GOMBE STATE GOVERNMENT

2018 - 2021 GOMBE STATE HEALTH SECTOR REPORT

Based on the integrated JAR/MTR of the SSHDP-II/NSHDP-II 2018 – 2022

Foreword:

Acknowledgments:

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List of Acronyms:

LIST OF ACRONYMNS	
Abbreviations/Acronyms	**Meaning**
ANC	Ante-Natal Care
DHIS2	Data Health Information System 2
FCT	Federal Capital Territory
FGD	Focus Group Discussion
HRH	Human Resource for Health
LGA	Local Government Area
IMR	Infant Mortality Rate
JAR/ MTR	Joint Annual Review
KII	Key Informant Interview
MMR	Maternal Mortal Rate
NE	North East
NDHS	Nigeria Demographic and Health Survey
SSHDP-II/NSHDP-II	State Strategic Health Development Plan
PMDCF	Performance Metrics Data Collection Frameworks
PHC	Primary Health Care
CIHP	Center for Integrated Health Program
IDPs	Internally Displaced Persons
EPHS	Essential Package for Health care services
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
TB	Tuberculosis
SDG	Sustainable Development Goals
CBO	Community Based Organization
CSO	Civil Society Organization
SSA	Senior Special Advisor
PHC	Primary Health Center
EPHC	Essential Package of Health Care service
HCW	Healthcare Worker
DRF	Drug Revolving Fund
DHIS	
EOC	Emergency Operation Center
VAT	Value Added Tax
GOMSACA	Gombe State Agency for Control of AIDS
NDHS	Nigeria Demographic Health Survey
FMOH	Federal Ministry of Health
SPHCDA	State Primary Healthcare Development Agency
ANC	Antenatal Care
MICS	Multiple Indicator Cluster Survey
MSP	Minimum Service Package
MDA	Ministries Department and Agencies
NMA	Nigerian Medical Association
NANNM	
MHWUN	
PSN	
PHRRA	
MNCH	Maternal and Neonatal Child Health
OVC	Orphans and Vulnerable Children
USAID	United State Agency for International Debelopment

CDC	Center for Disease Control
EU	European Union
CIHP	Center for Integrated Health Program
SCI	
MSH	Management Sciences for Health
UNFPA	
CiSHAN	Civil Society for HIV and AIDS in Nigeria
AONN	Association of OVC NGOs in Nigeria
NEPHWAN	Network of People Living with HIV in Nigeria
WHO	World Health Organization
IMCI	
NTD	Non-Tropical Diseases
FP	Family Planning
IPAS	
AHEF	
S2S	State to State
PIPP	
HSS	
JHF	Janna Health Foundation
APH	Ante-partum haemorrhage
PPH	Pre-eclampsia, Postpartum Haemorrhage
OL	Obstetric Labor
NAIIS	Nigeria Aids Indicator Survey
NMEP	National Malaria Eradication Program
LLIN	Long Lasting Insecticide Net
IPT	Intermittent Preventive Treatment
STH	Soil Transmitted Helminthic
WHO	Word Health Organization
NCD	Non-Communicable Disease
TSTS	Task Shifting and Task Sharing
SOP	Standard Operating Procedures
PHCUOR	Primary Health Care Under one Roof
SHA	State Health Act
UHC	Universal Health Coverage
SHRHIS	State Human Resources for Health Information System
LMCU	Logistics Management Coordination Unit
HIS	Health Information System
M&E	Monitoring and Evaluation
SEMA	State Emergency Management Agency
NEMA	National Emergency Management Agency
RMNCAH+N	Reproductive Maternal Newborn Child Adolescent Health Plus Nutrition
IDP	Internally Displaced Persons
TWG	Technical Working Group
AOP	Annual Operation Plan
DMA	Drug Management Agency
NGO	Non-Governmental Organization
NLC	Nigerian Labour Congress
TUC	Trade Union Congress
BHCPF	Basic Healthcare Provision Fund
NSHIP	Nigerian State Health Investment Project

Executive Summary:

Health is considered by Gombe State Government to be central to sustainable development as it promotes productivity among the populace. Consequently, access to quality health care and prevention services are vital for poverty reduction and economic growth, which is key to the attainment of the SDG 3, Ensure Healthy Lives and Promote Well Being for all at all ages. In recognition of the importance of achieving universal health coverage for all Nigeria as set by the Federal Government of Nigeria, and in pursuit of this cause, Gombe State launched the first five-year State Strategic Health Development Plan (SSHDP-I) 2010-2015 in 2010. The first SSHDP sought to address the weaknesses in the health systems that have militated against effective health care delivery.

A review of the implementation of SHDP-I showed achievements in some areas. However, the health system remains with challenges. A new SHDP-II (2018-2022) was developed in 2018 which is designed to consolidate and build on achievements made on the first plan. The plan was developed to provide specific direction and guidance on increasing investment in health sector in order to derive the desired outcomes in Gombe State. The SSHPD-II (2018-2022) was developed in collaboration with stakeholders. The vision is **"*To Guarantee a Healthy and Productive State*"** while the Mission is ***"To ensure that the Gombe populace have universal access to comprehensive, appropriate, affordable, efficient, equitable, and quality essential health care through a strengthened health system"***

The SHDP-II (2018-2022 is prepared within the framework of Vision 2020, the Economic Recovery and Growth Plan (2017-2020), Sustainable Development Goals (SDGs) covering the period of 2016-2030 and the 2016 revised National Health Policy. It is also being guided by all relevant national and international policies and legislations, including the National Health Act and international declarations, majorly the UN-Social Development Goals (SDGs) as well as State policies and legislations.

This report provides an integrated Joint Annual Review (JAR) and Mid-Term Review (MTR) of the Gombe SSHDP-II (2018-2022). The report elaborates the key findings of this review based on the basic components that drives the health sector and this includes

a. **Enabled Environment for attainment of sector outcomes**
   A lot of effort is recorded by the state government in recognizing stakeholders such as the private sector, community and religious leaders, CBOs, CSOs and partners in policy and planning processes for health care delivery in the state. A state council on health meeting was held once. Moreover, the state government established the office of SSA on partner coordination and also ensure Ward Development Committee (WDC) was constituted across the 114 wards in the state, that oversees the affairs of PHCs in their wards as a sustainability plan and ensure community ownership.
b. **Increase utilization of the essential package of health care services**
   Gombe State has been making concerted efforts aimed at promoting health and addressing some of the social determinants of health, which includes development of relevant Health Policies, procurement of ambulances for emergency medical services and hospital care among others. This is shown in rapid drop in the prevalence rate of communicable, non-communicable and neglected tropical diseases (% Reduction in TB mortality is 84%, Malaria prevalence among children under five is 33.7%, % Reduction in incidence of Viral B hepatitis per 100,000 population is 3.7%, Prevalence rate of tobacco use among adults is 9.7%, Infant mortality rate (infant deaths per 10,000 live births (<1yr) is 763)
c. **Strengthen health system for delivery of the EPHS**
   Gombe State has 589 health facilities with (562) 95.4% being Primary Healthcare Centres, (26) 34.4% secondary, (1) 0.1% Tertiary facilities. The state has a strong HRH system that oversees employment, development and monitoring of HCW distribution between rural and urban areas. Though there is a plan for HRH, but it is not costed. Although the state has institutions of higher learning geared toward improving the numbers of HRH in the state, but there has been no recruitment of health care workers at Health Facilities in the last 3 years. The state supply chain system constitutes a systemic approach to product selection, quantification, and warehousing of commodities and consumables. The state operates Drug Revolving Fund (DRF) but the system challenges include funding constrain for procurement of essential commodities. For data management greater than 90% of LGAs have submitted complete and timely reports into national DHIS2 in the past 2 years.

d. Protection from health emergencies and risks

Gombe State has designated isolation units located at state specialist hospital and general hospital Zambuk for containment of public health emergencies. Also the state established Emergency Operations Center (EOC) during the first wave of COVID19 pandemic, which serve as emergency response unit for all public health emergencies. Rapid increase in the population of the state as a result of trooping of IDPs creates high burden of demand for health care services, although the state government has procured about 49 ambulances for responding to health emergencies.

e. Predictable financing and risk protection

Health care financing in Gombe State is through the State budgetary allocation, donor funding, out-of-pocket payments, and health insurance. The health expenditure of Gombe State in 2018, 2019, 2020 & 2021 are 8%, 9%, 10% and 9% of the total state allocations respectively. The existence of a functioning state-managed health insurance agency (GOHEALTH). The agency has so far enrolled 35,352 formal sector beneficiaries and 25,565 equity programme beneficiaries. The state does not have a resource mobilization plan for health financing. Although many opportunities exist for increased domestic funding of health such as corporate social responsibility funds, health impact bond, taxes, VAT, mandatory health insurance, philanthropy; which still remain grossly underexploited

1.0 INTRODUCTION

1.1 Background (including desk review elements)

Health is the first wealth of a Nation and central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy population live longer, more productive and save more. Many factors influence health status and a country's, as well as a State's ability to provide quality health services for its people. Ministries of health are important actors and so are other government departments, donor organizations, civil society groups and communities themselves.

