# Gombe State Integrated PHC Planning and Execution Support

Execution Grant · KSDF as Cross-Cutting Technical Assistance Partner

| | |
|---|---|
| **Status** | Active |
| **Duration** | September 2025 – September 2028 |
| **Funder** | Gates Foundation |
| **Lead implementing agency** | Gombe State Primary Health Care Development Agency (GSPHCDA) |
| **KSDF role** | Cross-Cutting Technical Assistance Partner |
| **Geographic coverage** | Gombe State — all 11 LGAs |
| **Framework** | 16 Strategic Objectives across 13 Intermediate Outcomes, spanning eight thematic workstreams and a state-wide Health Facility Census |

## Project overview

The Gombe State Integrated PHC Planning and Execution Support Investment is a health systems strengthening initiative designed to improve equitable access to quality primary healthcare services across Gombe State. Funded by the Gates Foundation and implemented by GSPHCDA, it strengthens health system performance through improved governance, workforce development, digital transformation, sustainable financing, supply chain optimisation, quality service delivery, and gender-responsive programming.

As the Cross-Cutting Technical Assistance Partner, KSDF provides strategic and operational support across all thematic workstreams — helping government institutions translate ambitious plans into coordinated implementation, measurable results, and sustainable system improvements.

## The challenge

Despite substantial progress in primary healthcare, health systems face persistent, interconnected challenges: workforce shortages, fragmented data systems, weak coordination, financing gaps, supply chain inefficiencies, and inconsistent quality of care. Addressing them requires a whole-system approach that strengthens both technical and managerial capacity at every level — which is precisely what a cross-cutting partner exists to hold together.

## HIGHLIGHTS FROM IMPLEMENTATION — MAY TO JULY 2026

In the first full quarter after implementation commenced, KSDF provided technical assistance across twelve distinct engagements spanning six of the eight workstreams — from designing and facilitating trainings, to brokering partner alignment, to producing the analytical and reporting products the grant runs on.

| Workstream | KSDF technical assistance this quarter |
|---|---|
| Digitisation & Health Facility Census | Census instrument harmonisation; Technical Champions Training of Trainers; enumerator cascade; data-architecture field visit and SDIU framing |
| Gender Integration (GESI) | Gender & GBV Training of Trainers; cascade planning; three-cohort cascade training |
| Supply Chain & Logistics | Drug Revolving Fund capacity building across all 114 PHCCs, with field verification |
| HRH — community workforce | CARMNIS alignment and harmonisation; merit-based CBHW screening |
| Leadership & Governance | Monthly coordination meeting; Health Sector Planning Cell review |
| Health Financing | GoHealth coordination inputs — M&E, enrolment, grievance redress |

## Digitisation, data and the Health Facility Census

The census was the quarter's largest single thread of KSDF technical assistance — from harmonising the instruments, through preparing the trainers, to readying the enumerators for the field.

### *Harmonising the census instruments before the count*

KSDF supported a three-day workshop that reviewed and finalised the full instrument suite for the 2026 Gombe Health Facility Census — the health facility assessment tool, the doctor and specialist interview questionnaire, the nurses and midwives' tool, the community health workers' tool, and the pharmacy/PPMV tool. The work merged partner-developed tools into one unified format, removed duplicate questions, and secured consensus among the State Ministry of Health, the primary healthcare board and development partners on definitions, scope and method.

### *Preparing the people who run the census*

- A three-day Training of Trainers for state Technical Champions (8–10 June), building mastery of the census software, GPS mapping and the survey instruments, and equipping champions to lead step-down training across all 11 LGAs.
- A seven-day cascade training for enumerators — standardising survey terminology and facility taxonomy, offline data capture on CAPI/ODK/KoboCollect, GPS accuracy, ethical interviewing and informed consent, and ward-level deployment.

### *Mapping the state's data architecture*

KSDF took part in a four-day field visit examining how Gombe's health system and data architecture function, and where a State Data Intelligence Unit could add value without duplicating existing structures — then converted the findings into a structured narrative report mapping eight distinct data streams, each with its review pathway, platform and integration status.

