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LHSS Nigeria GESI Analysis: Findings from Nasarawa, Plateau, and Zamfara States

Local Health System Sustainability Project

June 2023

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

ADS	Automated Directives System
ANC	Antenatal care
AIDS	Acquired Immunodeficiency Syndrome
BA-N	Breakthrough Action Nigeria
BHCPF	Basic Health Care Provision Funds
CDCS	Country Development Cooperation Strategy
CHEWs	Community Health Extension Workers
CSOs	Civil Society Organizations
FBO	Faith-Based Organization
FCT	Federal Capital Territory
FGD	Focus Group Discussion
GBV	Gender Based Violence
GESI	GESI
GFP	Gender Focal Point
GoN	Government of Nigeria
HAT	HIV/AIDS and Tuberculosis
HPN	Health, Population and Nutrition
H SS	Health Systems Strengthening
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HWM	Health Workforce Management
IGAs	Income Generating Activities
IEC	Information, Education and Communication
IHP	Integrated Health Program
IP	Implementing Partner
LGA	Local Government Area
LHSS	Local Health Systems Sustainability
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MEL	Monitoring, Evaluation, and Learning
MoH	Ministry of Health
NAPHCDA	Nasarawa State Primary Health Care Development Agency
NASHIA	Nasarawa State Primary Health Insurance Agency
NGOs	Non-Governmental Organizations
NDHS	Nigeria's Demographic Health Survey
NSHDP II	National Strategic Health Development Plan 2018–2022
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLASCHEMA	Plateau State Contributory Health Management Agency
PSPHCDB	Plateau State Primary Health Care Development Board
SFI	Sustainable Financing for HIV/AIDS
SHIA	State Health Insurance Agency

SPHCDA	State Primary Health Care Development Agency
STIs	Sexually Transmitted Diseases
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WDC	Ward Development Committee
WHO	World Health Organization
ZAMCHEMA	Zamfara Contributory Health Management Agency
ZSPHCDA	Zamfara State Primary Health Care Development Agency

EXECUTIVE SUMMARY

In line with its commitment to Gender Equality and Social Inclusion (GESI) integration, the United States Agency for International Development (USAID) Local Health Systems Sustainability (LHSS) Project conducted a GESI analysis[1] in March and April 2023 in target Nigerian states of Nasarawa, Plateau and Zamfara. The purpose of the analysis is to inform the implementation approaches for LHSS Nigeria, ensuring that GESI considerations are addressed and fully integrated in all elements of the project. The analysis is guided by the USAID Automated Directive System (ADS) 205 five gender analysis 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).[2] The data for this GESI analysis was collected from desk reviews of relevant literature, key informant interviews (KIIs), and focus group discussions (FGDs).

Across Nasarawa, Plateau and Zamfara, the analysis found that state governments are not applying a GESI approach to the identification and enrollment of individuals in health insurance and there are many institutional issues with health care provision that reduce the ability of marginalized groups, such as rural women, unemployed youth and persons with disabilities, to seek care.

These issues include societal expectations on women, limiting their ability to freely engage with health care workers and having less decision-making power in the family. This imbalance also leads to restrictions on women's participation in certain income generating activities (IGAs), reducing mobility and healthcare choices. In all three states there are issues with the stigmatization of individuals with disabilities including people living with HIV, resulting in reduced income and lower access to care. The interviews also found that among young men there is a perception that seeking care at a Primary Health Center (PHC) is unnecessary and that traditional norms and expectations around masculinity promote adoption of risky health behavior. It was also found that across Nasarawa, Plateau and Zamfara states, youth rarely used PHC facilities, and young men even less so. Young men in the three states reported a belief that their bodies are resistant to many diseases.

In terms of the provision of health care it was found that the opening times of PHCs as well as male/female staff ratio impacted the way in which marginalized individuals accessed care as the facilities are often not open at times convenient to those working in rural areas or individuals prefer seeing a female/male clinician, who may not be available. Additionally, there is a gender imbalance in the types of positions that males work in compared to females at both the PHC and Health System level (State Health Insurance Agencies (SHIAs)/State Primary Healthcare Development Agencies (SPHCDAs))

The LHSS team did identify a few differences between the states including that in Nasarawa, men seem to maintain less power and influence in decision making pertaining to health care compared

[1] GESI analysis "is a social science tool used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries" (ADS 205, p.10). Such an analysis will result in integrating gender considerations, i.e., provides a way of looking at how social norms and power structures impact on the lives and opportunities available to different groups of women and men, girls and boys, ensuring that women and men, girls and boys from different social groups are not disadvantaged by any particular project's programs and activities.

[2] These domains provide five major areas that gender inequality and social inclusion issues can be identified and addressed.

to other states. Additionally, in Zamfara where purdah[3] system is widely practiced, female mobility is more limited and that insecurity further restricts movement of people.

Recommendations for how LHSS can support state governments to improve this situation are outlined towards the end of the report, however, broadly there needs to be more targeted capacity strengthening, technical support, and advocacy for these issues within the SHIA and SPHCDA offices as well as intentional outreach programs to connect with marginalized communities. LHSS will work with SHIAs to identify strategies to target these communities for enrollment in the Basic Healthcare Provision Fund (BHCPF) as well as work with SPHCDAs to improve healthcare service delivery.

To ensure effective implementation of the recommendations, a twin-track approach should be employed, ensuring women, men, girls and boys and people with disabilities have equal rights and opportunities to participate and benefit from state sponsored healthcare programs.

[3] Purdah is a religious and social practice of female seclusion prevalent among some Muslim and Hindu communities.

1. INTRODUCTION

This report contains findings of a Gender Equality and Social Inclusion (GESI) analysis of the United States Agency for International Development (USAID/Nigeria) Local Health Systems Sustainability Project (LHSS) which was carried out by the LHSS Nigeria Equity Advisor with support from the Banyan Global GESI Technical Lead, LHSS Nigeria Chief of Party and the Monitoring, Evaluation and Learning (MEL) Specialist. The report presents findings from the Project's Health, Population and Nutrition (HPN) States of Nasarawa, Plateau and Zamfara. The GESI analysis field work was carried out in March and April, 2023.

1.2 Activity Background

In collaboration with Banyan Global, Results for Development (R4D), Training Resource Group (TRG), and the Government of Nigeria (GoN), Abt Associates Inc is implementing the LHSS Project in Nigeria. The project is USAID's flagship initiative in integrated health systems strengthening and is being implemented in five states in Nigeria including Nasarawa, Plateau, Zamfara, Lagos and Kano. The overall objective of the program is to strengthen the health system towards achieving universal health coverage (UHC). LHSS supports the GoN to reduce financial barriers and out-of-pocket payments; increase health coverage for the poor through fully functioning social health protection programs (i.e., Basic Health Care Provision Fund and State Health Equity Fund) and increase the number of fully functioning primary health centers to provide quality essential health services. Specifically for Lagos and Kano States, LHSS works to increase the utilization of state health insurance schemes and the basic health care provision fund and increase government funding and expenditure for HIV/AIDS services. Please note that this report covers only the HPN states of Nasarawa, Plateau and Zamfara. A separate report will be prepared for the project's HIV/AIDS and Tuberculosis (HAT) states of Lagos and Kano. The project has following three main objectives for its HPN stream of work:

a) Financial risk protection expanded in targeted states to reduce financial barriers and out of pocket payments so that the poor can obtain health care services they need without getting pushed deeper into poverty.

b) Increased health coverage by 10 percent for the poor through fully functioning social health protection programs (i.e., basic health care provision fund and state health equity fund schemes) in target states to improve equitable access to essential health services for people facing vulnerability, especially women, girls and persons with disability.

c) Increase the proportion of revitalized "one main health facility per ward" in target states to 50 percent to increase the number of fully functioning facilities to provide quality essential health services.

