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NIGERIA HEALTH WORKFORCE MANAGEMENT ACTIVITY

GENDER EQUALITY AND SOCIAL INCLUSION (GESI) ANALYSIS

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TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS ii
EXECUTIVE SUMMARY 1
1. INTRODUCTION 4
1.2 Activity Background 4
1.3 Purpose of GESI Analysis and Analytic Questions 4
1.4 Background and Context 5
2. METHODS AND LIMITATIONS 8
2.1 Data 8
2.2 GESI Analysis Team 8
2.3 Data Collection 8
2.4 Data Limitations 9
3. FINDINGS 9
3.1 Laws, Policies, Regulations and Institutional Practices 9
3.2 Cultural Norms and Beliefs 13
3.3 Gender Roles, Responsibilities, and Time Use 16
3.4 Access to, and Control Over Assets and Resources 17
3.5 Patterns of Power and Decision-Making 18
4. STAKEHOLDERS 20
5. CONCLUSIONS 21
5.1 Intermediate Result Area 1: Training of Health Workforce 21
5.2 Intermediate Result Area 2: Human Resources Information Systems 22
5.3 Intermediate Result Area 3: Governance and Management of Health Workforce 22
5.4 Intermediate Result Area 4: HRH research to understand HRH practices and retention 23
6. RECOMMENDATIONS 23
6.1 Intermediate Result Area 1: Training of Health Workforce 23
6.2 Intermediate Result Area 2: HRIS 25
6.3 Intermediate Result Area 3: Governance and management of health workforce 25
6.4 Intermediate Result Area 4. Research on HRH Practices and Retention of Health Workforce 26
7. GENDER ACTION PLAN 27
ANNEX A: DOCUMENTS CONSULTED 35
ANNEX B: LIST OF STAKEHOLDERS INTERVIEWED 35
ANNEX C: DATA GATHERING TOOLS (KIIs & FGDs) 39
ANNEX D: STAKEHOLDER MAPPING OF GESI CHAMPIONS 52

ACRONYMS AND ABBREVIATIONS

ADS	Automated Directives System
ANC	Antenatal care
CHEW	Community Health Extension Workers
CHPRBN	Community Health Practitioners Registration Board of Nigeria
CNMP	Community Nursing and Midwifery Program
ESPHCDA	Ebonyi State Primary Health Care Development Agency
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FY	Fiscal Year
GBV	Gender-based violence
GESI	Gender and social inclusion
GFP	Gender Focal person
GoN	Government of Nigeria
HRH	Human resources for health
HRIS	Human Resources Information System
HWM	Health Workforce Management
IHI	Institute for Healthcare Improvement
IHP	Integrated Health Program
IP	Implementing Partner
IR	Intermediate Result
JCHEW	Junior Community Health Extension Worker
KII	Key informant interview
MEL	Monitoring, Evaluation and Learning
PHC	Primary health care
PHCDA	Primary Health Care Development Agency
PWD	Persons with disabilities
SGBV	Sexual and gender-based violence
SOP	Standard Operating Procedures
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organization
NMCN	Nursing and Midwifery Council of Nigeria
Q	Quarter
NSHDP II	National Strategic Health Development Plan II
USAID	United States Agency for International Development
VAPP	Violence Against Persons (Prohibition) Act
WHO	World Health Organization

EXECUTIVE SUMMARY

In June-July 2021, the Health Workforce Management Activity (HWM) conducted a Gender Equality and Social Inclusion (GESI) analysis to inform gender integration in the implementation approaches for the United States Agency for International Development (USAID) Nigeria Health Workforce Management (HWM) Activity. The analysis investigates key constraints restricting or limiting women's and men's (including youth and persons with disabilities) participation, capacity-building opportunities, promotion and retention in the rural health workforce. The analysis is guided by the USAID Automated Directive System (ADS) 205 five gender domains (laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and patterns of power and decision-making).

The data for this GESI analysis was collected from desk reviews of relevant literature, Key Informants Interviews (KIIs), and Focus Group Discussion (FGDs) with selected stakeholders across the target states of Bauchi, Ebonyi, Kebbi, and Sokoto and the Federal Capital Territory (FCT).

KEY FINDINGS

HWM Intermediate Results Area 1: Training of Health Workers

Career choices often follow traditional gender roles: Men tend to consider cadres such as physicians, pharmacists, and medical laboratory technicians; whereas women often go for the "caring" roles, such as nursing and midwifery. These gender inequalities are due to social norms, early marriage and domestic obligations that limit women's career choices and professional development. Cultural norms leading to the preference for female clients to be attended to by female health workers is a major factor discouraging men from going into Nursing/Midwifery and CHEW/JCHEW pre-service training. This has created a huge gender gap in the profession.

Certain government, regulatory bodies policies, regulations and institutional practices affect female students more than male, resulting in more female students dropping out of pre-service training. The absence of scholarships and financial incentives for CHEWs and JCHEWS has made pre-service training inaccessible to many promising but indigent students, particularly females. The absence of female-friendly study environment is hindering successful completion of training programs for women particularly, pregnant and breastfeeding female students.

The roles that society imposes on women to meet domestic responsibilities affect their participation in in-service training programs and career growth. Furthermore, the failure of training institutions to organize both pre-service and in-service training at times and places that could make it possible for women to balance care and family responsibilities, constitutes formidable barrier to the successful completion of pre-service training and indeed active participation of women in the health workforce. Cases of sexual harassment often go unreported because issues pertaining to sex are culturally seen as taboo topics, preventing many victims from reporting abuse.

PWD are generally excluded in training and recruitment of certain category of health workers.

The curriculum of pre-service training programs primarily lacks GESI considerations, which are considerable social determinants of health.

HWM Intermediate Results Area 2: Human Resources Information Systems

Although the collection and use of sex-disaggregated data is essential in identifying key GESI challenges and opportunities facing HRH, there are wide gaps in the collection, analysis, report and use of such data. This is mainly attributable to lack of skills on the part of policy makers to properly disaggregate data according to sex and age and use such information for decision-making.

HWM Intermediate Results Area 3: Governance and Management of Health Workforce

HRH Policies lack robust features to improve GESI in HRH recruitment, distribution, and management. This gap accounts for inequitable distribution of health workers.

Although the workforce is dominated by women, it is led by men. Biased and traditional views about women's capacity as public leaders and decision-makers remain pervasive. Opportunities of mentorship, career development, networking opportunities and role models across the target states and the FCT contributes to limited women in top HRH leadership and management positions, as well as the low commitment of many top government officials. The dominance of men in top HRH leadership and management positions results in the development of certain policies and institutional practices that have little considerations for the complex roles of women at home and workplace.

The male-controlled nature of Nigerian society engenders a de facto job segregation between male and female health workers with certain tasks shifted down to female health workers, adding more workload to women resulting in over-utilization of female health providers. Certain tasks such as ANC, labor, and family planning fell to women, while emergency typically fell to men; this creates challenges in efficient use of time and overburdening, but also leads to less promotional opportunities as certain tasks are more highly valued. In several states, there is an embargo on employment, leading to the utilization of volunteer health workers who are mostly women and also underpaid in many facilities.

While the HRH policies in each focus state and the FCT has expressed a commitment to increasing the number of female midwives and community health workers, especially in remote areas, to help reduce maternal and neonatal fatalities, there are no actions proposed on how to reduce this gap. Likewise, there is a lack of GESI resources. For example, the appointment of gender focal persons is done by the states with noticeable reluctance and is very donor driven.

Intermediate Result Area 4: HRH research to understand HRH practices and retention

Major gaps in implementation research on impact of certain HRH policies and institutional practices on male and female students/health workers exist. Policy makers lack skills to assess potential differential impacts of policies they developed/adapt on male and female students/workers. Although each target state and the FCT has developed/adapt particular HRH policies, a noticeable gap is that they do not include gender dimensions to the retention of health workers. The absence of HRH migration policy has resulted in unregulated relocation of thousands of health workers particularly female nurses and midwives to higher-income regions.

Although pervasive, sexual harassment is often unreported. The absence of policies on sexual harassment predisposes the absence of reporting mechanisms; hence many cases of sexual harassment in training institutions and at workplace go unreported. Inadequate security and protection measures in many rural communities is one of the major factors preventing female health providers from staying/working in such communities.

KEY RECOMMENDATIONS

HWM Intermediate Results Area 1: Training of Health Workers

- Catalyze progress in the development of HRH policies in the target states and the FCT and encourage the adoption and implementation of gender-responsive and socially inclusive training policies, regulations, and institutional practices.
- Work with regulatory bodies such as Nursing and Midwifery Council of Nigeria (NMCN) and Community Health Practitioners Registration Board of Nigeria (CHPRBN) to develop policies that will give pre-service training access considerations for PWDs, teens and other marginalized groups in health workforce.

- Encourage policy makers to offer scholarships or financial incentives to hardworking tutors to further their education as a way of improving the quality of students' training and developing the tutors' capacity to effectively teach GESI contents in the curricula.
- Offer scholarships and financial supports to promising but indigent students particularly female students pursuing CHEWS and JCHEWS to ensure the successful completion of their healthcare training.
- Support the training institutions in the target states and the FCT to make study environments and pre-service training programs more female-friendly through policy modifications such as eliminating curfew for female students.
- Review the curricula of Nursing and Midwifery training programs to make it more gender responsive.

HWM Intermediate Results Area 2: Human Resources Information System

- Build capacity of HRH policy makers to collect, analyze, report, and use sex- and age-disaggregated data.