As a successor to the Gombe State Strategic Health Development Plan–I (GSSHDP-I), 2010-2015, the second plan SSHDP-II (2018-2022) was designed to consolidate and build on achievements made. The plan was developed to provide specific direction and guidance on the imperative of increasing investment in health sector in order to derive the desired outcomes. There have been a growing number of players in the health sector which calls for an organized, structured and coordinated system for the delivery of health care services in the State in order to avoid duplication of efforts and achieved the desired synergy for effective and efficient delivery of health care services.

After three years of implementation of the second plan SSHDP-II, there is a need for Mid-Term Review (MTR) and Joint annual Review (JAR) of the plan Implementation. The purpose of the Mid-Term review is to assess the achievements and performance in the areas of Relevance, Efficiency, Effectiveness, Impact, Sustainability so that the key lessons and recommendations are well analysed and documented for further reflection, learning and use in the proceeding plan while the Joint Annual Review (JAR) is aimed at assess the progress of implementation of the SSHDP-II against defined milestones and targets, identify key bottlenecks/ challenges in the implementation, documents best practices and make recommendations for improving performance in succeeding years and subsequent Plans.

State Profile

Gombe State (**Jewel in the Savannah)** was created from the old Bauchi state on 1st October 1996. It is one of the 36 States of Nigeria, located in the North-east part of the Country on the coordinates of 10017 degree north and 11010 degrees east covering an area of 20,265sq. Km. It shares common boundaries with Borno to the east, Yobe to the north-east, Bauchi to west, Taraba to the south, and Adamawa to the South East (GomSACA, 2010 – 2015). With a growth rate of 3.2% and based on the 2006 figures, the State has a projected population of 3,225,382 of which, 615,916(50.1%) are males and 1,609,466(49.9%) are females. Young persons (10-29 years) comprise 39.9%, while women of reproductive age are 4.4% of the population. The population of children aged 5years and below is 645,076,

Gombe State has 11 LGAs and 114 wards with a total population of 3,585,330. The female counterpart constitutes 49% of the total population of the State. Population growth in less than 15 years is 1,577,457, while population growth in less than 1 years is 161,423 (Census 2006).

Structurally, the State has 11 local government areas including, Akko, Balanga, Billiri, Dukku, Funakaye, Gombe, Kaltungo, Kwami, Nafada, Shongom and Yamaltu Deba (Fig 1). For political administrative purposes, the State is organized into three senatorial districts (North, Central and South districts) with one hundred and fourteen (114) political wards. Additionally, the literacy level in the State is low (Male 66.6%; females 32.7%) (NDHS, 2013). The major tribes in the State includes; Hausa, Fulani, Tangale, Waja, Tera, Bolewa, Tula, Cham, Lunguda, Awak, Kamo, Dadiya, Pero, Shonge. An estimated 68.7% of the population are self-employed with 70% engaged in subsistence agriculture.

A number of economic activities take place in the state. The people of the state engage in both dry and rainy season farming as well as trading. In the area of agriculture, the main cash crops are sorghum, maize, groundnut, rice, millet, soybeans, cotton, beniseed and vegetables. In addition livestock farming contributes significantly to the economy of the State. Three major dams including DadinKowa, Balanga and Cham as well as some rivers provide appropriate environment for irrigation farming and fishing activities. Solid minerals available in the State also present high potential for economic activities that will support health provision in the state. These include: coal, uranium, calcium, silica, limestone and gypsum.

The presence of some industries in the State including Coal mining activities in Maiganga, Ashaka Cement Factory, Gombe Oil Mill and Cotton Ginneries have also boosted economic activities in the State.
The State has nine (9) tertiary institutions which are; Federal University Kashere, Gombe State University, College of Nursing and Midwifery Gombe, College of Health Sciences and Technology Kaltungo, Federal College of Education Gombe, Gombe State College of Education Billiri, Gombe State Polytechnic Bajoga, Federal College of Horticulture DadinKowa, College of Legal and Islamic Studies Nafada.
Gombe has 627 public and private health facilities. 413 of this figure are public Primary Health Care (PHC) with 7,393 Health Workers and 1,279 Nurses and Midwives. Health Workers Density is 20person:10,000pop. Health Facility Density is 1.7person10, 000 pop (2021 PHC diagnostics).

The state Context
Gombe state economy is financed from the Federal allocation, grants, aid and to a lesser extent internally generated revenue. Industrial activity is in three forms viz: large scale manufacturing e.g. Ashaka Cement Factory, medium and small scale industries, and other forms of commercial activities, farming (crop and livestock). Health system administration and governance in the state is decentralized in line with the provisions of the National Health Policy (FMOH 2006); consequently the State Primary Health Care Development Agency (SPHCDA) take administrative responsibility for primary health care facilities, while the State Ministry of Health is responsible for secondary health facilities. The Federal government owns and is responsible for the Federal Teaching Hospital Gombe.
The State Ministry of Health occupies the central position in this structural and functional arrangement and sets and adapts policy, provides strategic leadership and stewardship for the entire health system. Health governance permeates down to the community level through Ward Development Committees (WDCs) and health facility management committees.
There is a broad range of health facilities in Gombe state, characterized principally as public and private health facilities. The public health facilities consist of the Specialist, General and Cottage Hospitals, Primary Health Centres., dispensaries and health posts. The private health facilities consist of individually owned clinics and hospitals, faith-based health clinics, and traditional medicine practitioners.
The majority of the public health facilities are primary health facilities followed by the secondary health facilities and then the federal government-owned tertiary health facility. There are 23 secondary public health facilities spread across the 11 LGAs. The state has 592 primary public health facilities. Similarly, there are 68 private health facilities in the state. In total, there are 616 health facilities in the state distributed across the 11 LGAs (State DHIS, 2016).
Government Health Expense Per Annum is less than 15% of the Government Annual Budget. About 34.1% of the Pregnant Women attend 4+ 1 ANC. The Infant Mortality Rate IMR of Gombe is 35/1,000 live birth, while the Maternal Mortality Rate is 1,576/100,000.
Gombe State has high Early Child Mortality rates per 1000 live births far above average in the North-east showing; neo-natal (45), Post-neo-natal (59), Infant (104), Child (95) and Under-5 (189) (NDHS 2018). In terms of spacing of births between pregnancies, 27.1% of women do not observe the 24 month birth intervals. In addition, 25.4% did not attend ANC, only 46.4% received ANC from skilled providers at some point while 91.8% did not return for Post Natal Care (MICS). Available data also reveals that rate of teenage pregnancy and motherhood (15 – 19 years) in Gombe State is high as 19.8% of girls within that age cohort have had a live birth.

In 2018, over 70% of facility deliveries took place in rural primary health facilities (DHIS2). These statistics and indicators emerges from several factors like poverty, low literacy level, lack of awareness, culture, gender inequalities, preventable maternal disorders for instance pre-eclampsia and eclampsia, attitude of health providers, inadequate skilled personnel and ill equipped infrastructure. Preventable or treatable infectious diseases such as malaria, pneumonia, diarrhoea, measles and HIV/AIDS account for other factors responsible for MMR estimated at one million under-five deaths in Nigeria.

