PATHS2

Review of Gender Equity & Social Inclusion In PATHS2 Activities: Enugu State

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by

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TABLE OF CONTENTS

ABBREVIATIONS

AHS	Annual Health Scorecard
ANC	Antenatal Care
ARFH	Association for Reproductive and Health Care
BCC	Behaviour Change Communication
BCIA	Big Common Impact Areas
CBHI	Community Based Health Insurance
CBO	Community-Based Organization
CEPHA	Centre for Public Health and Humanitarian Aid
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CHV	Community Health Volunteer
CHW	Community Health Worker
CMS	Central Medical Store
CONHESS	Consolidated Health Salary Structure
CONMESS	Consolidated Medical Salary Structure
CREASUP	Child Rescue and Survival Project
CSO	Civil Society Organization
D&E	Deferral and Exemption
DCF	Development Cooperation Framework / Donor Coordination Forum
DFID	Department for International Development
DHIS	District Health Information System
DMA	Drug Management Agency
DRF	Drug Revolving Fund
ELSS	Emergency Life Saving Skills
ENSSHDP	Enugu State Strategic Health Development Plan
EOC	Emergency Obstetric Care
ESP	Essential Services Package
ESSP	Essential Systems & Services Package
ESSPIN	Education Sector Support Programme in Nigeria
FHC	Facility Health Committee
FHI	Family Health International
FMCH	Free Maternal and Child Health
FMOH	Federal Ministry of Health
FRCN	Federal Radio Corporation of Nigeria
GESI	Gender Equity and Social Inclusion
GHAIN	Global HIV/AIDS Initiative in Nigeria
HCH	Honourable Commissioner for Health
HCP	Health Commodities Programme
HDCC	Health Data Consultative Committee
HE	Health Equity
HERFON	Health Reform Foundation o f Nigeria
HF	Health Facility
HMIS	Health Management Information System
HoA	House of Assembly
HR	Human Resources
HRH	Human Resources for Health
HW	Health Worker
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
ISS	Integrated Supportive Supervisory
JD	Job Description
KM	Knowledge Management
LG	Local Government
LGA	Local Government Area
LSS	Life Saving Skills
LTA	Local Technical Assistant
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals

MLSS	Modified Lifesaving Skills
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MSS	Midwife Services Scheme
MTEF	Mid-Term Expenditure Framework
MTR	Mid-Term Review
MTSS	Medium Term Sector Strategy
NGN	Naira (currency)
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPF	National Strategic Health Development Plan Framework
NTA	Nigerian Television Authority
NYSC	Nigeria Youth Service Scheme
OIC	Officer in Charge
OPD	Outpatient Department
OR	Operations Research
PATHS	Partnership for Transforming Health Systems
PEMR	Public Expenditure Management Review
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPFN	Planned Parenthood Federation of Nigeria
PPP	Public Private Partnership
PRRINN-MCH	Partnership for Reviving Routine Immunisation in Northern Nigeria – MCH Initiative
PRS	Planning, Research and Statistics
PSA	Public Service Announcement
SAVI	State Accountability and Voice Initiative
SDSS	Sustainable Drug Supply System
SFH	Society for Family Health
SLP	State Led Programme
SMI-D	Safe Motherhood Initiative – Demand Side
SMOGA	State Ministry of Gender Affairs and Social Development
SMOH	State Ministry of Health
SMS	State Medical Store
SOGON	Society of Gynaecologists in Nigeria
SOP	Standard Operating Procedure
SPARC	State Programme for Accountability Responsiveness and Capability
SPHCA	State Primary Health Care Agency
SSHDP	State Strategic Health Development Plan
SPO	State Program Officer
STL	State Team Leader
SUBEB	State Universal Basic Education Board
TA	Technical Assistance
TBA	Traditional Birth Attendant
TFD	Theatre for Development
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
V&A	Voice and Accountability
VHW	Village Health Worker
WACOL	Women's Aid Collective
WARO	Women's Action Research Organisation
WHO	World Health Organization

PREFACE

This gender review was prepared from May-August 2011 with sporadic interaction between the international consultant and the PATHS2 office in Enugu. There was no on-site consultation.

The final draft was circulated to the State Team Leader for comments, additions and/or corrections. None were proposed. Hence, this report is now being published in final, even though important information is still missing.

As an improvement for the future, the consultant will work with the Jigawa PATHS2 office in early 2012 to develop a model for how to improve reporting on the important GESI initiatives already underway in PATHS2 that are not easily communicated currently.

SECTION 1: EXECUTIVE SUMMARY

This Gender Review was devised to assess the level of gender equity and social inclusion (GESI) mainstreaming in the PATHS2 Project's strategies and implementation. PATHS2 was designed to reach a wide cross-section of men and women in Nigeria, primarily the poorest and most vulnerable. This intention is captured in the logical framework, at the purpose and output level. However, gender equity and social inclusion are not emphasized systematically in the day-to-day work of the project. A desired outcome of this Gender Review is a methodology for improving mainstreaming of gender equity and social inclusion for the remainder of the project.

1.1 Objectives

Objective One was to determine the extent to which Gender Equity and Social Inclusion (GESI) has been mainstreamed into PATHS2 strategies and activities in Enugu, based on a series of key questions, and to prepare a synthesis report outlining the level at which Enugu State is factoring GESI into its work.

Objective Two was to propose a methodology and additional steps to improve mainstreaming of GESI into forthcoming project initiatives in Enugu.