HWM Intermediate Results Area 3: Governance and Management of health Workforce

- Sensitize current HRH leadership and decision-makers on the importance of gender equity, inclusion, and equal opportunities for male and female health provides, PWDs and other marginalized groups in the health workforce. This should also involve equipping policy makers with skills for gender-sensitive and inclusive HRH recruitment and management.
- Encourage HRH policy makers in the target states and the FCT to develop gender policies that will guide the development/review of HRH policies, plans, processes and operations.
- Provide technical support to reviewing HRH policies to ensure they are gender-sensitive and support women's complex roles at work and at home.
- Strengthen the capacity of gender focal persons in the target states and the FCT and actively engage them in designing and implementing HWM Activity programs and activities.

HWM Intermediate Results Area 4: Retention of Health Workers

- Work with policy makers and other relevant stakeholders to develop and implement interventions to prevent sexual harassment, discrimination and violence against female students and female health workers and create a culture where sexual harassment and violence is unacceptable to both male and female health providers.
- Engage in advocacy for the payment of reasonable rural posting and hardship allowances to health providers, particularly female health workers deployed to rural and remote areas.
- Work with gender focal persons in the SMoH in the target states and the FCT to mobilize traditional leaders and youth leaders to provide adequate security and protection to female health providers deployed to their communities.
- Ensure gender and social inclusion are integrated into Monitoring and Evaluation frameworks and capacity-building plans across the Ministries of Health and Primary Health Care Development Agencies in the target states and the FCT.
- Provide gender sensitive mentorship structures and opportunities for male and female health workers. This should involve development of description of roles for mentors and mentees, including suggested plans for mentorship; and the selection/recruitment and training of mentors on gender norms and biases to facilitate greater understanding of gender-related career challenges.

1. INTRODUCTION

This report contains findings of a Gender and Social Inclusion (GESI) analysis of the United States Agency for International Development (USAID) Nigeria Health Workforce Management (HWM) Activity which was carried out by an independent consultant with support from the Banyan Global Gender and Social Inclusion Specialist and Monitoring, Evaluation and Learning (MEL) team. The GESI analysis field work was carried out in June and July 2021.

1.2 Activity Background

In collaboration with Abt Associates, the Institute for Healthcare Improvement (IHI) and Solina Health, Banyan Global is implementing the USAID Nigeria HWM Activity. The Activity supports establishing a cost-effective, well-trained and motivated health workforce in targeted rural and remote areas of Bauchi, Ebonyi, Kebbi, and Sokoto States, and the Federal Capital Territory (FCT). To achieve this, the activity focuses on:

a) Strengthening the pre-service training learning environment and enhancing teaching faculties' capacity to deliver state-of-the-art and gender-sensitive curricula;

b) Building a robust human resources information system (HRIS) to keep track of recruitment, deployment, retention and continuing education in both the public and private sectors;

c) Strengthening governance and management of the health workforce, in particular targeting rural areas; and

d) Conducting human resources for health (HRH) research to understand HRH practices and retention.

1.3 Purpose of GESI Analysis and Analytic Questions

The purpose of this GESI analysis[1] is to inform the implementation approaches for the HWM Activity, ensuring meaningful participation by men and women and activities have a positive impact on gender and social norms to influence sustainable, inclusive results. The analysis involves examination of existing HRH policies, strategies, guidelines; and analysis of stakeholders' perspectives to identify GESI-related gaps and opportunities. It provides evidence to inform identification of target populations, tailoring of responses, and resource allocation where most needed. It is premised on the assumption that integrating GESI into HWM activities and programs will increase the capacity and commitment of HRH policy makers/managers to effectively plan, train, recruit, deploy and retain health workforce for primary health care (PHC) service provision. This will in turn increase the ability of the health workforce to deliver timely, high-quality health care which will strengthen demand for and utilization of health services and improve maternal and child health outcomes.

The analysis is guided by the USAID Automated Directive System (ADS) 205 five domains (laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and patterns of power and public representation). The domains provided a suitable framework for identifying key gaps, challenges, and opportunities for integrating GESI into HWM Activity.

As this GESI analysis focuses at the Activity level, ADS chapter 205.3.2 requires that the analysis: "*should detail key gender inequalities and suggest ways that the activity could narrow or close gender gaps, address*

[1] GESI or gender analysis is a subset of socio-economic analysis. It is social science tool used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries. It is also used to identify the relevance of gender norms and power relations in a specific context (e.g., country, geographic, cultural, institutional, economic, etc.). (ADS 205, p.10).

inequalities, and/or empower women and girls in the specific sectors or areas that will be addressed by the activity." (ADS 205, p.14).

The key analytic questions to be addressed include:

1. What are the key GESI considerations to strengthen the pre-service training learning environment and enhances increased enrollment of female students in health training institutions and teaching faculties' capacity to deliver state-of-the-art and gender-sensitive curricula?
2. What are the key GESI considerations to build a robust HRIS to keep track of recruitment, deployment, retention and continuing education in both the public and private sectors?
3. What are the GESI considerations to strengthen governance and management of the health workforce, in particular targeting rural areas?
4. What are the key GESI considerations in conducting HRH research to understand HRH practices and retention?

1.4 Background and Context

Despite having the largest stocks of human resources for health (HRH) in sub-Saharan Africa because of its large population[2], Nigeria is listed as one of the 57 countries with an HRH crisis due to insufficient health workers[3], especially in PHC. According to the Nigeria Health Workforce Country Profile 2018 (2020), Nigeria has only 116,454 community health workers and 124,561 nursing and midwifery personnel, with 87 percent being females.[4] The country's estimated health workforce density is 1.95 per 1000 population[5], which is far below the Sustainable Development Goals' threshold of 4.45 skilled health workers per 1000 population.[6] Researcher Abimbola and colleagues observe that this shortfall is further aggravated by the inequity in health workforce distribution, as there is no national policy guiding the deployments, postings, or transfers of health workers.[7] Consequently, as Abimbola and colleagues further observe, redeployment of health personnel is usually based on discretion of superior administrative officers with multiple influences and lots of competing and often conflicting interests, often resulting in inequitable distribution of health workers.

Globally, more men than women enter higher-paying roles as physicians or surgeons. Women tend to enter the health workforce at higher rates than men in roles like nurses, midwives and paid or unpaid community health workers.[8] Communities often look to frontline health workers to provide care and see physicians as those who cure. In fact, unpaid female community health workers sometimes experience backlash from communities if they seek compensation for their work, because of beliefs that caring is 'naturally' women's responsibility and paid work is for men.[9]

These global trends align with women's and men's occupational segregation in the Nigerian health workforce with men dominating cadres such a physicians, pharmacists, and medical laboratory technicians; and women having majority in nursing and midwifery professions.[10] There are no publicly available sex-disaggregated data on the number of female community health extension workers (CHEWs), junior

[2] The population of Nigeria is estimated to be over 200 million.
[3] World Health Organization (WHO), 2006.
[4] Nigeria Health Workforce Country Profile 2018, 2020, p.11
[5] WHO, 2016.
[6] WHO, 2016, p. 11
[7] Abimbola et al 2016.
[8] Hay et al., 2020
[9] Feldhaus, 2015; Geldsetzer, 2017; and Morgan, 2018
[10] Nigeria Health Workforce Country Profile 2018

CHEWs (JCHEWs) and community health officers (CHOs); however, qualitative data suggests most of them are women.

Table 3. Gender Distribution of Frontline Health Workers in Nigeria

S/N	Category of Health Workers	Total	Male	Female
1.	Medical doctors	74,543	48, 452 (65%)	26,090 (35%)
2.	Nurses/Midwives	124,561	16.192 (13%)	108,368 (87%)
3.	CHEWs/JCHEWs	Data not available	Data not available	Data not available

Source: Nigeria Health Workforce Country Profile 2018

Nigeria suffers one of the highest maternal mortality rates in the world at 512 per 100,000 live births.[11] According to a 2019 WHO report, the country accounts for nearly 20 percent of all global maternal deaths.[12] This, as researcher Okereke and colleagues observe, is related to, among other things, the shortage and inequitable distribution of well-trained and skilled health care providers[13], especially in PHCs in rural areas, where 52 percent of the population lives.[14] In northern Nigerian states, including Bauchi, Kebbi and Sokoto, additional factors such as negative perceptions and attitudes about health workers negatively affect utilization of health facilities.[15] Due to certain cultural and religious beliefs many women in the North, particularly in Hausa communities prefer receiving care from female health workers, especially for family planning, antenatal, and childbirth.[16]

In terms of access to pre-service training and completion of such training program, early marriage often limits the opportunities of many girls to enroll in school and complete a pre-service training program. Evidence from this GESI analysis indicates that taking on new roles as wives and mothers tend to contribute to disruption of or self-withdrawal from training programs. According to researcher Philipose and colleagues, 'Nigeria has the largest number of child brides in West and Central Africa, at 22 million, accounting for 40 percent of all child brides in the region,'[17] with 43.4 percent of girls married before age 18. Early and child marriages are most common in Hausa communities in northern Nigerian states, like Bauchi, Kebbi, and Sokoto, where on average girls marry at age 15.8, compared to 23.6 years in the South.[18] Parents and guardians often arrange such marriages for cultural and religious beliefs that early marriage protect the moral integrity of girls. Even for women who are able to pursue a career in health services, early marriage, childbirth, and care tend to disrupt their plans and inhibit their participation in in-service training. Although boys are also vulnerable to early marriage in Nigeria, its frequency and effects have not been reported in the literature, to the knowledge of the research team. The Government of Nigeria (GoN) has enacted the Child Rights Act in 2003 to, among other things, protect girls from early marriage; however, this has not resulted in reduced rates of such marriages due to the failure of the GoN to have the Act domesticated across all the states in the country.

