PATHS2

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

November 2011

by

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ABBREVIATIONS

AHS	Annual Health Scorecard
ANC	Antenatal Care
ARFH	Association for Reproductive and family health
ARTV	Abubakar Rimi Television
BCC	Behaviour Change Communication
BCIA	Big Common Impact Area
CBHI	Community Based Health Insurance
CBHIS	Community Based Health Insurance Scheme
CBO	Community-Based Organization
CEDPA	Centre for Development and Population activities
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CHR	Community Health and Research Initiative
CHV	Community Health Volunteer
CHW	Community Health Worker
CSO	Civil Society Organization
D&E	Deferral and Exemption
DCF	Donor Coordination Forum
DFID	Department for International Development
DMA	Drug Management Agency
DMCSA	Drugs and Medical Consumables Supply Agency
DRF	Drug Revolving Fund
EJISS	Enhanced Joint Integrated Supportive Supervision
ELSS	Emergency Life Saving Skills
EOC	Emergency Obstetric Care
ERC	Expert Review Committee
ESP	Essential Services Package
ESSP	Essential Systems & Services Package
ESSPIN	Education Sector Support Programme in Nigeria
FHC	Facility Health Committee
FMCH	Free MCH
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women's Association of Nigeria
GESI	Gender Equity and Social Inclusion
GHAIN	USAID HIV/AIDS programme
GHON	Grassroots Health Organization Nigeria
HCH	Honourable Commissioner for Health
HCP	Health Commodities Programme
HDCC	Health Data Consultative Committee
H/E	His Excellency
HERFON	Health Reform Foundation of Nigeria
HES	Health Equity Specialist
HF	Health Facility
HFC	Health Facility Committee
HoA	House of Assembly
HMB	Hospitals Management Board
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
HW	Health Worker
ICC	Inter Agency Coordinating Committee
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood illnesses
IMNCH	Integrated Maternal and New Child Health
JD	Job Description

KM	Knowledge Management
KSSHDP	Kano State Strategic Health Development Plan
LGA	Local Government Area
LHC	Local Health Committee
LSS	Life Saving Skills
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MLSS	Modified Lifesaving Skills
MNCH	Maternal, Neonatal & Child Health
MOP&B	Ministry of Budget and Planning
MSS	Midwife Services Scheme
MTEF	Mid-Term Expenditure Framework
MTR	Mid-Term Review
MTSS	Medium Term Sector Strategy
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NMCN	Nurses and Midwifery Council of Nigeria
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 Corps
OIC	Officer in Charge
OPD	Outpatient Department
PATHS	Partnership for Transforming Health Systems
PEMR	Public Expenditure Management Review
PER	Public Expenditure Review
PHC	Primary Health Care
PHCC	Primary Health Care Coordinator
PHCMIS	Primary Health Care Management Information System
PPFN	Planned Parenthood Federation of Nigeria
PPMCH	Partnership for the Promotion of Free Maternal and Child Health
PPP	Public Private Partnership
PSA	Public Service Announcement
SAVI	State Accountability and Voice Initiative
SFH/GHAIN	Society for Family Health/ Global HIV and AIDS Initiative Nigeria
SHA	Public Health Accounts
SHC	Secondary Health Care
SHCF	Secondary Health Care Facility
SHF	Secondary Health Facility
SHMB	State Hospitals management Board
SLP	State Level Programme
SMOH	State Ministry of Health
SMOLG	State Ministry of Local Government
SMOWA	State Ministry of Women's Affairs
SMI-D	Safe Motherhood Initiative – Demand Side
SMS	State Medical Store
SNHA	Sub-National Health Accounts
SOGON	Society of Gynaecologists in Nigeria
SOP	Standard Operating Procedure
SPARC	State Programme for Accountability Responsiveness and Capability
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
SPO	State Program Officer

STL	State Team Leader
SUBEB	State Universal Basic Education Board
SUNMAP	DFID malaria programme
SWAAN	Society for Women Against AIDS in Nigeria
TA	Technical Assistance
TBA	Traditional Birth Attendant
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
VVF	Vesico Vaginal Fistula
WDO	Women Development Officer
WHADNET	Women's Health and Development Network
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 Kano. 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 Kano, based on a series of key questions, and to prepare a synthesis report outlining the level at which Kano 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 Kano.