The methodology involved a review of the documents, including a report and recommendations by a gender team in 2009, Quarter 10 and 11 reports to DFID, the Enugu State-specific MTR progress report, and the Year Three Work Plan, as well as correspondence with Enugu State PATHS2 officers.

1.2 Objective One: Key Findings: Extent of Mainstreaming of GESI in Enugu

In Enugu, it is clear from available reports that concerted efforts are being made by PATHS2 at the State level to transform Enugu's health system. From a GESI perspective, too, there are impressive achievements, though they do not appear in any consistent manner and must be gleaned from a variety of sources (e.g. GESI Action Plan, quarterly reports, consultant reports, log frame, Mid-Term Review, work plan), making it difficult to determine the actual extent of GESI mainstreaming.

1.3 Objective Two: Key Recommendations: Proposed Next Steps to Improve GESI in Forthcoming Initiatives

A series of general recommendations were offered, as it was difficult to identify specific recommendations with incomplete documentation and limited consultation. As a 'next steps' follow-up to this Gender Review, the PATHS2 Enugu State Office needs to conduct an on-site exercise, preferably with a GESI expert, with the following objectives:

- To review and confirm the findings about GESI in the report;
- To discuss implementation of the general recommendations;

- To identify additional emerging issues, lessons learned, and challenges; and
- To develop improved specific, recommendations for improved GESI mainstreaming.

1.4 Review Questions

The review was conducted based on the following general and specific questions:

General

- Does the PATHS2 Office have a GESI Advocate? A GESI Plan? Has it been updated?
- Is GESI mainstreamed into programmes? Is this apparent from documentation?
- Is there coordination between the various plans, programmes, and activities so that GESI is visible? For example, are the Activities related to GESI in the log frame transported into the work plans?
- Are both men and women consciously engaged in health programs, including related to reproductive health?
- Is there cross-fertilization on GESI amongst other SLPs in the State? Across PATHS2 programs in other States?

Specific

- Output 1: Stewardship role for health at State level strengthened
    - SSHDP: Does the SSHDP pay attention to GESI issues?
    - Health policies: Do the health policies mainstream GESI?
- Output 2: State systems to support appropriate health services improved
    - HRH: Is there an adequate gender balance in the health system to reach both women and men?
    - HMIS: Is the data disaggregated when it is collected? Into what categories (e.g. sex, age, disability, geographic location, income level)
- Output 3: Delivery of, and access to, sustainable appropriate health services and supplies improved
    - Supply side
        - Health Workers: Is there a balance by sex of health workers so that access is increased for women?
        - CHEWs: Are both women and men trained as CHEWs?

- Demand side
  - Barriers: What are the barriers that limit access to health services? Are they different for various groups? Can they be overcome? If so, how?
  - FMCH: Is it clear that FMCH reaches the most vulnerable families?

- Output 4: Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved
  - Work with LHCs: Are both women and men allowed and encouraged to be members? What about those who are often socially excluded?
  - Engagement with CSOs: Are they selected based on their approach to GESI, amongst other criteria? Are they trained in GESI concepts?
  - Community dialogue: Are the voices of the hard-to-reach heard? How does this happen?
  - Advocacy: Has Free MCH been adopted as a result of PATHS2?
- Output 5: Capacity of citizens to make informed choices about prevention, treatment and care strengthened
  - 'Ask Nigeria' campaign: Are the media approaches used appropriate for the hard-to-reach, such as women and the poor?

SECTION 2: INTRODUCTION

2.1 Background: Mainstreaming GESI in PATHS2

2.1.1 Partnership for Transforming Health Systems (PATHS2)

PATHS2 is a six-year development initiative that aims to ensure that Nigeria achieves the health related Millennium Development Goals (MDGs). It is funded by UK Aid, through the Department for International Development (DFID). PATHS2 works in partnership with the Government of Nigeria and other key stakeholders to improve the planning, financing and delivery of pro-poor health care services.

In order to achieve the purpose and goal of the programme, PATHS2 was created with five outputs:

- Stewardship role for health at national level strengthened;
- State systems to support appropriate health services improved;

- Delivery of, and access to, sustainable appropriate health services and supplies improved;
- Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved; and
- Capacity of citizens to make informed choices about prevention, treatment and care strengthened.

PATHS2 is currently working at the Federal level and in five States (Enugu, Jigawa, Kaduna, Kano, and Lagos).

PATHS2 builds on and consolidates the gains of PATHS1. In addition, PATHS2 has incorporated the DFID-funded Health Commodities Programme (HCP).

2.1.2 Gender Equity and Social Inclusion in PATHS2[1]

In 2009, a team of four consultants was hired to support PATHS2 in developing gender equity and social inclusion action plans. In Phase One, in June 2009, the consultant team travelled to Enugu, Kaduna, Kano and Jigawa. In the field, the consultants met with PATHS2 technical experts, government officials, and civil society representatives to assess the extent to which national and State-level partners were considering GESI issues in their work.

Each PATHS2 state team then spent one-half day with the consultants, drafting 'Gender Equity and Social Inclusion Action Plans'. The planning was participatory, with the State teams focussed and engaged throughout the workshops. The plans were developed quickly, with PATHS2 teams who had limited technical knowledge of GESI, and relatively little knowledge of disaggregated health data or the main drivers of exclusion in Nigeria and their state.