Gains in the health sector:

Gombe state has consistently shown commitment to improve her health indices, hence, the state a good proportion of its annual budget to health care sector. These commitments have led to improved health for its citizenry as shown by some key indicators of the last 2 Nigeria Demographic and Health Survey (NDHS) rounds:

Gaps still exist in the following areas:

- Data quality and utilization for decision making
- Human resources for health (HRH)
- Financing for primary health care
- Service delivery
- Equity gaps in urban and rural areas

1.2. Objectives of the 2018 - 2021 Mid-Term Review (MTR) of the SSHDP-II/NSHDP-II

- Assess the achievements and performance in the areas of Relevance, Efficiency, Effectiveness, Impact, Sustainability so that the key lessons and recommendations are well analyzed and documented for further reflection, learning and use in the proceeding plan.
- Develop a system strengthening plan based on the results of the review that will outline a menu of priority interventions/reforms taking the state's fiscal space into consideration

1.3 Objectives of the 2020 Joint Annual Review (JAR)

- Assess the progress of implementation of the NSHDP II against defined milestones and targets for 2020
- Identify key bottlenecks/ challenges in the implementation of the NSHDP II
- Document best practices in the implementation of the NSHDP II
- Make recommendations for improving performance in succeeding years and subsequent Plans

1.4 Methodology:

The methodology of this review is Mixed-Methods Approach which includes desk review and sampling of data. The data are sourced from

- **Quantitative Data Collection**: structured data collection tool for quantitative data collection, information to be driven from DHIS2, SSHDP-II and M&E framework.
- **Qualitative Data Collection:** Purposive sampling technique used for qualitative data collection, clients and Government stakeholders selected to participate in FGDs and KIIs based on pre-specified inclusion criteria

This review is in two (2) Phases:

Phase 1:

- Desk Reviews and preliminary analysis of the health sector

Phase 2

- Collection of Primary Data from DHIS2:
- **3 FGD:** total of 15 participants
- **3 KIIs** with key decision-makers

3.0 FINDINGS OF THE 2018 - 2021 JOINT ANNUAL REVIEW

3.1 Strategic Pillar 1: Enabled environment for attainment of sector outcomes

3.1.1 Priority Area 1 Leadership and Governance

The State made effort to create an effective policy environment by adapting the Public Private Partnership for health policy 2005. Furthermore, effort has been made to include other stakeholders such as the private sector, CBOs, CSOs and partners in policy and planning processes for health care delivery. A significant progress was made in multi-sectoral collaboration as demonstrated by the broad response to epidemics, insurgency and Disaster as well as the State HIV response. Despite all these efforts a lot needs to be done to reinforce inter-sectoral collaboration. There is inefficiency and accountability challenges in the health system, in addition to monitoring and supervisory role resulting to ineffective service delivery. Although, the government has initiated strategies and coordination platforms such as State Council on Health, Office of the SSA to the governor on Partner Coordination and Emergency Operation Center (EOC). However, the council on health meeting was observed only once during the period under review. The partner coordination platform exist but no single meeting was held since 2018. The state implement annual budget on health which is funded by the state government and corresponding partners on health, but the annual state budget implementation rate does not increase by 25% as expected. Moreover, the annual state of health reports has not been published. So, there is need to put in place mechanisms for quality assurance in the health sector at all levels.

3.1.2 Priority Area 2: Community Participation and Ownership

Community participation involves the engagement of communities in the planning, implementation, monitoring and evaluation of various health interventions to promote ownership and sustenance thereby empowering them to manage their health challenges. This approach also ensures that the services are provided to the underserved populations. The state has 114 functioning Wards Development Committees (WDCs) across the 114 wards. The WDCs are linked to the PHCs in their wards. The WDCs oversees the affairs of PHCs in their wards and meets regularly at ward level to address challenges affecting their communities. However, State Primary Health Care Agency (SPHCDA) and Local Government Area Primary Health Care Development Committees (LGAPHCDC) were not established Gombe state has about 627 health facilities and more the 50% of the PHCs are implementing minimum service package (MSP). However there is still need to formulate appropriate policies and guidelines on community partnership and ownership and disseminate them to the health committees and other relevant stakeholders as well as facilitate the training and capacity building of members of health committees to enable them adequately understands their roles and responsibilities and effectively participates in health planning, monitoring and evaluation for decision making. The segregation of the 622 health facilities in the state is shown below:

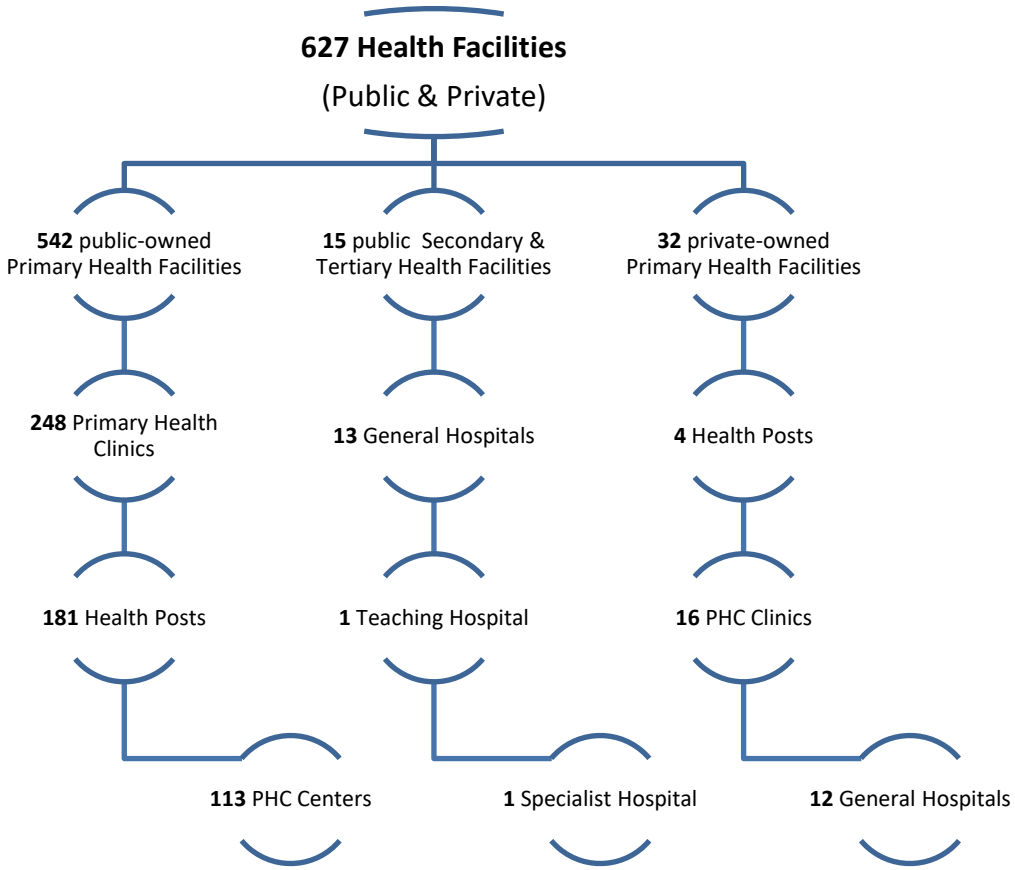

Fig: Segregation of Health care facilities in Gombe

3.1.3 Priority Area 3 Partnerships for Health

Health sector is multidimensional which underscores the imperative of partnership and collaboration between the State government and the private sector, non- governmental organizations, community and development partners as well as other social and economic sectors essential to deliver health services that can meet the needs of its populace on a sustainable basis.

The key actors within Gombe Health Sector include the donors/funding organizations, the implementing partners, government Ministries, Department & Agencies, Civil Society Organizations and their Networks and Trade Unions. The health MDAs are: State Ministry of Health, Gombe State Primary Health Care Development Agency, Gombe State Agency for the Control of AIDS, Specialist and General/Cottage Hospitals, College of Medicine, College of Nursing and Midwifery, College of Health Sciences & Technology and Trade Unions (NMA, NANNM, MHWUN, PSN). The State has also established a board for Traditional Medicine Practitioners under department of public health to test the efficacy of the herbs in addressing the health challenges in the State. The sector is also endowed with 14 Private Laboratories, 21 Private Pharmacy Shops and 1391 Patent Medicine Vendors (PHRRA, MoH). The state government committed 8%, 9%, 10% and 9% of its annual budget allocation as supplementary appropriation for health in the fiscal year 2018, 2019, 2020 and 2022 respectively. The major coordination platform in the State is the Technical Working Group/Core Technical Committees for various issues like MNCH, OVC, and HIV etc. However, there has been a lack of a harmonized framework for coordination between the SMOH and health development partners. As a result, effective coordination has been poor with donors working separately through various departments and agencies within the sector. Other key health partners are donor agencies that include World Bank, World Health Organization, Bill & Melinda Gates Foundation, USAID, CDC, United Nations, EU Prime and UNICEF. The key implementing partners are Pact, CIHP, SCI, Mamaye, Marie Stopes, MSH, UNFPA, and Society for Family Health, PATHFINDER etc. The major Civil Society Organizations/Faith-Based Organizations include members of the following Networks & Coalitions: Gombe State Accountability Mechanism, CiSHAN, AONN, NEPWHAN, etc

However total commitment by the partners in the state is not available, but the table below gives the list of partners and their involvement and responsibilities in the healthcare system in Gombe state.