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

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

In Kano, it is clear from available reports that concerted efforts are being made by PATHS2 at the State level to transform Kano'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 Kano 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 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 PATSH2 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 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

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

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]

2.1.3 Mainstreaming GESI in PATHS2

As part of the GESI mainstreaming exercise in 2009, two of the gender specialists, Gretchen Bloom and Olabisi Aina, visited Kano and prepared a GESI Assessment Report. Essential sections are quoted here.

Kano State Gender Equality & Social Inclusion Assessment Report

Gretchen Bloom & Olabisi Aina, PATHS2, June 2009

Climate for GE/SI in Kano State

Overview: Kano State, the most densely populated state in the North, largely Hausa and Fulani, is 75% rural with 61% of the population below the poverty line. In the NW zone, it shares the worst nutritional statistics in the country, with 55% of under-5's stunted and 42.9% underweight. Adult literacy rates are 71.2% for men, 50.2% for women. School enrollment also shows strong sex differentials (primary enrollment is 81.3% for boys, 65.5% for girls). The IMR is 110/1000 live births, close to the national level; MMR is high at 1700/100,000 births, more than double the national average; and 17,000 women are disabled every year after giving birth (e.g. with VVF). The disease burden is heavy, especially for the poor. Most in Kano are practicing Moslems, with Kano State championing Sharia Law; the majority practices polygamy.

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[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).

<u>Climate for GESI:</u> The Kano State Roadmap for Development includes health outcome targets that aim at 'offering quality services that are accessible to all', and that target 'increased access to comprehensive gender-sensitive…services'. This approach to facilitating access for the underprivileged complies with Muslim values of providing welfare to the poor, with the feudal structure responsible, now shifted to the government. In addition, Kano State was the first in Nigeria to adopt the Free MCH program (2001), and a bill is in the State Assembly that was developed by CSOs (especially FOMWAN) and promoted by the SMoH. However, it is available only in the 33 state hospitals and is sorely under-funded.

<u>PATHS2:</u> Project staff have a willingness to do GE/SI but lack the necessary skills. In their GE/SI Action Plan, the PATHS2 Office has requested capacity building on GE/SI. It is recommended that this training should include gender budgeting. Nonetheless, with the constant distraction of the Muslim prayer schedule, an 8-hour workday is not the norm.

<u>CSOs</u>: Many CSOs that work on issues such as women's rights, gender equity, reproductive health, and social inclusion, are aware that the entry points for work in the conservative Northwest, esp. Kano State, need to be within the traditional religious and cultural context. They have developed acceptable and successful approaches that deliver results.

<u>Opportunities</u>

<u>PATHS2</u>: The PATHS2 Office participated enthusiastically and diligently in the GE/SI Working Meetings, ending by strengthening their entire Work plan with GE/SI language where needed. They then prioritized the actions needed immediately to make this a reality, including: sharing the revised Workplan with partners; working with the SMoH to improve attention to GE/SI in the HSSP; providing technical assistance for improved disaggregated data collection; and assessing HRH personnel policies and staff from a GE/SI perspective; doing GE/SI capacity building with PATHS2 staff and partners; and raising GE/SI issues at the Donor Coordination Forum (DCF). In addition, the STL agreed with the team's recommendation to add responsibility for promoting GE/SI to the SIO's job description, calling him the 'Inclusion Coach', as his work requires him to look across all outputs; or otherwise convert the half-time V&A Adviser to full-time, with responsibility for GE/SI as well as V&A. This would help PATHS2 to implement its newly GE/SI-sensitive Work plan.

<u>GE/SI Unit in SMoH:</u> The SMoH was preparing a ten-year Health Sector Strategic Plan (2009-2019) which has equity, gender mainstreaming and pro-poor in its vision and outputs. Throughout the HSSP, there are references to these themes and some disaggregated data information. PATHS2 could help the SMoH deepen the approach to GE/SI in the HSSP. It was recommended that a Unit be created in the Planning and Research Directorate to lead the development of this policy and other

GE/SI activities in the SMoH and that PATHS2 collaborate closely with the SMoH in this process.