Phase Two of the GESI assignment took place in September 2009. It was focussed on providing an introduction to gender and social analysis for the 60+ technical staff in PATHS2. The training design was explicitly tailored to PATHS2: all the GESI concepts were framed in the context of health equity and relevance to PATHS2's own logical framework. The two-day course drew heavily on Nigerian health data, and used training exercises and case studies from lead states.

Health equity training was delivered through two workshops, the first in Kano for the PATHS2 technical teams in Jigawa, Kaduna and Kano, and the second in Abuja for the technical teams in Enugu and Abuja. During the workshops, State teams revised some of the ambitious goals in the earlier GESI Action Plans, drafted in Phase One

[1] From *Health and Equity Report,* by Sam Gibson, September 2009.

in June, and strengthened them, building on the earlier foundation. 'Raising awareness of GESI with partners' was a theme common to many of the action plans. 'Screening all TORs for GESI potential' was another action that featured prominently.

All State teams expressed the need for on-going technical support in GESI, and requested assistance from a Health Equity Specialist (HES) who could spend time providing hands-on advice to the State programmes upon his/her recruitment. Many States spoke enthusiastically of then being able to provide 'step-down' training in GESI to their partners in civil society and government.

In August 2009, PATHS2 senior management agreed to recruit a Health Equity Specialist to ensure that issues of gender equity and social inclusion would receive the technical attention they require on the programme. One has since been hired on a short-term basis.[2]

After the two-day training course, the national team spent a day developing the foundations of a Health Equity Strategy and Action Plan for PATHS2.

GESI is cross-cutting and is a good entry point or common impact area for interlinking the various programmes and promoting integration between State-ledl programmes (SLPs).[3]

2.1.3 Enugu State Gender Equality & Social Inclusion Assessment Report (June 2009)

In June 2009, two of the PATHS2 gender consultants, Gretchen Bloom and Olabisi Aina, visited Enugu for a more thorough review of the status of GESI mainstreaming ain Enugu in general and the PATHS2 office and program in particular. Here are some of the key points made in the report:

Climate for GESI in Enugu State

It is easy to assume that Enugu offers few challenges for GE/SI mainstreaming in comparison to the Muslim North where social restrictions, especially for women, are very obvious. However, there are serious gender and exclusion issues in Enugu as well.

Enugu appears at first glance to be very open-minded about GE/SI. However, upon further prodding, there are clear issues around widowhood and inheritance rights, for example, and there is an old caste system (ohu, osu). Ibo society is individualistic,

[2] Eleanor Nwadinobi, Author , GESI Review

[3] Other DFID SLPs include the Education Sector Support Programme in Nigeria (ESSPIN), the State Programme for Accountability Responsiveness and Capability (SPARC) and SAVI (State Accountability and Voice Initiative).

focused on wealth status, male dominance, and respect based on freeborn status. Money talks and one is considered weak if poor, making it difficult to reach out to the disadvantaged, and inappropriate for men to have women in decision-making positions, making gender discrimination common. Men and women do not sit together in town meetings; and taking the census traditionally meant counting only men, not women.

Still, many women do have free choice to access health services and, in fact, are well supported by Ibo husbands who want the best for their wives, although there is still a strong son preference, putting pressure on women to continue having children until there is a son. Nonetheless, there is a strong tradition of August Women's Meetings where women gather in communities throughout the State to determine their priorities, then present them to the men. Women are acknowledged to be competent leaders and even 'drivers of change' when given the opportunity, e.g. as school headmistresses.

The categories of social exclusion include migrants, castes, rural dwellers, widows, persons living with disability, the elderly, and those outside the traditional structure.

Health Structure / Health Indicators

In the health system in Enugu, there are 17 LGAs (5 urban and 12 rural), a State Health Board, 7 District Health Boards, and 56 Local Health Authorities (each responsible for 1 20 health facilities). With a population of approximately 3.9 million (2006), Enugu State is in relatively good condition, with the lowest population to facility ratio amongst the PATHS2 states. The use of private facilities is almost as high as that of the public facilities. Health service coverage is nonetheless inadequate with 44 percent of the population, especially rural communities and the urban poor, poorly served.

Health indicators in Enugu State are better than in some other states, including:

- IMR = 110 per 1000 live births against national figure of 99 per 1000 live births;
- MMR = 286 per 100000 births, against the national figure of 1,100 per 100,000 births;
- Under-five mortality rate of 103 per 1000 children, against the national figure of 217 per 1000.

PATHS2 Outputs

Output 1: SMoH technical staff claimed that there had been considerable progress in improving health services over the past few years.. They were willing in 2009 to consider a more inclusive approach. The PRS (Planning, Research and Statistics) Director even accepted having the functional capacity of mainstreaming GE/SI in the SMoH added to his officer responsibilities. In addition, with a new Commissioner, this was a perfect time to orient him on the GE/SI approach that is integral to PATHS2 work and to achieving the MDGs.

Output 2: A capacity assessment and gap analysis State HRH was planned with PATHS2 taking the lead on preparing the TORs for the TA, reviewing the results with the SMoH, and proposing modifications in HRH policies and personnel for improved services. This was a perfect window of opportunity for making sure that the whole process is GE/SI sensitive, for better results in the long run. [Note: the SMoH had already started posting new staff to remote facilities, recruiting doctors (60) and nurses (250), using pay incentives.].

The State-level HMIS data being collected did not show any disaggregation in 2009 when summarized for State-level use. Hence, it was only minimally useful for planning. However, PATHS2 intended to print the Federal HMIS forms which request disaggregation at least by sex and age, offering an opportunity for PATHS2 to work with the SMoH to train staff on the use of the forms and interpretation of the data.

