management teams at all levels.

d. Review and streamline roles and responsibilities of professional associations and regulatory bodies.

Strategy 5.4 ***Facilitating accreditation of eligible private sector health facilities to increase training opportunities for internship, and post basic training for all health professionals***

Rationale

Currently, the public sector has limited capacity to provide practical training sites for interns, and specialists. There is need to review private sector capacity with a view to accrediting eligible facilities to complement internship and residency training. This will help to reduce frustrations among new entrants into health professions and also provide opportunities for expanding postgraduate and post basic training.

Activities

a. Review and strengthen mechanisms for assessing the capacity of private health facilities to provide internship and residency training for health care providers.

b. Support private facilities that meet minimum requirements to get accredited

c. Encourage private providers to take advantage of training opportunities provided by the public sector and vice versa

Policy Objective 6.0 Strengthen the institutional framework for human resources management practices in the health sector.

Strategy 6.1. Establishing a system for effective HRH development and management

Rationale

HRH management systems are weak at all levels. In order to implement the HRH Policy, there is need to establish and strengthen HRH Divisions at federal and state levels, and provide staff with qualified and competent HRH practitioners.

Activities

a. Establish and strengthen at federal and state levels HRH Divisions staffed with officers competent in HRH planning, development, and management.
b. Use the HRH Divisions as secretariat for the National and State HRH Observatory to monitor and facilitate HRH management systems development and promote cross learning of HRH best practices.
c. Design and implement on a sustainable basis incentive systems to promote HRH best practices at all levels.

d. Organise forum for frequent interaction of managers of regulatory bodies, professional associations, training institutions, and health facilities to review status of HR development, and management at all levels.

e. Assign and train officers within the M&E Unit in LGAs to update and maintain records of all health workers, and communicate such frequently to the state level.

f. Work with the Collaborating Centres to develop programmes for continuous professional development of HR Managers for the health sector.

Strategy 6.2 . ***Establishing Database of Nigerian Human Resources for Health***

Rationale

Dearth of reliable HRH information makes planning difficult. Development of an HRH database routinely updated using modern information and communication technology would enhance evidence based HRH planning by government, and other HRH stakeholders.

Activities

a. Develop and routinely update database of Nigerian HRH nationwide, and those in the Diaspora, and ensure integration of public and private HR information systems

b. Develop ICT infrastructure with interactive website for response to HRH inquiries and career development opportunities.

c. Establish mechanisms for HRH data to be communicated within and across levels.

d. Evaluate periodically HRH status in Nigeria

e. Publish the State of the Health Work force annual report.

Strengthening Human Resources for Health Management Systems, Procedures and Practices at all Levels

Implementation of the strategies at all levels will be very challenging. This will particularly be so because decisions on human resources for health are made in various locations and at different levels of government. There will be need to integrate systems strengthening and refining of procedures and practices for staff management at each of the levels.

In order to determine where coordination needs to be strengthened and the additional skills and experiences required, there is need to review the human resources functions with involvement of the key players at each of the levels. Based on findings relevant capacities need to be developed at all levels as part of the implementation process.

F. Options for the Implementation of the Human Resources for Health Plan

To address the current shortfalls and mal-distribution of some critical staff across and within states, 4 options are proposed for review. All the options focus on increasing the number of the critically needed staff in the grossly underserved areas. This is to ensure that staff per 100,000 population ratios in the affected states steadily gets closer to the national figures.

Option 1

- Within states, redistributing staff on the basis of workload and established norms. This will help to maximize the use of available staff and reduce their under-utilisation in some facilities whilst their counterparts are overloaded with work in others.
- Targeting health professionals graduating from training institutions for posting to under-served locations for NYSC. To retain them in those locations however there will be need

to provide attractive incentive packages and enforce non-discriminatory recruitment regulations. Adequate drugs and relevant equipment and supplies should also be made available.

- Increasing intake into existing training programmes to meet projected needs of underserved locations through zoning of the schools. It is noteworthy however that, decisions taken now on intakes will yield results after, or towards the end of the implementation period of this plan. This is because duration of most university-based programmes for training health professionals is 4 years. Medical education takes longer.

Option 2

In addition to the first 2 in "option 1" above, also

- Building new health training institutions in states where these are not available. This may be expensive in the short term but beneficial in future. Products from such institutions will be entering the health labour market after 6-10 years(depending on when structures are completed and intake begin and also duration of the programmes)

Option 3

In addition to the first 2 in "option 1" above, also

- Reviewing and revising curricula of existing relevant training programmes and enhancing component on skills that are in short supply but are critically needed. Eg. Obstetric care for CHEWS and basic surgery for CHOs (this may be a short-term stop-gap measure and may not meet approval and specifications of the relevant regulatory bodies).

Option 4

In addition to the first 2 in "option 1" above, also

- Recruiting additional staff from abroad. Eg. Cuban Brigade. This may be expensive compared with providing appropriate incentives to locally trained professionals. The expatriate professional has the additional disadvantage of spending time to adjust to socio-cultural dynamics of a new environment and also grappling with language difficulties.

These options have not been costed since salaries, other incentives and cost of training varies from one state to the other. It is recommended that states do their detailed costing based on the realities on the ground.

G. Key Assumptions of the Strategies

The strategies are developed to address challenges in human resources management and development in the country in order to achieve the set objectives. There may however be factors beyond the control of the Ministries of Health at the various levels that may impede achievement of the set objectives. It is assumed during the planning process that the factors will be addressed to ease the implementation of the strategic plan. The table below is a summary of the key assumptions.

Table 5 Key Assumptions Associated with the Strategies

Objectives	Strategies	Assumption
1: Provide framework for analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the country	1.1: Ensuring that long, medium and short term plans and projections are in place and up-to-date to guide HRH development at all levels 1.2: Establishing Human Resources Research as a tool for improving on health staff management in the public and private sector	a. Adequate funding will be allocated for HR planning and research at all levels. b. All key stakeholders continue to show interest in integrated human resources planning for health
2: Rationalise and align production of health workforce to the priorities of the health sector	2.1: Strengthen health workforce training capacity and output based on service requirements 2.2: Assuring Quality in Pre-Service Training Institutions and Programmes	a. All stakeholders agree to review training programmes to fit the priority needs of the health sector regularly b. Regulatory bodies will be well resourced to facilitate quality assurance in training.
3: Apply best practices of human resource management and development that promote equitable distribution and retention of the right quality and quantity of health human resource to ensure universal access to quality health services.	*3.1: Establishing mechanisms to strengthen and monitor performances of health workers at all levels.* 3.2: Re-orienting postgraduate and post-basic training programmes to the priority needs of the country 3.3: Recruiting, selecting and deploying staff to reflect organizational objectives	a. Health sector management committed to institutionalizing performance management culture at all levels of service delivery b. Stakeholders agree to implement continuous professional development plans.
4: Institutionalise management systems, and performance incentives that promote the retention of health workers in deprived and unpopular locations, and recognize hard work.	Strategy 4.1. Collaborating with states and local governments: cross-state collaboration to encourage implementation, and monitoring of federal government circulars, guidelines, and policies 4.2. Creating incentives for health workers with emphasis on those that will attract and retain staff in rural and deprived areas. 4.3. Establishing systems for effective management of staff performance. 4.4. Developing and streamlining career pathways for Health Promotion, community health workers, and other health professionals critically needed to foster demand and supply creation in the health sector.	a. All states prioritise health and get committed to implement federal government circulars on health staff remunerations. b. States and other stakeholders commit resources to provide special incentives to attract critically needed health staff to deprived locations. c. Stakeholders agree to operate a uniformed career progression pathways for health professionals with similar educational backgrounds and are on analogous grades.
5. Foster collaboration among public, Private, and non-government providers of health services, and other HRH stakeholders	5.1. *Developing and institutionalising forum for policy review, supervisory and monitoring support framework for public and private practitioners at all levels of health service delivery.* 5.2. *Promoting collaboration among*	a. Stakeholders remain committed to collaborate in service delivery. b. Stakeholders commit resources to joint planning and actions c. Private health providers will be

	stakeholders in public and private institutions to ensure that adequate numbers of quality health staff are available in line with health sector development policies and plans. ***5.3.*** *Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system* **5.4.** Facilitating accreditation of eligible private sector health facilities to increase training opportunities for internship, and post basic training for all health professionals.	committed to taking on interns and residents.
6. Strengthen the institutional framework for human resources manmanagement practices in the health sector	*Establishing a system for effective HRH opment and management* Establishing Database of Nigerian Human urces for Health.	MOH and States committed to gthening Strategic HRH functions. vibrant multi-sectoral committee set up pport National and State level HRH rvatory.

H. Resourcing the Plan

Successful Implementation of the HRH Strategic Plan will require substantial resources and commitment of all stakeholders. Federal Government, State Governments, Partners, professional associations, health workers unions, private practitioners and Non-Governmental Organisations in Health will all be required to play their roles in order to achieve the objectives of the plan.

Most of the human resources for health cost related to salaries and training are already being borne by governments and the private sector at the various levels. These will continue to be funded from the regular sources as usual. These are not reflected in the budget in this document. The costing reflects additional staff required to bring the underserved and deprived areas closer to achieving the national staff per 100,000 population ratios for some critically needed staff categories. It also covers some new primary health centres that need to be staffed in line with the ward minimum services package.