Challenges and Risks

Sharia Law: Kano State sees itself as the most exemplary Sharia state in Nigeria, the self-styled 'vanguard' of Sharia Law. This can be disastrous for progressive social change. For example, the CSOs reported that the Attorney General has absolutely prohibited the development of a Kano State Gender Policy. Also, a DFID/British Council publication was rejected by many traditional leaders due to its international support, even though the title is 'Promoting Women's Rights through Sharia in Northern Nigeria' and it was prepared by scholars (male and female) at Ahmadu Bello University: this could indicate an anti-West bias. A major lesson learned is the need to be exceptionally sensitive to Sharia principles in publications appealing for changes in public sentiments on GE/SI: violent reactions were recorded against pictorial expressions assessed to be obscene according to Sharia Laws (e.g. in the Women's Rights publication and the National Gender Policy).

> *[Update on Sharia Law (2011): According to the PATHS2 Office, Sharia does not have a negative impact on achieving the goals and objectives of PATHS2. On the contrary, Sharia, as a Muslim's total way of life, is very clear on the role of women in nation building. Sharia is particularly supportive of women's participation in health issues. One of the Hadiths (sayings of the Holy Prophet) is: "If you educate a woman, you educate a nation; but if you educate a man, you educate him alone." This is the level of support Islam gives to women.]*

2.2 Review Objectives

The methodology for this Gender Review of Kano State involved a review of documents, including the 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 Kano State-specific MTR progress reports, the updated log frame, and the Year Three Work Plan, as well as correspondence with Kano State PATHS2 officers, in order to achieve the following two objectives:

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

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

SECTION 3: KEY FINDINGS: KANO STATE

In Kano, it is clear from available reports that concerted efforts are being made by PATHS2 at the State level to transform Kano'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 promised Equity & SI Unit in the MOH has not been accomplished. However, GESI is regularly discussed at the DCF with PATHS2 giving voice to GESI issues. A working group has been proposed to develop a comprehensive State Gender Policy for the Health Service.

Under Output 2, all the operational guidelines for the SHCs and the PHCs have had gender mainstreamed into them. In addition, gender has been included in the operational manual for the State DRF Committee and gender inclusion is taken into consideration in the membership. At present, there are 16 men and 5 women in the 21 members, a percentage breakdown of 76% men and 24% women.

The MTR highlights an acute shortage of health manpower. In response, PATHS2 provided support for an HRH assessment with a focus on availability, productivity, quality and gender disparity in the health services. As a result, new training institutions have been created, including the School of Community Midwifery at Dambatta to train midwives.

In addition, a massive in-service training has been undertaken on life saving skills, extended on a mandatory basis to community extension workers, including many women. Over 70% of all new health workers are female, leading to increased ante natal visits, increased attendance at birth by skilled health workers, and improved health care of children by mothers.

PATHS2 also has worked with the MOH on gender disaggregation in the HMIS tools. This disaggregated data is now available from the HMIS registers at the SMOH.

Under Output 3, PATHS2 supported training of 30 female CHEWS in MLSS as master trainers. For women and children, known as the 'biologically vulnerable', PATHS2 supported a week aimed at MNCH.

Efforts are being made to identify strategies to help poor people access health services, including D&E schemes, birth preparedness planning, community transport schemes, and community-based health insurance schemes. LHCs are addressing social and cultural barriers that prevent women from seeking care, especially related to antenatal care, labour and delivery when pregnant. PATHS 2 is supporting the SMOH Free MCH program, helping to make it more effective and sustainable.

Under Output 4, it is noted in the Q11 Report that 41 master trainers from Local Health Committees were trained on Part Two of the LHC manual. Of these, five were women. According to the MTR, under the LHC intervention, 360 community members have been trained in the 11 LGAs where PATHS2 is active. Of these members, at least one-third in each LHC are women.