1.3 The GESI Analysis Objectives

The purpose of this GESI analysis is to inform the implementation approaches for LHSS Nigeria, ensuring that GESI considerations are addressed and fully integrated in all elements of the project. Understanding the differential needs and vulnerabilities of women and men, girls and boys, persons with disabilities, the poor, elderly, and other marginalized groups will help to identify target populations, tailor the response, and dedicate resources where they are most needed.

The GESI analysis investigates constraints to making health services gender equitable and socially inclusive; examines gender-based and other discriminatory factors restricting or limiting

population health coverage and utilization of state health insurance schemes; and explores opportunities for increasing financial risk protections for women and the poor. It draws upon findings from the LHSS GESI Strategy and additional peer-reviewed literature, programmatic findings, white papers and grey literature. The analysis also collects primary data to close gaps in the secondary sources.

1.4 Analytical Framework

The GESI analysis is guided by the USAID Automated Directive System (ADS) 205 five domains, as outlined below. The domains are specified in ADS chapter 205.3.2:

i. Laws, policies, regulations and institutional practices that influence the context in which women and men act and make decisions.
ii. Cultural norms and beliefs related to gender.
iii. Gender roles, responsibilities, and time use.
iv. Male and female access to and control over assets and resources; and
v. Patterns of power and decision-making.[4]

The domains provided a suitable framework for identifying barriers and constraints, and opportunities for integrating GESI into the LHSS Nigeria project.

As this GESI analysis[5] focuses at the Project level, ADS chapter 205.3.2 requires that the analysis should identify the following:

- Relevant gaps in the status and anticipated levels of participation of women and men (including age, ethnicity, disability, location, etc.) that could hinder overall project outcomes;
- Differences in the status of women and men (e.g., economic, political, etc.) that could be addressed as a result of the project; and
- Possible differential effects the project might have on women and men.[6]

1.5 Background and Context

Despite being the largest economy in sub-Saharan Africa[7], Nigeria has one of the worst health indices in the continent[8], and this has been attributed to, among other things, inequitable access to essential health care services in the country[9],[10],[11]. Nigeria also has one of the highest out of pocket (OOP) spending rates on health care in the world[12], and extremely low health insurance

[4] ADS 205, p. 11
[5] 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).
[6] ADS 205, p. 14
[7] World Bank (2019a). https://datatopics.worldbank.org/world-development-indicators/stories/many-economies-in-ssa-larger-than-previously-thought.html
[8] USAID (2022). Global Health. https://www.usaid.gov/nigeria/global-health
[9] Umeh, C.A. (2018), Challenges toward achieving universal health coverage in Ghana, Kenya, Nigeria, and Tanzania. Int J Health Plann Manage, 33(4): p. 794-805
[10] Nnamuchi, O., et al. (2019), Successes and Failures of Social Health Insurance Schemes in Africa-Nigeria versus Ghana and Rwanda: A Comparative Analysis. Annals of health law / Loyola University Chicago, School of Law, Institute for Health Law, 28: p. 127 – 148
[11] Oni, M. Abiodun, and B. Olayinka (2019). Awareness of and Access to National Health Insurance Scheme in Nigeria and Ghana.
[12] Gustafsson-Wright and Schellekens (2013)

coverage. Statistical figures of health insurance enrollment in the country indicate that only six percent of the population are covered, exposing many people living in the country, particularly women and girls, to unaffordable health care costs. Of the six percent of Nigerians enrolled into insurance schemes in the country, 56.7 percent are male as against 43.3 percent of the female,[13] creating a significant gender gap in the enrollment and perhaps, service utilization. Evidence from this GESI analysis indicates that since many women (particularly women in rural areas) work mostly in the informal sector and spend more time doing unpaid job at home, they do not earn enough income to afford health services.

In Nigeria, certain cultural beliefs around health insurance constitute strong barriers to health insurance enrollment. According to researcher Barau[14], many people, particularly in northern Nigeria, erroneously see health insurance enrollment or planning for health care as wishing for ill-health. Religious beliefs also impact health insurance enrollment. Evidence from this GESI analysis indicates that many adherents of Islamic religion in the target states of Zamfara and Plateau hold the belief that there is no need for insurance coverage as their health is in the hands of God.[15] That God protects them, not health insurance, vaccine or any health care services. Further, individuals that have a ''comfortable income'' often take pride in being able to pay health care bills for themselves and their family members rather than relying on health insurance.

Furthermore, in many northern Nigerian states, including LHSS focus states of Nasarawa, Plateau and Zamfara, additional factors such as negative perceptions and attitudes about service providers negatively affect utilization of health facilities.[16] Due to certain cultural and religious beliefs many women in the northern part of Nigeria, particularly in Hausa-Fulani communities prefer receiving care from female service providers, especially for family planning, antenatal, and childbirth.[17]

Research has shown that inequities in access to essential health care services in Nigeria are pervasive and tied to conditions of gender, disability, age, geographic location and socio-economic standing.[18] For instance, the 2018 Nigeria's Demographic Health Survey (NDHS) indicates that men are the main decision makers at household and community levels, and many women and adolescent girls, particularly in the three LHSS target states, need permission from their husbands or guardians to leave their homes or seek care at health facilities. Only 26.8 percent of the married women surveyed in the 2018 NDHS make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care. This unequal power relationship between women and men can lead to poor health outcomes in the country.

Looking at a specific health outcome in Nigeria, the country suffers one of the highest maternal mortality rates in the world. With just 2.4 percent of the world's population, Nigeria contributes 10 percent of global deaths for pregnant mothers and has the fourth highest maternal mortality rate (576 per 100,000 live births) and the second highest infant mortality rate in the world.[19] Infant mortality currently stands at 69 per 1,000 live births while for under-fives it rises to 128 per 1,000 live births.[20] This has been attributed to, among other factors, inequitable access to and utilization of health care services by many pregnant women and children under five years old. The 2018 NDHS report indicated that only 67 percent of the surveyed women aged 15–49 used antenatal

[13] https://www.statista.com/statistics/1124773/health-insurance-coverage-in-nigeria-by-type-and-gender/
[14] Barau, M. (2021). Gender and Health care in Northern Nigeria. *Degel: The Journal of FAIS*, 18(1): 47-60.
[15] Barau, M. (ibid)
[16] Mohammed et al., (2020)
[17] Okereke et al., (2020)
[18] USAID/Nigeria Gender Analysis (2020).
[19] https://www.unicef.org/nigeria/situation-women-and-children-nigeria
[20] https://www.unicef.org/nigeria/situation-women-and-children-nigeria

care (ANC)[21]. Further, the survey revealed that only 39 percent of live births in Nigeria took place in a health care facility.[22]

Research has also shown that Nigeria's health care service delivery is among the worst globally in terms of access and quality. The 2018 Lancet[23] report on access to and quality of health care service delivery showed that, among the 195 countries surveyed, Nigeria ranked 142.[24] Similarly, the World Bank in its 2019 universal health coverage index ranked Nigeria 42 on a scale of 100,[25] which further indicates that Nigeria's health care service delivery is poor.