A number of HRH initiatives are already being supported by Partners. This comprehensive and integrated National Human Resources for Health Strategic Plan aims at attracting funding agencies to join forces with governments at the various levels to put in more support for the optimum management and development of the health workforce in a well coordinated manner. Potential sources of funding for human resources for health management and development during the plan period 2008-2012 are as follows:

1. Government sources – federal, state, LGA
2. Donor and other external sources of funding
3. Direct employer funding
4. National Health Insurance Scheme
5. Public – Private Partnerships
6. Individual and community self help/ investment in human resources development

7. Philanthropic sources
8. Faith based organizations
9. Other special funds.

I. Implementation of the Strategies

The strategic plan will be implemented at all levels of the Nigerian health care delivery system. The Steering Committee of the National Human Resources for Health Observatory will oversee the implementation of the strategies. Within each state, the State Steering Committee will oversee implementation. The Steering Committee will appoint a scientific/technical working group to be responsible for follow up on issues, monitoring of implementation, analysis of data and reporting to the Committee as required.

The Steering Committees will facilitate annual reviews of the implementation of the plan. At federal level the strategic plan will inform the development of the human resources component of the Medium Term Sector Strategy Document. The state and local government levels will translate the strategies into costed annual action plans. Hospital Management Teams and Health Training Institutions will be expected to prepare their action plans based on their human resources needs and in line with the strategic HR objectives as guidance.

A major first year activity will include national, zonal and state level discussions and consensus building and mobilizing of technical capacity for all the levels for HRH management.

During the first year (2008) of implementation, the following will constitute the key activities and tasks:

Strategy 1.1 Ensure long, medium and short term plans and projections are in place and up-to-date to guide HRH development at federal, state and local government levels.

Activity A Develop, introduce and utilize staffing norms and standards based on workloads and sectoral priorities.

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Remarks
1	Undertake analysis of workloads using Workload Indicators of Staffing Needs Methodology	HRH Divisions at federal and state levels	X				
2	Profile the existing workforce to establish an overview and baseline of the total number of health posts etc	HRH Divisions at federal and state levels		X			
3	Establish and update staff database to facilitate evidence based decisions	Federal state & LG levels	X	X	X	X	
4	Develop level and location specific costed HRH Action Plans	Federal, state and LG levels			X	X	

Strategy 1.2 Strengthen capacity, structures and systems for responsive HRH planning, management and development at all levels.

Activity A Review existing HRH planning, management and development capacity, systems and structures at all levels across the sector

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Outputs
1	Develop tools for assessing the existing HRH planning, management & development systems at all levels	HRH Divisions at federal and state levels	X				
2	Conduct a review of HRH systems at all levels	HRH Divisions at federal and state levels	X	X	X		A review of HRH systems
3	Disseminate findings and intensify advocacy for improved integrated HRH systems at all levels.	HRH Divisions at federal and state levels		X	X	X	Evidence based advocacy
Activity B. Establish or strengthen HRH Structures both within and outside the Federal and State Ministries of Health and Local Government Health Departments							
1	Appoint competent staff to be responsible for HRH planning and management	Federal & State MOHs and Local Governments	X				Full time staff for HRH
2	Design and provide appropriate training in HRH planning, management and development for HRH staff	Federal & State MOHs and Local Governments			X	X	Capacity built for HRH staff
3	Provide appropriate equipment and furnishings to HRH offices	Federal & State MOHs and Local Governments	X	X			HRH offices well furnished and equipped
Activity C. Review and refine the functions, mandates and responsibilities of regulatory and professional bodies							
1	Appoint a task force with TOR to review functions, mandates & resp. of regulatory and professional bodies	Federal Ministry of Health	X				
2	Refine the functions, mandates, responsibilities and develop benchmarks for regulatory and professional bodies.	Federal Ministry of Health	X				Functions, mandates, & responsibilities reviewed
3	Review, improve and develop systems for regular updates of registers of regulatory and professional bodies.	Regulatory and Professional Bodies		X	X	X	Registers regularly updated
Activity D. Establish a high level multi-sectoral HRH Steering Committee to oversee HRH Planning, Management and Development at National and State levels							
1	Develop Terms of Reference for Steering Committee	HRH Division FMOH	X				
2	Link up with Ministries of Finance, Education, and Local Government, office of Health of Service, Public Service Commission, Planning Commission, Private sector Providers, NGOs in Health and other health related institutions to submit details of representatives	HRH Divisions, Federal and State Ministries of Health	X				Multi-sectoral HRH Steering Committee formed
3	Appoint an HRH Monitoring Technical Working Group	Steering Committees National and States)	X				
4	Develop operational framework for the Steering Committees	HRH Steering Committees	X	X			
5	Initiate operations of HRH Observatories	HRH Steering Committees			X	X	Steering Committee providing support for HRH dev't

Strategy 2.1 Strengthen health workforce training capacity and output based on service demand

Activity A. Conduct a rapid capacity assessment of sector-wide supply, production and absorption of newly trained health care providers in the country.

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Remarks
1	Design a study for a sector-wide rapid assessment of supply, production and requirements of health workforce	Federal and State MOHs	X				
2.	Carry out assessment of health workforce requirement and supply	Federal and State MOHs		X			Study carried out
3.	Initiate discussions among stakeholders in under-served zones on sharing of training facilities for prioritized staff	FMOH and States in deprived zones	X				Stakeholders agreeing to share facilities

Strategy 3.2 Recruit, select and deploy staff to reflect organizational objectives

Activity A Liaise with authorities to recruit additional staff to under-served areas

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Outputs
1	Arrange for NYSC Drs, Midwives and other critically needed staff to PHC facilities	FMOH, SMOH, SMOLG	X	X	X	X	NYSC health professionals in PHC facilities
2	Determine additional staffing requirements	SMOH and SMoLG in Underserved states	X				Records on additional staff requirement
3	Initiate redistribution from areas of higher concentration to deprived areas.	SMOHs and SMOLGs			X	X	Redistribution initiated in favour of deprived areas
4	Initiate bilateral agreements to recruit from better endowed states to deprived ones	SMOH and SMoLG in Under-served states	X				

Strategy 4.2 Create incentives for health workers with emphases on those that will attract and retain staff in rural and deprived locations

Activity B. Implement systems to address staff concerns and problems

No.	**Tasks**	**Responsible**	**Q1**	**Q2**	**Q3**	**Q4**	**Remarks**
1	Create staff welfare and counseling desks in health facilities	HRH Divisions federal and states	X				Staff welfare and counseling desks
C.1	Design differential incentives for critically needed staff in deprived areas	HRH Division l states and LGAs		X	X	X	Differential incentives
G1	Develop mechanisms for recognizing and rewarding initiatives, quality service and hard work in facilities	HRH Division federal states and LGAs		X	X	X	Rewards for initiatives and hard work

Strategy 5.3 Strengthen Communication, Cooperation and Collaboration between health professional associations and regulatory bodies

Activity B Create structures to promote teamwork, multidisciplinary collaboration and understanding of professional roles and responsibilities at all levels

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Output
1	Set up working group to review roles and responsibilities of occupational groups in health institutions	FMOH, SMOH	X				Roles and responsibilities reviewed
2	Develop Clear cut modalities for appointment into management positions in health institutions	FMOH, SMOH		X			Leadership & managerial positions & responsibilities clearly defined

Strategy 5.4 Facilitate accreditation of private sector health facilities to increase training opportunities for internship, and post basic training for all health professionals.

Activity A. Review and strengthen mechanisms for assessing the capacity of private health facilities to provide internship and residency training for health care providers.

No.	Tasks	Responsible	Q1	Q2	Q3	Q4	Output
1	Review/Develop criteria for assessing capacities of private facilities for accreditation as training sites	Regulatory and professional bodies	X				Assessment criteria
2	Assess capacities of private facilities for their eligibility to serve as training sites	Regulatory and professional bodies		X			Level of readiness of facilities documented
3	Support facilities that meet above 70% of requirement to meet full requirements	FMOH			X	X	Relevant support provided for completion
4	Set up mechanisms for regular monitoring of eligible facilities	Regulatory and professional bodies			X	X	Facilities regularly monitored

Major Accomplishments Envisaged In The First Year

It is expected that implementation of the above strategies will make the health sector especially in the underserved areas more competitive and attractive to health workers. This will eventually result in significant improvements in service delivery and improvement in the health indicators in those locations.

Implementation Framework

Leadership

The Federal Ministry of Health will provide strategic guidance and provide technical support to states to translate the strategies of the 5-year plan into annual plans. At the national level, the proposed high level HR Steering Committee will oversee the monitoring of the implementation of the Plan.

LGAs will be expected to develop their own human resource action plans based on their human resource needs and these will inform state level plans. Training institutions will be expected to develop their plans based on their needs and requirements from the state or zone within which they are established. All action plans will be guided by the strategic objectives of this National HRH Strategic Plan.

J. Monitoring and evaluation

Implementation of the strategic plan will be monitored at federal, state and local government levels. At the federal level the Steering Committee of the National Human Resources for Health Observatory will have the overall oversight responsibility for monitoring implementation nationwide. The Committee will set up a Monitoring and Evaluation Team that will work in collaboration with the Health Management Information Systems (HMIS) Unit of the Federal Ministry of Health to develop a monitoring and evaluation framework in line with the HRH Strategic Plan. A monitoring report will be compiled and presented at the annual stakeholders meetings and the National Council on Health(NCH). At the state level, monitoring reports will be shared with all stakeholders at that level with copies of half yearly reports submitted to the National HRH Observatory at the federal level. Table 10 below depicts some set of human resources performance indicators.