With regard to health workforce governance and management, despite the increased influx of women into health professions in Nigeria, they are highly underrepresented in and decision-making positions. Many top HRH leadership and management positions at both Federal and State levels are occupied by men, reflecting gender inequity in regard to career advancement and attainment of decision-making positions. For instance, only once a woman was appointed as the minister for health in Nigeria. At State level, only five (5) out of thirty-six (36) current state commissioners for health are female.[19] In northern

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[11] NDHS 2018, p. 371.
[12] WHO, 2019.
[13] Awofeso, 2010.
[14] Awofeso, 2010.
[15] Mohammed et al., 2020
[16] Okereke, 2020
[17] Philipose et al, 2018.
[18] United Nations Children's Fund 2017, and National Demographic and Health Survey 2018.
[19] Nigeria Health Watch, 2020.

Nigeria, there are fewer women in leadership and management positions in HRH. For example, in Bauchi State, as Ahmadu (2020) notes, women hold only 9.4 percent of HRH leadership positions.[20] Several factors contribute to this disparity in Nigeria. Women are generally perceived as less effective leaders than men due to stereotypes that they are too emotional to lead. However, for researchers Longo and Straehley (2008), gender disparity in HRH leadership can be attributed to the difference in the access of both genders to equal opportunities of mentorship and networking, amid organizational cultures and cultural norms that tend to favor men and place women at a disadvantage.[21] Fewer women in leadership spaces limits the influence and decision-making that could be favorable to female students and health workers.

Furthermore, studies have shown that in many northern states of Nigeria, religious and cultural norms affect deployment, posting, and retention of many married female health workers, particularly those of Muslim faith. Under Islamic family law, a husband has rights and control over his wife's mobility (Adamu et al 2018). Consequently, as researcher Adamu and colleagues observe, some husbands tend to disallow their wives to working or staying far away from their town or local government area of residence.[22]

Persons with disabilities (PWD), which is over 25 million persons or about 13 percent of the population in Nigeria,[23] are generally excluded in training and recruitment of certain category of health workers such as nursing and midwifery personnel.[24] Although, the Discrimination Against Persons with Disabilities Prohibition Act (2018) is enacted to protect PWDs, negative perceptions about PWDs and their capabilities have continued to hinder their opportunities to access pre-service training and enter the health workforce.

Nigeria has attempted to address the country's health workforce challenges through various policy initiatives, including the 'National Health Act (2014)', 'National Health Policy (2016), 'National Human Resources for Health Strategic Plan (2008-2012)', and 'National Strategic Health Development Plan (NSHDP) II (2018-2022)'. The Nigeria's National Human Resources for Health Policy, for instance, outlines key strategies for improving HRH, including applying best practices to promote equitable distribution and retention of health workers; institutionalizing performance and management incentives; promoting collaboration between health service providers including the public, private, Non-Governmental Organizations (NGOs), and Implementing Partners (IPs); creating a monitoring and evaluation framework; and strengthening human resources management.[25] However, these policies and plans have not been fully implemented due to lack of adequate financing, political will, and a dearth of experience in strategic HRH management and development. There is also lack of guidance on how States can adapt and implement these strategies to mainstream GESI issues in State-level HRH policies. This lack of guidance is reflected in State-level health policies and strategies. For example, while the Kebbi and Bauchi State HRH policies recognize the importance of recruiting and retaining female health workers, they do not include any strategic steps on how to do so.

A couple of donor-funded programs in Nigeria have aimed to increase staff capacity to provide gender-sensitive care and promote gender-responsive working or learning environments. In Bauchi, the World Health Organization (WHO) worked with local stakeholders, including the Bauchi State College of Nursing and Midwifery, to review and revise the pre-service curriculum to make it more gender-sensitive.[26] The USAID Sustaining Health Outcomes through the Private Sector (SHOPS) Plus Project

[20] El Arnaout et al., 2019
[21] Longo and Straehley 2008, p. 88–100.
[22] Adamu et al 2018.
[23] WHO, 2011.
[24] Interview with an official of the Nursing and Midwifery Council of Nigeria (NMCN). The interview was conducted on June 21, 2021 at NMCN headquarters, Abuja.
[25] Nigeria National Human Resources for Health Policy, 2007.
[26] Ahmadu, 2020

implemented a gender-transformative supportive supervision approach in FCT, giving supervisors tools to address gender disparities within the family planning workforce to improve performance, retention and gender equity.[27]

Given that the HWM Activity views GESI as central to achieving its overall objective, this analysis examines issues, constraints, and opportunities facing HRH in Nigeria through a GESI lens. The analysis seeks to provide evidence to inform GESI integration in designing interventions aimed at supporting the establishment of a cost-effective, well-trained and motivated health workforce, particularly in targeted rural and remote areas in Bauchi, Ebonyi, Kebbi and Sokoto and the FCT.

2. METHODS AND LIMITATIONS

2.1 Data

The data for this analysis was collected from primary and secondary sources which the research team has complemented and triangulated. Materials reviewed include peer-reviewed journal publications, GESI analyses, publicly available HRH data, GoN HRH policies and documents, donor-funded program documents, grey literature, and other relevant materials. Only data and publications from reputable journals, organizations and institutions were considered. To the extent possible, only literature published in the past 10 years was considered for the desk review. A list of documents consulted is available in Annex A.

Primary data was collected through key informant interviews (KIIs) and focus group discussions (FGDs) with relevant stakeholders across the four focus states of Bauchi, Ebonyi, Kebbi, and Sokoto, and the FCT. The KIIs and FGDs were conducted in June and July 2021. They provided qualitative data that helped the research team gain a deeper understanding of issues relevant to the analysis through stakeholder perspectives, including experiences and opinions on certain gender issues, constraints, and opportunities facing HRH in Nigeria. A list of stakeholders interviewed is available in Annex B and the data gathering tools for KIIs and FGDs are available in Annex C.

2.2 GESI Analysis Team

The HWM GESI analysis was led by gender expert Umar Ahmed, Ph.D. The consultant was supported by the Banyan Global Gender and Youth Specialist Samantha Wilde, and HWM Activity MEL Specialist Olufolake Akeju.

2.3 Data Collection

The team collected data from the relevant stakeholders in the target focus states for the HWM Activity, and the FCT located within four (4) out the six (6) geopolitical zones in Nigeria, as shown in Table 1. The data was collected in Nigeria from June to July 2021.

Table 1. Geopolitical Zones and States/Territory Visited during Data Collection

S/N	Geopolitical Zone	Focus State/Territory
1.	Northeast	Bauchi
2.	Southeast	Ebonyi
3.	Northcentral	FCT Abuja
4.	Northwest	Kebbi and Sokoto

Data collection was carried out in two phases. Phase one involved desk review of relevant documents. Phase two included KIIs and FGDs, conducted in Bauchi, Ebonyi, Kebbi, and Sokoto states, and the FCT.

[27] Mutebi, 2020. Key findings from the application of this approach in Nigeria are forthcoming.

In sum, qualitative data was collected from 185 individuals across the four focus states and FCT, as shown in Table 2.

Table 2. Respondents Interviewed by sex

Respondents category	Male	Female	Total
Government officials	5	9	14
Regulatory bodies	2	0	2
NGOs/IPs	3	5	8
Health workers	8	10	18
Provosts/Directors of Training Institutions	7	4	11
Healthcare Students	70	62	132
Total	95	90	185

Table 3. Respondents Interviewed by location

	National	FCT	Bauchi	Ebonyi	Kebbi	Sokoto	Total
Government officials	2	3	2	3	2	2	14
Regulatory bodies	2	-	-	-	-	-	2
NGOs/IPs	2	2	1	1	1	1	8
Health workers	-	4	4	3	3	4	18
Provosts/Directors of Training Institutions	-	2	2	3	2	2	11
Healthcare Students	-	28	28	20	28	28	132
Total	**6**	**39**	**37**	**30**	**36**	**37**	**185**

2.4 Data Limitations

Most of the quantitative data used for this analysis were collected from the reports by other organizations and partners, including the GoN. The research team could not conduct thorough investigations to determine the appropriateness of the methodologies used to collect the data as well as, the authenticity of the data. Another limitation is related to the availability of up-to-date quantitative data. When particular quantitative data was not available for the current year, prior-year statistics was relied upon, which may not accurately reflect the current situation in the country and/or in particular HWM Activity focus state/territory. Moreover, some of the stakeholders interviewed lacked access to data. As a result, their responses often were based on impressions and anecdotal evidence rather than on reliable data; this may misrepresent the true situation in the focus states and the FCT. There may also be some information bias as respondents are likely to wish to answer in a way they perceive as correct to the research team.

3. FINDINGS

3.1 Laws, Policies, Regulations and Institutional Practices

3.1.1 Training of the Health Workforce

There are several factors affecting women's entry into and successful completion of pre-service training. Occupational segregation, shaped by social and gender roles and responsibilities, affects career selection and admission and entry into training programs. Quotas, like those established for pre-service nursing programs in Bauchi requiring 70 percent of students to be women, can support women's entry into programs.[28] Related to the policy on age requirement for admission into pre-service training is the policy on limited indexing/admission quotas given to training institutions by the regulatory bodies. Key informants expressed the need for increasing the indexing/admission quotas to training institutions. This, according

[28] Ahmadu, 2020

an official of a training institution, would allow for the enrolment of more eligible and interested students, particularly female students.

Interviews, FGDs, and desk review showed that Bauchi, Kebbi, Sokoto, and the FCT has a policy of offering limited support for students during pre-service training in terms of the provision of stipends to students. Such support however, is limited to those studying Nursing and Midwifery; students pursuing courses in CHEW and JCHEW at Colleges of Health Technology do not enjoy any form of support. In Ebonyi State however, no scholarships or stipends are given to any category of students during pre-service training, as confirmed by both the officials of the state and the students. In these states many female students especially those from poor families are dropping out of school due to lack of financial support.