SAVI, another DFID-supported SLP, helped form a coalition of CSOs active in promoting Free MCH, called the Partnership for the Promotion of Free Maternal and Child Health, which is working to ensure passage of the Free MCH bill in the legislature.

Under Output 5, 'Ask Kano' reflects the challenges the poor underserved populace face in accessing basic health care services, especially related to pregnancy and malaria, has a conscious focus on real women's authentic experience to provide evidence, identifies poor people and women during community intervention with stories that substantiate evidence on how poverty undermines access to quality health care services, and discusses the barriers communities face to accessing health care, ranging from inadequate health facilities, numbers of staff, and lack of equipment to poor human relations among health workers.

PATHS2 worked with CSO partners to prepare for state-wide media debate in January, holding a five-day residential training workshop with 27 members (19 males, 8 females) on essential elements of health promotion and BCC.

In addition, a ten-minute documentary was produced based on community dialogue malaria and pregnancy. Women formed 50 percent of the participants as they are the ones who get pregnant and mostly care for children with malaria. Both mothers-in-law and husbands, often difficult audiences, have now become convinced of the importance of antenatal care and skilled delivery.

A commendable and unusual intervention, highlighted in the MTR, is the engagement of a female psychiatric nurse to counsel women anxious about their reproductive health and/or traumatized by earlier pregnancy-related experiences.

The updated Logical Framework lists quite a few proposed Activities that address GESI issues:

1.9: Strengthen institutional capacity for implementing the human resources for health policy and strategic plan, with attentions to gender and equity issues, in collaboration with SPARC

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 and 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

4.5: Provide technical assistance to support the roll out of the Safe Motherhood Demand-Side Initiative and other key initiatives addressing community-based barriers to accessing health services

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

5.6: Strengthen and improve capacity of key State institutions and professionals to effectively design, implement, and monitor targeted, pro-poor health communications accurately and accessibly

Nonetheless, a word search of the Kano Mid-Term Review document indicated mention of the words gender and gender equity only twice, with no mention of 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.

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

3.1 GESI Action Plan

Kano 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, as of May 2011, the Kano PATHS2 Office has reported the following achievements against the September 2009 Action Plan:

Under Output 1, the promised Equity & SI Unit in the MOH has not been accomplished. However, GESI is regularly discussed at the DCF with PATHS2 giving voice to GESI issues.

Under Output 2, all the operational guidelines for operations of the SHC and the PHC have had gender mainstreamed into them. In addition, gender has been included in the operational manual for the State DRF Committee and gender inclusion is taken into consideration in the membership. At present, there are 16 men and 5 women in

the 21 members, a percentage breakdown of 76 percent men and 24 percent women.

Under Output 3, the planned review of the Terms of Reference of the DMA Pricing Committee, focused on the pro-poor component, has not yet been undertaken. It has been prioritized in the next quarter of program implementation.

Under Output 4, the promised GESI training with PATHS2 partners has not yet been done. It is programmed to be taken up on a priority basis, as soon as the necessary approvals are received.

Under Output 5, there are no actions listed.

In addition, GESI was added to one Donor Coordination Forum in Year 1, as promised. PATHS22 intends to keep adding GESI to the DCF each year and to be a voice for GESI at each meeting.

PATHS2 also has worked with the MOH on gender disaggregation in the HMIS tools. This disaggregated data is now available from the HMIS registers at the SMOH.

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. However, following discussions with the PATHS2 office staff, there is activity as noted here:

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, nor to the impact of Sharia Law on PATHS2's efforts to address GESI. When questioned about the latter, the PATHS2 Office replied that Sharia is very clear on the role of women in nation building, on the importance of women's participation in addressing health issued, and on the strong support in Islam for women's education, expressed in the following Holy Prophet Hadith: "If you educate a woman, you educate a nation; but if you educate a man, you educate him alone."

- Under Political Environmental Analysis, there is note made of the strong support of the State government for the health sector, including unlimited support for PATHS2/Kano, despite the political upheavals. Yet, no reference is made to GESI mainstreaming.