Health care service delivery constraints and inadequacies tend to disproportionately impact women and girls, particularly women and girls living in rural areas, where the burden of disease seems to be disproportionately high. An examination of the BHCPF package of services revealed that it does not adequately address needs of women and adolescent girls. For example, while many pregnant women and adolescent girls are facing vulnerability, and in need of additional services to ensure they receive the health care they need, the BHCPF service package fails to capture them outside of pregnancy. It also treats women as objects of health care services rather than as humans with agency who are key actors/stakeholders in their health. Additionally, evidence from this GESI analysis shows that there is poor Gender-Based Violence (GBV) knowledge and service provision among health care providers.

In terms of human resources for health (HRH), Nigeria's estimated health workforce density is 1.95 per 1000 population[26], which is far below the Sustainable Development Goals' (SDG) threshold of 4.45 skilled service providers per 1000 population. Research has shown that this shortfall is worsened by the inequity in HRH distribution, as there is no national policy guiding the posting, deployments or transfers of health service providers at PHC level.[27] Consequently, redeployment of service providers is often left at the discretion of HRH administrative officers, with many competing and often conflicting interests, resulting in inequitable HRH distribution across many PHCs in country including PHCs in the LHSS target states.

While recent data on the population of persons with disabilities in Nigeria are difficult to find, a 2011 WHO report indicates that there were about 25 million persons with disabilities in the country.[28] In spite of the large number, persons with disabilities in Nigeria face many barriers when it comes to accessing and utilizing health care services. For instance, studies have shown that female persons with disabilities experience peculiar barriers, different than their male counterparts. A 2022 Women Enabled International study reveals that women and adolescent girls with disabilities "*are prevented from fully realizing their SRHR and their rights to legal capacity and to be free of GBV.*"[29] Similarly, researchers Eleweke and Ebenson noted that in many PHCs in Nigeria, most health service providers felt that pregnant women and adolescent girls with disabilities were not capable or equipped to handle a pregnancy due to their disability status. Moreover, within PHCs and in communities (particularly in rural areas), many people misunderstood the needs and capabilities of female persons with disabilities. Thus, disability brings an added layer of vulnerability, with the ability to make decisions concerning seeking health

[21] NDHS 2018, p.173. Retrieved from: https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf
[22] NDHS 2018, p.173. Retrieved from: https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf
[23] The Lancet is a world-leading general medical journal. https://www.thelancet.com/lancet/about
[24] Measuring performance on the Health care Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016 - The Lancet
[25] https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD
[26] WHO (2016, P. 11)
[27] Abimbola et al 2016.
[28] WHO (2011). World Report on Disability. Retrieved from: http://www.who.int/disabilities/world_report/2011/report.pdf?ua=1
[29] https://womenenabled.org/reports/needs-assessment-pwd-fiji/

care, often being taken away as finding from this GESI analysis suggests. Although in January 2019, Nigerian President Muhammad Buhari signed the Discrimination Against Persons with Disabilities Prohibition (VAPP) Act into law, findings from this GESI analysis show that persons with disabilities in many communities in the three LHSS Nigeria target states continue to face barriers when it comes to accessing and utilizing health care services.

Nigeria reportedly has a high disregard for the rights of Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI+) persons.[30] The LGBTI+ population is brutalized by the Nigerian legal system, hindering their access and utilization of essential health care services. In 2014, Nigerian President Goodluck Ebele Jonathan signed the Same Sex Marriage Prohibition Act (SSMPA) into law. The impact of this law is felt in health care access and delivery all over Nigeria. Service providers are, by default, requested to report people identified as LGBTI+ as criminals, as a 2020 USAID/Nigeria country-wide gender analysis found.

With regards to Nigerian government efforts towards improving equitable access to health care services, in 2014 the BHCPF was established under Section 11 of the National Health Act. As Nigeria operates a decentralized health care system, direct implementation of the BHCPF is at sub-national (states) level. While the BHCPF is a much needed health care reform in Nigeria, the program is insufficiently funded, and lacks an accountability system to ensure improved service quality.[31] Further, a review of other Nigerian government health policies and programs revealed that while formal policies and legislation provide equal access to essential health care services for women and men, girls and boys and other social groups, there is lack of sufficient institutional mechanisms to prevent, mitigate, and respond to practices that increase health risks for women and men, the poor, and people facing vulnerability.[32]

A couple of donor-funded projects in Nigeria have aimed to support access to universal health coverage and improve health and well-being. For instance, in Abia, Ebonyi and Osun states, and the Federal Capital Territory (FCT), the USAID/Nigeria Health Policy Plus (HP+) project supported the states to strengthen state-level institutions and capacities in preparation for rollout of the BHCPF program in the states. Similarly, the USAID/Nigeria Integrated Health Project (IHP) has been implementing programs and activities aimed at strengthening Nigeria's Health Systems, through increasing access to and improving quality of PHC services in the Nigerian states of Bauchi, Ebonyi, Kebbi, Sokoto, and the FCT. To address HRH shortages in Nigeria's PHC, Banyan Global in collaboration with Abt Associates and other partners, is implementing USAID/Nigeria Health Workforce Management (HWM) Activity. The Activity supports establishing a cost-effective, well-trained and motivated health workforce in targeted rural and remote areas of target states and the FCT. However, none of these interventions target the northern Nigerian states of Nasarawa, Plateau and Zamfara. Hence, LHSS Nigeria was designed to support these three states to strengthen their health systems and increase equitable access to essential health care services at PHC level.

Given that the LHSS project views GESI integration as central to achieving its objectives, this analysis examines issues, constraints, and opportunities facing pro-poor health financing options through a gender and social inclusion lens. The analysis seeks to provide evidence to inform GESI integration in designing interventions aimed at reducing health inequalities, improving access to essential health services for persons marginalized and facing vulnerability, and increasing government expenditure on health services for greater sustainability of health service delivery in target states of Nasarawa, Plateau and Zamfara.

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[30] https://www.africaportal.org/publications/2019-report-human-rights-violations/

[31] USAID Local Health Systems Sustainability Nigeria (2022). Request For Applications (RFA) #Nigeria-Yr1-001. https://www.lhssproject.org/about/grants-and-rfps/organizational-capacity-assessment-and-strengthening-nigeria

[32] IHP GESI Desk Review (2020).

1.5.1 Background on Plateau, Nasarawa and Zamfara Sates

Plateau State was created in 1976. It is located near the center of Nigeria and includes a range of hills surrounding Jos, its capital city. The State has 17 local government areas (LGAs) and has an estimated population of 4.7 million people.[33] The state's overall health system performance is poor, and its health service delivery is hampered by low HRH exacerbated by inequitable HRH distribution, high cost of medical services, and low health insurance.[34]

Nasarawa State was carved out of the neighboring Plateau State in 1996. The state is made up of 13 LGAs comprising diverse ethnic groups. It is the second least populous state with an estimated population of about 2,679,433 as of 2022.[35] Women and girls who constitute about 55% of the population are largely illiterate, poor and have low access to health services, economic and political rights and opportunities.[36] Health service delivery in Nasarawa State like in Plateau State, is poor due to shortage of HRH, dilapidated infrastructure, and low health insurance coverage.