Table 1: List of donors/partners and their involvement in health care system in Gombe state

Donor	**Field of Intervention and Activities**	**Timeline and Duration**	**Amount of Commitment (Naira)**	**Project Location**
WHO	Immunization DSR Malaria	Ongoing		11 LGAs
UNICEF	Immunization MNCH Soc. Mob Nutrition IMCI NTDs	2021-2022		11 LGAs Kwami LGA 11 LGAs 11 LGAs Kwami LGA 11 LGA
UNFPA	Family Planning	Ongoing		11 LGAs
Marie Stopes	FP	2018-2023		11 LGAs
Pathfinder	FP	2018-2023		11 LGAs
IPAS	MCH FP	Ongoing		11 LGAs
CIHP	HIV/AIDs/STI	2021-2022		11 LGAs
Shop Plus	TB	2020-2022		7 LGAs
AHEF	NTD	Ongoing		11 LGAs
S2S	ARH	2020-2025		11 LGAs
CHAD INT'L	Child Protection	2021-2022		
TCI	FP	2021-2022		11 LGAs
GIZ Backup Health	Service Integration	2021-2022		11 LGAs
PIPP	HSS	2021-2024		11 LGAs
JHF	TB	2019-2023		11 LGAs

3.2 Strategic Pillar 2: Increased utilization of the essential package of health care services

3.2.1 Priority Area 4 Reproductive, Maternal, New born, Child, Adolescent Health Services & Nutrition

Maternal mortality during pregnancy, childbirth and postpartum periods continue to remain high and therefore of a serious health concern. The current maternal mortality is 576/100,000 live birth (NDHS, 2013). According to the National Health Policy 2016, maternal deaths account for 32% among women of reproductive age group. Recently, maternal death review was introduced in public health facilities in the State, about 214 deaths of women related to pregnancy were reported out which 116 were audited (DHIS, 2.0, 2016). Causes of the deaths includes; Ante-partum haemorrhage (APH), Pre-eclampsia, Postpartum haemorrhage (PPH), Sepsis, Obstetric Labor (OL), Abortion, Malaria, Anaemia and HIV. Both public and private health care facilities provide focused Ante-natal care services with at least four (4) ANC visits. However, the revised WHO policy now recommends at least 8 visits. ANC uptake in the State is 67.5% (MICS, 2016/208) while number of visits is 27.9% (MICS, 2016/208). Only 34.1% of the women who attended ANC completed at least four ANC visits. The quality of ANC is encouraging

as coverage Percentage of women whose last birth was protected against neonatal tetanus was 58.0% (NDHS, 2013). Percentage of women who received any IPT during an ANC visit is 32.0% (NDHS, 2013). Facility delivery is low at 26.4% (NDHS, 2013).

Gombe State has high Early Child Mortality rates per 1000 live births far above average in the North-east showing; neo-natal (45), Post-neo-natal (59), Infant (104), Child (95) and Under-5 (189) (NDHS 2018). In terms of spacing of births between pregnancies, 27.1% of women do not observe the 24 month birth intervals. In addition, 25.4% did not attend ANC, only 46.4% received ANC from skilled providers at some point while 91.8% did not return for Post Natal Care (MICS). Available data also reveals that rate of teenage pregnancy and motherhood (15 – 19 years) in Gombe State is high as 19.8% of girls within that age cohort have had a live birth. The table below shows data extracted from the DHIS2

Table 2: RMNCAH+N indicators results versus targets 2018-2021 (DHIS)

	State Target				State Results			
INDICATOR	**2018**	**2019**	**2020**	**2021**	**2018**	**2019**	**2020**	**2021**
No of deliveries					59,215	78,607	71,536	63,791
No of deliveries by skilled birth attendants					59215	78607	71536	63791
No of women who attended ANC(at least one visit, in the state)							43,355	156,565
No of women having ANC at least 8 visits					343,708	398,519	296,691	367,181
No of LGAs with health facilities					11	11	11	11
No of LGAs with health facilities providing BEmONC services					11	11	11	11
Contraceptive prevalence rate					12.9	15.2	12.6	0
% Reduction in unmet FP need among all females of reproductive age					16.8	16.8	16.8	16.8
DPT Immunization coverage					111,153	135,063	134,153	129,695
Neonatal mortality rate					385	550	384	227
Infant mortality rate (infant deaths per 1000 live births (<1yr)					858	1040	929	763

3.2.2 Priority Area 5 Communicable disease (malaria, TB, HIV leprosy) and neglected tropical diseases (NTDs)

HIV/AIDS, tuberculosis, malaria and neglected tropical diseases contributes 32% of the burden of ill health in Africa, and seriously impact on health outcomes in every region of the world. The HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases (HTM) Cluster is concerned with the prevention and treatment of these high-burden diseases. In Nigeria these diseases account for 66% of the total burden of morbidity. To consolidate and extend progress on SDG Goal 3, challenges that need to be addressed include scaling up Communicable Disease such as Malaria, TB, Leprosy, HIV/AIDS) and Neglected Tropical Diseases and effective implementation of the national strategic frameworks for HIV/AIDS, malaria and tuberculosis control. In an effort to address these challenges, government has adopted and reinforced the implementation of an integrated approach to malaria control, tuberculosis and neglected tropical diseases (NTDs).

In Gombe State, access to and utilization of HIV prevention, care and support services increased with consequent reduction in prevalence from 3.4% in 2014 to 1.4% in 2018 (NAIIS, 2018). Gombe State was supported by the Global fund to boost malaria interventions through National malaria eradication Program (NMEP). LLINs use in Gombe is 54.4% against the north east average of 50.4%. Percentage of women 15-49 years in the state who slept under LLINs was 53.7% against the north east average of 47.8%. The proportion of pregnant women that received at least one dose of Intermittent Preventive Treatment (IPT) was 38.2% for Gombe against the north east average of 59.9% (MICS, 2016/208). Children with malaria whom treatment was sought from health facility provider was 72.5%. On the other hand, treatment sought from community health providers was 11.4%. Percentage of children who received ACT -3 was 4.5% in Gombe, higher than the north east average of 3.5% (MICS, 2016). The burden of most NTDs in Gombe State is not known as no survey/mapping was done. However, Leprosy, Lymphatic Filariasis, Onchocerciasis or river blindness; Soil Transmitted Helminthic (STH) are endemic in some LGAs while trachoma appears to be a disappearing disease in the State, considering that none of the LGAs had prevalence in children at or above the 5% elimination threshold set by WHO. This indicates gaps in the effort towards NTDs control in the state, therefore more need to be done. Challenges plaguing the delivery of intervention for communicable diseases and NTDs are largely hinged on issues limiting the optimal functioning of the health system, ranging from issues on governance and stewardship, inadequate human resources for health and physical infrastructures; paucity of quality data; Inadequate logistics management systems, inadequate and poor utilization of drugs, low awareness and funding

Table 3: Communicable disease and NTDs indicators results versus target 2018-2021 (DHIS)

	State Target				State Results			
INDICATOR	**2018**	**2019**	**2020**	**2021**	**2018**	**2019**	**2020**	**2021**
Rate of mother to child transmission of HIV					6	7	6	
% of PLHIV currently on HIV treatment services (ART)					23957	26370	28737	
% of those on PLHIV receiving ART who receive sustained virological suppression					21.8	39.4	59.7	
% Reduction in incidence of Viral B hepatitis per 100,000 population					3.7%	2.4%	0.89%	-
% Reduction in prevalence of targeted NTDs					0.17	1.7	1.94	2.0
% Reduction in the incidence of snake bites					4.18	4.14	4.8	6.4
Malaria prevalence among children under five					43.4%	38.8%	39.4%	33.7%
% of individuals with confirmed malaria treated with effective antimalarial in private or public facilities								
No of individuals with comfirmed malaria in private or public facilities								
No of individuals with comfirmed malaria treated with effective antimalarial in private or public facilities					433,376	555,627	559,016	613,158

No of health facilities providing malaria services					583	583	583	583
% of health facilities that report stock out of anti-malaria commodities								
% Reduction in TB prevalence								
% Reduction in TB mortality					90%	96%	84%	-
Case detection rate of all forms of TB					22	27	25	32
% Reduction in incidence of HIV infections among the key population								
% Reduction in incidence of HIV infections among the general populations								
% Increase in the general population who know their HIV status					6.1%	5.7%	5.5%	4.9%

3.2.3 Priority Area 6 Non-Communicable diseases (NCDs), elderly, mental, oral & eye health care

The Federal Ministry of Health through the Non-communicable Diseases Division is currently reviewing the National Policy and Strategic Plan of Action for the Prevention and Control of NCDs (2013), to ensure compliance with global best practices. In addition, various sub-programme guidelines such as the National Nutrition Guideline on the Prevention, Control and Management of NCDs, Guideline for the management of Sickle cell, NCD Case Management Desk Guide for Clinicians and NCD education and lifestyle guide for health Educators have been developed.