Output 3: The Public-Private Partnerships strategy was seeking, amongst other interventions, to reduce the financial burden on the poor when they seek medical care through risk pooling schemes. One that would be pilot tested in Enugu and Kaduna was CBHI. With the potential to reach deep, to the hard-to-reach, and far, into rural areas, this was an excellent opportunity for GE/SI. In addition, the Enugu PATHS2 Office had agreed to mainstream GE/SI in all policies, guidelines, and capacity building, through collaborative interaction.

Output 4: The SAVI scoping exercise on CSOs was to be supplemented by PATHS2. As it seeks appropriate partners for community work, PATHS2 should strive to select those that already have a GE/SI approach. Then, in work in the communities, it will be easy to convey this new concept. Where possible, PATHS2 can advocate for a broader range of members, encouraging at least one-third female members, for greater gender equity. Where not possible, through interactions with the committees, partners can serve as local 'inclusion coaches', building capacity around the concepts of GE/SI.

Output 5: The Enugu BCC/COM Officer agreed to formulate a Communications TWG while wearing his GE/SI 'goggles.' The 'Ask Enugu' approach was expected to be able to reach far and deep using creative pro-poor approaches to get the voices of

the voiceless heard. This is an excellent opportunity to ensure that GE/SI principles are taken into consideration, raising awareness about cultural and social issues around health while eliciting the views of ALL community members, not just the elites.

2.2 Review Objectives

The methodology for this Gender Review of Enugu State involved a review of the documents, including GESI Action Plans, Gender Mainstreaming Reports from 2009, the Health and Equity Report by Sam Gibson in September 2009, Quarter 10 and 11 reports to DFID, the Enugu State-specific MTR progress report, and the Year Three Work Plan, as well as correspondence with Enugu State PATHS2 officers, in order to achieve the following two objectives:

2.2.1 Objective One: Key Findings: Extent of Mainstreaming of GESI in Enugu State

Objective One was to determine the extent to which Gender Equity and Social Inclusion (GESI) have been mainstreamed into PATHS2 strategies and activities in Enugu, based on a series of key questions, and to prepare a synthesis report outlining the level at which Enugu State is factoring GESI into its work.

2.2.2 Objective Two: Key Recommendations: Proposed Next Steps to Improve GESI in Forthcoming Initiatives

Objective Two was to propose a methodology and additional steps to improve mainstreaming of GESI into forthcoming project initiatives in Enugu.

SECTION 3: KEY FINDINGS: ENUGU STATE

In Enugu, it is clear from available reports that concerted efforts are being made by PATHS2 at the State level to transform Enugu's health system.

From a GESI perspective, too, there are impressive achievements, though they do not appear in any consistent manner and must be gleaned from a variety of sources (e.g. GESI Action Plan, quarterly reports, consultant reports, log frame, Mid-Term Review, work plan). For example:

Under Output 1, the new Commissioner of Health is a 'pro-active' and 'supportive' woman, representing a window of opportunity for PATHS2 reforms, including GESI mainstreaming.

Under Output 2, related to HMIS, the Q11 gives some breakdowns by sex of the staff trained on DHIS (16 males, 7 females), as well as a breakdown for the participants from the PHCs in the LGAs, including an impressive number of women (157 women v. 26 men).

Under Output 3, a new training program is described, established for both TBAs and VHWs, to improve their skills to avoid the high loss of patients during delivery when women choose traditional medical services over clinics. There is also an attempt through this program to overcome the negative image of traditional practitioners.

PATHS2 Enugu has also developed an interesting new program, to create Community Drivers of Change or Mobilization Agents, to break down cultural, social and financial barriers for women to access health services, despite supply side improvements. The goal is to encourage women to move from the traditional sources of health care (TBAs) to modern health facilities. Two hundred have already been trained.

Under Output 4, the Q10 reports that operations research will assist in determining the impact of FHCs on strengthening citizen voice, including women's voice, and on improving service delivery and service utilization.

Training was carried out with 28 FHC trainers (10 were women, 18 were men). Both women and men, including the socially excluded, are now able, and expected, to be members. These LHC members dialogue with community members, especially the disadvantaged, according to the MTR, to understand their views about the health services and barriers to accessing them.

Under Output 5, the 'Ask Enugu' community dialogue program paid attention to GESI by having an all-inclusive dialogue, with the poor, aged and young, physically challenged, and both women and men. The theme was 'Your Voice Counts'. The PSAs focused particularly on MCH issues related to malaria and pregnancy, with an emphasis on the need for antenatal care and skilled delivery, in both English and the local language.

The updated Logical Framework (as of Summer 2011) lists quite a few proposed Activities that address GESI issues:

> **2.1: Support and facilitate the adaption and implementation of the gender- and equity-sensitive State HRH policy**
>
> **2.3: Strengthen gender-sensitive and pro-poor state-level health planning and implementation processes in collaboration with SPARC and other state-level health programmes**
>
> **2.6: Develop and implement sustainable pro-poor health commodities management system**

3.1: Support the state government to provide pro-poor and gender-sensitive quality health services

3.2: Support state government in developing and implementing pro-poor and gender-sensitive Essential Package of care

3.7: Strengthen service providers' capacity for data management and utilisation, including the use of gender-disaggregated data to improve health service delivery

3.8: Promote financial, social and physical access of poor and vulnerable groups, especially women and children in collaboration with other SLPs

4.2: Develop and implement issue-based coalitions which deliver more responsive and accountable services and address the needs of women and the poorest, in collaboration with SAVI

4.3: Develop and implement mechanisms to enable citizens, especially women and the poorest, to claim their health entitlements

4.4: Support State and Local Governments to engage effectively with civil society on health policy and service delivery, especially for women and the poorest

4.6: Strengthen local capacity to monitor process and outcomes from Output 4 and other PATHS2 work, especially for women and the poorest, including through community sentinel monitoring and formative research.