- Under Output 2, there is no mention of efforts made to mainstream a gender perspective into the HRH Policy and Strategic Plan, drawing on the example of Jigawa State. However, GESI is integrated into the SSHDP, in Section 6.4. The major strategy for Kano State is to focus resources on safe motherhood and newborn care. However, there is no State Gender Policy. Hence, there is a big gap between women and men in the State health care workforce. This will be taken up in the reform timetable: a working group is proposed to develop a comprehensive State Gender Policy for the Health Service.

- PATHS2 has developed a HRH Policy Brief but has yet to engage a consultant, as promised in the GESI Action Plan, to review and prepare a report on gender mainstreaming, as was done in Jigawa State, because it was not in the Year 2 Work Plan. This will be done in the early part of Year 3.

- Because there is currently no HRH tool available for the collection of sex-disaggregated data on HRH, PATHS2 has supported the SMOH to develop two gender-sensitive HRH data collection forms for sex-disaggregated data on the health workforce in health sector facilities and training institutions, including enrolments and graduations.

- Under Output 2, the revised HMIS tool promotes sex-disaggregation for data elements in Section C of the LGA Quarterly Data Summary Form.

- Under Output 3, PATHS2 supported training of 30 female CHEWS in MLSS as master trainers.

- Under Output 4, under *Strengthening the* ability *of civil society to reflect citizen priorities for health in government policy, planning and budgeting*, to ensure that both women and men as well as the socially excluded get their voices heard in compliance with Kano's GESI Action Plan, three CSO representatives were drawn from the wider CSO network to participate in the planning team. Out of three, two were women.

- Furthermore, the priority for the CSOs at the sector planning sessions was to promote pro-poor budgeting which includes making more resources available for healthcare provision for increasing skilled attendance at birth. All the CSOs have been active in promoting women's and children's health at their various organizations.

- Under Output 5, Kano State held focus group discussions with 40 participants at the community level and produced two public service announcements on malaria and safe pregnancy for radio and TV.

- In addition, under 'Ask Kano', a ten-minute documentary was produced based on community dialogue which sheds light on key issues. Adolescent women and married women formed 50 percent of the participants, divided into four groups of 10 participants each (young males, elderly male group, young women's group and elderly women's group). The documentary was centered on individual roles and responsibilities in the prevention, treatment and management of malaria and pregnancy. There was a concerted effort made for women's voices to be heard as they are the ones who get pregnant and mostly care for children with malaria.

- Furthermore, the PSAs were designed to represent real people's authentic experiences in order to inspire wider audience acceptance of the key BCC messages communicated, which highlighted the importance of ANC and skilled delivery to reduce pregnancy-related complications and death. To this end, the messages appealed to men to persuade them to grant consent and provide overall support to ensure women attend ANC and seek skilled delivery.

- For malaria, environmental sanitation and the use of nets was conveyed as a major malaria prevention measure. Men, women and children were all illustrated in the PSA as supporting these malaria prevention measures.

- Under Output 5, PATHS2 worked with CSO partners to prepare for state-wide media debate in January. As part of this process, a five-day residential training workshop was held in Kano with 27 members (19 males, 8 females) on essential elements of health promotion and BCC.

- 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 HRH, the report notes that PATHS2, following discussion with the Nurses and Midwifery Council of Nigeria (NMCN) on the possibilities of increasing the annual intake of students to nursing and midwifery schools from 50 to 100, succeeded in getting the annual membership up to 100, increasing the number of staff available to be fielded in rural areas.

- Under Output 2, the Q11 does not give a breakdown by sex of the 84 health workers trained in use of the new HMIS tools, nor was it mentioned whether disaggregation of data is regularly done and whether training was offered about disaggregation. The PATHS2 Office reported later that men comprised 57.1 percent and women 42.9 percent of those trained on the tools.

- Under Output 3, with its new title of *Pro-Poor Services,* no mention is made of the commitments in the GESI Action Plan.

- Under Output 4, as with Q10 Report, there is no indication of whether the CSO partners in MTSS are in compliance with standard GESI approaches. It only notes that the sensitization was on MTSS so that CSOs can play a role in it. In follow-up discussions, it was learned that all of the CSOs participating have the promotion of MCH as part of their objectives.