Created in 1996, Zamfara State had an estimated population of 5.8 million people in 2022.[37] The State is located in Northwestern part of Nigeria and has 14 LGAs, with Gusau as the capital city. The State has the highest number of the poor in Nigeria, with about 74 percent of the residents living below the poverty line.[38] In terms of health outcomes, Zamfara is among the states with the highest maternal, infant, and under-five mortality rates in the country. As Zamfara State is governed by Shari'ah law in addition to common law, the State recognizes polygamous marriages. Polygamy – a marriage between one man and multiple women – is correlated with high fertility rates in Zamfara, according to the 2018 NDHS.[39] This is because women in such relationships tend to have lower negotiating and decision-making power, as well as lower access to, and control over resources. Women who would want to limit or space children may be unable to, due to unequal gender dynamics within polygamous relationships. Moreover, competition to bear children between wives in polygynous households may be a driver of higher fertility.

Furthermore, the insecurity challenges in Zamfara occasioned by armed banditry, kidnapping and farmer-herder conflict, have led to the breakdown of health care system already experiencing decades of neglect and underfunding by successive administrations. While insecurity affects the health status of the entire Zamfara population, women, girls, and children under five years suffer worse health outcomes due to certain gender and social norms.

2. METHODS AND LIMITATIONS

2.1 Study Design and the Data

The methodological approach used for this gender analysis was predominantly qualitative and drew upon a range of secondary and primary data involving a desk review, key informant interviews (KIIs) and focus group discussions (FGDs). These methods addressed the analysis questions by eliciting information from multiple sources and creating an opportunity to triangulate trends and themes.

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[33] https://citypopulation.de/en/nigeria/admin/NGA032__plateau/
[34] Plateau State Ministry of Health, Plateau State Strategic Health Development Plan, 2016-2022.
[35] https://www.nipc.gov.ng/nigeria-states/nassarawa-state/
[36] Nasarawa State Ministry of Health, Nasarawa State Strategic Health Development Plan, 2016-2022.
[37] https://citypopulation.de/en/nigeria/admin/NGA037__zamfara/
[38] Statista (2022). Poverty Headcount in Nigeria. https://www.statista.com/statistics/1121438/poverty-headcount-rate-in-nigeria-by-state/
[39] NDHS 2018. Retrieved from: https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf

A first step in this process was a desk review, applying the five domains of the USAID Automated Directive Systems (ADS) 205 framework[40]. Materials reviewed include relevant gender analyses reports, journal articles, briefs, and relevant reports and policy documents. To the extent possible, literature published in the past ten years was considered for the desk review. The review involves examining the context for women and men, girls and boys, and adolescents of different social groups across the five ADS 205 domains, with a focus on differential circumstances for women and men in rural and urban areas, adolescent girls and boys, and persons with disabilities – and differentiators on the basis of income and employment (formal sector versus informal sector) and education. Beyond context, the desk review explored GESI considerations as they related to access to and utilization of health services, particularly at PHC level.

Primary data was mainly collected through KIIs and FGDs with relevant stakeholders across focus states of Nasarawa, Plateau and Zamfara. The KIIs and FGDs were conducted in March and April 2023. A total of 73 KIIs and 5 FGDs were conducted with relevant stakeholders across the three states. The KIIs and FGDs provided qualitative data that helped the GESI analysis team gain a deeper understanding of issues relevant to the GESI analysis through stakeholder perspectives, including experiences and opinions on gender issues, constraints and opportunities facing health financing space in target states. The data collection tools for the KIIs and FGDs are available in Annex B.

2.2 GESI Analysis Team

The LHSS Nigeria GESI analysis was led by the Senior Equity Advisor Umar Ahmed, Ph.D, under the supervision of the Chief of Party Dr. Bolanle Olusola-Faleye, the Monitoring, Evaluation and Learning (MEL) specialist Deji Bodunde, and the Banyan Global Senior GESI Technical Lead Stephanie Perlson.

2.3 Data Collection

The GESI analysis team collected data from the relevant stakeholders in three LHSS Nigeria focus states, as shown in Table 1.

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

S/N	Geopolitical Zone	Focus State
1.	Northcentral	Nasarawa and Plateau
2.	Northwest	Zamfara

Data collection was carried out in two phases. Phase one involved review of secondary data and Phase two included KIIs and FGDs, conducted in Nasarawa, Plateau and Zamfara states. In sum, qualitative data was collected from 169 (78 males and 91 females) individuals across the three states, as shown in Tables 2 and 3.

[40] The USAID ADS 205 five domains are: 1. Laws, policies, regulations, and institutional practices; 2. Cultural norms and beliefs; 3. Gender roles, responsibilities, and time use; 4. access to and control over assets and resources; and 5. patterns of power and public representation.

Table 2. Respondents Interviewed by Sex

Respondents' category	Male	Female	Total
Government officials	14	11	25
Health service providers	7	10	17
Local CSOs/IPs	10	6	16
Ward Development Committees	18	1	19
Community members	26	61	87
Community leaders	3	2	5
Total	**78**	**91**	**169**

Using the results of the desk review, respondents in Nasarawa, Plateau and Zamfara were identified. They (key informants) were purposively selected based on their involvement in health services at PHC level, as well as their ability to speak on behalf of or have knowledge of, barriers, constraints and opportunities facing health care service delivery in their respective communities/states. Semi-structured KII and FGD guides were developed based on type of respondents, yet with interview questions largely along the same lines and scope of inquiry. Each interview guide, with a series of questions and associated prompts, looked at level of understanding of the GESI-related barriers and constraints to health care service access and utilization, and the importance of addressing GESI constraints to health care delivery and related issues.

Table 3. Respondents Interviewed by location

Respondents Category	Nasarawa	Plateau	Zamfara	Total
Government officials	6	11	8	**25**
Health service providers	6	4	7	**17**
Local CSOs/IPs	9	5	2	**16**
Ward Development Committees	8	6	5	**19**
Community members	15	52	20	**87**
Community leaders	2	2	1	**5**
Total	**46**	**80**	**43**	**169**

2.4 Data Limitations

The GESI analysis team could not conduct a thorough investigation into the collection methodologies for the secondary data used for this analysis and could not confirm absolute reliability of the secondary data. Related to this limitation, is that up-to-date quantitative data is

not always available. Hence, when particular quantitative data was not available for the current year, statistics of prior year(s) was relied upon, which may not accurately reflect the current gender or other social dynamics in particular study state. Furthermore, some of the key informants lacked access to data. As a result, their responses were often based on impressions and anecdotal evidence, and this may misrepresent the current reality in particular target states. To mitigate these limitations, the analysis team enhanced, complemented, triangulated and authenticated the data. However, despite these limitations, the quality and validity of the data were not significantly affected.

2.5 Ethical considerations

Prior to the commencement of the field work for the GESI analysis (which involves collecting data from human subjects), ethical clearance was sought and obtained from Abt Associates Internal Review Board and Government of Nigeria at national and subnational levels. Please see Annex A for copies of the ethical approval letters. Furthermore, the consent of all respondents was sought before their participation. Participation was voluntary, and no study participant was forced or induced to participate in the study. The choice of whether to participate or not, was solely with each respondent. The privacy and confidentiality of the study participants was ensured. The venues for KIIs and FGDs were spaces that guaranteed privacy, safety and comfort of participants. Results for all respondents were presented in aggregate. No identifiable information was collected from any respondents, thereby ensuring that their identity is well-protected. The audio of the interviews and discussions was audio recorded with the consent of the participants.