However, a word search of the Enugu draft Mid-Term Review report indicated NO mention of the words gender, gender equity, mainstreaming, or social inclusion. There is mention of women and men in some sections, but only as number counts, e.g. of staff trained or clients attending health facilities.

Furthermore, the Year Three Work Plan mentions gender only in one place under Output 2, and the poor are referenced only twice in the document, under Outputs 3 and 5. There is no mention of men or women, male or female, or equity.

3.1 GESI Action Plan

Enugu State developed a GESI Action Plan, as did the other States, in June 2009, which was then revised in September 2009. The GESI Action Plan has not been updated since then, nor has the office reported achievements against the original Action Plan of September 2009.

The September 2009 GESI Action Plan contains seven actions: many are relevant to all Outputs, although some pertain to only one.

- There is no evidence in any documentation, or in conversation with PATHS2 staff, that a GESI Officer (Action 1) was appointed to serve as the GESI 'Inclusion Coach', or whether an Equity Focal Person was identified in the SMOH (Action 6), or whether an Equity and Inclusion Working Group (EIWG) was constituted (Action 7).

- Workshops were proposed (Actions 8, 11, 14), assessments were planned (Actions 2, 3, 12) and advocacy activities were named (Actions 5, 15, 16).

But no update has been provided on the status of these or other actions proposed in the 2009 Action Plan.

3.2 Q10 and Q11 Reports to DFID

In the latest quarterly reports to DFID that were available for review at the time of writing, Q10 for October to December 2010, and Q11 for January to March 2011, there is very little attention paid to GESI.[4] Here are some areas where glaring omissions exist:

Q 10 Report to DFID – October-December 2010

- In the Summary of Key Accomplishments in the Quarter, there is no reference made to GESI mainstreaming or special efforts and activities, even though there are accomplishments to report.

- In the Summary, it is not clear whether the community dialogues or the Public Service Announcements (PSAs) broadcast on the 'Ask Enugu' program on radio and TV paid any attention to GESI or whether these media products reach all people, even the hard-to-reach. But in conversation with the PATHS2 Office, it is apparent that the dialogue was all inclusive, in that it included the poor, aged and young, physically challenged, and both women and men. The theme of the dialogue was 'Your Voice Counts', which attracted participants. The PSAs focused particularly on MCH issues related to malaria and pregnancy, with an emphasis on the need for antenatal care and skilled delivery. The PSAs were done in both English and the local language.

- No mention is made about the approach of the new Commissioner of Health, a woman, to GESI. It is noted, however, that she is 'pro-active' and

[4] See Annexes

'supportive', representing a window of opportunity for PATHS2 reforms, including perhaps GESI mainstreaming.

- Under Output 2, there is another opportunity for innovative programming related to GESI due to the establishment of the State Primary Health Care Development Agency (SPHCDA).
- Meetings held about the HMIS system under Output 2 highlighted improvements in data capture but no mention is made whether this data is disaggregated.
- Under Output 3, it is noted that a rapid assessment was conducted of the capacity of 76 health facilities across six PATHS2 model LGAs to provide services for the Essential Services Package, without describing how this assessment took GESI into consideration. This is important for GESI mainstreaming as the assessment is being used to develop a profile to serve as a benchmark for future evaluations.
- Under Output 4, under Strengthening Facility Health Committees for service improvements and promotion of citizen health entitlements, there is no indication that the strategy addresses the different needs of men and women, as well as the socially disenfranchised. Also, there is no disaggregation by sex, minimally, of the FHC trainers.
- Under Output 4, under Strengthening Facility Health Committees for service improvements and promotion of citizen health entitlements, there is the ONLY mention of gender in the Q10 Report (see 221), as follows:
    - 221 (iv) The number of participants reporting a good or very high knowledge of approaches to involving women and other hard-to-reach groups in discussions about health services increased from 4 to 27.
    - 223. Operations research will assist in determining the impact of FHCs on strengthening citizen voice, including women's voice, and on improving service delivery and service utilization.
- Finally, there is no mention of what is planned for GESI in the next quarter.

Q 11 Report to DFID – January-March 2011

- Under Output 2, related to the HRH Health Policy and Strategic Plan, there is no mention of any gender mainstreaming or inclusion of any SI elements, even though the Jigawa PATHS2 Office has paid attention to this, through a consultant report.

- Under Output 2, related to HMIS, the Q11 does give some breakdowns by sex of the staff trained on DHIS, including 16 males and 7 females, as well as a breakdown for the participants from the PHCs in the LGAs, including an impressive number of women (157 women v. 26 men).

- With relation to Output 2, no mention is made of the GESI Action Plan commitment to "conduct an HRH assessment and gap analysis in HR policies sensitive to GESI issues."

- Under Output 3, a new training program is described, established for both TBAs and VHWs, to improve their skills to avoid the high loss of patients during delivery when women choose traditional medical services over clinics. There is also an attempt through this program to overcome the negative image of traditional practitioners.