Female healthcare students are also at a disadvantage because of the absence of support for pregnant and breastfeeding mothers during pre-service and in-service training. This finding cuts across all the states. There are policies stipulating anyone that absent from school for 28 days must repeat the team, which tends to affect time to graduation of many pregnant and breastfeeding female students. For in-service trainees, trainings are often not organized at times and places that make it possible for female health workers to balance care and family responsibilities.

There is a policy that stipulates age 17 as the minimum age set for admission into Nursing and Midwifery training institutions, which prevents teen secondary or higher school leavers from enrolling in pre-service training programs. The analysis observed that this policy affects more girls than boys. A female student lamented that: "due to certain cultural norms girls are expected to complete their studies and get married earlier than boys. If you apply for a [training] program, and you are denied because of age factor, your parents will not allow you to wait till you are 17 years old. They will force you to go to University or other higher institutions of learning who don't have such restrictions." Desk review suggests that parents often arrange early marriages for cultural and religious beliefs that early marriage protects the moral integrity of women.

Another relevant finding at the level of pre-service education is policies that do incorporate gender, but actually limit female participation and empowerment. For example, the policy for female students requiring that female hostels be closed at 10:00 p.m. which affects their ability to study in classes beyond that time while the hostels are never conducive to learning in view of noise and other distractions. This places them at a disadvantage in relation to their male counterparts and contributes to female students failing their exams and subsequently withdraw from school. This practice is found in Sokoto, Kebbi and Bauchi states. In Ebonyi and the FCT, male hostels are located outside the premises of the schools while the policy of restricting interactions between male and female students after 10:00 p.m. are not in place. Moreover, the analysis observed that training institutions in the target states of Bauchi, Kebbi, and Sokoto prohibit interaction at night between male and female students except inside the classroom which potentially makes it difficult for such students to have meaningful social interactions and cooperative learning and subsequently, affect their ability to work as a team at the end of their training. Another example is the policy on dress code, cutting of fingernails, non-use of make-up and rings except wedding rings. Even though the policy was meant to protect the female students from sexual harassment, it has the unintended consequence of limiting women's expression and diminishing their ability to feel confident and able to complete their studies.

In all the target states and the FCT, PWDs are not offered admission in the colleges of Nursing and Midwifery. In the colleges of Health Technology where they are considered, PWD are encouraged to take courses such Health Information Management and Nutrition and Dietetics, rather than choose their career path.

3.1.2 Human Resources Information System

Despite policies to disaggregate data, the analysis observed that in the target states and the FCT, there is an overall lack of proper collection and utilization of sex- and age-disaggregated data. Government officials interviewed in the target states and the FCT mentioned that they disaggregate both sex and age superficially and that not all sex-disaggregated data are included in dashboard and decision-making reports.

However, to improve data disaggregation by sex, age and other relevant health workforce indicators, the Federal Ministry of Health has established a Health Workforce Registry, which could improve availability of sex and age-disaggregated data for making decisions on training, recruitment, distribution and retention of health workers. While Bauchi, Kebbi, and Sokoto states are already working on the establishment of the Health Workforce Registry, Ebonyi and the FCT have yet to commence working on the Registry. Government officials in the target states and the FCT indicated the need for more training of Human Resource for Health personnel on collection and utilization of HRH data (see textbox at right). Moreover, another government official observed that the Health Workforce Registry template developed by the Federal Ministry of Health made no provision for non-binary gender and PWDs.

3.1.3 Governance and Management of Health Workforce

Desk reviews revealed that management of health workers in the target states particularly in Ebonyi is often "marked by abuse and intimidation of staff, non-availability of structures for coaching or mentoring, and a lack of State-led governance of HRH."[29] These factors, according to a 2021 study by IHP, contribute to the poor retention of health providers particularly in rural areas.

Another important finding is that from poor HRH leadership and management have been cited in the literature "as the most common and most important factor attributable to industrial actions by Nigerian health workers."[30] Consequently, from 1985 – 2019, there was total of 42 strike actions by health workers, including 58.1% by Nurses/Midwives and other frontline health workers.[31]

Both the KIIs and desk reviews conducted point towards the absence of deliberate policies on the deployment of health workers across all the target states and the FCT. Consequently, posting of health workers are often at the discretion of administrators and sometimes, the influence of politicians. As a result, there is a gender-blind institutional policy and gender and equity is not considered. As a consequence, there is often a concentration of a particular gender in a given facility; mainly female health workers in urban centers and male health workers in the rural areas. Key informants mentioned that only females without political connections and non-indigenes find themselves in rural facilities.

As can be seen from Table 4, all the states including the FCT have a Primary Healthcare HRH policy. Some of the HRH policies include GESI. For example, the Bauchi State HRH Policy expresses the need for gender sensitivity in the training of health workers and calls for the reduction of gender discrimination in the workplace. However, strategies or action plan for achieving such were not explicitly explained. Similarly, the Ebonyi State HRH policy recognizes gender disparities in HRH distribution but does not define or describe the disparities.

Table 4. State/Territory-Level Laws, Policies, Strategic Plans and Agendas Related to Gender in HRH

S/N	State	Existing Policy
1.	Bauchi	a. Bauchi State Strategic Health Development Plan (2016–2020) b. Bauchi State 5-Point Health Agenda c. Bauchi State Revised Gender Policy (2017) d. Bauchi State Human Resources for Health Policy

[29] Ebonyi State Primary Health Care Development Agency [ESPHCDA] 2019, Integrated Health Program [IHP] 2021a, p.30

[30] Oleribe et al (2016) and Adeloye et al (2017)

[31] Nyango & Mutihir (2020, p. 1)

		e. Bauchi State Task Shifting/Sharing Policy for Essential Services (2016)
2.	Ebonyi	a. Ebonyi State Primary Health Care Human Resources for Health Policy (2019) b. Ebonyi State Strategic Health Development Plan II (2018-2022) c. Ebonyi State Violence Against Persons (Prohibition) Law (2018)
3.	FCT	a. FCT Primary Health Care Board 2019 Annual Operational Plan b. FCT Primary Health Care Board Human Resources for Health Policy (2019-2024) c. FCT Primary Health Care Board Human Resources for Health Strategy (2019-2024)
4.	Kebbi	a. Kebbi State Strategic Health Development Plan II (2018-2022) b. Kebbi State Human Resources for Health Policy c. Kebbi State Task Shifting and Sharing Policy for Essential Services (2017)
5.	Sokoto	a. Sokoto State Strategic Health Development Plan II (2018–2022) b. Sokoto State Gender Policy (2017) c. Sokoto State Primary Health Care Development Agency: Operational Guideline (2015)

A key finding during both KIIs and FGDs is the lack of policies on sexual harassment across all the states and the FCT, despite the prevalence from both other health workers and patients or patient's family members. For health workers, the only remedy for sexual harassment is enshrined in work ethics while for students, such issues are addressed only in students' handbooks. The absence of policies translates to the absence of reporting mechanisms; hence many cases of sexual harassment go unreported or are grossly underreported (see textbox at right). In Ebonyi State for example, there are no clear-cut policies against sexual harassment; instead, they depend on work ethics and Violence Against Persons Prohibition (VAPP) Act. Additionally, according a human rights lawyer, reporting of cases of sexual harassment hardly translates into conviction. Nigeria has only recorded 18 rape convictions in its legal history.[32] Absence of strong reporting mechanisms, infrequent prosecution and conviction, minimal sentences, and shame and stigma associated with sexual harassment and violence continue to discourage female health workers who were violated from speaking out.

> "There is no any policy on sexual harassment and reporting mechanisms are not strong and when sexual harassment occurs between colleagues, the case is not usually reported because they will see it to be as if they are exposing themselves; they have to sit down and resolve it internally."
> – Female health worker

Related to the lack of policy on sexual harassment is the lack of policy on the recruitment of PWDs. In all the facilities visited across the states and the FCT, no PWDs were seen either as pre-service or in-service health workers. KIIs and FGDs indicated PWDs, if offered admission at all, are restricted to defined roles in Health Information Management and Nutrition and Dietetics due to their perceived lack of capacity to serve as frontline health workers.

Another important finding is there is overall shortage of health workers particularly in rural and remote areas across all the states and the FCT. Sokoto and Kebbi states are found to be offering automatic employment to both male and female nurses and midwives. This however, does not attend to the staffing needs of the PHCs as such category of health workers are not usually posted there. As for Bauchi and Ebonyi states, there is an embargo on employment, leading to the utilization of volunteer health workers who are mostly women and also underpaid in many facilities.

3.1.4 Motivation and Retention of Health Workforce

Both interviews and desk reviews show that national and local HRH policies, action plans and agendas are in place. However, the policies, action plans and agendas lack information on the gender dimensions to the retention of health workers. Another finding is that there is no written policy or regulation related to the migration of health workers either from rural areas into urban areas or outside the country, which is

[32] Only 18 rape convictions recorded in Nigeria's legal history - Lawyer. Premium Times Nigeria; November 9, 2015. https://www.premiumtimesng.com/news/top-news/192895-only-18-rape- convictions recorded-in-nigerias-legal-history-lawyer.html. Accessed 20 June 2021.

a substantial issue. The Federal Ministry of Health (FMoH) acknowledged the migration of health workers and said it was developing a HRH migration policy. The policy was meant to address the problem of health workers' migration to other countries. "The policy will for example state that you cannot leave the country until you serve for a certain number of years and the beneficiary countries need to send their professionals to train our doctors, nurses and midwives" according to an official of the FMoH.

To address the issue of shortage of female health workers in Bauchi, Kebbi, and Sokoto states, a scheme was put in place to support students undergoing Nursing and Midwifery training. Such students are usually bonded so that after graduation they would remain and serve in the states; however, despite the implementation of the bonding agreement, there is lack of enforcement resulting in many health providers mostly males leaving the states after graduation.