## Gender equality and social inclusion

KSDF supported a complete gender and GBV integration sequence this quarter — from building a state trainer pool, through planning the cascade, to delivering it across three cohorts — producing a state-owned capability rather than a partner-delivered event.

- **A state trainer pool.** A Training of Trainers on gender, gender equality and GBV integration into PHC, held at the Execution Grant Office, drawing trainers from GSPHCDA, the State Ministry of Health, GoHealth and GODMA — covering gender concepts, GBV types and impacts, the legal and policy framework including the VAPP Act, and practical screening, referral and survivor-support skills using the WHO LIVES protocol.

- **A properly planned cascade.** A planning meeting that validated the training plan, assigned trainers to the three cohorts (Gombe, Kaltungo and Funakaye) with team leads, and finalised modules and materials for consistent delivery.
- **Delivery to the frontline.** A two-day cascade reaching facility managers, LGA M&E officers, HRH desk officers, social safeguard officers and PHC stakeholders across three cohorts — on screening, survivor-centred and trauma-informed care, safeguarding, confidential documentation and inclusive service delivery.

***A measurable baseline to move against***

The GESI work is anchored by the GO-Inclusive baseline — a field assessment across 114 PHCs in all 11 LGAs, in a sample 87.7% rural — which found a willing workforce constrained by systems rather than attitudes:

| What is working | Where the gaps are |
|---|---|
| 86% of respondents can define GBV | Only 11% correctly understood the concept of gender |
| 87% understand the health consequences of GBV | Only 35% trained on confidential GBV case management |
| 78% know the standard GBV response steps | Only 40% knew the National GBV Clinical Management Protocol |
| 70% feel confident handling GBV cases | Only 47% had a designated GBV focal person |

Facility readiness across the 114 PHCs: private counselling space 66%, locked cabinet for confidential files 37%, GBV reporting register 24%, referral pathway displayed 18%, gender/GBV information materials 0%.

### Supply chain and the Drug Revolving Fund

KSDF supported a six-day Drug Revolving Fund capacity-building programme delivered in three cohorts to staff from all 114 PHCCs across Gombe State — PHC coordinators, drugs and equipment focal persons, and DRF operators. The curriculum covered DRF governance and pricing policy, inventory and store management, logistics, monitoring and accountability tools, inventory software, pharmacovigilance, stock-taking, safe disposal of expired drugs, and the computation of average monthly consumption and security stock.

A companion field spot-check assessed 20 PHC facilities against DRF guidelines. Commodity availability was strong; compliance and documentation were not — the headline finding being that none of the spot-checked facilities were applying the approved DRF price list, alongside unrequested and near-expiry commodities pushed to facilities, and only 70% of facilities holding a pharmacy technician.

### Human Resources for Health — the community workforce

KSDF convened and took part in the alignment and harmonisation meeting between the Execution Grant PIU, KSDF, CARMNIS and GSPHCDA, to operationalise roles on the redesigned Community-Based Health Worker strategy. It produced a clear delineation of the two investments' mandates, an agreed coordination framework that minimises duplication, and a joint action plan — including KSDF institutionalising a continuing PIU–CARMNIS coordination cycle and fast-tracking the NPHCDA continuity MoU.

KSDF then supported a two-day computer-based screening to evaluate, rank and shortlist community health worker candidates across the 11 LGAs and 114 political wards, with real-time automated ranking disaggregated by score, gender, LGA and ward. Of 500 profiled candidates invited, 390 sat the test (78% attendance), 81% scored above the threshold, and only five (1.3%) scored at or below the floor — a qualified pool comfortably larger than the state's 400-worker recruitment ceiling.

### Leadership, governance and coordination

KSDF services and strengthens the coordination structures the state already owns rather than creating parallel ones. This quarter it supported the June monthly coordination meeting — reviewing departmental performance, quality-assurance and compliance findings, complaint trends and grievance-redress resolutions, enrolment figures and ICT system performance — and the fourth Health Sector Planning Cell meeting, reviewing implementation of the 2026 Annual Operational Plan across MDAs and strengthening the Planning Cell's role as the sector's coordinating mechanism.