- Under Output 4, the 'Ask Enugu' pilot project featured a State public dialogue on health. These dialogues are being turned into a documentary. It is, unfortunately, not stated whether any GESI elements were highlighted. Who was able to participate in the dialogue, for example, and what were the issues they raised?

- Training was carried out with 28 FHC trainers (10 were women, 18 were men). Both women and men, including the socially excluded, are now able, and expected, to be members.

- Under Output 5, although not mentioned in the Q11 Report, PATHS2 staff indicated in conversation that women, albinos and the physically challenged were all given an opportunity to engage policy makers. These conversations are captured in the video documentary.

- There is no indication of GESI mainstreaming activities in the list of planned progress for the next quarter.

3.3 Proposed Log Frame for Enugu State – February 2011

In 2009, during the preparation of the original log frame, a gender expert[5] participated in the planning session and offered the following comments and recommendations:

Recommended Gender Mainstreaming Strategy (Bloom Report, 2009)

The PATHS2 Project recognizes that achievement of the three health-related Millennium Development Goals (MDGs) at the Goal level of the PATHS2 Logical

[5] Gretchen Bloom, Report

Framework rests in part on the effectiveness with which a gender mainstreaming approach is applied so that both women and men are reached by the health services and that they can and will access them.

MDG 4 – Reduced Infant and Child Mortality (IMR / CMR)

MDG 5 – Reduced Maternal Mortality (MMR)

MDG 6 - Reduced Incidence of TB and Malaria

If all of PATHS2 supply-side interventions succeed, and policies, systems, and delivery are strengthened, but the demand-side fails, so that insufficient numbers of persons, especially women, take advantage of these newly strengthened systems, then infant, child and maternal mortality will not be reduced and the incidence of TB and malaria will not be affected. Cultural norms and practices that affect the status of women present challenges to achieving health objectives.

This concern was captured in the following PATHS2 assumption at the Output to Purpose level in the log frame:

Women and disadvantaged groups are able to utilize opportunities to access health care and participate in civil society activities.

The following generic logical framework was developed and proposed by the gender expert to achieve a gender mainstreaming perspective in the project.

Table: Gender Mainstreaming Strategy Logical Framework – PATHS2 – Proposed in 2009 (G. Bloom)

Level	Objective	Indicators
Purpose	Gender Equality Achieved in Sustainable and Replicable Pro-Poor Health Services	X% increase in number of women and children attending Maternal and Child Health (MCH) service by End of Project (EOP) (disaggregated by sex for children, wealth quintile and rural/urban location) Number of states and national level institutions that develop and implement PATHS2 systems-strengthening approaches to increase access to quality health services by EOP
Output	Commitments to Gender Equality in National-level	All new and revised health policies and legislation that meet minimum standards

1	Policies, Plans and Strategies for Health Stewardship Supported and Strengthened	at national level are evidence-based, gender sensitive, pro-poor, increasingly responsive to citizen views, and consistent with the achievement of the MDGs by EOP
Output 2	Pro-Poor Responsive Health Systems Modified to Address Gender Inequality	All new and revised health policies and legislation meet minimum standards at national [or state] level are evidence-based, gender sensitive, pro-poor, increasingly responsive to citizen views, and consistent with the achievement of the MDGs by EOP X% increase in capacity of States, Local Government Authorities (LGAs) and Health Facilities (HFs) for HMIS (data capture, analysis and utilization) by EOP X% increase in the number of skilled health workers with greater equity in terms of sex and geographical distribution by EOP
Output 3	Equality to Access to Gender-Sensitive Sustainable Efficient Pro-Poor Health Services Improved	X% increase in the proportion of clients reporting satisfaction with health services by EOP disaggregated by sex and rural/urban location X% of communities with functioning and sustainable community mechanisms to overcome financial, social and cultural barriers to access emergency obstetric care by EOP
Output 4	Participation in Voice for Accountability Improved for Women	X% increase in the number of Facility Health Committees (FHCs) in primary and secondary health settings meeting an agreed standard for community participation by EOP At least one established and functioning

		system for defining and enforcing health rights and entitlements per state, with demonstrated access for women and excluded groups by EOP
Output 5	Capacity of Both Men and Women to Make Informed Choices about their Health Strengthened	X% increase in the number of people (disaggregated by sex, age and urban/rural location) who have heard and/or participated in public dialogue on key health issues in the last two months by EOP X% increase in the number of people (disaggregated by sex, age and urban/rural location) who know and follow the correct protocols for preventing and/or managing selected health conditions from X at baseline by EOP X% increase in the number of people (disaggregated by sex, age and urban/rural location) who can correctly identify at least three health service entitlements by EOP

GESI Elements in New Log Frame

The new Log frame proposed to DFID in February 2011 for the PATHS2 programme in Enugu State includes GESI-disaggregated Indicators at the Goal, Purpose and Output levels, capturing some of the above recommendations, as follows:

Indicators

Goal Level:

G1. Under-5 mortality rate (disaggregated by location [urban, rural], sex, and wealth quintiles)

G2. Proportion of births attended by skilled health personnel (disaggregated by location [urban, rural], and wealth quintile)

Purpose Level:

P5. Number of LGAs implementing systems strengthening approaches to increase access to quality health services for women and the poorest

Output Level:

3.3 Percentage of clients in Enugu State reporting satisfaction with primary health care services (disaggregated by LGA, location [urban, rural], and wealth)

5.1 Percentage of people in PATHS2 supported LGAs who have heard of and/or participated in public dialogue on public health issues (disaggregated by LGA, location [urban, rural], and sex)