Table 6 Human Resources for Health Strategies and Expected Outputs

Objective	Strategies	Indicators	Means of Verification	Total Cost Naira
1: Provide framework for analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the country	1.1: Ensuring that long, medium and short term plans and projections are in place and up-to-date to guide HRH development at all levels	HRH planning management and development structures in place, Updated HR Strategies and Plans available at all levels	Up to date detailed HRH plans available at federal, state and LGA levels	97,900,000
	1.2: Establishing Human Resources Research as a tool for improving on health staff management in the public and private sector	Research agenda set annually and carried out in federal and state levels	Documented research agenda, Reports on research carried out, and status of implementation.	126,748,000
2.0. Rationalise and align supply of health workforce to the priorities of the health sector	2.1: Strengthen health workforce training capacity and output based on service requirements	Training infrastructure expanded and improved Intake into training institutions based on projected requirement	Physical inspection of structures and training equipment Enrolment lists from training institutions	346,000,000
	2.2: Assuring Quality in Pre-Service Training Institutions and Programmes	Quality recognition initiatives introduced in training institutions	Report on quality assurance initiatives	1,267,859,000
3.0 Apply best practices of human resource for health management and development that promote equitable distribution and retention of the right quality and quantity of health human resource to ensure universal access to quality health services.	*3.1:* Establishing mechanisms to strengthen and monitor performances of health workers at all levels.	Management performance monitoring initiatives in place at all levels and in facilities Improved management performance	Management performance reports	616,000,000
	3.2: Re-orienting postgraduate and post-basic training programmes to the priority needs of the country	Content and approaches to postgraduate and post basic training programmes reflecting requirements priorities of the health sector including, HSR and HMDGs	Reports and curricula from training programmes	680,400,000
	3.3: Recruiting, selecting and deploying staff to reflect organizational objectives	Staff selection and deployment reflecting competences required to meet requirements	CVs of newly recruited staff and selection reports	8,342,852,000
4.0. Institutionalise performance incentives and management systems that recognize hard work and service in deprived and unpopular locations.	Strategy 4.1. Collaborating with states and local governments: cross-state collaboration to encourage implementation, and monitoring of federal government circulars, guidelines, and policies	States implementing federal government circulars on remunerations for health staff.	Federal government circulars and payment vouchers.	136,880,000
	4.2. Creating incentives for health workers with emphasis on those that will attract and retain staff in rural and deprived areas.	Differential incentives introduced in favour of staff in rural deprived areas. Improved retention of health professionals in deprived areas	Records of provision of relevant incentives to staff in targeted locations. List of professionals in deprived locations indicating their length	230,000,000

			of stay	
	4.3. Establishing systems for effective management of staff performance.	Framework in place for staff performance management at all levels.	Reports on staff performance management	12,400,000
	4.4. Developing and streamlining career pathways for Health Promotion, community health workers, and other health professionals critically needed to foster demand and supply creation in the health sector.	Conditions and Schemes of service of Health Promotion and Community Health workers reviewed with Career Progressions clarified	Copies of revised schemes of service	170,000,000
5.0 Foster collaboration among public sector, non-government providers of health services and other HRH stakeholders	5.1. Developing and institutionalising forum for policy review, supervisory and monitoring support framework for public and private practitioners at all levels of health service delivery.	Joint policy review forums organized for public and private practitioners	Reports of forums	153,500,000
	5.2. Promoting collaboration among stakeholders in public and private institutions to ensure that adequate numbers of quality health staff are available in line with health sector development policies and plans.	Staff from both private and public health sectors at various locations being used on basis of comparative advantages	List of staff distribution and reports on service delivery.	145,000,000
	5.3. Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system.	Frequent meetings between staff in public and private sectors, regulatory bodies and associations	Minutes of meetings	115,500,000
	5.4. Facilitating accreditation of eligible private sector health facilities to increase training opportunities for internship, and post basic training for all health professionals.	Private facilities accredited to provide internship and residency training	List of private health facilities providing internship and residency training.	25,000,000
6.0. Strengthen the institutional framework for human resources management practices in the health sector.	6.1. Establishing a system for effective HRH development and management.	HRH Divisions established in FMOH and in states HRH Steering Committee in place and functioning optimally	Organogram reflecting the structure of HRH Division within FMOH and SMOHs Reports on activities of HRH Steering Committees	200,000,000
	6.2. Establishing Database of Nigerian HRH	An up-to-date database on all categories of Nigerian HRH in place.	Electronic data and hard copies of staff list	135,500,000
			Total	**12,801,539,000**

ANNEXES

Annex 1. Costed HRH Strategies

Annex 2. 5-Year Projected Critically Needed Health Professionals For Underserved States

Annex 3. Continuous Staff Development Plan

Annex 4. Type and Number of Health Training Programmes in the States

Annex 5. Statistics of Health Workers as at December 2005 by State of Practice

Annex 1. Costed HRH Strategies

Table 8. Costed HRH Strategies

Objective 1: Provide framework for analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the countr					
Strategy 1.1: Ensuring that long, medium and short term plans and projections are in place and up-to-date to guide human resources for hea and local government levels.					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Develop, introduce and utilize staffing norms based on workload to guide planning and use service availability and health sector priorities to determine staffing needs	Federal, State and LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department	20,000,000	2,000,000 Technical support and monitoring to states	2,000,000 Technical support and monitoring to states
b. Provide appropriate coordinating mechanisms towards mutual consistency in human resources for health planning and budgeting among the Ministries of Health, Finance, Education, Office of Head of Civil Service, Planning Commission, Regulatory Bodies, Private Sector Providers, NGOs in health, and other institutions	Federal, State & LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department	3,000,000	3,000,000	3,000,000
c. Set up effective structural and technical capacity, both within and outside the Federal and State Ministries of Health and Local Government Health Departments for human resources policy, planning and management	Federal, State and LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department	10,900,000	37,000,000	10,000,000
d. Provide the necessary framework for integrating the processes of health infrastructure planning, human resources planning and health technology planning to minimize mismatches	Federal, State and LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department	5,500,000	5,500,000	5,500,00
		Sub total	**39,400,000**	**37,500,000**	**18,500,000**
Strategy 1.2: Establishing Human Resources Research as a tool for improving on health staff management in the public and private sector.					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Allocate at least 10% of HRH programme budget to HRH research activities	Federal, State and LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department			
b. Conduct and commission at all levels regular operational research into issues such as staff supply, requirement, utilization, and health provider and manager satisfaction	Federal, State and LGA	FMOH – DHPRS, HRH Branch NPHCDA SMOH – DHPRS LGA – Health Department			
c. Disseminate and utilize research findings to improve staff productivity, utilization and motivation	Federal, State, LGA and Private	FMOH – DHPRS, HRH nch, NPHCDA, gulatory Bodies SMOH – DHPRS LGA – Health Department Professional Associations Association of private health care providers			

Objective 2: Rationalise and align supply of health workforce to the priorities of the health sector					
Strategy 2.1: Strengthen health workforce training capacity and output based on service requirements					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Collaborate in designating, refurbishing and equipping zonal colleges to cater for the special training needs of states within the zones in medical, paramedical, nursing, and midwifery education	Federal and State	FMOH – DHPRS, HRH Branch SMOH – DHPRS	16,000,000	75,000,000	75,000,000
b. Set up and strengthen training institutions for production of health care providers in states based on need	Federal and State	FMOH – DHPRS, HRH Branch SMOH – DHPRS	-	??	
c. Develop acceptable arrangement for admissions into designated zonal health training institutions based on predetermined requirements of each deprived state and LGA	Federal, State and LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS	5,440,000	-	-
d. Sponsor candidates and bond them to return to serve for an agreed period after training	Federal, State and LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department	To be budgeted by states and LGAs based on needs		
e. Review and adapt relevant training programmes and practices for the production of adequate numbers of community health oriented professionals based on national priorities	Federal, State and Private	FMOH – DHPRS, HRH Branch, NPHCDA, Regulatory Bodies SMOH – DHPRS Private – Faith-based organizations, NGOs, Entrepreneurs	-	50,000,000	50,000,000
f. Train and retrain Training Administrators and Tutors in designated zonal institutions	Federal, State and LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department	-	25,200,000	-
		Sub Total	**21,440,000**	**150,200,000**	**125,000,000**
Strategy 2.2: Assuring Quality in Pre-Service Training Institutions and Programmes					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Provide adequate infrastructure, teaching and learning materials, and financial support for training institutions	Federal, States	FMOH – DHPRS SMOH - DHPRS	**-**	100,000,000	100,000,000
b. Establish quality assurance units and education review units in all training institutions	Training Institutions	Accredited Health Training Institutions	72,109,000	48,450,000	48,450,000
c. Establish incentives and upgrading structures for academic staff regularly so as to ensure their retention	Federal, States	FMOH – DHPRS SMOH - DHPRS	**-**	30,600,000	30,600,000
d. Periodically review training curricula and programmes by appropriate accrediting and regulatory bodies	Federal	FMOH – Regulatory Bodies	-	225,000,000	
e. Continuously review assessments conducted by training institutions to meet accreditation and professional requirements	Federal	FMOH – Regulatory			
f. Reward training Institutions with high quality standards and innovations	Federal, States	FMOH – DHPRS SMOH – DHPRS	-	30,000,000	30,000,000