- Under Output 4, it is noted in the Q11 Report that 41 master trainers from Local Health Committees were trained on Part Two of the LHC manual. Of these, five were women.

- Under Output 5, there is no explanation offered as to whether participants in the public debate and dialogue, organized by 'Ask Kano', include women, the poor, or the otherwise socially excluded. This would be especially important in discussions about the barriers faced by communities in accessing health care.

- When queried about how the voices of women and the poor are heard in public dialogue, the PATHS2 Office replied that 'Ask Kano':

    - Reflects the challenges the poor underserved populace face in accessing basic health care service, especially related to pregnancy and malaria.

- Has a conscious focus on real women's authentic experience to provide evidence.

- Identifies poor people and women during community intervention with stories that substantiate evidence on how poverty undermines access to quality health care services.

- Discusses the barriers communities face to accessing health care, ranging from inadequate health facilities, numbers of staff, and lack of equipment to poor human relations among health workers.

- The barriers identified from a GESI perspective include inadequate female service providers, especially related to the uptake of ANC and skilled delivery. The Honorable Commissioner of Health has urged parents to make cognizant efforts to increase enrollment of girls in school to alleviate this problem.

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

3.3 Proposed Log Frame for Kano State – February 2011

In 2009, during the preparation of the improved log frame, a gender expert[4] participated in the planning session and offered the following comments and recommendations:

Goal for PATHS2 for Gender Mainstreaming (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

[4] 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 is 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 logical framework was developed to achieve gender mainstreaming in the project.

Table: Gender Mainstreaming Strategy Logical Framework – PATHS2

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 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	X% increase in the number of Facility Health Committees (FHCs) in primary and secondary health settings meeting an

	Women	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 Kano 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:

3.2 Percentage of health facilities in Kano State providing basic emergency obstetric care services (disaggregated by LGA)

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

3.4 Number of communities in PATHS2 supported LGAs with effective mechanisms to overcome socio-cultural and/or financial barriers to access emergency obstetric care (disaggregated by LGA, location [urban, rural])

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:

1.9: Strengthen: Institutional capacity for implementing the human resources for health policy and strategic plan, with attentions to gender and equity issues, in collaboration with SPARC

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 and 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

4.5: Provide technical assistance to support the roll out of the Safe Motherhood Demand-Side Initiative and other key initiatives addressing community-based barriers to accessing health services

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

5.6: Strengthen and improve: capacity of key State institutions and professionals to effectively design, implement, and monitor targeted, pro-poor health communications accurately and accessibly

3.5 Mid-Term Review – Kano – April 2011

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

The MTR for Kano State cites human development indicators that make the State one of the poorest in the country. The poverty level is high, with 49.7 percent, and the literacy rate is low, especially for women. There are many social and cultural

barriers that prevent access to basic social services. The MTR highlights some of them and indicates where inroads have been made in overcoming them.

The MTR notes that many of the indicators were poorly chosen as they did not measure accurately what was intended. In addition, they do not measure gender inequity well.

One of these indicators, #5, should 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 Kano MTR document indicated mention of the words gender and gender equity only twice, with no mention of 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.

The PATHS2 project uses an approach of five Outputs which, when integrated, according to the MTR, should lead to improved pro-poor health services. Each Output has several indicators for measuring achievements.

<u>Output 1:</u> Stewardship role for health at State level strengthened

The main reported strategy for achieving Output 1 centers on supporting the SMOH to develop the Kano State Strategic Health Development Plan (KSSHDP). This plan was developed following dialogue with stakeholders, from the public, private and voluntary sectors, including traditional and religious institutions. Unfortunately, the MTR does not report whether these stakeholders include the poor, the usually excluded, the hard-to-reach, and both women and men.

One positive result of the KSSHDP has been an increase in the percentage budget allocation for health from 0.27% in 2010 to 9.07% in 2011, which has positive implications for the State's ability to reach more clients.