5.2 Number of people in PATHS2-supported LGAs who participated in public health dialogue events with good recall of public health issues (disaggregated by LGA, location [urban, rural], sex, and age group)

5.3 Percentage of people in PATHS2 supported LGAs who have adequate knowledge on the signs and prevention of common health conditions (disaggregated by LGAs, location [urban, rural], and sex)

5.4 Percentage of people in PATHS2 supported LGAs who can correctly identify health service entitlements (disaggregated by LGAs, location [urban, rural], and sex)

In addition, there are quite a few proposed Activities that address GESI issues:

Activities

2.1: Support and facilitate the adoption and implementation of the gender- and equity-sensitive State HRH policy

2.3: Strengthen gender-sensitive and pro-poor State-level health planning and implementation processes in collaboration with SPARC and other state-level health programmes

2.6: Develop and implement sustainable pro-poor health commodities management system

3.1: Support the State government to provide pro-poor and gender-sensitive quality health services

3.2: Support State government in developing and implementing pro-poor and gender-sensitive Essential Package of care

3.7: Strengthen service providers' capacity for data management and utilisation, including the use of gender-disaggregated data to improve health service delivery

3.8: Promote financial, social and physical access of poor and vulnerable groups, especially women and children in collaboration with other SLPs

4.2: Develop and implement issue-based coalitions which deliver more responsive and accountable services and address the needs of women and the poorest, in collaboration with SAVI

4.3: Develop and implement mechanisms to enable citizens, especially women and the poorest, to claim their health entitlements

4.4: Support State and Local Governments to engage effectively with civil society on health policy and service delivery, especially for women and the poorest

4.6: Strengthen local capacity to monitor process and outcomes from Output 4 and other PATHS2 work, especially for women and the poorest, including through community sentinel monitoring and formative research

3.4 Mid-Term Review – Enugu – April 2011

A thorough Mid Term Review was conducted in May 2011 in all five States.

From a GESI perspective, a word search of the Enugu document indicated NO mention of the words gender, gender equity, mainstreaming, or social inclusion. There is mention of women and men in some sections, but only with reference to number counts.

In the section reporting Progress against Outputs, under each Output, there is a report against the log frame indicators.

Output 1: Stewardship role for health at State level strengthened

In Enugu, PATHS2 supported the SMOH to prepare the Enugu State Strategic Health Development Plan (ENSSHDP) with broad stakeholder participation, including community members and health development organizations in a public-private format. It is not clear whether both women and men were involved or whether the stakeholders included the usually excluded.

The ENSSHDP has been the guide for important health policies, including the Medium Term Implementation Plan (MTIP), the PPP, the HRH, DRF, and the MTSS, leading to an increase from 6% to 8.7% of the total State expenditure on health, allowing for improvements in facilities, supply of critical inputs, and support for the Free MCH program on the supply side. This is turn has led to increased demand, e.g. in ANC attendance.

Output 2: State systems to support appropriate health services improved

This Output focuses on HRH, HMIS and logistics systems for health commodities.

No information is given in the MTR about any support to improved HRH.

Re HMIS, clearly the PATHS2 interventions have helped improve the health data collection system, achieved partly through the recreation of the Health Data

Consultative Committee (HDCC), a coordinating mechanism. There is no mention in the MTR, however, whether the data collected is now disaggregated, and, if so, by what categories.

PATHS2 funded an assessment and gap analysis of the DRF program, along with an evaluation. Improving supplies of drugs has resulted in an increased utilization of the health services, according to the MTR, although no numbers or percentages are provided in the draft.

Output 3: Delivery of, and access to, sustainable health services and supplies improved PATHS2 works at two levels to achieve this Output. First, it tries to strengthen both the supply and demand sides of the health system; secondly, it works to reduce or eliminate barrier to access to services, especially MCH services.

On the supply side, there is capacity building to improve the skills of EOC practitioners, for example, done in conjunction with LSS and DRF training. Teaching methods were improved at the Enugu State University Teaching Hospital School of Nursing and Midwifery. PATHS2 is also working to develop an improved training curriculum for CHEWs working in PHCs, using the MLSS techniques. Drug supplies have also been improved.

On the demand side, PATHS2 Enugu has developed an interesting new program, to create Community Drivers of Change or Mobilization Agents. Two hundred have already been trained on community mobilization and referrals as a mechanism for overcoming barriers. Their purpose will be to break down cultural, social and financial barriers for women to access health services, despite supply side improvements. The goal is to encourage women to move from the traditional sources of health care (TBAs) to modern health facilities.

Unfortunately, there are no percentages or numbers offered in the draft MTR to show the results of these efforts against indicators.

Output 4: Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved

Under this Output, PATHS2 has supported strengthening of the FHCs to create an environment for citizens to participate in compelling the health facilities to provide pro-poor quality health services, training FHC members, with 30% females. These LHC members dialogue with community members, especially the disadvantaged, according to the MTR, to understand their views about the health services. To quote:

“FHCs…together with other stakeholders identify and address facility and community-based barriers that discourage community members, particularly women and the poor, from using health services.”

PATHS2 has also engaged CSOs, developing training manuals and conducting training primarily to improve their advocacy skills re MCH. Nowhere is it mentioned, however, whether the CSOs selected are required to have a good track record in mainstreaming GESI principles nor does it mention whether the training focused on GESI issues.