g. Promote horizontal communication and cooperation among accreditation bodies	Federal, States	FMOH – DHPRS SMOH – DHPRS	2,000,000	2,000,000	2,000,000
		Sub Total	**74,109,000**	**435,600,000**	**211,050,000**
Objective 3: Apply best practices of human resource management and development that promote equitable distribution and retention of t health human resource to ensure universal access to quality health services.					
Strategy 3.1: Establishing mechanisms to strengthen and monitor performances of health workers at all levels.					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Strengthen regulatory bodies to enable them establish professional standards	Federal	FMOH – DHPRS Regulatory Bodies, Professional Associations	-	30,000,000	-
b. Set up structures and monitoring systems in the geo-political zones to effectively monitor professional practices	Federal	FMOH – DHPRS	_	25,000,000	20,000,000
c. Develop and provide job descriptions and specifications for all categories of health workers	Federal and State	FMOH – DHPRS, HRH Branch SMOH – DHPRS	-	15,000,000	-
d. Institutionalise structured in-service training on policy development and analysis for strategic level managers at all levels	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	-	35,700,000	35,700,000
e. Support formulation of policies and analysis of key management positions	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs		16,000,000	16,000,000
f. Strengthen continuing professional development of health staff	Federal, State, LGA, Private and Professional Associations	FMOH – DHPRS, HRH Branch SMOH – DHPRS Private – Faith-based organizations, NGOs, Entrepreneurs	10,000,000[a]	20,000,000	30,000,000
g. Develop systems for managing performances of staff and the health team in both public and private facilities to ensure achievement of health sector goals	Federal, State and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS Private – Faith-based organizations, NGOs, Entrepreneurs	10,000,000		
h. Strengthen supportive Supervision of all cadres of health workers	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs		25,000,000	25,000,000
		Sub Total	**20,000,000**	**166,700,000**	**136,700,000**
Strategy 3.2: Re-orienting postgraduate and post basic training programmes to the priority needs of the country					
Activity	**Level of**	**Responsible**	**2008 Cost**	**2009 Cost**	**2010 Cost**

	Implementation	Department/Agency			
a. Conduct appropriate periodic specialist needs assessments for postgraduate and post basic training programmes in the country and using these as basis for admissions	Federal and State	FMOH – DHPRS, HRH Branch SMOH – DHPRS – HRH Branch	5,000,000	5,000,000	3,000,000
b. Provide sponsorships for trainees/residents in needed specialties to attract them to such specializations and bond them to return to serve after training	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	20,000,000[a]	40,000,000	60,000,000
c. Provide sponsorships and incentives for doctors and other eligible professionals who want to undertake postgraduate degree in public health for the provision of community health practice in the country	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	27,280,000	27,280,000	27,280,000
d. Set criteria for special bridging programmes of training to allow desirous technical grade health workers to attain professional qualifications with relative ease	Federal	FMOH – DHPRS – HRH Branch Regulatory Bodies,	-	5,000,000	-
e. Work with the Collaborating Centres to develop programmes for continuous professional development of managers for the health sector	Federal, State, LGA Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	**1874000000**	**2910000000**	**3935000000**
		Sub Total	**1,926,280,000**	**2,987,280,000**	**4,025.280,000**
Strategy 3.3: Recruiting, selecting and deploying staff to reflect organizational objectives					
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Create conducive environment to attract, induce, and retain health workers to serve in difficult terrain and areas where their services are in most need.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs			
b. Provide induction and relevant orientation to all new entrants into the health sector within the first three months of their appointments.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	10,000,000	25,000,000	25,000,000
c. Promote the use of non-discriminatory appointment policies especially for critically needed professionals.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department			

		Private – Faith-based organizations, NGOs, Entrepreneurs			
d. Recruit retired health professionals in maternity care to undertake services in rural areas: for example, in their rural areas of origin	State, LGA and Private	SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs			
e. Establish mechanisms for effective collaboration between public and private sectors	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	3,000,000		
f. Encourage skilled Nigerians working abroad to return and contribute to the Nigerian Health Care System based on well-determined HRH needs.	Federal, State and Private	FMOH – DHPRS, HRH Branch Min. of Foreign Affairs - Diaspora Office SMOH – DHPRS Regulatory Agencies Private – Faith-based organizations, NGOs, Entrepreneurs	10,000,000	10,000,000	10,000,000
g. Strengthen Health Promotion Units with provision of adequate and competent staff to support demand creation.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	5,000,000	5,000,000	5,000,000
h. Use HR plans and staffing norms as bases for efficient staff utilisation and monitoring across health facilities at all levels.	Federal, State and LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department	-	8,000,000	8,000,000
i. Divide each LGA into community nursing/midwifery areas and assign community nursing and midwifery personnel (or in their absence retrained CHEWs) specifically to each one of them.	State & LGA	LGA – Health Department LGAs, Local Government Services Commission	2,000,000	2,000,000	2,000,000
j. Liaise with relevant authorities for the deployment of NYSC doctors and other appropriate health professionals to PHC facilities as first contact.	Federal and State	FMOH – DHPRS, HRH Branch SMOH – DHPRS NYSC Directorate Regulatory Bodies	1,123,000,000	1,123,000,000	1,123,000,000
k. Design and implement integrated support supervisory arrangements.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	-	10,000,000	10,000,000
l. Develop emergency staff with necessary logistics to support the referral arrangements.	Federal, State, LGA and Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS	_	5,000,000	5,000,000

		LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs			
m. Recruit Medical Officers of Health (with community health experience) and midwives for effective implementation and supervision of primary health care services.	LGA	LGA – Health Department LGAs, Local Government Services Commission	-	375,840,000	591,840,000
n. Develop health systems that make community/rural health workers rise to the top of their specialty practices in primary health care/community health services without having to move into secondary or tertiary health facility .	State and LGA	SMOH – DHPRS LGA – Health Department			
o. At all levels provide patent medicine vendors opportunities (training and other) to improve their performance – in line with the Patent Medicine Vendors' policy.	Federal, State, and LGAs	Food and Drugs Dept SMOH, Training Institutions, LGA PHC Department, Private health Organisations		30,000,000	30,000,000
		Sub Total	**1,153,000,000**	**1,480,963,000**	**1,686,963,000**

Objective 4: Institutionalise management systems, and performance incentives that promote the retention of health workers in deprived recognize hard work.

Strategy 4.1. ***Collaborating with states and local governments to encourage implementation, and monitoring of federal government circulars, gu***

Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Establish monitoring indicators to measure HRH performance at all levels.	Federal, state and LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	5,000,000	2,000,000	2,000,000
b. Conduct half yearly monitoring of implementation of HRH strategic plan at all levels	Federal, state, LGA & Private	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	-	17,220,000	17,220,000
c. Organise annual stakeholders consultative forum to discuss critical HRH issues at national and state levels.	Federal, State & LGA	FMOH – DHPRS, HRH Branch SMOH – DHPRS LGA – Health Department Private – Faith-based organizations, NGOs, Entrepreneurs	9,000,000	9,000,000	9,000,000
		Sub total	**24,000,000**	**28,220,000**	**28,220,000**

Activity	**Level of Implementation**	**Responsible Department / Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**
a. Establish special programmes for recruiting and deploying HRH from areas of abundance to areas	Federal, State & LGA	FMOH – HRH Branch, NPHCDA SMOH, MOLG Private – Entrepreneurs	6,000,000	6,000,000	6,000,000

	of scarcity.					
b.	Implement systems to address staff concerns and problems	Federal, State, LGA	FMOH – HRH Branch, Dep't of Personnel Management SMOH LGA, Private	10,000,000	10,000,000	10,000,000
c.	Provide appropriate incentives that encourage private providers to set up practices in underserved areas.	Federal, State, and LGAs, private sector, communities	FMOH, NHIS, SMOH, FMOF, SMOF	-	-	-
d.	Design incentive packages to attract and retain health staff with rare skills in deprived and hard-to-reach areas.	State, and LGAs	SMOH, NPHCDA, SMOF.	-	-	-
e.	Provide incentives and establish motivational mechanisms to encourage health professionals remain in the country to deliver health care.	**State**	SMOH, NPHCDA, SMOF			
f.	Provide differential remuneration for community health professionals and technical staff to encourage them take up jobs in under-served and rural areas.	Federal, State, LGAs	FMOH - NPHCDA, SMOH, SMOF, Local Gov. Service Commission			
g.	Establish systems for recognising and rewarding initiatives, quality of service, and hard work in every public and private health care facility.	Federal, State, LGAs	FMOH,SMOH, NPHCDA, Guild of Private Practitioners, Regulatory Bodies, and Health Associations.	30,000,000	30,000,000	30,000,000
			Sub Total	**46,000,000**	**46,000,000**	**46,000,000**

Activity	Level of Implementation	Responsible Department/Agency	2008 Cost	2009 Cost	2010 Cost
a. Facilitate adherence to disciplinary codes and code of conduct at the work place.	Federal, State, LGAs	National Hospital Service Commission, SMOH, Local Gov. Service Commission, SERVICOM, Health Regulatory Bodies.			
b. Review, in consultation with states and local governments, schemes of service, salary scales, and other emoluments in the public health sector to ensure harmony in salaries at all levels.	Federal, State, LGAs	FMOH, National Hospital Service Commission, National Salaries and Wages Commission, SMOH, Local Gov. Service Commission, Health Regulatory Bodies, and Professional Associations, .	-	6,200,000	-
		Sub total		**6,200,000**	**-**

Strategy 4.4. Developing and streamlining career pathways for Health Promotion , community health workers, and other health professionals critically demand and supply creation in the health sector.