### The technical assistance system behind the activities

Beneath the individual engagements sits the management and reporting architecture KSDF built for the grant — the instruments that make a programme of this scale executable and reportable.

| KSDF product | What it does |
|---|---|
| Implementation Tracker and weekly work plan | Breaks the grant into discrete, costed, weekly-phased activities against status and responsible lead; names KSDF support across eight lines in four workstreams |
| Reform-significance discipline | Requires every activity and report section to state what changes in the health system if it succeeds — not merely that it was completed |
| Activity report form and quarterly TA report | A single reporting spine from facility level to the Foundation period report, so results feed reporting without re-work |
| Handshake/interface register | Names each critical interface between partners and systems, its current position and the action attached |
| Frontline reporting redesign | A monthly outreach report and quick-reference guide frontline teams can complete honestly in minutes rather than by estimation |
| Activity design packages | Full concept notes, terms of reference, curricula and assessment tools for community workforce domestication, quarterly workload analysis and HRH managers' training |

> ***"We measure ourselves by what continues after we leave, not by what we deliver while we are there."***

### Learning as a design discipline

KSDF closes each cycle with lessons that carry a design change already made — not an observation filed for later.

| Lesson | Design change made |
|---|---|
| Readiness is not capacity — workers hold gender-equitable attitudes but lack SOPs, registers, referral directories and budget lines | The next cascade is paired with tool distribution and a focal-person ToR, not delivered alone |
| Zero is a data finding, not a result — two LGAs recorded zero GBV cases against high antenatal volumes | Documentation coverage becomes the indicator; case counts are treated as secondary |
| Coordination must be routine, not convened — the CARMNIS duplication risk surfaced only when a meeting was called | PIU–CARMNIS coordination institutionalised as a standing cycle |
| Work outside the plan is invisible work — delivery not captured in the AOP cannot be tracked, financed or defended | MDA presentations now carry fund utilisation alongside activity status |
| Go-live is not adoption — platforms went live ahead of training, validation routines and devices | Every digitisation line now carries device, training and validation provisions dated to go-live |
| Timely reporting depends on process, not goodwill | KSDF disseminates each activity report on completion through a GSPHCDA focal person, and recommends a centralised activity tracker for the grant |

### How KSDF works

| Principle | What it means in practice |
|---|---|
| Government ownership over consultant delivery | KSDF sits inside the state trainer pool rather than training it; instruments are built as government tools; data, systems and intellectual property belong to the state |
| Honest reporting over smoothed narratives | A zero-per-cent pricing-compliance finding, and platforms that went live before training, were reported as found; open items are preserved with owners and dates |
| The reform-significance test | Every activity and report section must state what changes in the health system if it succeeds |
| Institutionalisation as the measure of success | Outputs are wired into the state's own planning and budgeting cycle and tracked through government forums, so routines survive the grant |

### Health Facility Census — KSDF's continuing support role

A critical component of the investment is the statewide Health Facility Census, generating a comprehensive evidence base for health sector planning. Beyond the instrument and training support delivered this quarter, KSDF provides continuing technical oversight and quality assurance across the census: validation of survey tools, enumerator training support, quality assurance during data collection, coordination between government and implementing consultants, and integration of census findings into health workforce planning, the digital health architecture, and health-system decision-making.

### What comes next

KSDF's priorities for the coming quarter:

- Adaptation and domestication of the national community health worker guideline for Gombe.
- Completing the community health worker screening and the training that follows.
- HRH capacity-building training for GSPHCDA staff.

- Continued integrated supportive supervision across health facilities.
- Finalising the sustainability and transition roadmap for the technical assistance engagement.

### Expected impact

Over its life, the investment is expected to contribute to stronger primary healthcare governance; improved workforce planning and management; enhanced digital health systems and data use; better financial protection and health financing performance; improved availability of essential medicines and commodities; increased quality and utilisation of services; stronger accountability and performance management; and sustainable institutional capacity within government structures.