3. FINDINGS

3.1 Laws, Policies, Regulations, And Institutional Practices

3.1.1 Financial Risk Protection

Findings across the three states show a similar pattern. In Nasarawa State, findings show that many women and youth in the State work in the informal sector because of limited formal sector employment opportunities; hence, they have limited access to financial resources. This hinders their participation particularly in employer-based health insurance scheme of the State. According to a key informant in Lafia, ‘‘*even though women need more health services than men, women are mostly engaged in non-productive economic activities, and that places them at an economic disadvantage and thus affects their ability to pay for health services.*’’

Another finding is that the operational guidelines of the State Health Insurance Agency (NASHIA) are largely gender blind (i.e., do not give consideration to gender issues). The document does not explicitly state how GESI issues that could potentially affect financial risk protection in the State will be identified and addressed. The need for accessible care is expressed with little reference to women in the informal sector, unemployed youth, persons with disabilities and other social groups whose access to health services may be hampered by financial difficulties. The analysis also observed that most government officials interviewed demonstrated limited understanding of GESI and what it means to apply a GESI approach to the state health insurance scheme (i.e., how the scheme can expand access for economically disadvantaged and typically marginalized groups). Possible consequence of this is that GESI issues may not be considered when developing policies on health.

The desk review also reveals that in Nasarawa State, the objectives of the NASHIA include increasing the number of residents with financial risk protection and reducing out of pocket expenditure. However, key informants noted that not much progress was made in the

implementation of the scheme in the State in terms of reach and coverage over the years, as enrollment is largely limited to those working in the formal sector. They key informants also reported that in many health facilities in the State, a client could be deprived of health care services if they were unable to pay. The analysis observes that this increases the vulnerability of persons living in poverty, who would eventually forgo health care services, or resort to borrowing which puts them in more financial difficulties. According to Nigeria's National Bureau of Statistics report from 2022, Nasarawa has the twelfth (12th) highest poverty rate in the country, with a poverty index of 57.3 percent.[41]

Furthermore, the analysis learned that the cost of treatment in a health facility in the State tends to push many pregnant women to give birth at home instead of a health facility. Some key informants reported that traditional birth attendants are appealing to many pregnant women as they are inexpensive and highly accessible. ''*I gave birth six times at home because my husband and I couldn't afford giving birth at hospital and I lost four of my children in the process, only two survived"*, a female respondent in Lafia stated.

Findings from Plateau State indicate that like in Nasarawa, the State, established its state health insurance scheme in 2019 to promote health financial risk protections to residents in the state. However, key informant interviews (KIIs) and desk reviews conducted point toward the absence of policies that integrate GESI (GESI) lens into the scheme. For example, while women, youth, persons with disabilities, and other groups facing vulnerability are often unable to access and utilize health services due to financial impediments, the operational guidelines and policies of the scheme do not explicitly state how issues that could affect the participation of women and men, girls and boys from different social groups in financial risk protection for residents in the state will be identified and addressed.

Several key informants in the State spoke of the need to amend the law establishing the state health insurance scheme to provide a subsidy to women, particularly women in rural communities. As one key informant observed, *"many women in Plateau State work mostly in the informal sector and do not earn enough income to afford paying health insurance premiums"*. The health insurance premium is charged at twelve thousand Naira (₦12, 000) annually per head. Most of these women, the analysis revealed, are economically disadvantaged and are excluded from formal sector employer-based health financial risk protection programs because of limited formal employment opportunities.

Findings from Zamfara State show that the State also set up a health financial protection scheme in 2019 with the aim of ameliorating the financial hardship that usually results from out-of-pocket health care expenditure. However, findings show that poverty remains a major barrier to participating in the scheme, particularly for women and girls, unemployed youth, and persons with disabilities, retirees and other persons facing vulnerability. A desk review indicates that Zamfara has the highest number of the poor in Nigeria, with about 74 percent of the residents living below the poverty line.[42] Several key informants noted that while women tend to face higher health care costs than their male counterparts due to reproductive and maternal health care needs, many women in the State have less opportunity to participate in health financial protection schemes due to factors such as lack of formal employment, limited opportunities to participate in income generating activities (IGA) outside the family compound, lack of control over household resources and decision-making. Findings also indicate that most women, youth, and persons with disabilities

[41] https://www.dataphyte.com/latest-reports/nasarawa-governor-improves-igr-but-poverty-joblessness-still-big-issues/#:~:text=According%20to%20the%20report%20by,the%20second%2Dhighest%20poverty%20rate.

[42] Statista (2022). Poverty Headcount in Nigeria. https://www.statista.com/statistics/1121438/poverty-headcount-rate-in-nigeria-by-state/

in Zamfara face higher levels of unemployment and underemployment, making them unable to afford paying for health care services or health insurance premiums.

Furthermore, a desk review of both the operational guidelines of the Zamfara Contributory Health Care Management Agency (ZAMCHEMA) and the Agency's draft 10-year strategic plan reveals that the documents are largely gender blind, as they fail to recognize gender and social inclusion issues that could potentially affect participation in the state financial risk protection program. For example, GESI considerations are not considered a priority nor integrated throughout the draft 10-year strategic plan. GESI considerations are not reflected in monitoring and evaluation systems, health finance and budgeting. Moreover, there is nothing about prioritizing and providing financial protection to certain social groups such as people with disabilities, persons with mental illnesses, internally displaced persons, retirees, and persons who inject drugs.

3.1.2 Population Health Coverage

Across the three states covered by this analysis, the government and society do not recognize the rights of Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) individuals to health services, which hinders their access to health services. No respondent including government officials acknowledges the existence or recognizes the rights of persons LGBTQI+ individuals to health services. Similarly, no key informant mentions or acknowledges health needs of persons with mental illness and key populations (such as persons who inject drugs and female sexual workers), as if they do not exist in society. This lack of recognition of these social groups has serious implications for achieving universal health coverage (UHC) in the three states and the country as a whole. From a rights-based standpoint, everyone – no matter their gender identity or sexual orientation, mental health status, etc., can and/or should get the health care they need.

KIIs reveal that while health insurance is mandatory for all residents in the State, there is lack of sufficient institutional measures to enforce compliance. According to a government official, *"we have the law but we need other government agencies to support NASHIA. For instance, health insurance cards need to be made a requirement for driver license renewal, for you to enjoy any benefit [from government] – looking for contract, tax clearance, you must show that you are insured by NASHIA."* The analysis also observed that while equity was mentioned as a core value of NASHIA, the Agency's operational guidelines do not state how this value will be promoted and upheld in its everyday practices.

The analysis finds that across all the six health facilities visited during the data collection exercise, the service providers, local civil society organizations (CSOs), ward development committees (WDCs), community leaders and the community members interviewed had no knowledge of the state health insurance scheme. *"I am just hearing it [the State Health Insurance Scheme] for the first time; I am hearing it for the first time [repetition is from the respondent]. But it is a welcome idea, I don't know why in all the meetings with government officials, it was never mentioned"*, an official of a local CSO in Lafia stated. This suggests that the scheme is either unpopular among the government officials (the CSO had meetings with) or they need more information about it.

Several key informants spoke of a policy related to free medical services for pregnant women and children under five years of age, and children in registered orphanages, but mentioned poor implementation of the policy due mainly to paucity of funds. Similarly, government officials and CSOs lamented the poor implementation of the Discrimination Against Persons with Disabilities (Prohibition) Act, Child Rights Act, Anti-HIV/AIDS Stigma and Discrimination Act, and Disclosure of HIV/AIDS Status Act. Furthermore, the analysis learned that none of the policies was communicated to the public in an equitable and inclusive way. For example, the policy documents were not provided in braille for people with sight problems. Similarly, the analysis also learned that most information is communicated via the State Television to the public without the provision of sign language interpretation for those with hearing challenges.

