

PATHS2

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

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by

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ABBREVIATIONS

AHS	Annual Health Scorecard	ESSP	Essential Systems & Services Package
ANC	Antenatal Care	ESSPIN	Education Sector Support Programme in Nigeria
ARFH	Association for Reproductive & Family Health	FHC	Facility Health Committee
BCC	Behaviour Change Communication	FMCH	Free MCH
BCIA	Big Common Impact Areas	FMOH	Federal Ministry of Health
CBHI	Community Based Health Insurance	FOMWAN	Federation of Muslim Women's Association of Nigeria
CBHIS	Community Based Health Insurance Schemes	GESI	Gender Equity and Social Inclusion
CBO	Community-Based Organization	GWG	Gender Working Group
CHA	Community Health Assistant	HCH	Honourable Commissioner for Health
CHEW	Community Health Extension Worker	HCP	Health Commodities Programme
CHO	Community Health Officer	HDCC	Health Data Consultative Committee
CHV	Community Health Volunteer	HE	Health Equity / Health Education
CHW	Community Health Worker	HERFON	Health Reform Foundation of Nigeria
CSO	Community Service Organization	HES	Health Equity Specialist
D&E	Deferral and Exemption	HF	Health Facility
DCF	Development Cooperation Framework	HFC	Health Facility Committee
DFID	Department for International Development	HMIS	Health Management Information System
DMA	Departments, Ministries, and Agencies	HR	Human Resources
DRF	Drug Revolving Fund	HRH	Human Resources for Health
ELSS	Emergency Life Saving Skills	HW	Health Worker
EOC	Emergency Obstetric Care	ICC	Inter Agency Coordinating Committee
ERC	Expert Review Committee	IEC	Information, Education and Communication
ESP	Essential Services Package	IMCI	Integrated Management of Childhood Illnesses

JD	Job Description	PHCMIS	Primary Health Care Management Information System
KD	Kaduna		
KHF	Kaduna Health Forum	PPFN	Planned Parenthood Federation of Nigeria
KM	Knowledge Management	PPP	Public Private Partnership
LGA	Local Government Area	PSA	Public Service Announcement
LSS	Life Saving Skills	SAVI	State Accountability and Voice Initiative
M&E	Monitoring and Evaluation	SFH	Society for Family Health
MCH	Maternal and Child Health	SLP	State Level Programme
MDGs	Millennium Development Goals	SMI-D	Safe Motherhood Initiative – Demand Side
MLSS	Modified Lifesaving Skills		
MNCH	Maternal, Newborn & Child Health	SMOH	State Ministry of Health
MSS	Midwife Service Scheme	SMS	State Medical Store
MTEF	Mid-Term Expenditure Framework	SOGON	Society of Gynaecologists in Nigeria
MTR	Mid-Term Review	SOP	Standard Operating Procedures
MTSS	Medium Term Sector Strategy	SPARC	State Programme for Accountability Responsiveness and Capability
NGO	Non-Governmental Organization	SPHCA	State Primary Health Care Agency
NHIS	National Health Insurance Scheme	SSHDP	State Strategic Health Development Plan
NHMIS	National Health Management Information System	SPO	State Program Officer
NPHCDA	National Primary Health Care Development Agency	STL	State Team Leader
NSHDP	National Strategic Health Development Plan	SUBEB	State Universal Basic Education Board
NSHDPF	National Strategic Health Development Plan Framework	TA	Technical Assistance
NYSC	Nigeria Youth Service Scheme	TBA	Traditional Birth Attendant
OIC	Officer in Charge	TOR	Terms of Reference
OPD	Outpatient Department	TOT	Training of Trainers
PATHS	Partnership for Transforming Health Systems	UN	United Nations
PEMR	Public Expenditure Management Review	UNFPA	United Nations Population Fund
PHC	Primary Health Care	UNICEF	United Nations Children’s Fund
PHCC	Primary Health Care Coordinator	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 Kaduna. 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.

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, including 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 Kaduna, based on a series of key questions, and to prepare a synthesis report outlining the level at which Kaduna 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 Kaduna.