However, there is no current national nor Gombe State statistics on NCDs and over the years Nigeria has relied on estimates from the 1990-1992 survey, which is out dated and unsuitable for planning purposes. Major barriers to prevention and control of NCDs in Gombe include gross underfunding, lack of donor support, poor legislation and enforcement of laws linked to prevention and control. Others include inadequate screening equipment particularly at the PHC level, paucity of adequately trained staff, weak health systems, high cost of treatment, un-coverage of NCDs in the NHIS and lack of multi-sectoral approach to their prevention and control. The burden of NCDs is further compounded by ignorance, cultural beliefs and misconceptions about these diseases.

Table 4: Non-Communicable diseases indicators results versus target 2018-2021 (DHIS)

	State Target				**State Results**			
INDICATOR	**2018**	**2019**	**2020**	**2021**	**2018**	**2019**	**2020**	**2021**
% Reduction in overall mortality from NCDs								
Prevalence rate of tobacco use among adults					9.7%	9.7%	9.7%	9.7%
% of blind & virtually impaired persons that have adequate access to eye treatment and rehabilitative services by 2022					145,971	32,666	41,174	53,157
% Reduction in the incidence of snake bites						4.14%	4.8%	6.4%

3.2.4 Priority Area 7 Emergency medical services and Hospital care

The health care delivery system is divided into the primary, secondary and tertiary sub-systems. The primary and secondary sub-systems are under the supervision of the Local and State governments respectively and they are the links. In the State, they are functional and this has seriously improved referral services. Gombe people have full confidence in these two sub-systems, and usually use them in their quest to access medical services.

The tertiary health care delivery sub-system is operated by the Federal Ministry of Health and is only one (1) Federal Teaching Hospital, providing services in this sub-system, is under the direct supervision of the Department of Hospital Services of the Ministry. The hospitals have adequate manpower and some level of equipment to deliver reasonable services but this is not usually the case as a result of poor attitude of health workers, inter-professional wrangling, incessant strike actions, conflict of interest, poor housekeeping and unregulated Labor Unionism etc. The result is that most of Gombe people are fast losing confidence in this level of care and those who can afford it go outside the country to access care, which in some cases may not be up to the standard obtainable in the country. 49 facilities in the state have functional ambulances that response to emergencies within the shortest period of time.

Blood transfusion services are provided in 23 secondary and tertiary health facilities, but the complete blood system, where blood is preserved in a refrigerator is lacking in most of the facilities due to challenges of lack of power and funds to manage the facilities. Each of these facilities has a refrigerating system for the storage of blood and blood products such as serum, which is separated from whole blood. However, the problem is that the equipment cannot be used for the preservation of blood because of power supply problems and lack of funds to manage the facilities. There are currently only two functional blood banks in the state. Gombe State has qualified medical laboratory scientists, and the facilities to carry out desktop investigation to be certain the blood collected is free from blood-borne pathogens such as HIV, syphilis, malaria, and hepatitis B and C before transfusion. In Gombe state, there is no Public Health laboratory. However, public sector clinical laboratory services are provided in primary, secondary and tertiary health care facilities, owned by the different tiers of government. Private health facilities also provide laboratory services, and some of them are free standalone laboratories with some of them well equipped.

3.2.5 Priority Area 8 Health promotion and social determinants of health

Gombe State has been making concerted efforts aimed at promoting health and addressing some of the social determinants of health. Some of the actions initiated over the years include: Development of relevant Health Policies including the State Strategic Health Development plan (2018-2022), Human Resources for Health policy 2014, Human Resources for Health Strategic Plan 2014, Task Shifting and Task Sharing(TSTS) plan 2015, Standard Operating Procedure (SOP) for (TSTS) the State Food and Nutrition Policy(2016), State costed Plan on Food and Nutrition(2018-2022), Legislation on the State Health Acts (SHActs), Primary Health Care Under one Roof (PHCUOR) Act, as a strategy to reduce geographic and economic inequities to access, strengthening Community Action and promoting the concept of Ward Development Committees and Reorienting health services. The state Lack a strong platform for multi-sectoral actions towards the promotion of supportive environments for health behavior change, as well as Inconsistent and poor implementation of health education across the levels of the health care system. There is need for the integration of health promotion in curative services and across programs

3.3 Strategic Pillar 3: Strengthened health system for delivery of the EPHS

3.3.1 Priority Area 9: Human Resource for Health

Several studies have shown that Human Resources for Health (HRH) are pivotal to attaining, sustaining and accelerating progress towards Universal Health Coverage (UHC). According to the World Health Organisation (WHO), a strengthened health policy environment is critical to the delivery of quality health care to the population as it creates an enabling environment for the health workforce; and that health services, particularly at the primary health care level, are critical to Maternal, New-born and Child Health (MNCH), and can be only as effective as the persons responsible for delivering them. Unfortunately, in Nigeria, there is critical shortage in HRH. But there are efforts to optimise the available workforce in the provision of quality essential services towards realisation of UHC. The size, distribution and skill mix of health personnel of a health system significantly influence its impact on health outcomes. However, the number of health staff in Gombe state is inadequate to meet the State health needs.

The state has a strong HRH system that oversees employment, development and monitoring of HCW distribution between rural and urban areas. Though there is a plan for HRH, but it is not costed. About 52.3% of the health budget is allocated to recurrent expenditure (personnel and overhead cost). However, most of these funds are used for payment of salaries /allowances. The state has institutions of higher learning geared toward improving the numbers of HRH in the state. However only 30% of these institutions have essential primary health care embedded into the curriculum. There has been no recruitment of health care workers at Health Facilities in the last 3 years. There is however a sub-optimal oversight from regulatory bodies in terms of the supportive supervisory visits to facilities to ensure that services are being delivered adequately. The key challenge to the HRH is a sub-optimal budgetary allocation for capacity building of HRH in the state and poor oversight by authorities.

Gombe state government has done much in the development of Human Resources for Health in Gombe with the development of appropriate legislations and policies. The SMoH has developed policies such as the State Human Resources for Health Policy (SHRHP), State Human Resources for Health Strategic Plan 2015-2020 (SHRHSP) and Task Shifting and Task Sharing (TSS) Policy with Standard Operating Procedures In line with the policy provisions, LGAs, are expected to establish HRH units in their respective PHC units. State Human Resources for Health Information System (SHRHIS) is currently undergoing development which will inform efficient performance of HRH management functions such as forecasting, recruitment, deployment, retention, and motivation and performance management.

Table 5: Public Sector Human Resource Availability in Gombe State 2021

Health Workers Categories	Year	No	Density/ 100,000 population of 3,341,591	Ratio
Doctors	2021	193	5.77	1:17,331
Dentists	2021	2	0.06	1:666,666
Optometrist	2021	1	0.0	1:3,341,591
Nurses/Midwives	2021	816	24.45	1:4166
Dental Nurses	2021	1	0.0	1:3,341,591
Radiographers	2021	9	0.27	1:370,370
Pharmacists	2021	56	1.67	1:59,880
Pharmacy Technicians	2021	34	1.0	1:91771
Physiotherapists	2021	20	0.62	1:159,392
Community Health Officers	2021	67	2.0	1:50,000
CHEW	2021	615	18.40	1:5434
JCHEWs	2021	375	11.22	1:8912
Medical Lab Scientists	2021	80	2.40	1:41,666
Medical Lab. Technicians	2021	32	0.96	1:104,166
Medical Lab. Assistants	2021	11	0.33	1:303,030
Environ. Health Officers	2021	62	1.85	1:54,054
Environ. Health Technicians	2021	152	4.54	1:22,026
Environ. Health Assistants	2021	79	2.36	1:42372
Health Records Officers	2021	24	0.79	1:126,582
Dental Therapists	2021	11	0.33	1:303,030
Dental Technologists	2021	13	0.39	1:256,410
Dental Health Technicians	2021	9	0.27	1:370,370
Biomedical technicians	2021	3	0.090	1:1,111,111

3.3.2 Priority Area 10 Health Infrastructure:

Health Infrastructure comprises buildings, both medical & non-medical equipment, furniture and hospital plant; communications (ICT equipment); and ambulatory facilities (ambulances, cars, pick-up vans, trucks, etc.) as required for healthcare delivery at different levels. Critical infrastructures are understood as facilities and services vital to the basic operations of a society. Over the years, the pace of infrastructural development in this sector has not matched the health demands of the people while support for even the most basic healthcare package is grossly inadequate. The inadequacy number and spread of health facilities coupled with cost, socio-cultural factors may explain why more than two third of the deliveries in the state take place at home, inadequate availability and low uptake of CBS services and high unmet need for CBS services.