Findings also reveal that institutionally, GESI integration[43] remains a challenge because both the NASHIA and the Nasarawa State Primary Health Care Development Agency (NSPHCDA) do not have designated focal points responsible for ensuring that attention is paid to GESI issues. Key informants attributed this to lack of awareness on the part of policy makers about the importance of gender focal points, resulting in insufficient institutionalization of efforts to address gender-based and other types of barriers in population health coverage efforts.

The analysis also found that the cost of treatment in a health facility tends to push those without the means to alternative medication, such as patronizing medical stores and drugs sold on the streets. Key informants reported that many people preferred to buy their medicine at commercial medical stores because it was relatively cheaper than buying at a government-owned health facility. According to a key informant in Lafia, *"a drug that you are supposed to pay Ten Naira it would be sold to patients at Thirty Naira in a health facility."* Similarly, another respondent reported that *"when you are sick and they [service providers] prescribe drugs for you, they will tell you that you must buy [the drugs] from them and their price is higher than at a chemist [a commercial medical store] where we can even buy on credit but they insist that if we can't buy the drugs [from them], they will not prescribe the drugs".*

The analysis observed that in all the facilities visited in Nasarawa State, there was a lack of tailored care services for the elderly people. None of the service providers interviewed mentioned that they received training on providing care to the elderly persons. If PHC services are to be GESI responsive, there is a need for designing GESI responsive health care services that would address the differential health needs of different social groups in the society, including elderly people.

In Plateau State, key informants frequently spoke about the law that made health insurance mandatory for all residents of the Plateau. However, several key informants observed that the law has not translated into actions required to improve population health coverage in the state due mainly to poor implementation and lack of awareness of the law. While general awareness of the law is not necessarily a GESI issue, it is important because improving equitable access to essential health services for persons facing vulnerability, especially women, children, and persons with disabilities inherently requires a GESI sensitive approach that would be used to identify and address the health needs of people from different social groups. More so, many times we need legal solutions to achieve the changes that we want to see; we can't depend on everyone to make these changes on their own, sometimes, we need the laws to support this, along with other factors. Therefore, such an approach needs to first begin with a level of awareness of GESI considerations in targeting the poor and vulnerable to improve their access and use of health care services.

Institutionally, GESI integration remains a challenge because both the state contributory health care management agency (PLASCHEMA) and the state primary health care development board (PSPHCDB) don't have designated focal points responsible for overseeing attention to GESI issues. Similarly, out of the three other relevant government agencies visited during the data collection exercise in the state, only one has a gender focal point (GFP) – an officer designated to oversee attention to GESI issues. Key informants attributed this to lack of awareness on the part of policy makers about the importance of GFPs, as GESI issues are often dismissed by some male policy makers as "women's issues". According to an official of the state health insurance agency, *"the concept of gender and social inclusion are new to us, we need more sensitization about them […]. Currently, we don't have a gender focal person responsible for overseeing attention to gender issues."*

[43] This refers to a process and strategy for ensuring that the concerns of women and men, girls and boys from all social groups are identified and addressed.

Another finding is that despite policies to disaggregate data, there is an overall lack of proper collection and utilization of sex and age-disaggregated data across all the five government agencies visited during the data collection exercise. The implication of this is that programs will be designed without GESI lens which means planning and budgeting could be inaccurate, resulting in insufficient health service coverage for women, people living with disabilities, and youth, for example. Government officials interviewed mentioned that they disaggregate both sex and age superficially and that not all sex-disaggregated data are included in dashboard and decision-making reports. *''Most of the data on sex and age we collected are sent to NGOs who often demand for it. We are yet to start including such data in our dashboard because we don't see the reason for doing that'',* a government official stated. This would likely result in lacking enough budget to address women's, youth, the elderly, etc. health needs.

Some key informants spoke of the need to enact a law that would ensure that all health care services covered under the state health insurance scheme are made free for persons with disabilities. A desk review revealed that services under both the BHCPF and the state health insurance scheme for persons with disabilities are not explicitly specified, and disability is undefined, which as some key informants observed, make certain forms of disability such as Dyslexia to be overlooked.

Interviews revealed that Zamfara State is not different from Nasarawa and Plateau states in terms of population health coverage. The State has a number of enabling laws and policies to increase population health coverage. For example, in addition to the law establishing the state health financial risk protection scheme, Zamfara has a social protection policy that focuses on improving the wellbeing of the residents of the state including providing the enabling environment for improving equitable access to essential health care services for persons facing vulnerability, especially women, girls, internally displaced persons, the poor, and persons with disability. However, key informants noted that the social protection policy has not translated into actions required to improve population health coverage particularly for women and girls, and persons with disabilities due mainly to poor implementation. *''There are enabling laws but the issue is with the implementation […] what we are calling for is proper implementation''*, an official of a local CSO stated.

A desk review revealed that while all residents of Zamfara are entitled to participate in the state health insurance scheme, there is low coverage of the residents. The analysis learned that currently, less than two percent of the over five million population of Zamfara is covered by the scheme. According to a government official, *''men dominated the formal sector enrollment while over 90 percent of the BHCPF [Basic Health Care Provision Fund] enrollees are women and children under five years.*''

Findings reveal that both the Zamfara primary health care development agency and the state contributory health care management agency do not have designated focal points responsible for overseeing attention to GESI issues; making GESI integration in population health coverage a challenge in the State. The analysis also observed that all government officials interviewed demonstrated limited understanding of (GESI) and what it means to apply a GESI approach to the state health insurance scheme (i.e., how the scheme can expand access for economically disadvantaged groups).

The analysis also observed that across the ministries, departments and agencies visited during the data collection exercise, there was an overall lack of proper collection and utilization of sex and age-disaggregated data. Government officials interviewed mentioned that they lacked the knowledge/skill of in-depth analysis of sex and age-disaggregated data. *''We don't use it – the age and sex disaggregated data. We should actually [use the data] but we don't because we lack the skills''*, a government official stated.

Furthermore, across the three states it was found that only Ministries of Health (MoH) have created the positions of GFPs to support gender-responsive health sector planning. However, the GFPs demonstrated limited knowledge of GESI issues in health sector. Additionally, the GFPs have limited ability to influence decisions. For example, a GFP in one of the states lamented that ‘‘I am not always invited to the meetings on the development of new policies. Even when invited my inputs are not always considered.’’

3.1.3 Service Coverage of Quality Essential Services

In Nasarawa State, the analysis did not identify any policies or guidelines governing service delivery in general or as it relates to GESI in the state health insurance scheme. Quality and availability of both male and female service providers pose key challenges to equitable service delivery in the state. It was also found that there were no service providers who understood sign language, or who specialize in geriatric care. The analysis learned that for close to 20 years, there was no recruitment of primary health centers (PHC) staff in the State, leading to the utilization of volunteer service providers who are mostly female and also underpaid in many facilities. However, the analysis learned that because the bulk of the manpower in most health facilities were volunteers, some facilities had to charge fees, even for services that were supposed to be free, in order to pay the volunteers and sustain the facility.