The methodology involved a review of the documents, including PATHS2 routine data collection reports, Kaduna State-specific MTR progress reports, and Quarter 10 and 11 reports to DFID, as well as correspondence with Kaduna State PATHS2 officers.

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

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

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 developed 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 PATHS2¹

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

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

some of the ambitious goals in the earlier GESI Action Plans, drafted in Phase One 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 ongoing 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-level programmes (SLPs).³

2.2 Review Objectives

The methodology for this Gender Review of Kaduna State involved a review of 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 MTR progress report, the updated log frame (February 2011), and the Year Three Work Plan, as well as a special report on gender mainstreaming by a health equity specialist and correspondence with Kaduna State PATHS2 officers, in order to achieve the following two objectives:

2.2.1 Objective One: Key Findings: Extent of Mainstreaming of GESI in Kaduna

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

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).

2.2.2 Objective Two: Key Recommendations: Proposed Next Steps to Improve GESI in Forthcoming Initiatives for PATHS2 in Kaduna State

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

SECTION 3: KEY FINDINGS: JIGAWA STATE

In Kaduna, it is clear from available reports that concerted efforts are being made at the State level to improve on the gains of last year. There is evidence of improved attendance at clinics, greater client satisfaction, and better engagement of TBAs, civil society and the nomads.

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 PATHS2 Office has been working with the Kaduna Health Forum to identify GESI issues, e.g. in the Kaduna State Strategic Health Development Plan for 2010-15.

Under Output 2, the draft HRH Policy and Strategic Plan for Kaduna State has considered GESI in employment, retention, deployment, and remunerations. There is now an improved gender balance among health workers as a result of new HRH recruitment and employment policies.

GESI considerations have also been factored into the CBHIS in Kaduna State. However, the scheme has not yet been launched yet, pending completion of a Federal-level inventory

Under Output 3, antenatal attendance at PHCs has increased since PATHS 2 provided equipment and beds, helped improve drug availability, and offered 24-hour services. Essential Service Packages are being implemented, leading to reduced maternal mortality.

Information about health issues is being disseminated through an innovative program of female workers and town criers, important to reach women who have less access to other communication tools (e.g. radio, TV, newspapers), and more materials are being translated into local languages.

Cultural inhibitions to access have been identified and addressed. For example, resistance to men training women in reproductive health issues is being overcome by assistance from CHEWs and CBOs such as FOMWAN. However, male involvement in antenatal visits is minimal for cultural reasons. Husbands encourage purchase of drugs at the facility but insist that their wives show them their receipts. PATHS2 is working with men to encourage their involvement.

Under Output 4, work has been done to include GESI considerations while strengthening FHCs and CHVs, including in the training manuals. Trainers are both male and female. Addressing barriers to access amongst women and other socially excluded groups also serves as a training component for FHCs. Membership criteria for FHCs have been modified to allow both women and men to be members.

Community dialogues have become important means for mobilizing voices, with women and the poor also given an opportunity to express their opinions.

CSO networks have been mobilized to become more active in addressing GESI issues in health, through the creation of a Gender Working Group and through development of an MTSS Guidebook with a GESI checklist. CSOs and CBOs are generally closer to the communities and can reach women and the poor who trust them.

The Free MCH Coalition and the Health Sector Reform Coalition have developed an action plan for reproductive health and family planning advocacy,

Under Output 5, a Terms of Reference has been developed for communications mapping that includes specific reference to social analysis.

The updated Logical Framework 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

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 Kaduna draft Mid-Term Review report indicated NO mention of the words gender, gender equity, mainstreaming, or social inclusion, despite the presence of an updated GESI Action Plan and a recent review of GESI mainstreaming by a health equity specialist. 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

Kaduna State developed a GESI Action Plan, as did the other States, in June 2009, which was then revised in September 2009. In a recent update, in May 2011, the Kaduna PATHS2 Office has reported the following achievements against the original Action Plan:

Under Output 1, the PATHS2 Office has been working with the Kaduna Health Forum (KHF) to identify GESI issues as they restructure. In addition, the Kaduna State Strategic Health Development Plan (SSHDP) for 2010-15 has taken care of GESI issues, as captured in its indicators, e.g. for FMCH, MCH.