A female health worker observed that health providers employed by the federal government earned more than their state government counterparts. "If I have the opportunity, I will change my employer. For promotion, even if you are promoted there will be no implementation but federal staff, they get promotion and they even pay them arrears" she said. Both male and female health workers said there was no motivation for either category of health workers to serve in rural areas although female health workers said the perception of carrying out work that would culturally be seen as appropriate for women was enough motivation. "We are satisfied by the care we give to our fellow women but dissatisfied with the compensation in relation to our services" according to a female health worker in Ebonyi State.

Even though an official of the State Ministry of Health recognized the importance of conducting performance reviews for male and female staff, she regretted that such reviews were not done because they lacked the capacity to design a tool for the review.

3.2 Cultural Norms and Beliefs

3.2.1 Training of Health Workforce

Several cultural norms discourage many male health workers from going into nursing and midwifery training in all the states. One is the perception of certain tasks or cadres as culturally "inappropriate" for their gender. This is even worse in southern Nigeria where in Ebonyi state for example, Nursing, Midwifery, CHEW and JCHEW are perceived as women's jobs; hence, very few men are into such professions. A second cultural norm discouraging men in nursing and midwifery is the preference for female clients to be attended to by female health providers. This has created a huge gender gap in the professions, with women constituting 87 percent of nurses.[33]

The analysis observed that in Ebonyi State, the cultural belief that Nursing, Midwifery, CHEW and JCHEW are exclusively for females discourages males from enrolling (see textbox at right). The few men that are currently enrolled perceive themselves as being the minority as captured in an FGD with the students: "Being minority in the program affects the psychology of the students".

> "When I bought the application form and I went for the screening exams, I saw that the school was filled with plenty female students and this discouraged me and I wanted to withdraw but my dad encouraged me not to withdraw."
>
> – *Male student*

Marriage and early marriage in particular is another cultural norm affecting the availability of females for healthcare training and their full participation in the health workforce. The Provost of a College of Nursing and Midwifery related an incident involving the withdrawal of a brilliant female student from her school because of early marriage. She said when the College set up a high-powered committee headed by the Registrar to plead with the husband to allow her to resume her training, not only did the husband refuse to budge; but he mischievously accused the members of having the intent of infidelity with his wife. Across the target states,

[33] Nigeria Health Workforce Country Profile (2020, p. 11)

especially in Bauchi, Kebbi and Sokoto states, there is the fear that higher levels of education could deter men from wanting to marry women resulting in some female students withdrawing from pre-service training. Even for unmarried women who are able to pursue a career in health services, such fears often prevent them from pursuing further education.

Although there is no overt policy against PWD's enrolment in pre-service training, in most situations others' perception of their ability limits their opportunities. For example, a student wondered how a "a patient could treat another patient" in reference to the training of PWDs in healthcare delivery.

Likewise, the curriculum of pre-service training programs in some training institutions in northern Nigeria is gendered. In Kebbi State for example, female health workers mentioned female students are not exposed to male reproductive organs and male students to female reproductive organs. A female health worker at a facility in Kebbi State said that she was never trained on male reproductive system; hence, many female health workers trained in the State do not know how to insert a catheter on a male patient. This claim was validated by an official of the State College of Health Technology who said that courses related to reproductive health are exclusively for female students. Only tutors who teach Reproductive Health and other related courses such as fundamentals of midwifery handle gender topics. In Sokoto, gender is covered under Medical Sociology but usually limited to a one-hour presentation. An official of Nursing and Midwifery Council said however, that topics on gender and social inclusion were not in the curriculum but considering the growing importance attached to gender issues globally, a review of the curriculum would be undertaken to incorporate such topics. At in-service level, only trainings organized by Integrated Health Project (an IP) had components of gender and social inclusion.

3.2.2 Governance and management of the health workforce

Cultural norms and beliefs impact the distribution of health workforce, as women are not expected in northern Nigeria to accept postings outside their places of residence without the prior consent of their spouses.

Although women are well represented in the health workforce, leadership is culturally seen as a male domain (see textbox at right). For the health workforce, this starts in pre-service training; although there are more female students than males in all the training institutions visited during the study, male students are usually appointed as the class representative. For example, at the College of Nursing and Midwifery Bauchi, even though the ratio of female to male students is 70:30, only male students become class representatives. While at the College of Health Technology Ningi (Bauchi State), the students interviewed mentioned that a document from their national association clearly stated that in a school with two genders, only male can be presidents of the students' union. Similarly, the FCT School of Nursing Sciences has a policy that only male students can be appointed as class representatives because according to a respondent, "a female student cannot cope with the stress of managing a class and the stress of school work". Even when elections are conducted, male students usually get the position due to the cultural norms and beliefs that men are more fitted to public leadership than women. In Ebonyi state, a female government official said "when it comes to representation, the Ministry prefers sending a man than a woman to represent the organization because of gender norms that give preference to males". The tendency to look at a woman first as a wife before considering her puts female staff at a disadvantage in competing with men for positions in the health sector.

> "You see socially we are socialized to accept men as the leaders. Recently, our family was given a slot but I was denied the position because I am a woman and it was given to my younger brother who is my junior in the civil service and less experienced than me. You see the society has placed us as subordinates to men."
>
> – *Female health worker*

As shown in Table 5, in all the states included in the study, not a single female Commissioner for Health or Permanent Secretary is appointed. Only Ebonyi State has a female as the Executive Secretary, State Primary Healthcare Development Board.

Table 5. Distribution of the Gender of the Current HRH Top Policy Makers in the Target States

Category of HRH Policy Makers	Male	Female
State Commissioner for Health	100%	0%
Permanent Secretary SMoH	100%	0%
Executive Secretary SPHCDA	80%	20%
Provost/Director of Training Institutions	70%	30%

Source: HWM GESI Analysis Field Work 2021

A government official contended that both male and female health workers have equal access to leadership positions although in practice, due to cultural factors, female health workers are not given the chance because of the roles assigned to women by the society (see textbox at right). Leadership positions perceived as more feminine such as Director (Maternal and Child Health), Director (Family Planning); and Director (Immunization) are often set aside for female staff.

"In theory, male and female health workers have equal access to leadership positions but in reality, female health workers are not given the chance simply because they are women."
– *Female health worker*

Exacerbating the challenge of women not being viewed as leaders, women have less mentoring and networking opportunities. A female health worker in Bauchi State observed that superior male officers preferred to mentor male staff more than females. According to her, some male superior officers were skeptical of engaging female staff for the fear of accusation of infidelity. Health workers in the category of Officer-in-Charge of PHCs and those below them would have equal training and mentorship opportunities. However, once they started progressing beyond such levels, male health workers tended to receive more mentorship than female health workers, which contributes to more men in positions of leadership.

3.2.3 Motivation and Retention of Health Workforce

Female health workers with higher levels of education and skills living in more affluent urban areas lack incentives to move and work in rural areas. Poor infrastructure, concerns about safety and limited social networks can deter women and men alike from moving to rural areas for short- or longer-term assignments. Women from Christian-majority regions of Nigeria may be discouraged from moving to Muslim-majority areas in the Northeastern and Northwestern regions. Interviews and desk reviews frequently touched upon the challenges cultural norms and beliefs pose to the deployment and retention of health workers particularly in northern Nigeria. Many married female health workers feel pressure to reject postings to places other than where their spouses live. In some situation, husbands exercise substantial control over their wives and require consent for the posting of a female health worker. In addition, in some parts of northern Nigeria there is an expectation that women marry and unmarried female health workers can be targeted for sexual violence as they are not under the "protection" of a man. This concern was raised by a female health worker in Sokoto who said some women refuse posting to rural areas because of sexual violence.

Cultural factors equally suppress females, in particular from reporting cases of sexual harassment. There is a tendency to accuse the woman of seducing the offender through her actions or inactions. Similarly, issues pertaining to sex are seen as taboo topics, contributing to many cases of sexual harassment going unreported. Sometimes health workers, particularly females, face violence from patients' relatives when a patient brought to the facility was not promptly attended to or when they felt dissatisfied with the way the patient was handled (see textbox at right).

'Hardly do we spend 3 months without GBV in this facility and the issue is not restricted to only this facility. Sometimes if you report it to the authorities they will not do anything. We feel we are endangered."
– *Female health worker*

3.3 Gender Roles, Responsibilities, and Time Use

3.3.1 Training of the health workforce

> "Male students are more likely to successfully complete their training; female students have a lot of issues: marriages, burial ceremonies, etc. Some male students when they come to school they will never visit home until when they graduate but female students always want to attend one function or the other which distracts them from paying attention to their studies."
>
> – *Provost of a college of nursing sciences*

Interviews and FGDs reveal society expectations for women to meet domestic responsibilities challenge their performance in pre-service training (see textbox at right). Female students are expected after school to engage in domestic chores, prioritized over studying. A female government official in Ebonyi State said: "Male health workers have more access to training because they have less family responsibilities. A man can take care of his family from a faraway place but a woman cannot do so; she has to stay and manage the home. It is her cross". Desk reviews equally show that on average females spend three to four hours on domestic work compared to one hour per day for men, giving female students less time for studies and leisure.[34] These responsibilities coupled with training not always organized at times and places that make it possible for female students to balance care and family responsibilities, constitute formidable barriers to the successful completion of pre-service training program and indeed full participation in the health workforce by women.

3.3.2 Governance and Management of Health Workforce

The analysis observed that the appointment of gender focal persons (GFPs) is done by the states with noticeable reluctance. Across the SMoH in target states, it was observed that the GFP positions usually go to middle career female staff. Currently only FCT Health and Human Services Secretariat (HHSS) has a male GFP. In Ebonyi, out of the five departments in the State Ministry of Health, only one has a gender focal person, which reportedly was filled because of donor requirements.