The analysis also learned that because the stipend paid to the volunteers was not enough to support a family, some volunteers engaged in unethical practices including providing services to clients outside the hospital premises for a fee. This unethical practice is further exacerbated by the way in which some people prefer to receive care at home than at health facilities, as reported by several respondents. When asked why they preferred receiving care at home, several respondents mentioned that seeking care at facilities wasted time and was expensive because it often required payment for laboratory tests and other services. The impact of this is that the health of the clients might be compromised without laboratory investigations, a more thoroughly trained provider, etc. to provide additional information about their condition.

Majority of the PHCs visited were in need of additional rooms and space – the rooms were often too small and lack privacy. Some female respondents reported experiencing neglect and abandonment, which they linked to unprofessional conduct of some service providers and overcrowding of clients, in addition to limited privacy in the facility. These factors, the analysis learned, discourage some women from seeking care and skilled delivery in health facilities. *‘‘You see at home you receive better attention from service providers than at hospital and there is privacy […] and they [service providers] don’t charge much [for providing the services outside the facility]’’*, a female respondent stated.

Additionally, the facilities and equipment in sixty percent of the PHCs visited require structural improvements because they do not seem to be conducive to the provision of accessible services to persons with disabilities. There were no wheelchair ramps, accessible beds for persons with disabilities, nor toilet facilities for persons with disabilities. Similarly, across the six PHCs visited across the three senatorial zones in the State, the analysis noted the absence of services specific to adolescents, as none of the facilities had an adolescent-friendly center, which makes it more difficult for adolescents to learn about their health and to obtain health services.

Findings show the absence of motivation for service providers in the state. Several service providers interviewed complained about the non-implementation of their promotion and other entitlements outside the salary. *‘‘For 14 years now, we did not enjoy any promotion implementation, we are not motivated at all,’’* a health service provider stated. The implication of this is that poorly motivated service providers may not put in their best effort to ensure that the services they provide meet quality standards for all patients and ensure inclusivity.

In Plateau State, findings reveal that the laws establishing the Plateau State Primary Health Care Board (PSPHCB) and PLASCHEMA – the two main health services policy implementing agencies – do not have a specific mandate to include, or enforce, a quota of women in leadership positions. However, while PLASCHEMA has achieved a balanced gender representation in the management board, only two out of the seven directors in the PSPHCB are women. The implication of this under-representation is that viewpoints and differential health needs of women and girls may not always be considered in the development and implementation of new health services policies.

Down to the ward level, BHCPF operational guidelines state that women should constitute at least 40 percent of membership of the ward development committees (WDCs), holding "effective roles." However, none of the six WDCs (the analysis Team interacted with) has achieved the required representation of women across the WDCs. Moreover, none of the six WDCs is headed by a woman. Key informants noted that leadership structures within the WDCs in the state largely follow traditional gendered patterns, stating that the positions of the chairperson, vice chairperson, secretary, assistant secretary, and other key roles go to men, whereas sometimes the post of treasurer is reserved for women. This unequal representation is due to certain social norms that exclusively assign leadership position to men.

Key informants mentioned that many male policy makers in the health sector in the state tend to view GESI integration as voluntary rather than mandatory, resulting in insufficient institutionalization of efforts towards GESI integration in health services. For instance, many key informants noted the extent of inaccessibility of health care facilities for persons with disabilities and the need for structural improvements. All the six PHCs visited (during the data collection exercise) across the three senatorial zones in the state lack persons with disabilities-friendly facilities. For example, none of the facilities has a wheelchair ramp, dedicated toilets for persons with disabilities and accessible beds for them. Moreover, the analysis observed that none of the service providers was well-trained to care for persons with disabilities. For example, there were no providers who were trained on sign language or braille to accommodate the needs of deaf and blind clients respectively.

The shortage of service providers in the state necessitated the engagement of volunteers – service providers who had completed their training in different institutions but did not have formal employment. Commenting on the effect of engaging volunteers, a key informant observed that the practice engendered the provision of services by non-specialists, stating that it is common to find an Environmental Health Technician performing the duties of a Community Health Extension Worker (CHEW). He said *"volunteers are promoting quacking in health care profession because you find an Environment Health Technician conducting labor due to shortage of staff."*

In Zamfara State, the analysis observed that almost all the service providers interviewed lacked the motivation to provide quality essential services mainly due to poor conditions of service. Both male and female service providers interviewed repeatedly complained that they do not receive salaries as and when due from the government. *"Today is 18th April [2023] and we are yet to receive our salaries for the month of March"*, a service provider lamented. Similarly, another service provider stated that: *"We have low salary and this made some staff not to be punctual at work […] you will find a staff receiving salary of seven thousand five hundred Naira, which cannot sustain one even for 10 days."* This not only puts pressure on the service providers but may also affect their productivity and quality of the care they provide to clients. It was found that in order to earn enough money to meet material needs of their families, many male service providers look for other work or engage in some business activities to survive, so this limits the time that most service providers spend in the facilities. In addition, the analysis learned that many officers in charge of PHCs do whatever is necessary to ensure their facilities have enough resources to keep operating, which results in putting financial pressure on the clients to pay.

It was also found that none of the six facilities across the three senatorial zones in the State operates 24 hours a day. *''It is not possible to operate the facility 24 hours [a day] because of salary issue''*, a service provider stated.

The analysis also learned that due to lack of effective supervision/monitoring mechanisms, many staff deployed to the health facilities visited did not always go to work. *''We have 40 full time staff but only 25 are punctual and as [officer] in charge I don't have the power to order for stoppage of salary of truant staff''*, an officer in charge of a facility reported. The implication of this is that the facility may not always have the required number of qualified service providers to attend to clients.

Another finding is that none of the service providers interviewed reported receiving appropriate training on the differential needs of clients, particularly persons with disabilities and elderly populations. Similarly, across the six PHCs visited across the three senatorial zones in the State, the analysis noted the absence of services specific to adolescents, as none of the facilities has an adolescent-friendly center. Additionally, it was also found that none of the facilities had wheelchair ramps, accessible beds for persons with disabilities, and dedicated toilet facilities for them. All these health service gaps can impact the experience of these groups and may discourage them from seeking care at the facilities, which could negatively affect their health.

3.2. Cultural Norms and Beliefs

3.2.1 Financial Risk Protection

Due to certain cultural norms, women and adolescent girls in many communities in Nasarawa State are not expected to engage in some jobs because traditionally such occupations fall within the ''male domain", according to some respondents in Lafia. Key informants also noted that many women are economically disadvantaged because they spend more time doing unpaid jobs at home, limiting their ability to earn enough income to afford health services.

The analysis learned that while helping one another and supporting the needy are virtues valued in many communities in Nasarawa, over 90 percent of the respondents do not see the need to enroll in health insurance schemes with the aim of helping to sustain the scheme for the benefit of other people. Key informants attributed this to lack of awareness about the importance of health insurance, which is a relatively new phenomenon in the state. This is further exacerbated by mistrust about insurance. *''Even me, I have reservation about insurance. I sometimes feel that it is 419 [a scam] because culturally insurance is alien to us''*, a key informant stated.