The State has 589 health facilities with (562) 95.4% being Primary Healthcare Centres, (26) 34.4% secondary, (1) 0.1% Tertiary facilities (MOH). The table below shows the breakdown of health facilities

Table 6: Distribution of Health Facilities in Gombe State by ownership and level of care (*MOH)*

Description	**Public**	**Private**	**Total**
PHC	542	20	562
Secondary Health Facilities	14	12	26
Tertiary Health Facilities	1	0	1
Total	557	32	589

Many of these facilities (particularly PHCs) are in different states of dys-functionality ranging from dilapidation, lack of water and electricity. The secondary levels also suffer from obsolete and non-functional equipment due to lack of maintenance. Although, the State has set the following infrastructural priorities relating to health sector; minimal number of PHCs linked to contiguous secondary health facilities in each LGA, States having functional secondary Health Facilities in each LGA with qualified personnel and the establishment of a strong referral system to a contiguous secondary health facility, However, one functional Primary Healthcare (PHC) centre was established in each ward to serve as a referral centre to facilitate the provision of universal health coverage to over its 3,225, 382 million citizens. Challenges include untimely release of funds for infrastructural development, non-involvement of community/users of the health facilities in the management of the facilities, inadequate infrastructural facilities (water, electricity, roads and irregular maintenance of the equipment in the health facilities, and inadequate health workers. However state Health Equipment Policy is yet to be developed

3.3.3 Priority Area 11 Medicines, Vaccines and Other Health Technologies and Supplies

Access to essential medicines is critical to achieving universal health coverage. It is one of the WHO key building blocks of a strong health system. The primary goal is to ensure **commodity security**. This is a situation where essential medicines are available, affordable, and people are able to choose, obtain and use high quality medicines and medical supplies, as at when needed. The supply chain activities include; product selection, quantification, procurement, warehousing, transportation, storage and rational use, among others.

Gombe state has functioning LMCU both at the state and LGA levels, and most of the procured drugs are in national essential drugs list and a very high percentage of drugs and commodities are registered in the country. The state operates on DRF scheme for the supplies to facilities. However managers in the health facilities are not too conversant with the forecast tool in the software due to weak capacity, hence most of the supplies are emergencies. Documentation of the inventory is also weak. Major challenge is the High prices of health commodities which lead to low spending on pharmaceuticals and vaccines as a proportion of health expenditure

3.3.4 Priority Area 12 Health Information System:

Gombe State adopted the revised 2013 Health Information System (HIS) policy which provides the framework for effective data collection, collation, analysis, storage, dissemination and use at different levels in the state. The HIS Strategic Plan 2016-2022 was guided by the HIS Policy.

The fragmented and weak health information system in the state is hampered with numerous vertical programmes, which are mostly Donor driven. Routine data completion rate and timeliness in DHIS is 90%

(PHC Diagnostics 2020). Although the state has 32 private health facilities, very few are not capturing their data into the DHIS. Generally, weak data quality still exists at all levels. Although there is an established data flow system, there is no systematic process of routine analysis of submitted HMIS data and feedback to health institutions. Other challenges include; weak M & E mechanism at all levels; inadequate trained human resource and equipment at state and LGA levels as well as inactive Health Data Consultative Committee forum which have compounded the situation. The state is not taking full decision on issues identified from the data generated**,** But some areas need funding to address them and nothing is being done in that direction.

3.3.5 Priority Area 13 Research for Health:

Research and Development is critical for innovative and sustainable development of the health sector. Eevidence-based policy and decision making at the State and Local Government level can be enhanced through the availability of research findings. However, Gombe state host many institutions involved in health research such as Gombe State University, Federal Teaching Hospital, College of Nursing and Midwifery, College of Health Sciences and Technology Kaltungo and many other private own institutions. Most of the researches conducted in these institutions are meant to fulfill academic or professional requirements with the exception of a few that are operational research as well as a few clinical trials. In addition some of the researches are also carried out by donors to generate baseline data before undertaking an intervention. Although in most of the researches conducted there weak linkages between health research and community needs as well as use of research findings for evidence-based policy making in health at all levels. Two functional Research ethics committees exist at the Federal Teaching Hospital Gombe and the State Ministry of Health. These committees have responsibility for review and approve any health research to be conducted in the state. Guidelines are provided to intending researchers to comply with in order to protect human subjects and to ensure added value to the health sector.

3.4 Strategic Pillar 4: Protection from health emergencies and risks

3.4.1 Priority Area 14 Public Health Emergencies: Preparedness and Response

Public health emergency is the occurrence of imminent threat of an illness or health condition caused by bio-terrorism, epidemic or pandemic disease or novel and highly infectious agents or biological toxins (WHO, Health emergency 2007).

Gombe State has designated isolation units located at state specialist hospital and general hospital Zambuk for containment of public health emergencies. Also the state established Emergency Operations Center (EOC) during the first wave of COVID19 pandemic, which serve as emergency response unit for all public health emergencies. These facilities require comprehensive upgrade to serve the emergency needs within the state health care system. However, there is no standard and functional laboratory service centre for public health emergencies to support the management of health emergencies. Additionally, there is a need to strengthen the collaboration between health sector and related emergency institutions such as SEMA and NEMA as well as promoting public education on health emergencies is paramount. Moreover the % of blood collected from voluntary non-remunerated donors remains 1.2%. (DHIS)

3.5 Strategic Pillar 5: Predictable financing & risk protection

3.5.1 Priority Area 15 Health Financing

Health care financing in Gombe State is through the State budgetary allocation, donor funding, out-of-pocket payments, and health insurance. The health expenditure of Gombe State in 2018, 2019, 2020 & 2021 are 8%, 9%, 10% and 9% of the total state allocations respectively. The state established GOHEALTH (Gombe State Contributory Health Management Agency) which has mandate to ensure to the attainment of Universal Health Coverage through a credible and sustainable mechanism for pooling of resources (deduct a proportion of all civil servant's basic salary on a monthly basis as contribution) to finance healthcare services, and improve access to quality healthcare provision with financial risk protection. Recognising the role PHCs play in terms of being the first point of call for most citizens (especially the poor and vulnerable), the scheme plans to empanel upgraded PHCs to cater to the health needs of the enrolees residing in the communities where the PHCs are situated. The state does not have a resource mobilization plan for health financing. Although many opportunities exist for increased domestic funding of health such as corporate social responsibility funds, health impact bond, taxes, VAT, mandatory health insurance, philanthropy; which still remain grossly underexploited in the state.

Gombe state ministry of budget monitors and reports (Annual Report on Gombe State Budget Performance) on general expenditures in the state including health expenditures. This system is not adequate for providing proper insight into health financing. Assessing the efficiency of resource use is therefore challenging leading to lack of transparency and leakages.

4.0 FINDINGS OF THE 2020 MID TERM REVIEW

4.1 Performance:

4.1.1 Performance Tables (Targets & results)

No data available on target from the state

4.1.2 Performance infographics (charts etc)

No data available on target from the state

4.2 Review of Relevance, Effectiveness, Efficiency, Impact & Sustainability

4.2.1 Relevance

Health promotion and public health emergencies were the two programme area that are most relevant to activities and interventions implemented in the state within the period under review, activities and intervention are also very relevant to HIV/AIDS and neglected tropical diseases area, furthermore, activities implemented within the period in question are categorized relevant in the areas of RMNCAH+N, malaria, TB, Non communicable disease eye health, emergency medical services.