Under the indicators for Output 1, note is made of the development or revision of seven State policies, plans or laws through PATHS2 assistance as well as improved institutional capacity. No mention is made here of GESI, however.

<u>Output 2:</u> State systems to support appropriate health services improved

The MTR highlights a serious challenge under Output 2, that of an acute shortage of health manpower, creating a critical constraint for delivering sustainable pro-poor health services in the State. In response to this challenge, PATHS2 provided support for an HRH assessment with a focus on availability, productivity, and quality and gender disparity in the health services. As a result, new training institutions have been created, including the School of Community Midwifery at Dambatta to train midwives.

In addition, a massive in-service training has been undertaken on life saving skills, which has been extended on a mandatory basis to community extension workers. Many of these trained are women; and, so reports the MTR, over 70% of all new health workers are female. These improvements have led to increased ante natal visits, increased attendance at birth by skilled health workers, and improved health care of children by mothers.

PATHS2 has also supported improved health data collection, supporting the establishment of the Health Data Consultative Committee (HDCC) and the strengthening of the HMIS Unit in the SMOH. This has already led to improved data collection. Nowhere is it mentioned in the MTR, however, whether the new tools collect disaggregated data.

Finally, an improvement in the availability of drugs through the DRF has led to improved outpatient attendance at health facilities. The MTR does not disaggregate the attendees, though, to show who is taking advantage of the DRF.

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

The results under Output 3 on the supply side are impressive, with drugs and medical supplies available at 329 health facilities and EOC kits at 53. Clinical staff have been trained, including doctors, nurses/midwives and CHEWs (228). The training included how to develop client-friendly attitudes as well as skills for life-threatening conditions. Assumedly these attitudes and skills mainstream GESI, although the MTR does not clarify. In addition, LHCs are now actively engaged in the management of HFs, though no details are provided.

For women and children, considered examples of the 'biologically vulnerable', PATHS2 supported a week aimed at MNCH. In the process, 34, 480 women were given tetanus toxoid vaccines and 7744 pregnant women received malaria prophylaxis. These numbers sound impressive, but as no percentages are offered, it is impossible to understand the magnitude of the response in relation to the overall possible vulnerable population.

On the demand side, efforts are clearly being made to identify strategies to help poor people access health services, including D&E schemes, birth preparedness planning, community transport schemes, and community-based health insurance schemes. At the same time, LHCs are addressing social and cultural barriers that prevent women from seeking care, especially related to antenatal care, labour and delivery when pregnant, though the MTR does not identify these barriers nor explain what is being done to overcome them. In addition, PATHS 2 is supporting the SMOH Free MCH program, helping to make it more effective and sustainable.

The results have been notable: according to the MTR, there has been a 'massive utilization of essential health services' by the target groups, although the indicators in the draft MTR are missing results.

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

PATHS2 is tackling Output 4 with three interventions: strengthening LHCs; enhancing civil society capacity for active participation in the MTSS; and improving civil society's ability to advocate for MCH services.

Under the LHC intervention, 360 community members have been trained in the 11 LGAs where PATHS2 is active. Of these members, at least one-third in each LHC are women.

Three CSOs are engaged in the second intervention. No mention is made of how these CSOs were selected, or whether one criterion for selection is the CSO's approach to GESI.

For the third intervention, SAVI, another DFID-supported SLP, helped form a coalition of CSOs active in promoting Free MCH, called the Partnership for the Promotion of Free Maternal and Child Health (PPMCH). The Coalition is working to ensure passage of the Free MCH bill in the legislature.

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

PATHS2 supported the SMOH to create the State Health Communications Forum (SHCF) to achieve Output 5. The SHCF uses the 'Ask Kano' platform to convey important health messages (e.g. about pregnancy, malaria) to an estimated five million citizens, though the MTR does not make it clear that all citizens can hear these radio and television messages. It does note that the BCC campaign was followed up with outreach and clinical sessions aimed at reaching hard-to-reach audiences, assumedly.

A commendable intervention, highlighted in the report, is the engagement of a female psychiatric nurse to counsel women anxious about their reproductive health and/or traumatized by earlier pregnancy-related experiences. This is most unusual.