Under Output 2, the draft HRH Policy and Strategic Plan for Kaduna State has considered all issues of GESI in employment, retention, deployment, and remunerations. However, the PATHS2 Kaduna State Office recommends that a GESI expert review the draft before it is finalized.

Under Output 3, GESI considerations have been factored in to the CBHIS in Kaduna State, including for the various committees that have been formed. However, the scheme has not yet been launched in Kaduna, pending completion of a Federal-level inventory.

Under Output 4, work has been done to include GESI considerations while strengthening FHCs and CHVs, including in the training manuals. They have not yet been included in the SERVICOM OPD toolkit as SERVICOM has not yet been launched in Kaduna. This is projected for Year 3.

Under Output 5, a Terms of Reference (TOR) has been developed for communications mapping that includes specific reference to social analysis. In addition, under the 'Ask Kaduna' program, media polling, community dialogue and PSAs have been completed in selected communities, providing an opportunity to document the health priorities for different stakeholder groups. Still to be achieved, however, is the media-led public dialogue to bring together stakeholders to engage with policymakers.

Under Outputs 1, 2 & 4, there have been great strides in helping CSOs and CBOs to hold government accountable for integrating GESI issues in the MTSS. One mechanism for doing so was through the creation of a Gender Working Group (GWG), in collaboration with SAVI. In addition, an MTSS Guidebook has been developed which includes greater emphasis on GESI, including a GESI checklist.

Under all Outputs, a number of GESI activities are ongoing, including: revising TORs; conducting Operations Research; training; and the development of criteria for selection of participants in activities.

3.2 Q10 and Q11 Reports to DFID

In the latest reports to DFID, Q10 for October to December 2010, and Q11 for January to March 2011, there is very little attention paid to GESI. Here are some areas where glaring omissions exist:

Q 10 Report to DFID – October-December 2010

- In the Summary of Key Accomplishments in Quarter 10, there is no reference made to GESI mainstreaming or special efforts and activities, even though there are accomplishments to report, per the GESI Action Plan Update (May 2011).
- Also in the Summary for the Q10 Report, there is no indication whether GESI was built into the *Results Framework for the Development Cooperation Framework*.
- HMIS workshops were held in Q10 under Output 2, but there is no indication that disaggregation of data was a key theme or whether disaggregated data is regularly collected on the revised HMIS forms.
- For Output 4, under *Strengthening Facility Health Committees for service improvements and promotion of citizen health entitlements*, in response to a specific reference in the GESI Action Plan to “work with consultants and stakeholders to incorporate appropriate GESI issues in strengthening FHC and CHV including review of training manuals”, this was done as part of the Facility Health Committee Strengthening Initiative in Kaduna state (see 288). In 2009, it is reported as achieved in the GESI Action Plan Update (May 2011). The trainers used in this process were both male and female. They had facilitated a workshop focused on sensitizing the PATHS2 technical team on the relevance of mainstreaming GESI within the PATHS2 programme in September, 2009. (See 288) The trainers were from Civil Society Organizations (CSO) and government officials; they were both men and women.
- Output 4’s strategy on Strengthening Community Participation at Primary Health Facilities, via Facility Health Committees, put into consideration GESI issues raised during the GESI workshop.

- For instance, the FHC programme of capacity building support has, as part of its components, methods of obtaining views on health service delivery from women and other marginalized community groups.
- FHCs will also be sensitized on the importance of prioritizing health service delivery issues faced by such groups when developing and implementing a programme of service improvements at their facility.
- Addressing barriers to access amongst women and other socially excluded groups also serves as a training component for FHCs.
- The FHC membership will be expected to have a mix of different community groups, including women and the poor, as well as other socially excluded groups.
- In the development of the FHC manual, the criteria for the selection of FHC members made provision for the inclusion of women representatives (at least one third), as well as the poor, the hard-to-reach, and persons with disabilities.
- For Output 4 under *Strengthening Facility Health Committees for service improvements and promotion of citizen health entitlements*, under Operational Research (289), there is the ONLY mention of gender in the Q10 Report, as follows:
 - *289. Operational research will aid impact assessment of the Facility Health Committee Strengthening Initiative in Kaduna state, by generating evidence about the impact of FHCs on quantity and quality of care, health outcomes, strengthening of voice, **and the role of gender**. In the current quarter, the first part of the Operational research baseline was conducted: a survey of health service delivery in 36 treatment sites and 36 control sites in PATHS2 8 supported LGAs (Birnin-Gwari, Jema'a, Lere, Kachia, Kaduna South, Kuru, Soba and Zaria).*