4.2.2 Effectiveness

Activities implemented in the state are most effective in areas of RMNCAH+N, Health promotion and public health emergencies. Interventions are very effective in malaria, TB, HIV and neglected tropical disease. So much has been done in HIV program with the Support of CIHP, indicators showed a drop in HIV prevalence from 4% in 2018 to 1% in 2021. Partners like Janna Health foundation supported TB program in the state through active case TB finding among vulnerable key populations (IDPs and NOMADIC) which contributed to about 21%, 18% and 25% of the TB cases notified in the state in 2019, 2020 and 2021 respectively. Activities implemented are effective in non-communicable disease program area but effectiveness are sub-optimal in eye health and emergency medical services, even though the state procured new brand ambulances and upgraded Accident and Emergency units of state specialist hospital and some selected general hospital but there is no enough trained health personnel in the emergencies and attached to the ambulances to provide emergency treatment. Area of eye health is neglected and not much is done to show significant change in the indicators. Areas where effectiveness is sub-optimal is associated to inadequate human resource and lack of funding, most programs rely only on government internal funds which is very small to improve the effectiveness. Some best practices that improve effectiveness in some area are TWG advocate to political leaders to provide support in area not supported by government like sickle cells, hypertension, eye surgeries through their constituency projects and source for funds from private organisation like Banks and Ashaka cement as part of corporate social responsibilities to augments some health intervention in the state

4.2.3 Efficiency

Activities implemented in the state are most effective in areas of RMNCAH+N, Health promotion and public health emergencies. Interventions are very effective in malaria, TB, HIV and neglected tropical disease. So much has been done in HIV program with the Support of CIHP, indicators showed a drop in HIV prevalence from 4% in 2018 to 1% in 2021. Partners like Janna Health foundation supported TB program in the state through active case TB finding among vulnerable key populations (IDPs and NOMADIC) which contributed to about 21%, 18% and 25% of the TB cases notified in the state in 2019, 2020 and 2021 respectively. Activities implemented are effective in non-communicable disease program area but effectiveness are sub-optimal in eye health and emergency medical services, even though the state procured new brand ambulances and upgraded Accident and Emergency units of state specialist hospital and some selected general hospital but there is no enough trained health personnel in the emergencies and attached to the ambulances to provide emergency treatment. Area of eye health is neglected and not much is done to show significant change in the indicators. Areas where effectiveness is sub-optimal is associated to inadequate human resource and lack of funding, most programs rely only on government internal funds which is very small to improve the effectiveness. Some best practices that improve effectiveness in some area are TWG advocate to political leaders to provide support in area not supported by government like sickle cells, hypertension, eye surgeries through their constituency projects and source for funds from private organisation like Banks and Ashaka cement as part of corporate social responsibilities to augments some health intervention in the state

4.2.4 Impact

Activities implemented in the period under review are impactful in all programme areas listed. Because, looking at the RMNCAH+N score card to monitor progress, it is shows that the state has a lot of reds and some few greens and a lot of yellows, meaning that there are still critical component of this RMNCAH+N that the desired results is not achieved, so there is still a long way to go for to achieve that. Malaria also can be impactful too, Tuberculosis is fairly impactful, HIV is very impactful, Neglected Tropical Diseases fairly impactful, Non-communicable Diseases fairly impactful, Eye is very impactful, Emergency Medical Services is the most impactful, Health promotion is impactful, Public Health Emergency is the most impactful

4.2.5 Sustainability

Activities implemented in the period under review in areas of RMNCAH+N, Malaria, TB, HIV, Emergency medical services are fairly sustainable, because they are all mostly supported by donors with little from the government budget allocations, neglected tropical diseases, non-communicable disease, eye health, health promotion and public health emergency are all sustainable

5.0 OTHER FINDINGS

5.1 *Strategic Pillar 1: Enabled Environment for Attainment of Sector Outcome*

5.1.1 Steering Committee for SSHDP-II/NSHDP

The state constituted the steering committee to coordinate the implementation of the SSHDP II immediately after completing the process of development of the plan upon the recommendation of the NSSHDP, but the committee had only two series of meeting and is not functioning any longer. The minutes of the meeting and the members are nowhere to be found

5.1.2 AOP

The state develop Annual Operation Plans (AOP) every year, but It has not been really used and followed very well because the State budget is mostly incremental not following exactly what is in the strategic plan, it is only of recent, (i.e 2020 AOP) the state tried to ensure that it is in line with the content of the SSHDP II.

Health sector coordinating platform does not exist in the state but there is a level of synergy between the different sectors that operates with health, but recently the executive governor appointed Special Advisor on NGOs in the state which is expected to coordinate activities of all partners in the state for both health and non-health sectors

5.2 *Strategic Pillar 2 Increased utilization of the Essential Package of Health Care Services*

Relevance(s) of the health interventions/activities implemented in the state from 2018 to 2021 in relation to the strategic interventions and priorities of the SSHDP-II

The two KII conducted revealed that health promotion and public health emergencies were the two programme area that are most relevant to activities and interventions implemented in the state within the period under review, activities and intervention are also very relevant to HIV/AIDS ad neglected tropical diseases area, furthermore, activities implemented within the period in question are categorized relevant in the areas of RMNCAH+N, malaria, TB, Non communicable disease eye health, emergency medical services.

Effectiveness of the health interventions/activities implemented in the state from 2018 to 2021 in achieving the desired health outcomes/state health sector performance

Activities implemented in the state are most effective in areas of RMNCAH+N, Health promotion and public health emergencies. Interventions are very effective in malaria, TB, HIV and neglected tropical disease. So much has been done in HIV program with the Support of CIHP, indicators showed a drop in HIV prevalence from 4% in 2018 to 1% in 2021. Partners like Janna Health foundation supported TB program in the state through active case TB finding among vulnerable key populations (IDPs and NOMADIC) which contributed to about 21%, 18% and 25% of the TB cases notified in the state in 2019, 2020 and 2021 respectively. Activities implemented are effective in non-communicable disease program area but effectiveness are sub-optimal in eye health and emergency medical services, even though the state procured new brand ambulances and upgraded Accident and Emergency units of state specialist hospital and some selected general hospital but there is no enough trained health personnel in the emergencies and attached to the ambulances to provide emergency treatment. Area of eye health is neglected and not much is done to show significant change in the indicators. Areas where effectiveness is sub-optimal is associated to inadequate human resource and lack of funding, most programs rely only on government internal funds which is very small to improve the effectiveness. Some best practices that improve effectiveness in some area are TWG advocate to political leaders to provide support in area not supported by government like sickle cells, hypertension, eye surgeries through their constituency projects and source for funds from private organisation like Banks and Ashaka cement as part of corporate social responsibilities to augments some health intervention in the state.

Efficiency of the health interventions/activities implemented, designed and managed that guarantee best results for available resources

The efficiency of health interventions in the state is not really impressive, only activities in HIV/AIDS, RMNCAH+N, health promotion and public health emergencies are said to be very efficient. Other area are fairly efficient. And the inefficacies are attributed to lack of integration and alignment of activities. Efficiency can be

improved to guarantee best result for available resources if activities are integrated and coordinated under a single coordination Platform.

Impact of the health interventions/activities implemented in the state from 2018 to 2021
Activities implemented in the period under review are impactful in all programme areas listed. Because, looking at the RMNCAH+N score card to monitor progress, it is shows that the state has a lot of reds and some few greens and a lot of yellows, meaning that there are still critical component of this RMNCAH+N that the desired results is not achieved, so there is still a long way to go for to achieve that. Malaria also can be impactful too, Tuberculosis is fairly impactful, HIV is very impactful, Neglected Tropical Diseases fairly impactful, Non-communicable Diseases fairly impactful, Eye is very impactful, Emergency Medical Services is the most impactful, Health promotion is impactful, Public Health Emergency is the most impactful.

Sustainability of the health interventions/activities implemented in the state from 2018 to 2021
Activities implemented in the period under review in areas of RMNCAH+N, Malaria, TB, HIV, Emergency medical services are fairly sustainable, because they are all mostly supported by donors with little from the government budget allocations, neglected tropical diseases, non-communicable disease, eye health, health promotion and public health emergency are all sustainable.