Output 5: Capacity of citizens to make informed choices about prevention, treatment and care strengthened

PATHS2 helped create a State Health Communication Group (SHCG) with a purpose to promote and coordinate community and other stakeholder participation in health promotion interventions in the State. This is a new initiative, as community members have never before been given the chance to dialogue with policy makers. There is no reference in the MTR, however, to the composition of the community members recruited to engage in this policy dialogue.

The 'Ask Enugu' campaign did seek to hear from people in order to identify barriers to change, including among the target groups of poor people and women of childbearing age. Two topics were selected for initial media campaigns: pregnancy and malaria. The result has been an overall increase in the use of health services in Enugu State, with increased ANC attendance and skilled birth delivery. There is also apparently 'noticeable behaviour change among citizens making informed choices as their capacity is strengthened', to quote the draft MTR.

Unfortunately, the progress against Output indicators table has not been completed in the draft.

3.5 Year Three Work Plan for Enugu State

The Year Three Work Plan for Enugu State provides content for only Outputs 2, 3, 4 and 5. Output 1 is handled at the Federal level

Three of the Outputs have been modified from the original project, as follows:

Output 2 has changed from State systems to support appropriate health services improved to State and LGA/District governance and management systems to support appropriate health services improved.

Output 3 is no longer Delivery of, and access to, sustainable appropriate health services and supplies improved but rather Replicable model to deliver quality MCH services demonstrated in selected LGAs.

Output 4 is slightly different, shifting from Ability of citizens and civil society to increase the accountability and responsiveness of the health system improved to

Ability of citizens and civil society to demand responsiveness of health system improved.

Output 5 remains the same as Capacity of citizens to make informed choices about prevention, treatment and care strengthened.

Gender is only found in one place in the Year Three Work Plan, under Output 2, as below:

- Sub-Output 2f. Capacity for human resources for health planning strengthened
    - Strategic Activity 2f.1 Facilitate development, adoption and implementation of state HRH policy and strategy including gender mainstreaming

The poor are referenced twice in the document, under Outputs 3 and 5:

- Sub-Output 3b. Mechanisms developed and demonstrated to facilitate private sector delivery of pro poor MNCH services
- Strategic Activity 5a.1: Strengthening individual, state/LGA capacity to implement and monitor pro-poor health communication

There is no inclusion of men or women, male or female, or equity.

SECTION 4: LESSONS LEARNED / CHALLENGES

- Culturally, Ibo society is very male-centric, and protective of the public space; hence, gender equity concept remains 'unwanted' in policy discourse. Ibo society abhors 'poverty', and embraces 'a money talk' culture. Labelling programmes as pro-poor may have problems if not well 'titled' within local Ibo communities. PATHS2 needs to be aware of these cultural sensitivities and do community awareness raising about pulling together while also raising community confidence in the health system.
- The name of the State Ministry of Women Affairs was changed to the State Ministry of Gender Affairs and Social Development (SMOGA) in 2007 by the then State Governor. Before that, and before the production of the National Gender Policy (2006-7), the old Ministry had already produced a Gender and Social Development Strategy (2005) but it still was really a WID strategy. Ministry staff were not well grounded in their Ministry's area of work in 2009 and may still have those characteristics.
- The Enugu PATHS2 Office is not consistent in how it portrays the work it is doing in GESI, making it difficult to understand if GESI is mainstreamed and, if so, how and where.
- There is no overlap between the updated Enugu State Log Frame and the Year Three Work Plan related to GESI.

SECTION 5: KEY RECOMMENDATIONS

General

- Assign one staff member to follow GESI, as a GESI Advocate, preferably a senior staff member with authority to make GESI mainstreaming happen.
- Update the GESI Action Plan annually according to the new log frame.
- Report on GESI on a quarterly basis in the Quarterly Reports, for greater visibility and accountability.
- Explain in detail how GESI activities mentioned in the log frame will be achieved in the annual work plans.
- Share 'Lessons Learned' and 'Success Stories' on GESI across States.

Enugu Specific

- Output 1: Integrate a GESI approach into the SMoH, providing capacity building where necessary.
- Output 2: Ensure that the HRH process is GESI sensitive, for better results in the long run
- Output 2: Train State HMIS staff on the use of the forms and interpretation of disaggregated data, if not already done.
- Output 3: Mainstream GESI in all policies, guidelines, and capacity building, through collaborative interaction.
- Output 4: Select CSOs as partners those that already have a GESI approach.
- Output 5: Ensure that GESI principles are taken into consideration in the 'Ask Enugu' initiative, raising awareness about cultural and social issues around health while eliciting the views of ALL community members, not just the elites.

SECTION 6: CONCLUSIONS / NEXT STEPS

The two objectives of the Gender Review have been achieved, although at varying levels:

- **Objective One**, to determine the level of GESI mainstreaming in PATHS2 programs in Enugu State, was easier, although still not conclusive, as many of the documents are not clear on the approach to GESI.
- **Objective Two**, to make recommendations for improved GESI mainstreaming in the future in Enugu State, is difficult to achieve with incomplete documentation and limited consultation. The recommendations thus still need to be strengthened through on-site work with the State Office.

Next Steps

As a follow-up to this Gender Review, the PATHS2 Enugu State Office needs to conduct an on-site exercise, preferably with a GESI expert, with the following objectives:

- To review and confirm the findings about GESI in the report;
- To discuss implementation of the general recommendations;
- To identify additional emerging issues, lessons learned, and challenges; and
- To develop improved concrete specific recommendations for improved GESI mainstreaming.

SECTION 7: BIBLIOGRAPHY

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