For the Operational Research related to gender, a health facility survey was conducted and the results are currently being analyzed. A household survey is still ongoing.

- There is, however, no mention of what is planned for GESI in the next quarter.
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Q 11 Report to DFID – January-March 2011

- Under Output 1, re Strengthening Coordination Mechanisms, it was reported, under *Translating Political Commitment to Action (165)*, that the Kaduna Health Forum (KHF), with the Development Partners Coordination Forum, plans to conduct an Annual Health Scorecard (AHS). This includes progress made towards finishing the 2009 SMOH annual performance review and development of the Kaduna state annual health report. Despite a commitment under Output 1 in the GESI Action Plan to “support Kaduna Health Forum to identify and include GE & SI issues in their restructuring and technical memos”, and indication in the GESI Action Plan Update (May 2011) noting that this commitment has been achieved, nothing was reported on GESI in the Q11 Report.
- Also under Output 1, the GESI Action Plan promises to “support the development of Kaduna state HDP that addresses issues of gender inequality and social exclusion in the provision of quality healthcare.” This is not mentioned as part of the MTSS in the Q11 Report (169) even though it has been achieved, according to the GESI Action Plan Update (May 2011).
- Under Output 2, related to HMIS, the Q11 does give some breakdowns by sex of the staff in the LGAs (175, 176), though not for those trained (180), nor was it mentioned whether disaggregation of data is regularly done and whether training was offered about disaggregation.
- With relation to Output 2, no mention is made of the GESI Action Plan commitment to “support the development of Kaduna state HDP that addresses issues of gender inequality and social exclusion in the provision of quality healthcare.”
- Under Output 3, no mention is made of the commitment in the GESI Action Plan to “develop and pilot gender sensitive community-based health insurance scheme to cater for vulnerable groups (men, women and socially excluded), even though the GESI Action Plan Update (May 2011) notes that the plan for the take off of CBHIS in Kaduna has factored in these issues.
- Under Output 4, as with Q10 Report, the commitment in the GESI Action Plan to “work with consultants and stakeholders to incorporate appropriate GESI issues in strengthening FHCs and CHVs including review of training manuals” was achieved. As indicated under the Q10 Report, this is reported as achieved, according to the GESI Action Plan Update (May 2011).The

workshop was carried out in Q10, and the FHC community forum and training was carried out in Q11.

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

3.3 Visit to Kaduna State by Health Equity Specialist as part of GESI Review in PATHS2⁴

In a recent Gender Review of GESI in PATHS2, undertaken by Eleanor Nwadinobi, a Health Equity Specialist⁵, she visited a Primary Health Centre (Unguan Shanau, Kaduna North), held a Round Table discussion with PATHS2 staff, met with several CSOs, and investigated GESI issues related to health with the State Health Educator.

As a result of this process, she was able to identify the following characteristics of Kaduna State and the PATHS2 program there, which have far reaching implications for Gender Equity and Social Inclusion. In her opinion, the gains of the PATHS 2 programme in Kaduna with regard to GESI far outweigh the challenges.

- Kaduna State plans to generate a database of the Nigeria Youth Service Scheme (NYSC) health care professionals which, if equitable, will be of benefit to both men and women.
- The planned dialogue on the National Health Bill is another opportunity for GESI-related health aspects to be addressed.
- The 'Ask Kaduna' community dialogue has provided a forum for discussing the various barriers and ways of overcoming them.
- Antenatal attendance at PHCs has increased since PATHS 2 provided equipment and beds and helped improve drug availability (DRF) so that deliveries have increased from 4-6 /month to 15-18/month. In addition, providing 24-hour services has improved attendance.
- Male involvement in antenatal visits is minimal for cultural reasons. Husbands encourage purchase of drugs at the facility but insist that their wives show

⁴ See Annex 2, Eleanor Nwadinobi, HES, Notes from Visit to Kaduna State, January 2011.