Both mothers-in-law and husbands, often difficult audiences, have now become convinced of the importance of antenatal care and skilled delivery, resulting in increases in attendance at both.

The indicators for this Output are interesting. Two are at the output level, measuring only participation, while two more are at the outcome level, measuring results in terms of knowledge acquisition. Unfortunately, the draft MTR does not give the results, nor does it indicate whether the data is disaggregated in any way to reflect sex, age, geographic group, income level, or disability.

3.5 Year Three Work Plan for Kano State

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

Two 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.*

Two other Outputs do not state the Output in the Work Plan, namely Outputs 4 and 5.

With reference to GESI, 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 three times in the document, under Outputs 2, 3 and 5:

- *Sub-Output 2h. Pro-Poor health financing mechanisms developed and strengthened*
- *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

- Kano PATHS2 Office: The 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. Also, there is no overlap between the updated Kano State Log Frame and the Year Three Work Plan related to GESI.
- SMoLGA (2009): The State Ministry of Local Government was a bottleneck in 2009 for PATHS2 for work at the local level as all work with the LGAs needed to go through the PHC Coordinator in the SMoLGA. LGA Chairmen are political appointees who are generally male and traditional leaders. It is unclear whether this is still the case.
- SMoH (2009): The Commissioner for Health in 2009 was an excellent 'gender champion', not as a gender expert but as a professional woman with some level of gender awareness. This offered an opportunity for major change in the SMoH that would need to be institutionalized for sustainability beyond her tenure. PATHS2 needs to continue as a 'driver of change' if the SMoH is to make changes for GE/SI.
- SMoWA&SD (2009): The Ministry of Women Affairs and Social Development was not proactive with other line ministries in 2009 and did not advocate for gender equity or social inclusion, even though it has a mandate for this. As a result, PATHS2 could not expect SMoWA to be an asset in its work for GE & SI. As an example, SMoWA blocked distribution of the National Gender Policy in 2007 when issued, claiming that local religious leaders found it unacceptable. SMoWA's reaction was to bury the NGP rather than 'domesticate' it for Kano State use. This may still be the case.

Impact of Sharia Law: Kano State offers a difficult cultural and religious environment for work around social change toward greater mainstreaming of GESI principles but examples exist of socially approved methods of working to reach the often-excluded, including women in purdah. When questioned about the impact of Sharia Law on PATHS2's efforts to mainstream GESI, the PATHS2 Office replied that Sharia is very clear on the role of women in nation building, on the importance of women's participation in addressing health issued, and on the strong support in Islam for women's education, expressed in the following Holy Prophet Hadith: "If you educate a woman, you educate a nation; but if you educate a man, you educate him alone."

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.

Kano Specific

- CSOs (2009): CSOs can be effective partners using their socially appropriate, yet innovative, approaches to reaching local conservative communities, guided by their 'best practices', targeting male religious and cultural leaders directly in order to reach the often excluded, especially women in purdah. PATHS2 should select CSOs that are already aware of GE/SI principles and practice them. Where necessary, their skills should be upgraded through capacity building.

  Also, CSOs working with the LGAs can often access them through traditional structures. PATHS2 can rely on these connections for entry when it is partnering with CSOs on community-based activities, especially for Outputs 4 and 5.

  Many CSOs that work on issues such as women's rights, gender equity, reproductive health, and social inclusion, are aware that the entry points for work in the conservative Northwest need to be within the traditional religious and cultural context. They have developed acceptable and successful approaches that deliver results.

- SMoWA (2009): For the sustainability of GE/SI work, PATHS2 needs to include SMoWA to build broader capacities in GE/SI in Kano State, including providing technical assistance to SMoWA to 'domesticate' the National Gender Policy for Kano.

- WDOs in LGAs (2009): There were 44 Women Development Officers in the LGAs in Kano State and Women Development Centers also spread throughout the LGAs. These WDOs were considered in 2009 to offer an opportunity for reaching women. They are not visible in any current reports.

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 Kano 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 Kano 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 Kano 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.

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