Activity	Level of Implementation	Responsible Department/Agency	2008 Cost	2009 Cost	2010 Cost	2011 Cost	2
a. Review and develop courses for in-service training at the universities and other educational institutions that offer relevant programmes to health staff.	Federal, State, LGA	FMOH, Federal Ministry of Education, SMOH, NPHCDA, Professional Associations, and Partners					
b. Streamline career progression and development within the sector to outline causes of stress arising from work-life linkages	Federal, State, LGA	FMOH, SMOH, NPHCDA, Federal Ministry of Labour, Professional Associations, and Partners		10,000,000			
c. Review and develop courses for in-service training at the universities and other educational institutions that offer relevant programmes to health staff.	Federal, State, LGA	FMOH, Federal Ministry of Education, SMOH, NPHCDA, Professional Associations, and Partners	-	15,000,000	15,000,000	15,000,000	1
d. Establish career progression schemes, and support career counselling, mentoring and coaching, and mainstream staff mentoring as part of responsibilities of health managers at all levels.	Federal, State, LGA	FMOH, SMOH, NPHCDA, Federal Ministry of Labour, LGA Service Commission, Professional Associations, and Partners		25,000,000	25,000,000	25,000,000	2
e. Adhere to promotion schedules on merit for all categories of staff at the various levels.	Federal, State, LGA	FMOH, SMOH, NPHCDA Federal, and State Civil Service Commission, Federal Ministry of Labour, LGA Service Commission.					
f. Promote equitable access to career development opportunities.	Federal, State, LGA	FMOH, SMOH, NPHCDA, Federal Ministry of Labour, LGA Service Commission, Professional Associations, and Partners					
		Sub total		**50,000,000**	**40,000,000**	**40,000,000**	**4**

Objective 5. Foster collaboration among public, Private, and non-government providers of health services, and other HRH stakeholders						
Strategy 5.1. Developing and institutionalising forum for policy review, supervisory and monitoring support framework for public and priv health service delivery.						
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
a. Establish mechanisms for Involving relevant stakeholders in HRH activities from planning, through implementation, monitoring, and evaluation.	Federal, and State	FMOH, SMOH, NPHCDA, and Partners	3,000,000	7,000,000	7,000,000	7
b. Establish systems for structured support and supervision of health professionals at federal, state and local government, and private health facilities.	Federal, State, and LGA	FMOH, National Hospital Service Commission, SMOH, NPHCDA, LGA PHC Department, Professional, and Regulatory Associations, and Partners	5,000,000	12,000,000	12,000,000	1
c. Establish mechanism for private sector providers to strengthen, update, identify, and deploy human resources in line with government policies.	Federal, and State	FMOH, National Hospital Service Commission, NHIS, State Hospital Management Board, SMOH, LGA PHC Department, Professional, and Regulatory Associations.	2,000,000	2,000,000	2,000,000	2
c. Strengthen collaboration between HRH Divisions and professional regulatory bodies at all levels.	Federal, State, LGAs	FMOH, SMOH, Professional, and Regulatory Associations	3,500,000	3,500,000	3,500,000	3
d. Organise regular workshops and forum for management staff to foster collaboration among relevant agencies, states, LGAs, private, and non- governmental organisations	Federal, and State	FMOH, National Hospital Service Commission , SMOH, NPHCDA, Federal Ministry of Labour, LGA Service Commission, Professional Associations, and Partners	5,000,000	10,000,000	10,000,000	1
		Sub total	**15,500,000**	**34,500,000**	**34,500,000**	**3**

Strategy 5.2. Promoting collaboration among stakeholders in public and private institutions to ensure that adequate numbers of quality h with health sector development policies and plans.						
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
a. Develop and strengthen mechanisms and guidelines for extra/ intra-mural practice.	Federal, State, and LGA	FMOH, National Hospital Service Commission, NHIS, State Hospital Mgt Board, SMOH, LGA PHC Department, Professional Assoc, Regulatory Bodies	2,500,000	2,500,000		
b. Create incentives to encourage specialists in private and public practice to operate in public health facilities especially where such skills are not readily available.	Federal, State, LGAs	National Hospital Service Commission, NHIS, State Hospital Management Board, Faith Based care providers		25,000,000	25,000,000	2
c. Pool resources of private and public health providers for effective health care in rural communities.	Federal, State, LGAs	National Hospital Service Commission, NHIS, State Hospital Management Board, Faith Based care providers, private health organizations, and partners		10,000,000	10,000,000	1
d. Renegotiate terms of employment in the public sector to allow flexible work hours, and alternate work schedules for health workers (full time, part time etc.).	Federal, State, and LGAs	National Hospital Service Commission, NPHCDA, State Hospital Management Board, Faith Based care providers, private health organizations				
			2,500,000	37,500,000	35,000,000	3

Strategy 5.3. **Strengthening communication, cooperation and collaboration between professional regulatory bodies on professional issues th for the health system.**						
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
a. Review and streamline roles and responsibilities of professional associations and regulatory bodies.	Federal, State and Private	FMOH, SMOH, Professional Associations and Regulatory Bodies.		5,000,000	5,000,000	5
b. Create structures to promote teamwork and multidisciplinary collaboration at all levels.	Federal, State, and LGAs	FMOH, SMOH, Training Institutions, NPHCDA, State Hospital Management Board, LGA PHC Dept, Professional Assoc. Regulatory Bodies, Private health Organ.		5,000,000	5,000,000	5
c. Establish multidisciplinary management teams at all levels.	Federal, State, and LGAs	FMOH, SMOH, Training Institutions, NPHCDA, State Hospital Management Board, LGA PHC Department, Private health Organisations	2,500,000	18,000,000	18,000,000	1
		Sub total	**2,500,000**	**28,000,000**	**28,000,000**	**2**
Strategy 5.4 Facilitating accreditation of eligible private sector health facilities to increase training opportunities for internship, and post basic traini						
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
a. Review and strengthen mechanisms for assessing the capacity of private health facilities to provide internship and residency training for health care providers	Federal , State and Private	FMOH, SMOH, Regulatory Bodies, Private Health Facilities	5,000,000	5,000,000	5,000,000	5
b. Encourage private providers to take advantage of training opportunities provided by the public sector and vice versa .	Federal, State, and LGAs	FMOH, SMOH, Training Institutions, NPHCDA, State Hospital Management Board, LGA PHC Department, Private health Organisations				
Objective 6. Strengthen the institutional framework for human resources management practices in the health sector.						
Strategy 6.1. **Establishing a system for effective HRH development and management** .						
Activity	**Level of Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
a. Establish and strengthen HRH Divisions staffed with officers competent in HRH planning, development, and management.	Federal, and State	FMOH, SMOH,	2,500,000	10,000,000	10,000,000	1
b. Use the HRH Divisions as secretariat for the National and State HRH Observatory to facilitate cross learning of HRH best practices.	Federal, and State	FMOH, SMOH, and Partners	5,000,000	10,000,000	20,000,000	2

c. Assign and train officers within the M&E Unit in LGAs to update and maintain records of all health workers, and communicate such frequently to the state level.	State, and LGAs	NPHCDA, SMOH, Training Institutions, and LGA PHC Department,				
d. Work with the Collaborating Centres to develop programmes for continuous professional development of HR managers for the health sector	Federal, State and Private	FMOH,SMOH and Private Health Facilities, NGOs	2,500,000	25,000,000	20,000,000	2
e. Organise forum for frequent interaction of managers of regulatory bodies, training institutions and health facilities to review status of HR development, and management at all levels.	Federal, State, and LGAs	FMOH, SMOH, Training Institutions, NPHCDA, State Hospital Management Board, LGA PHC Department, Private health Organisations, NGOs, Regulatory bodies, and Associations				
		Sub total	**10,000,000**	**45,000,000**	**50,000,000**	**5**

Strategy 6.2 . Establishing Database of Nigerian Human Resources for Health

Activity	**Implementation**	**Responsible Department/Agency**	**2008 Cost**	**2009 Cost**	**2010 Cost**	**2**
Develop and routinely update database of Nigerian HRH nationwide, including those in the diaspora , and ensure integration of public and private HR information systems	Federal, State, and LGAs	FMOH, National Universities Commission, Bureau of Statistics, SMOH, Training Institutions, NPHCDA, State Hospital Management Board, LGA PHC Department, Private health Organisations, NGOs, Regulatory bodies, and Associations	5,000,000	30,000,000	30,000,000	2
Develop ICT infrastructure with an interactive website.	Federal	FMOH, and Partners		2,000,000	1,000,000	1
Establish mechanisms for HRH data to be communicated within and across levels.	Federal, State, and LGAs	FMOH, Bureau of Statistics, SMOH, Training Institutions, NPHCDA, LGA PHC Department, Private health Organisations, NGOs, Regulatory bodies, and Associations	1,500,000	1,500,000	1,500,000	1
Evaluate periodically HRH status in Nigeria	Federal, State, and LGAs	FMOH, Bureau of Statistics, SMOH, Training Institutions, NPHCDA, LGA PHC Department, Private health Organisations, NGOs, Regulatory bodies, and Associations			15,000,000	
a. Publish state of the health work force annual report.	Federal	FMOH, and NPHCDA		2,000,000	2,000,000	2
		Sub total	**6,500,000**	**35,500,000**	**49,500,000**	**2**

Annex 2. 5-YEAR PROJECTED CRITICALLY NEEDED HEALTH PROFESSIONALS FOR UNDERSERVED STATES
Table 9. 5-YEAR PROJECTED DOCTOR REQUIREMENT FOR UNDERSERVED AREAS (Based on National Average)