⁵ Eleanor Nwadinobi, Health Equity Specialist.

them their receipts. Women access family planning and opt more for injectables which are less obvious to spouses. PATHS2 is working with men to encourage their involvement.

- Essential Service Packages (ESPs) are being implemented, leading to reduced maternal mortality.
- Cultural inhibitions to access have been identified and addressed. For example, resistance to men training women in reproductive health issues is being overcome by assistance from CHEWs and CBOs such as FOMWAN.
- Membership criteria for Facility Health Committees have been modified to allow both women and men to be members. For example. In the Unguwan Shanau, Kaduna North PHC, the Facility Health Committee is comprised of 13 people, including eight males and five females.
- Membership in Facility Health Committees is based on operational guidelines. A major review is underway with PATHS2 regarding composition by sex of the members as well as roles and responsibilities. A new FHC training manual with a TOT refresher should have already rolled out as of January 2011.
 - Cultural provisions have been considered in the design, including advocating the subcommittee approach as an innovative way of giving women, in particular, a chance to have their voices heard and transmitted to the main FHC.
 - Facility Health Committees that meet the criteria for membership are trained on roles and responsibilities.
- Information about health issues is being disseminated through female workers and town criers/ announcers, important to reach women who have less access to other communication tools (e.g. radio, TV, newspapers). In addition, more materials are being translated into local languages.
 - For example, the woman leader in Unguwan Shanau, Kaduna North assisted during a diarrhoea and vomiting epidemic by sensitizing members of the public.
 - IEC materials are being produced in English Hausa and Arabic as well as in pictorial format. Fulani nomads are a special population and cassettes are produced for them in the Ffulde language
 - Most town announcers are male; however, some respected female town criers exist, e.g. in Zaria.

- There is an improved gender balance among health workers as a result of new HRH recruitment and employment policies.
 - On human resources, despite the presence of a school of nursing and a school of health technology, there are not enough women to train 50 per year. With not enough educated women, there is an acute shortage in the health sector. In addition some fall by the way due to academic failure and others go to Federal establishments where the remuneration is more attractive.
- CSO networks have been mobilized to become more active in addressing GESI issues in health in Kaduna State. They generally are closer to the communities and can reach women and the poor who trust them.
 - Civil society engagement is through partnership with SAVI for Free MCH, an advocacy group. The FMCH-CSOs partnership has produced a report on the assessment of Free MCH in Kaduna State.
 - The Free MCH Coalition and the Health Sector Reform Coalition have developed an action plan for reproductive health and family planning advocacy, with areas identified which need advocacy such as increased health budget allocation.
 - CSO interventions include collation of good practices for presentation to the legislature and State Executive. The Government has responded by constituting a monitoring committee.
 - FOMWAN gives free care to those who cannot afford their bills.
- Community dialogues have become important means for mobilizing voices, with women and the poor also given an opportunity to express their opinions. Success stories are captured as case studies, anecdotal and human angle stories.
- Partnership opportunities exist through the Development Cooperation Framework (DCF), which is a joint agreement with Kaduna State government, DFID, the UN, and the World Bank, with resources managed through a State Steering Committee.
- A result from recent training has been the creation of an advocacy group of journalists. There is engagement with professional health bodies such as Nigerian Medical Association, the Pharmacists Guild of Medical doctors, nurses and midwives, lab scientists and community health prevention associations.

- Support is provided by PATHS2 for Life Saving Skills (LSS) training and Emergency Obstetric Care (EOC) kits. EOC kits have been provided to health centres as part of service delivery to improve maternal health.
- PATHS 2 provided support for a baseline survey in two LGAs and the results were disseminated through the community. A fact sheet was also produced with the findings used as a tool to solicit cooperation.
- Breastfeeding has increased in some PHCs as a result of health talks.
- TBAs are getting training, resulting in the use of gloves and delivery kits. In addition, TBAs now know to refer difficult cases rather than handling them by themselves.
- Capacity building has provided an avenue for receiving training in new techniques of health promotion. In addition, step-down training has been given to other staff.