GFPs in the target states and the FCT that, they have limited knowledge and skills to address gender issues within their ministries and targeted communities. The analysis also observed that although GFP position is a full-time job, the GFPs in target states and the FCT do not have clearly defined roles and are primarily relevant when donors brought an intervention. Similarly, the role is not always empowered to drive an agenda. For example, the gender focal person in the Kebbi State Ministry of Health expressed the concern that: "If you keep pushing gender issues, you will be frustrated by the [male] officials who prefer to give the positions to women who are not usually assertive so that they can have total control over them". Moreover, in Kebbi and Sokoto states, the GFP position is more or less an added responsibility because usually a deputy coordinator public reproductive health unit perform the GFP roles.

Furthermore, while the State Ministries of Health (SMOHs) have created the positions of Gender Desk Officers (GDOs) to support gender-responsive health sector planning, the GDOs' knowledge and skill levels are uneven across the targeted states. Additionally, the GDOs have limited ability to influence decisions. For example, sex-disaggregated data is generated at the State level. However, GDOs are not sufficiently trained on how to use this data for decision-making. GDOs also have limited authority within the SMOHs to influence leadership to use the data.

3.3.3 Motivation and Retention of Health Workforce

Within the Nigerian health workforce there is occupational segregation and then even within cadres, there is de facto job segregation between male and female health workers. Some health workers interviewed mentioned labor, antenatal care (ANC), and family planning as the domains of female health workers

[34] USAID Nigeria Gender Analysis Report (2020, p. 12)

whereas male health providers were responsible for accident and emergency, psychiatry, surgery, and orthopedic services. This segregation also contributes to leadership potential, when certain experiences are more rewarded than others. There was consensus that such divisions were mostly found in the rural areas. In Bauchi, Kebbi, and Sokoto states, a synthesis of the tasks in the PHCs showed that female health workers tend to do more work than their male counterparts, in part because women and children who constitute a larger percentage of patients patronizing the PHCs often prefer to be attended to by female health workers.

Findings showed that male health workers are more likely to be posted to rural areas than female health workers. A government official and a male health worker attribute this to the influence of government officials and politicians who do not allow their wives and daughters to be posted to such areas. This is in addition to the terrain in most rural areas which would be unbearably tough for women. A female health worker however said they refuse posting to rural areas mainly because of sexual violence.

3.4 Access to, and Control Over Assets and Resources

3.4.1 Training of Health Workforce

Female students tend to receive priority over their male counterparts in access to pre-service training (see textbox at right). Female students have more chances as they are accepted for both Nursing and Midwifery whereas male students are only considered for Nursing in all the training institutions visited across the target states. Currently, only the FCT college of Nursing and Midwifery accept limited number of male students into midwifery training program. The Nursing and Midwifery Council has also received complaints from male applicants not considered to study nursing and midwifery programs particularly in the southern part of Nigeria. For example, in Abia State only eleven male students were accepted out of the 696 candidates offered admission. Equally unable to access healthcare training are PWDs as mentioned in sub-section 3.2.1.

> "In the last admission for midwifery program, more than 100 male students applied for a place but only five were admitted. Although I can't say why only five male students were admitted, but I know that it is impossible to think that the other 95 male students failed the screening exams."
> – *Male student*

Furthermore, due to shortage of female nurses and midwives in rural and remote areas in the northern states of Kebbi and Sokoto, governments in the states, in collaboration with a local NGO (Nana Girls and Women) are running Community Nursing and Midwifery Program (CNMP) targeting young female secondary school leavers selected from various rural and remote communities to undergo training in basic Nursing and Midwifery program. On successful completion of the training, they are offered automatic employment by the state government and sent back to their respective rural communities to serve as nurses and midwives.

Funding is critical in making pre-service training accessible. However, a government official in Ebonyi observed: "There is no any scholarship for any health student; preventing many women from enrolling and in this part of Nigeria, parents are not so keen in training female children because they will marry and stay with another family, although the females are more inclined to enroll for training but there is no support. Boys are in the quest to make money fast; school is not an option for them".

With regards to access to in-service training opportunities, a representative of an implementing partner noted most of their training programs, male health workers outnumbered their female counterparts. This finding covers Kebbi, Sokoto and Bauchi states. Female health workers interviewed complained of lack of access to in-service training programs during pregnancy and breastfeeding (see textbox at right). Another female health provider observed domination of men in in-service training, adding that on many occasions, in-service

> "Most senior colleagues, when they know that you have a baby, they will not nominate you to participate in any workshop or seminar."
> – *Female health worker*

trainees were not practicing health workers but rather, people who were close to top government officials and got nominated for the training just for the stipend.

3.4.2 Governance and Management of Health Workforce

Findings on access to information for health workers show that there is equality of access to information related to training opportunities and decision-making bodies for both male and female health workers. However, a female respondent maintains that such access depended on the level of one's connection to the top government officials and Directors of Primary Health Care in the local governments. Some useful information according to her would be made available very late especially to female health workers. Furthermore, a female government official observed that men would learn about new information faster than women because "they are at the corridors of information since they occupy top leadership positions." Similarly, men are more willing to spend money on Internet data bundles than women and likewise if the information is in newspapers, men tend to read the newspaper more than women. "For a good number of women", she further observed, "such information must be brought to their doorsteps to get them informed as most of the time, they would be busy with domestic chores."

On the involvement of youth in decision-making, a government official justified the non-inclusion of youth representatives in HRH decision-making on the premise that such decisions were usually taken by top ranking officers while most youth were only beginners or in the middle level of their careers. In addition, they were generally considered inexperienced and hence, not fully groomed for leadership.

3.4.3 Motivation and Retention of Health Workforce

There is no clear gender pay gap according to respondents, although data was not available to confirm. Previous research indicates midwives in rural Nigeria, while satisfied by work outputs, were dissatisfied with compensation in relation to their effort.[35] While fair remuneration may motivate women, evidence shows that retention is also linked to access to satisfying, respectful and safe working conditions. This not only matters for the workers themselves. Respectful treatment of health workers and gender-responsive institutions are linked to improvements in quality of care.[36] Likewise, a female health worker attested to the lopsided implementation of promotion but observed that male health workers had an advantage of rising to management positions over their female counterparts.

3.5 Patterns of Power and Decision-Making

3.5.1 Training of Health Workforce

During the interviews, provosts, students and health workers all agreed that both male and female youth have equal opportunities to consider different cadres for their careers. Female students however expressed the concern that male students who could engage in any kind of manual work to make money and pay their fees had more leverage of choosing their careers than female students who mostly would have their career decided for them because they tended to depend on their parents and/or spouses for sponsorship. Due to certain cultural norms particularly in Bauchi, Kebbi and Sokoto states women are not expected to engage in some manual jobs because traditionally such jobs fall within "male domain'.

Staff in training institutions is not gender balanced. For example in Kebbi, the College of Nursing Sciences had a ratio of 10:90 in favor of female students whereas the College of Health Technology had a ratio of 40:60 in favor of male students. But on health trainers, the College of Nursing Sciences had a ratio of 40:60 in favor of male trainers while the College of Health Technology has a ratio of 15:85 in favor of male

[35] Adegoke, 2015
[36] Hay et al., 2020

trainers. The obvious implication of this imbalance is that health training itself would be gender-biased as observed by a female health worker

3.5.2 Human Resources Information System

The Federal Ministry of Health disaggregates by both age and sex but the FCT Health Secretariat disaggregates age only and does not disaggregated by sex (see textbox at right). Both the Federal Ministry of Health and the FCT Health Secretariat do not include the disaggregated data in dashboards and decision-making reports. Likewise, the Ministry said it lacked the skill to carry out an in-depth analysis of data for gender and sex disparity. For example, data on gender-based violence and live births were chronically underreported.

> "We don't really pay attention to sex disaggregation."
> – *FCT official*

3.5.3 Governance and Management of Health Workforce

Findings reveal that HRH leadership and management opportunities are not equitable. A female respondent in Kebbi State said there was not equality of access to leadership and management opportunities, citing as an example, her own self: "you can see that I am the only female senior officer in the Ministry, in a place where we have eight departments and there is no female director. The problem is that women are not given the opportunity; our people believe that a woman's place is home, not office". In Kebbi State for example, out of the 21 PHC Directors in the state, only one was a woman. Similarly, in Bauchi State, women hold only 9.4 percent of HRH leadership positions.[37] A female respondent complained that there were more male in leadership positions than women. She said: "you will see somebody who is your junior being appointed as your in-charge, not because he is more competent but because he is male and has a godfather. Due to this issue currently, I am considering retiring from service". Respondents from Ebonyi articulated similar situations (see textbox at right). At the FCT, a female health worker concurred that "there are more men in leadership positions than women partly because men are more interested in [public] leadership than women". She said that women had domestic responsibilities that needed their attention and that there could be HRH management meetings that might keep them late in the office; this might offend their spouses and potentially create problems in their homes; a situation that many women would try to avoid.

> "In contemporary Nigeria, getting an appointment depends on your political affiliations and connections. If appointment is based on merit, most women will be at the top; sometimes, you have to compromise to get some appointment and compromise can destroy your home."
> – *Ebonyi Ministry of Health Representative*

3.5.3 Motivation and Retention of Health Workforce

Interviews and desk reviews show that female health workers face challenges when it comes to active participation in-service training because most of the times the training require more time away from home, despite some of the trainings are pre-requisites for license renewal and promotion opportunities. This creates an obstacle to the professional development and growth of female health workers.