5.3. ***Strategic Pillar 3: Strengthened Health System for Delivery of EPHS***

5.3.1 DRF/DMA

The state operates Drug Revolving Fund (DRF) but Drug Management Agency (DMA) doesn't exist. A bill to establish DMA is drafted and has been going reviews which is presently at the ministry of justice hoping to be passed soon. The DRF operates using basically push and pull system, in which every facility has its own particular pattern, each hospital will generate a list of drugs and consumables required for their service delivery which will letter be collected at the central medical store where tender is been released and suppliers will be invite to bring quotations and awarded contracts to them for the supplies, which will be delivered to the central store and facilities (both primary and secondary facilities) will make a requisition and collect what they needed from the stores. Sometimes the state gets donations directly to the DRF and such drugs are directly pushed to various facilities for utilization. The DMA on the process serve as a sustainability plan for the DRF, once it is in place the state will have a robust and sustained DRF. Funding has been the major challenge impacting the operations of the DRF scheme, and for long there is no recapitalization of the funds, many request and memos for recapitalization has been sent but yet to be honoured. In order to address the challenge of funding sometimes drugs are collected from the supplies on credit pending on the establishment of the DMA. The DRF in the PHCs has a reagick by the basic health providence fund gateway and health insurance gateway (which is GoHeath), Using WDCs such facilities happened to be more effective in running the DRF, and expansion of new facilities in the states is the major cause to the DE capitalization of the scheme without the requisite injection of additional funds

5.3.2 Reporting on national DHIS-2 instance

The state DHIS-2 reporting is domiciled within the Primary Health care development agency which is accessible online. In terms of completeness and timeliness it can be rated at about 80% to 90%. All the 11 LGA M&E Officers were granted access with username and password, and were saddled with the responsibility of imputing their LGA results monthly. The M&E officers will go round all facilities (primary, secondary and tertiary, both public and private) under their LGA and collect information using standard and approved data collection tool, then validate and upload to the DHIS-2. The completeness and timeliness of the data is derived as a result of routine coordination meeting with the facility M&E officers to validate the data and ensure quality. Computers and solar powered light was also install in all LGAs to support data collection in the Local Government. Integrated supportive supervision also done quarterly to ensure data quality.

5.3.3 Reporting by private service providers and community entities

There is maximum cooperation by private facilities within the state in terms of data reporting, the major challenge is the rapid expansion of the state that leads to the opening of new health facilities and the attitude of some personnel by seeing the data as not theirs, and they see it as supporting partners' data. Over the years capacity building exercise has been going with support from different funders on the data reporting on DHIS which enables the state reporting rate to be high. Another enabler that improve reporting from health facilities is that the DHMOs were provided with Motor cycle and small allowance to go round the facilities for data collection

5.3.4 Data Management

The state has a data management system, but it is not robust. The data management is hybrid (not fully electronic), but a lot of resources are being put in to upgrade it and make it fully electronic. Data utilization is sub-optimal, because the database is a rich repository that has a lot of information. In most instances routine analysis is not done except when there is a request from funders or when there are reviews like this then extractions are forced to be made. But in the area of public health emergencies data from immunization coverage is been used to determine areas that required immediate posting of surveillance systems to depicts outbreak early and control further spread. At LGA level during quality assessment, performance of different PHCs are tracked with regards to their score cards to informed on what the PHCs developed as their plan for the quarter, only with that the facilities will access the basic healthcare provision fund. Serious capacity gab on the data utilization exist at state, LGA, facility and community level.

5.3.5 Health Research

The state ministry of health has research ethics committee. Health research ethics committee serve as the coordinating structure for health research in the state. The committee reviews proposals and protocol for any health research in the state, but has not yet gotten the requisite training for the functions. However the committee had always been guided by some members of the committee that work with the teaching hospital. The state ministry of health has in record about 417 health related researches carried out since 2018. These includes undergraduate, postgraduate and NGOs researches. Health research implementation, reporting and documentation can be improved by instituting active coordinating structures, and collaboration with tertiary institutions in and outside of the state.

5.4 ***Strategic Pillar 4: Protection from Health Emergencies and Risk***

5.4.1 Adequacy of content

The state established Emergency Operation Center (EOC) during the first wave of COVID19 pandemic, which serve as emergency response unit for all public health emergencies, but the level of preparedness is inadequate. One major gap that affects the response is suboptimal collaborations between health and non-health sector, which usually during an outbreak, different actors are doing their activities independently. The current strategy for emergency response in the state is leveraging on the support for COVID19 coming World Bank which is not sustainable. Fully equipped coordination unit should be established and government needs to commit a lot to it. A memo to establish Public health emergency fund was raised and currently undergoing reviews in the Governor's office which would serve as a sustainable way to address public health emergencies. Capacity building of human resources in the area of incidence management system has proven to be the best system that can tackle any public health emergency, not only health but even other emergencies that affects the population.

5.5 ***Strategic Pillar 5: Predictable financing and Risks Protection***

The issue of investment business cases for Universal Health Coverage was initially brought up when GOHEALTH (Gombe State Contributory Health Management Agency) was constituted, unfortunately it has not yet been pushed through because is a new agency that was established in 2020. So, is still at the early stage. The agency has the mandate to ensure to the attainment of Universal Health Coverage through a credible and sustainable mechanism for pooling of resources (deduct a proportion of all civil servant's basic salary on a monthly basis as contribution) to finance healthcare services, and improve

access to quality healthcare provision with financial risk protection. The Agency is regulated by a Governing Board which consists of major stakeholders such as the NLC, TUC, CSOs, among others. The agency has mandate to. The program is just coming up, and it will eventually take good shape and it will be effective and productive.

5.5.1 Budget allocation

The % of the state budget allocation to the health sector in 2018, 2019, 2020, and 2021 are 8%, 9%, 10% and 9% respectively. The major challenge here is that proportion of these budget is mostly spent on curative components of health sector which is only infrastructural support and renovation of facilities, and this is not good for the state because the preventive, and other component were also equally important in achieving effective, efficient, accessible and affordable delivery of health services in the state.

5.5.2 BHCPF

The Basic Healthcare Provision Fund is very relevant, a lot of health expenditures are out of pocket, it will provide a pool of financial resources that could be channelled to minimizing catastrophic spending of health. Concurrently the Basic Health Care Provision Fund is coming and it is structured such that every segment in the population has a will be covered, and this is very sustainable as it is coming directly from the federal. It will definitely make an impact looking at the results and achievement of NSHIP program in the state.

5.6 ***Next Steps on the NSHDP-II expiration***

On a general note, the implementation of the SSHDP-II against set milestone and targets is rated good. But there are unique issues within the state that were not addressed by the plan, for example some neglected Tropical Disease, like snake bite, the state is unique. So when the state is developing its strategic plan from that of the national there is need to take those peculiarities in to considerations. Secondly issues that have bearing on health but are principally humanitarian, like IDPs trooping in to the state are some of the assumptions that the strategic plan should include. It is suggested that the plan be revised and extended beyond 2022, after new administration came in to power comes 2023, then a new SSHDP to be developed.

5.7 ***Constraints/Challenges/Bottlenecks***

1. Lack of adequate and timely release of funding has been the major challenge for implementation of strategic plans.
2. Inability of developing and approving of AOPs in good time
3. Inability of government and community to take ownership of innovative intervention by donors and NGOs
4. Human resources constrain
5. Lack of coordination and overlapping of programs has affected the implementation of the plan

5.7 ***Best Practices***

1. State Government Declaration of state of emergency on health by the present administration
2. Government commitment in paying counterpart funding and government strong collaboration with iNGOs
3. Government establishment of the office of SSA on NGOs or partner coordination
4. Establishment of GOHEALTH to improve access to quality healthcare provision with financial risk protection

5.8 ***Lessons Learned***

The key lesson is the obvious visibility of the political leadership of the state in the implementation of most of the health programs, in all the programs it is either the commissioner is their present or the executive heads of agencies. There is government will to make prioritization of health sector as a whole.

Also, donor and NGOs interventions in the state are channelled to address activities and objectives of the SSHDP during the period

6.0 Recommendations

1. Government to ensure that various committees recommended like steering committee for implementation of SSHDP and SP TWG are instituted and have defined terms of reference.
2. SSHDP development and implementation should be government driven not partners driven, and the period of the development should be shortened
3. Other stakeholders under non health sectors to be engaged during the development of SSHDP
4. Gombe state MOH should have a portal that displays data/indicators such as HIV prevalence, immunization coverage, maternal mortality rate etc to improve data utilization for informed decision.
5. Continues capacity building on data utilization, emergency response or incidence management system (for both health and non-health sector personnel) is recommended
6. Establishment of public health emergency fund in the state
7. Partners funding should align with areas of priorities of the state

7.0 Conclusion

Annexes