	Population	No 2006	Doctor/ 100,000 pop	Addition No. Req	Projected Yearly Increment in No. of Doctors and cost in Underserved Areas (cost in millions)									
STATE/ ZONE	**TOTAL 2006**				**2008**	**Cost**	**2009**	**Cost**	**2010**	**Cost**	**2011**	**Cost**	**2012**	**Cost**
Zone: SW							**0**		**0**		**0**		**0**	
Lagos	9013534	3705	41	-2632										
Ogun	3728098	698	19	-254										
Oyo	5591589	1366	24	-701										
Osun	3423535	1093	32	-686										
Ekiti	2384212	173	7	111	22	19.9	44	39.8	22	19.9	11	9.9	11	9.9
Ondo	3441024	265	8	144	29		58		29		14		14	
Subtotal SW	**27581992**	7300	26											
Zone: SE														
Enugu	3257298	1017	31	-629										
Ebonyi	2173501	130	6	129	26		51		26		13		13	
Imo	3934899	914	23	-446										
Anambra	4182032	669	16	-171										
Abia	2833999	527	19	-190										
Subtotal SE	**16381729**	3257	20											
Zone: SS														
Bayelsa	1703358	179	11	24	5		9		5		2		2	
Rivers	5185400	404	8	213	43		85		43		21		21	
Cross River	2888966	320	11	24	5		10		5		2		2	

Edo	3218332	480	15	-97										
Delta	4098391	464	11	24	5		9		5		2		2	
Akwa Ibom	3920208	321	8	146	29		58		29		15		15	
SubTotal SS	**21014655**	2168	10											
Zone:NC														
Plateau	3178712	194	6	184	37		74		37		18		18	
Nasarawa	1863275	96	5	126	25		50		25		13		13	
Kwara	2371089	843	36	-561										
Kogi	3278487	185	6	205	41		82		41		21		21	
Benue	4219244	222	5	280	56		112		56		28		28	
Niger	3950249	69	2	401	80		160		80		40		40	
SubTotal NC	**18861056**	1609	9											
Zone: NW														
Jigawa	4348649	75	2	442	88		177		88		44		44	
Sokoto	3696999	164	4	276	55		110		55		28		28	
Zamfara	3259846	68	2	320	64		128		64		32		32	
Katsina	5792578	146	3	543	109		217		109		54		54	
Kano	9383682	234	2	883	177		353		177		88		88	
Kebbi	3238628	91	3	294	59		118		59		29		29	
Kaduna	6066562	610	10	112	22		45		22		11		11	
SubTotal NW	**35786944**	1388	4											
Zone: NE														
Gombe	2353879	139	6	141	28		56		28		14		14	

Borno	4151193	194	5	300	60		120		60		30		30	
Bauchi	4676465	92	2	464	93		186		93		46		46	
Adamawa	3168101	86	3	291	58		116		58		29		29	
Taraba	2300736	89	4	185	37		74		37		18		18	
Yobe	2321591	72	3	204	41		82		41		20		20	
SubTotal NE	**18971965**	672	4											
FCT	**1405201**	232	17	-65										
TOTAL	**140,003,542**	16626	12		**1293**		**2587**		**1293**		**647**		**647**	

TABLE 9.b. 5-YEAR PROJECTED NURSES REQUIREMENT FOR UNDERSERVED AREAS (Based on National Average)

	Population	**No. 2006**	**Nurse/ 100,000 pop**	**Add No. Req**	**Projected Yearly Increment in No. of Nurses Available in Underserved Areas**									
STATE/ ZONE	**TOTAL 2006**				**2008**	**Cost**	**2009**	**Cost**	**2010**	**Cost**	**2011**	**Cost**	**2012**	**Cost**
Zone: SW							**0**		**0**		**0**		**0**	
Lagos	9013534													
Ogun	3728098	988	27	-213										
Oyo	5591589	1650	30	-487										
Osun	3423535	1428	42	-716										
Ekiti	2384212	421	18	75	15		30		15		7		7	
Ondo	3441024	NA												
Subtotal SW	**27581992**	4487	16											
Zone: SE														
Enugu	3257298	NA												

Ebonyi	2173501	199	9	253	51		101		51		25		25	
Imo	3934899	2074	53	-1256										
Anambra	4182032	1214	29	-344										
Abia	2833999	971	34	-382										
Subtotal SE	**16381729**	4458	27											
Zone: SS														
Bayelsa	1703358	NA												
Rivers	5185400	1001	19	78	16		31		16		8		8	
Cross River	2888966	409	14	192	38		77		38		19		19	
Edo	3218332	1427	44	-758										
Delta	4098391	1949	48	-1097										
Akwa Ibom	3920208	2311	59	-1496										
SubTotal SS	**21014655**	7097	34											
Zone:NC														
Plateau	3178712	1165	37	-504										
Nasarawa	1863275	397	21	-9										
Kwara	2371089	NA												
Kogi	3278487	1294	39	-612										
Benue	4219244	995	24	-117										
Niger	3950249	1192	30	-370										
SubTotal NC	**18861056**	5043	27											
Zone: NW														
Jigawa	4348649	241	6	664	133		265		133		66		66	

Sokoto	3696999	NA												
Zamfara	3259846	232	7	446	89		178		89		45		45	
Katsina	5792578	904	16	301	60		120		60		30		30	
Kano	9383682	1001	11	951	190		380		190		95		95	
Kebbi	3238628	324	10	350	70		140		70		35		35	
Kaduna	6066562	1239	20	23	5		9		5		2		2	
SubTotal NW	**35786944**	3941	11		0									
					0									
Zone: NE					0									
Gombe	2353879	577	25	-87	-17									
Borno	4151193	1190	29	-327	-65									
Bauchi	4676465	56	1	917	183		367		183		92		92	
Adamawa	3168101	810	26	-151	-30									
Taraba	2300736	506	22	-27	-5									
Yobe	2321591	259	11	224	45		90		45		22		22	
SubTotal NE	**18971965**	3398	18		0									
					0									
FCT	**1405201**	735	52	-443	-89									
					0									
TOTAL	**140,003,542**	29159	21		0									

TABLE 9.c. 5-YEAR PROJECTED PHARMACIST REQUIREMENT FOR UNDERSERVED AREAS (Based on National Average)

	Population	No. 2006	Pharm/ 100,000 Pop.	Add No. Req.	Projected Yearly Increment in No. of Pharmacist Needed in Underserved Areas & Cost									
STATE/ ZONE	**TOTAL 2006**				**2008**	**Cost**	**2009**	**Cost**	**2010**	**Cost**	**2011**	**Cost**	**2012**	**Cost**
Zone: SW							**0**		**0**		**0**		**0**	
Lagos	9013534	4394	49	-3646										
Ogun	3728098	295	8	14	3		6		3		1		1	
Oyo	5591589	681	12	-217										
Osun	3423535	262	8	22	4		9		4		2		2	
Ekiti	2384212	66	3	132	26		53		26		13		13	
Ondo	3441024	164	5	122	24		49		24		12		12	
Subtotal SW	**27581992**	5862	21											
Zone: SE														
Enugu	3257298	417	13	-147										
Ebonyi	2173501	39	2	141	28		57		28		14		14	
Imo	3934899	197	5	130	26		52		26		13		13	
Anambra	4182032	342	8	5	1		2		1		1		1	
Abia	2833999	238	8	-3										
Subtotal SE	**16381729**	1233	8											
Zone: SS														
Bayelsa	1703358	35	2	106	21		43		21		11		11	
Rivers	5185400	448	9	-18										

Cross River	2888966	102	4	138	28		55		28		14		14	
Edo	3218332	436	14	-169										
Delta	4098391	277	7	63	13		25		13		6		6	
Akwa Ibom	3920208	130	3	195	39		78		39		20		20	
SubTotal SS	**21014655**	1428	7											
Zone:NC														
Plateau	3178712	346	11	-82										
Nasarawa	1863275	88	5	67	13		27		13		7		7	
Kwara	2371089	205	9	-8										
Kogi	3278487	112	3	160	32		64		32		16		16	
Benue	4219244	163	4	187	37		75		37		19		19	
Niger	3950249	174	4	154	31		62		31		15		15	
SubTotal NC	**18861056**	1088	6											
Zone: NW														
Jigawa	4348649	28	1	333	67		133		67		33		33	
Sokoto	3696999	60	2	247	49		99		49		25		25	
Zamfara	3259846	15	0	256	51		102		51		26		26	
Katsina	5792578	59	1	422	84		169		84		42		42	
Kano	9383682	275	3	504	101		202		101		50		50	
Kebbi	3238628	19	1	250	50		100		50		25		25	
Kaduna	6066562	476	8	28	6		11		6		3		3	
SubTotal NW	**35786944**	932	3											
Zone: NE														

Gombe	2353879	52	2	143	29		57		29		14		14	
Borno	4151193	123	3	222	44		89		44		22		22	
Bauchi	4676465	73	2	315	63		126		63		32		32	
Adamawa	3168101	116	4	147	29		59		29		15		15	
Taraba	2300736	38	2	153	31		61		31		15		15	
Yobe	2321591	21	1	172	34		69		34		17		17	
SubTotal NE	**18971965**	423	2											
FCT	**1405201**	720	51											
TOTAL	**140,003,542**	11686	8											

Table 9.d.