Male domination of top leadership positions in the health sector is attributed to the difference in the level of access of both genders to equal opportunities of mentorship, career development, networking and role models, amidst work environment and organizational cultures that tended to favor men and seem to place women at disadvantage.[38] It is estimated that 1 in 4 doctors and 1 in 20 nurses, trained in Africa are currently working in developed countries; and these trends, as researcher Adeloye and colleagues suggest, may be similar or even higher among Nigerian-trained doctors and nurses.[39] Evidence shows that health

[37] Ahmadu, 2020.
[38] Longo and Straehley 2008, p. 88–100.
[39] Adeloye et al., 2017

workers change employers or locations based on salary and other remunerations.[40] As can be seen from Tables 5 and 6, there is a progressive increase in the number of health workers (doctors and nurses/midwives) who migrated outside the country from 2014 to 2018. An official of the Nursing and Midwifery Regulatory Council revealed more female health workers were involved in relocation to higher paying regions such as in Europe, North America, and the Middle East. He also revealed that from 2019 to the time of the interview in 2021, more than 7000 health workers had migrated out of the country and 80 percent were female. Other push factors mentioned by the informants include poor remuneration, shortage of workplace equipment, and work overload especially for female health providers in PHCs.

Table 5. Trend in the Migration of Medical Doctors and Nurses from 2014 to 2018

Year	2014	2015	2016	2017	2018
No. of doctors who migrated outside the country	656	688	1018	1426	1551
No. of nurses/midwives who migrated outside the country	1325	1589	2005	2536	3561

Source: Nigeria Health Workforce Country Profile 2018.

4. STAKEHOLDERS

As HWM seeks to implement activities with a GESI lens it is important to know and engage GESI stakeholders across the focus areas. The GESI analysis revealed stakeholders, including individuals, such as GESI focal points or organizations, across government counterparts, training institutions, regulatory bodies, and NGOs and implementing partners. Priority stakeholders are mapped below and a complete list is available in Annex D.

State	Stakeholder
Bauchi	Ikra Foundation for Women and Youth Development
	Gender Focal Person, SMoH, Bauchi
	Provost, College of Nursing Sciences, Bauchi
	Breakthrough Action Gender Focal person
	Gender Focal Person, SMoH
Ebonyi	Provost, College of Nursing Sciences, Uburu
	Gender Focal Person, SMoH, Abakaliki
FCT	Breakthrough Action Gender Focal person
	IHP Gender Focal Person
	Women's Rights Advancement and Protection Alternative (WRAPA)
	Women Environmental Program (WEP)
	The Nigerian Women Trust Fund (NWTF)
	UN Women Abuja
	Director, Gender Federal Ministry of Women Affairs (FMoWA)
	Chairperson, Proximoprime, Abuja
	Federation of Muslim Women's Associations in Nigeria (FOMWAN) Abuja
Sokoto	Religious and Traditional Leaders
	Nana Girls and Women
	State Ministry of Women Affairs (MOWA)
	Gender and Women Empowerment Initiative
	Gender Focal Person, SMoH
	The National Agency for the Prohibition of Trafficking in Persons (NAPTIP), Sokoto
Kebbi	WRAPA Kebbi
	Chairperson, International Federation of Women Lawyers (FIDA), Kebbi
	Religious and Traditional Leaders
	Gender Focal Person, SMoH

[40] Nigeria National Human Resources for Health Policy, 2006.

State	Stakeholder
	Deputy Provost, College of Nursing Sciences, Birnin Kebbi
	MOWA Kebbi

5. CONCLUSIONS

Pervasive cultural norms and beliefs about gender roles continue to influence health workforce dynamics, often to the detriment of students and currently serving health workers. Across most states, gender-blind HRH policies, regulations, institutional practices, and policy makers' limited skills to collect, analyze, report, and use sex-disaggregated data limit an effective, efficient health workforce. Lack of equal access of both male and female genders to HRH leadership and management positions hampers overall functioning of the health workforce and prevents diverse leadership opinions, which could positively influence health outcomes. PWDs and youth are marginalized in the training and recruitment of health workers, limiting a potential source of health workers at a time when globally there is a predicted shortage of 18 million health workers. The findings from the GESI analysis across the five domains lead to the following specific conclusions per objective area of HWM.

5.1 Intermediate Result Area 1: Training of the Health Workforce

Pre-service training – male engagement. Career choices often follow traditional gender roles: Men tend to consider cadres such as physicians, pharmacists, and medical laboratory technicians; whereas women often go for the "caring" roles, such as nursing and midwifery. These gender inequalities are due to social norms, early marriage and domestic obligations that limit women's career choices and professional development. Gender norms limit the number of male students who consider careers in nursing and midwifery, and policies and lack of engagement of male students contribute to a female dominated profession. Cultural norms leading to the preference for female clients to be attended to by female health workers is a major factor discouraging men from going into Nursing/Midwifery and CHEW/JCHEW pre-service training. This has created a huge gender gap in the profession.

Pre-service training – lack of supportive policies for female students. Certain government, regulatory bodies policies, regulations and institutional practices affect female students more than male, resulting in more female students dropping out of pre-service training. The absence of scholarships and financial incentives for CHEWs and JCHEWS has made pre-service training inaccessible to many promising but indigent students, particularly females. The absence of female-friendly study environment is hindering successful completion of training programs for women particularly, pregnant and breastfeeding female students. Occasionally, policies are influenced by gender norms, such as a curfew for female students, or seek to protect students, such as the policy on makeup for female students, actually have the inverse effect and limit female students' ability to study and succeed.

The roles that society imposes on women to meet domestic responsibilities affect their participation in in-service training programs and career growth. Furthermore, the failure of training institutions to organize both pre-service and in-service training at times and places that could make it possible for women to balance care and family responsibilities, constitutes formidable barrier to the successful completion of pre-service training and indeed active participation of women in the health workforce.

Cases of sexual harassment often go unreported because issues pertaining to sex are culturally seen as taboo topics, preventing many victims from reporting abuse.

Pre-service training – youth engagement. There is a policy that stipulates age 17 as the minimum age set for admission into Nursing and Midwifery training institutions, which prevents teen secondary or higher school leavers from enrolling in pre-service training programs. The analysis observed that this policy affects more girls than boys.

Pre-service training – equity for PWDs. PWD are generally excluded in training and recruitment of certain category of health workers. In all the target states and the FCT, PWDs are not offered admission in the colleges of Nursing and Midwifery. In the colleges of Health Technology where they are considered, PWD are encouraged to take courses such Health Information Management and Nutrition and Dietetics, rather than choose their career path.

Lack of gender balance in training institution staff. Although there are more female students, most trainers are male. For example in Kebbi, the College of Nursing Sciences had a ratio of 10:90 in favor of female students, but on health trainers, a ratio of 40:60 in favor of male trainers. The obvious implication of this imbalance is that health training itself would be gender-biased as observed by a female health worker

Pre-service training – GESI in curriculum. The curriculum of pre-service training programs primarily lacks GESI considerations, which are considerable social determinants of health. In some training institutions, curriculum are actually negatively gendered, limiting the clinical competencies of future health workers. For example, in some training institutions female health workers are not taught about male reproductive organs and male students taught about female reproductive organs.

5.2 Intermediate Result Area 2: Human Resources Information Systems

Although the collection and use of sex-disaggregated data is essential in identifying key GESI challenges and opportunities facing HRH, there are wide gaps in the collection, analysis, report and use of such data. This is mainly attributable to lack of skills on the part of policy makers to properly disaggregate data according to sex and age and use such information for decision-making.

5.3 Intermediate Result Area 3: Governance and Management of Health Workforce

Lack of GESI in HRH policy. HRH Policies across the focus states and the FCT lack robust features to improve GESI in HRH recruitment, distribution, and management. This gap accounts for inequitable distribution of health workers.

Women in leadership. Although the workforce is dominated by women, it is led by men. Women make up a large proportion of the state healthcare management team, but the topmost leadership positions are occupied by men. Biased and traditional views about women's capacity as public leaders and decision-makers remain pervasive in all the target states and the FCT, and are rooted in certain cultural and religious beliefs. The difference in the access of both male and female health workers to equal opportunities of mentorship, career development, networking opportunities and role models across the target states and the FCT contributes to limited attainment and the absence of women in top HRH leadership and management positions. The low commitment of many top government officials to gender promotion in HRH can be attributed to lack of awareness about benefits of addressing gender inequalities and inequities in health workforce. The dominance of men in top HRH leadership and management positions results in the development of certain policies and institutional practices that have little considerations for the complex roles of women at home and workplace. This tends to affect their training, recruitment, deployment and retention.

Gendered task shifting. The male-controlled nature of Nigerian society engenders a de facto job segregation between male and female health workers with certain tasks shifted down to female health workers, adding more workload to women resulting in over-utilization of female health providers. Certain tasks such as ANC, labor, and family planning fell to women, while emergency typically fell to men; this creates challenges in efficient use of time and overburdening, but also leads to less promotional opportunities as certain tasks are more highly valued. In several states, there is an embargo on employment, leading to the utilization of volunteer health workers who are mostly women and also underpaid in many facilities. In rural areas where there are shortages of female health workers, the Community Nursing and Midwifery schemes have potentials to address the shortage of female health workers in rural and remote areas.

Access to opportunities. Domestic responsibilities of women have put some female student /health workers at some disadvantage when information on training, opportunities, and networking is relayed through newspapers and radio programs because such responsibilities do not always allow them time to access such sources of information.

Adequate distribution of female health workforce. While the HRH policies in each focus state and the FCT has expressed a commitment to increasing the number of female midwives and community health workers, especially in remote areas, to help reduce maternal and neonatal fatalities, there are no actions proposed on how to reduce this gap.