3.4 Proposed Log frame for Kaduna State – February 2011

In 2009, during the preparation of the improved logframe, a gender expert⁶ 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 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

⁶ Gretchen Bloom, Report

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 to achieve gender mainstreaming 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 1	Commitments to Gender Equality in National-level Policies, Plans and Strategies for Health Stewardship Supported and Strengthened	All new and revised health policies and legislation that meet minimum standards 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	All new and revised health policies and legislation meet minimum standards at

	Gender Inequality	<p>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</p> <p>X% increase in capacity of States, Local Government Authorities (LGAs) and Health Facilities (HFs) for HMIS (data capture, analysis and utilization) by EOP</p> <p>X% increase in the number of skilled health workers with greater equity in terms of sex and geographical distribution by EOP</p>
Output 3	Equality to Access to Gender-Sensitive Sustainable Efficient Pro-Poor Health Services Improved	<p>X% increase in the proportion of clients reporting satisfaction with health services by EOP disaggregated by sex and rural/urban location</p> <p>X% of communities with functioning and sustainable community mechanisms to overcome financial, social and cultural barriers to access emergency obstetric care by EOP</p>
Output 4	Participation in Voice for Accountability Improved for Women	<p>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</p> <p>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</p>
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

		<p>key health issues in the last two months by EOP</p> <p>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</p> <p>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</p>
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GESI Elements in New Log Frame

The new log frame proposed to DFID in February 2011 for the PATHS2 programme in Kaduna 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 Kaduna 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 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

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

3.5 Mid-Term Review – Kaduna – April 2011

A thorough Mid Term Review was conducted in April 2011 in all four States.

The MTR for Kaduna State notes, in the introduction, that the Purpose of PATHS2 is “to improve the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to 6 states.”

Kaduna State has a low delivery rate for women in a health facility, at 18.4%, compared to the national average of 35%. The reasons given in the MTR are both ineffective governance and low citizen awareness of fundamental health issues. In addition, widespread poverty and low literacy levels limit the impact of development interventions.

The log frame lists five indicators to measure achievements against this Purpose. One of these indicators, #5, will allow attention to both gender and poverty. It is ‘Number of States implementing systems strengthening approaches to increase access to quality health services for women and the poorest’.

Nonetheless, a word search of the Kaduna MTR document indicated NO mention of the words gender, gender equity, mainstreaming, or social inclusion, despite the presence of an updated GESI Action Plan. There is mention of women and men in some sections, but only as 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

Kaduna State has one of the highest numbers of development partners in the health sector. PATHS2 took the lead in creating the Development Coordination Forum (DCF) in 2009. There is no indication in the MTR that PATHS2 raises GESI as an important issue at meetings.

PATHS2 has also been active with the tracking financial flows in the health sector. There is no mention in the MTR whether a gender-based budgeting approach used.

There is no way of knowing whether a GESI approach is being used in Kaduna State with regard to initiatives under Output 1.

None of the indicators have numerical answers in the draft MTR.

Output 2: State systems to support appropriate health services improved

PATHS2/Kaduna supported the SMOH to develop its KSSHDP (Kaduna State Strategic Health Development Plan). No indication is given in the MTR as to its sensitivity to GESI issues. PATHS2 did collaborate with other SLPs (SAVI, SPARC)

to create a 'Know Your Budget' group to do an analysis of the health MTSS 2011-13 to determine 'equity balance', though the meaning of this phrase is unclear.

An MNCH Week was launched in 2010 with support from PATHS2. PATHS2 supported an HRH assessment of the State HRH Policy and Strategic Plan. The results are not noted in the MTR.