5-YEAR PROJECTED COMM HEALTH PRACTITIONERS REQUIRED FOR UNDERSERVED AREAS (Based on National Average)														
	Population	**No. 2006**	**CH0-CHEW/ 100000**	**Add No. Req**	**Projected Yearly Increment in No. of Community Health Practitioners Needed in Underserved Areas & Cost**									
STATE/ ZONE	**TOTAL 2006**				**2008**	**Cost**	**2009**	**Cost**	**2010**	**Cost**	**2011**	**Cost**	**2012**	**Cost**
Zone: SW					**20%**		**40%**		**20%**		**10%**		**10%**	
Lagos	9013534	261*	3	983	197		393		197		98		98	
Ogun	3728098	524	14	######										
Oyo	5591589	787	14	-15										
Osun	3423535	1198	35	-726										
Ekiti	2384212	411	17	-82										
Ondo	3441024	598	17	-123										
Subtotal SW	**27581992**	3779	14											
Zone: SE														

Enugu	3257298	785	24	-335										
Ebonyi	2173501	373	17	-73										
Imo	3934899	374	10	169	34		68		34		17		17	
Anambra	4182032	336	8	241	48		96		48		24		24	
Abia	2833999	262	9	129	26		52		26		13		13	
Subtotal SE	**16381729**	2130	13											
Zone: SS														
Bayelsa	1703358	336	20	-101										
Rivers	5185400	786	15	-70										
Cross River	2888966	861	30	-462										
Edo	3218332	299	9	145	29		58		29		15		15	
Delta	4098391	149	4	417	83		167		83		42		42	
Akwa Ibom	3920208	224	6	317	63		127		63		32		32	
SubTotal SS	**21014655**	2655	13											
Zone:NC														
Plateau	3178712	1046	33	-607										
Nasarawa	1863275	336	18	-79										
Kwara	2371089	1047	44	-720										
Kogi	3278487	860	26	-408										
Benue	4219244	748	18	-166										
Niger	3950249	825	21	-280										
SubTotal NC	**18861056**	4862	26											
Zone: NW														

Jigawa	4348649	337	8	263	53		105		53		26		26	
Sokoto	3696999	186	5	324	65		130		65		32		32	
Zamfara	3259846	225	7	225	45		90		45		22		22	
Katsina	5792578	187	3	612	122		245		122		61		61	
Kano	9383682	374	4	921	184		368		184		92		92	
Kebbi	3238628	187	6	260	52		104		52		26		26	
Kaduna	6066562	1168	19	-331										
SubTotal NW	**35786944**	2664	7											
Zone: NE														
Gombe	2353879	486	21	-161										
Borno	4151193	374	9	199	40		80		40		20		20	
Bauchi	4676465	524	11	121	24		49		24		12		12	
Adamawa	3168101	1159	37	-722										
Taraba	2300736	411	18	-93										
Yobe	2321591	149	6	171	34		69		34		17		17	
SubTotal NE	**18971965**	3103	16	-485										
				0										
FCT	**1405201**	75	5	119	24		48		24		12		12	
TOTAL	**140,003,542**	19268	14											

* The low concentration of CHOs and CHEWs is because Lagos has a large stock of high caliber health professionals such as Drs, Nurses and Pharmacists.

TABLE 10

STAFF TYPE	No. Req. by Norm	Average Staff Cost/yr	STAFF REQUIRED FOR PRIMARY HEALTH CENTRES UNDER CONSTRUCTION NUMBER FACILITIES TO BE COMPLETED PER YEAR, STAFF REQUIRED AND CUMULATIVE STAFF COST								
			Facilities 2008	Staff Req.	Cost	Facilities 2009 Cumulative	Staff Req.	Cost	Facilities 2010 Cumulative	Staff Req.	Cost
CHOs	1	720000	140	140	100800000	193	193	138960000	243	243	174960000
CHEWs	3	480000	140	420	201600000	193	579	277920000	243	729	349920000
JCHEWs	6	360000	140	840	302400000	193	1158	416880000	243	1458	524880000
Nurse Midwives*	3	720000	140	420	302400000	193	579	416880000	243	729	524880000
Records Officer	1	480000	140	140	67200000	193	193	92640000	243	243	116640000
Pharm Techn.	1	480000	140	140	67200000	193	193	92640000	243	243	116640000
Lab. Techn.	1	480000	140	140	67200000	193	193	92640000	243	243	116640000
				Total Cost	**1108800000**			**1528560000**			**1924560000**

Source of Norms: Ward Minimum Services Package

* With the severe shortages of midwives it is proposed that 1 midwife per PHC facility will be more feasible.
It is assumed that CHEWs and JCHEWs will spend greater part of their time in carrying out outreaches and home visits in communities within the ward.

Annex 3. **CONTINUOUS STAFF DEVELOPMENT PLAN**
TABLE 11

CONTINUOUS STAFF DEVELOPMENT PLAN															
					Number To Be Trained Per Year and Cost										
					2008		2009		2010		2011		2012		
Training Programme	**Target Group**	**Justification**	**Duration (weeks)**	**Location**	**No,**	**Cost**	**No.**	**Cost**	**No.**	**Cost**	**No.**	**Cost**	**No.**	**Cost**	
Health Planning & Management	Senior & middle level managers at all level	Developing a critical mass skilled personnel in planning and mgt at all levels	**12**	Local	30	30000000	70	70000000	50	50000000	50	50000000	50	50000000	
Leadership	Senior & middle level managers at all levels	Improving leadership skills of managers	2	Local	30	3000000	70	7000000	100	10000000	100	10000000	100	10000000	
Health Information Systems	M & E Officers at all levels	Improving health information management	12	Local	30	3000000	40	40000000	30	30000000	40	40000000	0	0	
Health Financing	Budget officers, Planning officers, NHIS Managers	Imrpoving resource mobilization for health care	12	Local	25	25000000	40	40000000	35	35000000	50	50000000	50	50000000	
Health Economics	Budget officers, Planning officers, NHIS Managers at all levels	Developing a team to promote cost consciousness among health managers	12	Local	25	25000000	35	35000000	35	35000000	35	35000000	30	30000000	
Gender & Hlth Magt	Senior & middle level managers at all levels	Ensuring gender mainstreaming in health management	12	Local	40	40000000	70	70000000	70	70000000	60	60000000	60	60000000	

Gender Studies	Senior & middle level managers at all levels	Promoting gender in health care	2	Local	50	5000000	100	10000000	100	10000000	100	1000000	100	1000000
Hospital Mgt	Managers of Tertiary & Secondary hospitals	Sterngthening management of hospital services	12	External	15	15000000	35	3500000	45	45000000	35	35000000	30	30000000
Health Systems Research	Research officers at all levels	Capacity building for health systems research	12	External	10	10000000	10	10000000	10	10000000	20	20000000	0	0
Human resources for Health Studies	Human resources managers at federal, state and institutions	Improving of staff management in the health sector	12	External	20	20000000	20	50000000	20	50000000	20	50000000	0	0
Human Resources for Health Mgt	Human resources managers at federal, and state levels	Build capacity for strategic management of human resources for health at all levels	52	External	5	25000000	10	50000000	10	50000000	15	75000000	0	100000000
Pharmceuticals & medicines control	Pharmacists	Improving on assurance of drug quality	12	Local	10	10000000	10	10000000	10	10000000	10	10000000	10	100000000
Drug administration for patent medicine vendor	Patent medicine vendors	Build capacity for mgt of medicine by PMV	2	Local	150	150000000	400	40000000	400	40000000	550	55000000	0	0
Logistics Mgt	Logistics officers & Pharmacists at federal, state and institutions	Improving on logistics management at all levels	12	External	5	12500000	10	25000000	10	25000000	15	37500000	0	0
Rapid Appraisal for Health	Research officers and health service managers	Capacity building for assessment of	2	Local	50	5000000	80	8000000	120	12000000	150	15000000	150	150000000

		health interventions												
Quality Assurance	Middle level managers at federal, state and insitutions	Assuring conituous quality recognition in health care	2	Local	50	5000000	80	8000000	120	12000000	125	12500000	125	125000000
VCT for HIV/AIDS	Public health nurses Lab. Scientists, Health Promoters	Imsoroving on diagnosis, counseling and treatment of PLWAs	3	Local	50	7500000	100	15000000	150	22500000	150	22500000	150	150000000
PMTCT	Nurses, midwives	Capacity building to prevent mother to child transmission	2	Local	60	6000000	100	10000000	200	20000000	160	16000000	160	160000000
ELSS	NYSC Drs,	Preparing NYSC Drs to management obstetric emergencies	3	Local	1000	150000000	###	225000000	###	225000000	###	225000000	###	1000000000
LSS	Midwives	Preparing Midwives for safe motherhood interventions	3	Local	1200	180000000	###	225000000	###	270000000	###	262500000	###	1750000000
IMNCI	Nurses & mwives, CHOs	Promoting IMNCI	2	Local	2000	200000000	###	150000000	###	200000000	###	100000000	###	1000000000
Family Planning	Nurses, midwives	Improving on FP services & coverage	2	Local	1000	100000000	###	150000000	###	100000000	###	100000000	###	1000000000
Interpersonal Communications	All categories of staff	Improving on interpersonal skills of health workers	1	Local	2000	100000000	###	200000000	###	150000000	###	150000000	###	3000000000
Community Mobilisation	CHO, CHEWs, Midwives, Nurses	Create effective demand for	1	Local	2000	100000000	###	150000000	###	100000000	###	75000000	###	1500000000

		health services												
TB Control	Programme officers, nurses & CHOs	Improving on TB case containment & management	2	Local	15	1500000	30	3000000	25	2500000	10	1000000	0	0
I,E & C for Health	Public health nurses, Health Promoters, CHOs, CHEWs	Improving of effective behaviour change communicatio n	1	Local	1500	75000000	###	100000000	###	75000000	###	7500000 0	###	150000000
ICT	All categories of staff	Improving on computer literacy among health workers	2	Local	5000	500000000	###	1000000000	###	1.5E+09	###	1000000 000	###	1E+10
Project Design	Senior & middle level managers at federal & state levels	Developing internal capacity for project design	3	Local	5	750000	10	1500000	10	1500000	15	2250000	0	0
Project Mgt	Senior & middle level managers at federal & state levels	Improving on management of health projects	3	Local	5	750000	10	1500000	10	1500000	15	2250000	0	0
Tendering & Procurement	Planning officers	Assuring transparency & value for money in tendering & procurement	2	Local	5	500000	10	1000000	10	1000000	15	1500000	0	0
Change Mgt	Senior & middle level managers at federal & state levels	Capacity building for managing the HSR at all levels	2	Local	30	3000000	30	3000000	30	3000000	30	3000000	0	0
Cancer Mgt	Oncologist, oncology nurses, radiotherapist	Effective management of cancer patients	2	External	20	2000000	35	3500000	30	3000000	0	0	0	0