Lack of adequate GESI resources or political will. The analysis observed that the appointment of gender focal persons is done by the states with noticeable reluctance. In Ebonyi, out of the five departments in the State Ministry of Health, only one has a gender focal person, which reportedly was filled because of donor requirements. Gender issues are often dismissed by male policy makers as women issues.

5.4 Intermediate Result Area 4: HRH research to understand HRH practices and retention

Major gaps in implementation research on impact of certain HRH policies and institutional practices on male and female students/health workers exist. Policy makers lack skills to assess potential differential impacts of policies they developed/adapt on male and female students/workers. Although each target state and the FCT has developed/adapt particular HRH policies, a noticeable gap is that they do not include gender dimensions to the retention of health workers.

Sexual harassment. Although pervasive, sexual harassment is often unreported. The absence of policies on sexual harassment predisposes the absence of reporting mechanisms; hence many cases of sexual harassment in training institutions and at workplace go unreported. Inadequate security and protection measures in many rural communities is one of the major factors preventing female health providers from staying/working in such communities.

Gender and health worker migration. The absence of HRH migration policy has resulted in unregulated relocation of thousands of health workers particularly female nurses and midwives to higher-income regions.

Gender norms on pipeline of HRH. Cultural norms and beliefs have negative effects on HRH as they resulted in the general perception of Nursing, Midwifery, CHEW and JCHEW as feminine jobs; discouraging many men from seeking to join or remain in the professions.

Pay gap and remuneration. There was a consensus among all the respondents that there was no gender pay gap among health workers, but data was not available to confirm this. But there are gender-based factors affecting the pay of health workers. A female health worker attested to the lopsided implementation of promotion but observed that male health workers had an advantage of rising to management positions over their female counterparts.

6. RECOMMENDATIONS

6.1 Intermediate Result Area 1: Training of Health Workforce

Pre-service training – male engagement.

- Coordinate social and behavior change interventions with partners and USAID funded projects, including Breakthrough Action at the grassroots to transform cultural norms that diminish men's participation in Nursing/Midwifery and CHEW/JCHEW professions. This can also involve designing programs that will enable people at the grassroots to realize that their preconceived ideas or beliefs about Nursing and Midwifery professions are no longer valid or relevant.

- Engage role models and celebrities in transforming cultural norms that prevent men's enrolment in Nursing and Midwifery professions particularly in the southern state of Ebonyi. Research (e.g., Lindenberg et al, 2011) has shown that role models and celebrities have the power to influence changes in social norms, beliefs, and behaviors. This has the potentials to contribute to closing the gender gap in the professions.
- Invest in Community and Midwifery programs and ensure the inclusion of men and PWDs in the scheme. This should involve strengthening the capacity of the identified local NGO implementing the programs and providing the NGO with a grant.

Pre-service training – lack of supportive policies for female students

- Support training institutions to design and offer scholarships and financial supports to promising but indigent students particularly female students pursuing CHEWS and JCHEWS to ensure the successful completion of their healthcare training.
- Encourage regulatory bodies to increase indexing/admission quotas given to training institutions to allow for the enrolment of more students, particularly females into pre-service training programs. This will contribute to addressing shortage of female health providers in rural areas.
- Sensitize traditional and religious leaders on the advantages of increasing women's enrollment in training institutions and employ the strategy of creating reality around issues to make them (traditional and religious leaders) see reasons for supporting women to enroll in pre-service training. This can help to increase their commitment to investing in women's enrolment in pre-service training programs. These local actors exert lots of influence at the grassroots.
- Invest in campaigns against child marriage particularly in Bauchi, Kebbi and Sokoto states and encourage the enrolment of more rural women in pre-service training.
- Support the training institutions in the target states and the FCT to make study environments and pre-service training programs more female-friendly through policy modifications such as eliminating curfew for female students.
- Support training institutions to design and offer mentoring and career and leadership programs to female students and female health workers.
- Support the training institutions to improve policies on sexual harassment and breastfeeding or leniency for time off after pregnancy.

Pre-service training – equity for PWDs.

- Work with regulatory bodies such as NMCN and Community Health Practitioners Registration Board of Nigeria (CHPRBN) to develop policies that will give pre-service training access considerations for PWDs, teens and other marginalized groups in health workforce.

Pre-service training – youth engagement

- Work with NMCN to review the minimum age set for admission into Nursing and Midwifery training institutions. This will give interested teen secondary/higher school leavers the opportunity to enroll into pre-service training and begin practicing at age 18 or 19.

Lack of gender balance in training institution staff.

- Support training institutions to design and offer scholarships or financial incentives to hardworking tutors to further their education as a way of improving the quality of students' training and developing the tutors' capacity to effectively teach GESI contents in the curricula.

Pre-service training – GESI in curriculum.

- Complement skills-based training with training on gender-sensitive and socially inclusive care. GESI training, coaching, and e-learning approaches should be used to build and maintain capacity among the health workforce. This should include supportive supervision and regular performance assessments where demonstrating gender-sensitive approaches on the job is rewarded.
- Coach training institution staff to deliver trainings in gender-sensitive and inclusive ways for tutors in training institutions in the focus states and the FCT.
- Design a program to train and sensitize tutors in training institutions on GESI topics in the curricula. This should also involve equipping the tutors with skills of mentoring students particularly female students.
- Review with the Nursery and Midwifery Council the curricula of Nursing and Midwifery training programs to make it more gender responsive [*during stakeholder consultation, the council requested this support]*.

6.2 Intermediate Result Area 2: HRIS

- Build capacity of HRH policy makers to collect, analyze, use, and report sex- and age-disaggregated data.
- Develop an accountability mechanism for measuring the extent to which data is being collected and used for decision-making.

6.3 Intermediate Result Area 3: Governance and management of health workforce

Lack of GESI in HRH policy.

- Catalyze progress in the development of HRH policies in the target states and the FCT and encourage the adoption and implementation of gender-responsive and socially inclusive HRH policies, action plans, and agendas.
- Encourage HRH policy makers in the target states and the FCT to develop gender policies that will guide the development/review of HRH policies, plans, processes and operations.
- Provide technical support to reviewing HRH policies to ensure they are gender-sensitive and support women's complex roles at work and at home.
- Work with policy makers to ensure GESI is integrated into Monitoring and Evaluation frameworks and capacity-building plans across the Ministries of Health and Primary Health Care Development Agencies/Boards in the target states and the FCT.

Women in leadership.

- Sensitize current HRH leadership and decision-makers on the importance of gender equity, inclusion, and equal opportunity for male and female health provides, PWDs and other marginalized groups in the health workforce. This should also involve equipping policy makers with skills for gender-sensitive and inclusive HRH recruitment and management.
- Work with policy makers to promote gender balance and gender-sensitivity across the HRH pipeline – in recruitment, retention, training, management and supervision, and promotion. Evidence from this GESI research indicates that female health providers face certain barriers in each of these phases of the pipeline which can potentially cause them to exit the health workforce or change employer.
- Support advocacy for an affirmative action program to ensure that a significant percentage of HRH leadership and management positions are held by women.

- Strengthen the capacity of some women-led civil societies to push for affirmative action in health leadership. This will help to correct gender imbalance in HRH leadership in the target states and the FCT.
- Provide gender sensitive mentorship structures and opportunities for male and female health workers. This should involve development of description of roles for mentors and mentees, including suggested plans for mentorship; and the selection/recruitment and training of mentors on gender norms and biases to facilitate greater understanding of gender-related career challenges.

Gendered task shifting.

- Encourage policy makers in the target states and the FCT to develop policies that would reduce gendered task shifting and promote team work between male and female health workers.
- Work with partners and USAID funded projects, including Breakthrough Action to coordinate social and behavior change interventions at the grassroots to encourage receiving care from both male and female health providers. This can be done through sponsoring radio programs that would employ the strategy of creating reality around issues to make clients see reasons for receiving care from health providers irrespective of their gender.

Access to opportunities.

- Design a program to sensitize top government officials on the benefits of addressing gender issues and barriers in HRH and how that could lead to a more empowered health work force, improved staff motivation, and reduced attrition.

Adequate distribution of female health workforce.

- Encourage policy makers in the target states and the FCT to develop policy guiding the deployments/postings and transfers of health workers.

Lack of adequate GESI resources or political will.

- Strengthen the capacity of gender focal persons in the target states and the FCT and actively engage them in designing and implementing HWM Activity programs and activities. This will be beneficial for the HWM Activity, the HRH departments/units in the target states and the FCT, and health workers particularly, female health providers.

6.4 Intermediate Result Area 4. Research on HRH Practices and Retention of Health Workforce

Sexual harassment.

- Provide technical assistance to improve policies on sexual harassment and reporting mechanisms.
- Mobilize traditional leaders and youth leaders to provide adequate security and protection to female health providers deployed to their communities.

Gender and health worker migration.

- Provide technical support to the Federal Ministry of Health to enable it finalize HRH migration policy and encourage the target states and the FCT to adopt/adapt it [*during stakeholder consultation, the council requested this support]*.

Gender norms on pipeline of HRH.

- Invest in research on gender issues, gaps and opportunities facing HRH practices; disseminate the results widely and use them to guide the design and implementation of HWM Activity programs and activities. This should also involve encouraging policy makers to support research to better

understand impact of certain HRH policies and institutional practices on men and women, PWDs and other marginalized groups in the health workforce.

Pay gap and remuneration.

– Engage in advocacy for the payment of reasonable rural posting and hardship allowances to health providers, particularly female health workers deployed to rural and remote areas.

7. ACTION PLAN

ANNEX A: DOCUMENTS CONSULTED

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ANNEX B: LIST OF STAKEHOLDERS INTERVIEWED

ANNEX C: DATA GATHERING TOOLS (KIIs & FGDs)

ANNEX D: STAKEHOLDER MAPPING OF GESI CHAMPIONS