Output 3: Delivery of, and access to, sustainable appropriate health services and supplies improved

[Note: This Output has been changed in the draft MTR to: *Improved delivery of pro-poor preventive and curative services, including affordable drugs.*]

The MTR reports that all 144 Health Facilities in Kaduna by 2010 had been "earmarked for having their demands met", meaning the 1,631,555 women and children under five had increased access to health care. Over the duration of the project, a total of 5,260,371 women and children have accessed FMCH care services in Kaduna, although the baseline is not included for comparison purposes. This has been made possible in part by the scale-up through PATHS2 support for FMCH facilities from 114 to 510 in the State.

PATHS2 has provided support also for training of (1143, 637, 57, 40, 52, 12, 16, and 20) health personnel, although these numbers are not disaggregated by sex or any other variable.

The section reporting on HMIS shows all training statistics disaggregated by sex, showing that in the TOT, men (20) outnumbered women (3), but at the LGA level, it was nearly equal (163 males, 162 females). There is no mention, however, of whether the HMIS collects disaggregated data.

The achievements against indicators are missing from the MTR, so there is no way to know whether there is disaggregation of data (e.g. re Indicator 3, Percentage of clients reporting satisfaction). There is also no report on how accessible EOC has become to those prospective clients who need to overcome socio-cultural or financial barriers (Indicator 4).

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

[Note: This Output has been changed in the draft MTR to: *Raised public awareness of entitlement to, and demand for, quality healthcare.*]

Output 4 is geared to increasing demand for health services and improving health outcomes following greater utilization by making the system more accountable and responsive. The MTR report does not specifically indicate which citizens or groups are most apt to be excluded.

PATHS2 has adopted an 'integrated' strategy weaving in demand-side issues with all program outputs, aiming to get citizens' voices heard always for better accountability. As part of this effort, a household survey on FMCH has been conducted with 700 households included.

The report does conclude that the efforts have 'opened up a space for citizens' involvement' in the MTSS development and monitoring, without, however, specifying which citizens are involved.

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

The MTR notes that a baseline study that was conducted prior to PATHs beginning work in Kaduna to determine the status of health in PATHS2 focal states. The study, according to the MTR, revealed "low service utilization in health facilities due to poor knowledge and negative health seeking behavior."

The study also confirmed that "men often take decisions on health and other domestic issues due to poor spousal communication."

Another study, a qualitative survey, was undertaken in which data were collected from target groups in various communities using in-depth interviews and four group discussions to test knowledge, attitudes, perceptions and practices in relation to the health system. It is not clear, however, who comprised the target groups.

The four indicators for Output 5 count results in either the percentage of people or the number of people without indicating whether there is any disaggregation of the results, whether by sex, age, location or income level. They do attempt to measure both outputs (participation in dialogue) and outcomes (knowledge learned and retained). However, no results are included in the draft MTR.

3.6 Year Three Work Plan for Kaduna State

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

One of the Outputs has 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*.

Outputs 3, 4, and 5 are not indicated at the Output level in the Year Three Work Plan, although sub-outputs, strategic activities, and responsible persons are all included.

With regard to GESI in the Work Plan, 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 mention of men or women, male or female, or equity.

SECTION 4: LESSONS LEARNED / CHALLENGES

- The Kaduna 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 Kaduna State Log Frame and the Year Three Work Plan related to GESI.
- It is possible to break cultural barriers, e.g. by having women serve as town criers/ announcers.
- Lessons can be learned from the successes in other States; hence, cross-State collaboration and sharing should be encouraged.

- FHC meetings will probably never be held during harvesting months.
- State ministries do not always meet their obligations in provision of services, supplies and data.

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.

Kaduna Specific

- Continue to support TBA training and train more women leaders as well, including grandmothers.
- Ensure that CHEWS who have qualified are posted to their sites in a timely manner to increase access to health assistance and service provision at the village level, especially for women and the poor who are limited in their access to seek health care further away.
- Work more closely with men to encourage their involvement in family planning and antenatal care, not just as controllers of women's behaviour.

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 Kaduna 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 Kaduna State, is difficult to achieve with incomplete documentation and limited consultation. The recommendations thus still need to be strengthened through on-the-ground work with the State Office.

Next Steps

As a follow-up to this Gender Review, the PATHS2 Kaduna 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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