NIGEP	NIGEP programme officers, CHOs, CHEWs,	Improving management of NIGEP programme	2	Local	40	4000000	450	45000000	650	65000000	600	60000000	760	760000000
Health Tutor Training	Nurses, CHOs, Environmental Health Officers, Lab Scientist	Enhancing the competences of tutors of health training programmes	12	Local	40	40000000	250	25000000	500	500000000	350	350000000	360	360000000
IDSR	Disease surveilance officers	Improving on disease surveillance	2	Local	40	4000000	300	30000000	550	55000000	510	51000000	400	400000000
DOT in TB	TB control officers at federal, state and LGA levels.	Improving on TB case management	2	Local	40	4000000	300	30000000	550	55000000	400	40000000	510	510000000
Roll Back Malaria	Programme officers, nurses & CHOs	Improving on malaria control	2	Local	40	4000000	300	30000000	600	60000000	460	46000000	400	400000000
M & E	Records officers, Programme officers	Improving on monitoring and Evaluation of health programmes	2	Local	15	1500000	20	2000000	15	1500000	10	1000000	0	0
Integration of NCD into PHC	Programme officers, nurses & CHOs	Stepping up attention for NCD whilst discouraging verticalisation	2	Local	50	5000000	300	30000000	280	28000000	300	30000000	270	270000000
TOT on Infant & Child Feeding	Midwives, public health nurses, CHOs	Promoting exclusive breastfeeding and improving on weaning practices	1	Local	20	1000000	30	3000000	30	1500000	30	1500000	0	0
						1874000000		**2910000000**		**3.935E+09**		**3171500000**		**2.4034E+10**

Annex 4. Type and Number of Health Training Programmes in the States

Table 12: Type and Number of Health Training Programmes in the States

S/N	States	Medical	Nursing	Midwifery	Pharmacy	Radio-graphy	Health Records	Medical Lab.	CHO	CHEWS
1	Abia	1	3	3	0	0	1	0	0	1
2	Adamawa	0	1	1	0	0	0	0	0	1
3	Akwa Ibom	0	3	4	1	0	1	0	1	2
4	Anambra	2**	4	4	1	0	1	1	0	1
5	Bauchi	0	1	1	0	0	1	0	0	1
6	Bayelsa	0	1	0	0	0	0	0	O	1
7	Benue	0	2	2	0	0	0	0	0	4
8	Borno	1	2	1	0	1	2	1	1	2
9	C/ River	1	5	3	1	1	2	2	1	2
10	Delta	0	2	2	0	0	1	0	0	1
11	Ebonyi	1	1	1	0	0	0	1	0	1
12	Edo	2**	2	2	1	0	1	3	1	1
13	Ekiti	0	1	1	0	0	1	0	0	1
14	Enugu	1	3	3	1	1	1	2	1	4
15	F.C.T	0	1	1	0	0	0	0	0	0
16	Gombe	0	1	1	0	0	0	0	0	1
17	Imo	1**	5	3	0	0	0	1	0	2
18	Jigawa	0	1	0	0	0	1	0	0	1
19	Kaduna	1	4	4	1	0	2	1	1	4
20	Kano	1	1	1	0	0	1	0	1	2
21	Katsina	0	1	1	0	0	0	0	0	3
22	Kebbi	0	1	1	0	0	0	0	0	1
23	Kogi	0	1	2	0	0	0	0	0	1
24	Kwara	1	1	1	0	0	1	0	1	2
25	Lagos	2	3	3	1	1*	3	1	1	2
26	Nasarawa	0	0	1	0	0	1	0	0	2
27	Niger	0	1	1	0	0	0	0	0	2

28	Ogun	1	3	2	1	0	0	0	0	1
29	Ondo	0	1	1	0	0	1	0	0	1
30	Osun	2	5	4	1	0	2	1	1	2
31	Oyo	2	4	5	1	1*	3	1	1	2
32	Plateau	1	2	2	1	0	1	2	1	3
33	River	1	1	1	0	0	1	1	0	1
34	Sokoto	1	2	1	0	0	2	1	1	2
35	Taraba	0	1	0	0	0	0	0	0	1
36	Yobe	0	1	0	0	0	0	0	0	1
37	Zamfara	0	1	0	0	0	1	0	0	1
	Total	**23**	**69**	**62**	**9**	**5**	**30**	**16**	13	63

**The training institutions in these states have discontinued the training of radiographers because the programme for radiography was upgraded from diploma to degree awarding.*

*** One of the medical schools in the state is partially accredited.*

Annex 5. Statistices of Health Workers as at December 2005 by State of Practice

Table 8 Statistics Of Health Workers As At Dec 2005 By State Of Practice

S/N	State	Population	Doctors	Dentists	Nurses	Mid-wives	Med- Lab. Scientists	Rehab. Therapists	Radiogra-phers	Pharmacist	Health Records Officers	CHO/ CHEWs
1	Abia	2,963,275	527	NA	1123	NA	185	8	5	238	24	262
2	Adamawa	3,254,227	89	NA	882	NA	9	4	2	116	18	1159
3	Akwa Ibom	3,730,227	321	NA	6528	NA	122	3	9	142	32	224
4	Anambra	4,329,820	669	6	1395	240	239	8	11	342	22	336
5	Bauchi	4,431,424	110	5	200	330	7	4	1	73	1	524
6	Bayelsa	1,737,020	278	6	586	392	17	1	0	35	35	336
7	Benue	4,262,764	222	NA	995	305	41	5	5	163	25	748
8	Borno	3.926,764	198	20	1194	36	16	7	4	123	5	374
9	C/ River	2,551,896	407	2	1642	999	39	6	7	102	58	861
10	Delta	4,010,879	470	NA	1950	NA	144	18	16	277	57	149
11	Ebonyi	2,250,677	134	NA	349	NA	30	2	10	39	28	373

12	Edo	3,363,098	399	NA	1431	NA	203	18	7	436	38	299
13	Ekiti	2,377,829	173	NA	421	NA	48	7	3	66	61	411
14	Enugu	3,289,864	1017	NA	1196	NA	266	40	32	417	20	785
15	F.C.T	575,666	232	NA	913	NA	2	38	36	720	22	75
16	Gombe	2,305,771	81	NA	577	NA	16	1	5	52	9	486
17	Imo	3,848,656	914	NA	2074	NA	307	8	13	197	24	374
18	Jigawa	4,452,685	75	NA	408	17	13	1	0	28	1	337
19	Kaduna	6,094,506	610	NA	1903	NA	45	9	11	476	34	1168
20	Kano	8,997,330	234	NA	1001	NA	24	28	9	275	18	374
21	Katsina	5,811,165	146	NA	904	NA	5	7	0	59	13	187
22	Kebbi	3,202,837	91	NA	324	NA	2	6	0	19	1	187
23	Kogi	3,325,256	185	NA	1970	NA	27	1	4	112	26	860
24	Kwara	2,397,533	843	NA	1691	NA	30	24	10	205	48	1047
25	Lagos	8,865,999	3705	NA	NA	NA	313	302	129	4394	66	261
26	Nasarawa	1,870,248	147	NA	476	134	12	1	2	88	17	336
27	Niger	3,749,912	69	NA	1236	NA	5	3	4	174	4	825

28	Ogun	3,613,345	698	NA	1471	NA	63	31	4	295	15	524
29	Ondo	3,483,147	265	NA	NA	NA	99	8	6	164	18	598
30	Osun	3,341,326	1093	NA	1765	NA	222	37	11	262	24	1198
31	Oyo	5,346,017	1366	NA	1650	NA	288	89	23	681	12	787
32	Plateau	3,258,658	102	NA	1234	NA	55	16	12	346	14	1046
33	Rivers	4,936,589	404	NA	NA	NA	118	10	21	448	20	786
34	Sokoto	3,297,979	154	NA	599	746	2	12	5	60	10	186
35	Taraba	2,341,448	89	NA	235	409	7	2	0	38	0	411
36	Yobe	2,167,389	72	NA	607	NA	7	3	2	21	0	149
37	Zamfara	3,209,910	68	NA	285	NA	1	1	1	15	0	225
	Total		**16,572**	**2,649**	**121,243**	**87,171**	**3029**	**769**	**420**	**12,072**	**820**	**19268**

NA *– Not available*
Source of Population Data: National Population Census 2006.