In Plateau State, considerable cultural beliefs around health insurance were highlighted as constituting strong barriers to enrollment. The analysis learned that many people on the Plateau tend to see health insurance enrollment – or planning for health care – as wishing for ill health. Similarly, religious beliefs also prevent some people from enrollment. Some Muslims believe that God protects them, not health insurance. According to a key informant, *''Most of our people especially the Muslim community tend to look at health insurance as forbidden. They need to be sensitized about it.''* Further, those that have a ''comfortable income'' take pride in being able to pay their health care bills and that of their families rather than relying on insurance. These situations are further heightened by lack of public trust in government programs and policies, including the state health insurance scheme due to their experience of poor implementation of previous government programs. Further, some civil servants complained that for over a year, health insurance fees were being deducted from their salaries, but their enrollment was yet to be completed due to some technical issues.

The cost of treatment in a health facility also pushes those without the means to choose alternative medication, such as traditional/herbal medicines (roots and leaves), charms, church/mosque, or street drugs. Traditional medicines are very appealing to many as they are inexpensive and highly

accessible. The analysis learned that some people in the rural areas preferred to use traditional medicine as a first recourse for illnesses, and only turn to modern medicine when illnesses worsen. The analysis also learned that men are more likely than women to self-medicate. In case of *"small illnesses [minor ailments], we have roots and leaves which we can find on our way to the fields; we prefer to save money for the care of women and children. A man can always cope".*[44]

In Zamfara, women's lives are largely influenced by certain cultural and religious norms, which continue to limit their (women) ability to participate in income generating activities outside the family compound. The society expects a woman to perform household chores, while men – the traditional breadwinners – are expected to devote much of their time to earning income by participating in productive economic activities usually outside the household. Cultural expectations of women's and girls' domestic responsibilities tend to lessen the amount of time they have to participate in productive activities that could enable them to earn income to pay their medical bills or pay the health insurance premiums. The analysis learned that in many communities in Zamfara, particularly the rural communities, women's economic activities are often regarded as secondary to their traditional care-giving role. These social norms about the expected roles and responsibilities tend to limit women's participation in health financial risk protection, as the norms place restrictions on women's participation in certain income generating activities that traditionally fall within the ''male domain". In addition, the analysis learned that the *purdah*[45] system is widely practiced, limiting female mobility in accessing health services.

It was also found that some people tend to negatively view health insurance. According to a key informant, "*some people look at it [health insurance] from a religious perspective that insurance is like forecasting what will happen to one and this is not allowed in Islam."* However, over 80 percent of the respondents mentioned poverty as a strong barrier to participation in health insurance scheme than religious beliefs or cultural norms.

3.2.2 Population Health Coverage

Findings revealed in Nasarawa State that certain cultural norms continually impact the nature of men with regards to their health. Key informants noted that the society has designated men, by way of socialization, as very strong, brave, and resilient, and this tends to affect their health-seeking behavior. According to a community leader in Karu, *"many men can't imagine themselves lying on a hospital bed like a little kid."*

Cultural norms also lead to stigmatization and neglect of persons with disabilities and poor perception of their health needs, according to some respondents in Lafia and Karu (Nasarawa State). As one key informant in Karu reported, *''Physically-challenged people face stigmatization and discrimination in many communities and this is preventing some physically-challenged [individuals] from accessing care or wanting to associate with other people outside their family compound"*. This creates conditions where persons with disabilities are culturally discouraged from seeking care and considered not worthy of the social resources needed to support them, which can result in a shorter life expectancy for them.

Men's access to health care is greatly affected by the fear of being seen as weak, according to several male respondents across the three states. *''There is the belief that a man who allowed himself to be hospitalized is weak and may lose respect from his wife and children,"* a community leader in Karu stated. Findings also showed that men's health care-seeking behavior was

[44] FGD with men in Shendam, Plateau State.

[45] Purdah is a religious and social practice of female seclusion prevalent among some Muslim and Hindu communities.

generally low, with several male respondents self-reporting that they were reluctant to seek health care in facilities – a place some men think is designated for women and children.

It was also found that across Nasarawa, Plateau and Zamfara states, youth rarely used PHC facilities, and young men even less so. Key informants mentioned that young men in general believe that their bodies were resistant to many diseases. According to a young male respondent, *''I don't need to always take a medicine because most times the sickness will go on its own."*

In Plateau State, key informants mentioned that social norms do not favor the utilization of health care by women, particularly uneducated women in rural areas. For example, key informants mentioned that bravery and endurance are ''virtues'' expected of a pregnant woman in many communities on the Plateau. *''Some women think that if you come to hospital to deliver you are a lazy person and this is discouraging many women from giving birth at hospital,"* a female service provider stated. According to her, due to certain cultural norms many women would use health facilities for antenatal care but then revert to a traditional birth attendant at the time of delivery. *''Some women will tell you that they can't give birth at hospital because their parents never gave birth at hospital and nothing ever happened to them''*, a female service provider reported. There was also the belief that a pregnant woman who engaged in exercise such as mountain climbing and lifting of heavy loads would not experience difficulty in giving birth.

Findings also reveal that certain traditional norms and expectations around masculinity were promoting adoption of risky health behaviors, including the unwillingness of some men to access health facilities, which could not only diminish their health but also makes the burden of the health care role for the family largely fall on the woman. In an FGD with some male respondents in Shendam, it emerged that some people at the grassroots level believe that primary health care was a "feminine affair," an activity not well-suited for men. Similarly, in Zamfara, a male respondent stated, *''culturally, seeking care at facilities is for women and children. A man can handle himself without going to hospital*.''

Adolescent girls (ages 10 to 19)[46] and unmarried young women rarely use health centers because there was a tendency to suspect that they were pregnant when seen at a health facility, and this could deter some prospective male suitors from seeking their hands in marriage. Key informants mentioned that many adolescent girls do not use facilities as they fear a lack of confidentiality from some service providers; many do not know who to confide in, as some cultures on the Plateau consider talking about sex and reproductive health as taboo.

Another related finding is that in over 70 percent of the facilities visited, the service providers told the GESI analysis team that they did not usually attend to unmarried adolescent girls and unmarried young women who wanted to access reproductive health/family planning information and services in health facilities without being accompanied by a parent or guardian. *''Why would an unmarried girl come alone and request to access family planning services. What is she going to do with it since she is not married,''* a female service provider questioned. For this service provider, providing FP to unmarried adolescent girls is akin to promoting pre-marital sex and immorality in the society. This, as a 2018 WHO study suggests, demonstrates a lack of awareness of clients' rights and evidence about the benefits of providing comprehensive sexuality education by the service providers, since learning about FP/RH helps reduce unplanned pregnancies, STIs, and GBV, and promotes healthy relationships from a young age.[47]

Similarly, in Zamfara State, some key informants mentioned that seeking care at a health facility tended to be considered a sign of weakness among men, particularly uneducated men, who tended to see their bodies as being stronger than that of women. It was also found that long

[46] https://www.afro.who.int/sites/default/files/2019-08/6%20Nigeria%20AH18052018.pdf
[47] https://www.who.int/publications/m/item/9789231002595

waiting times at health facilities could deter many men from going to health facilities for their own care. *"I need to always provide for my family, so I don't have time to waste at hospital for an illness I can get a drug at a chemist [private medical store] within two minutes,"* a male respondent stated.

Another finding is that many men do not like coming to health facility because of the fear of being diagnosed with particular diseases. Key informants mentioned that many men are afraid of coming to the hospital to be diagnosed with HIV, Tuberculosis and Hepatitis that could make other people stigmatize them. According to a service provider, ''*when we asked some women [female client] to tell their husbands that we want to see them at the facility, many reported that the men had sleepless nights because of the fear of coming to hospital, thinking that they will be diagnosed with particular illness."*

It was also found that many elderly people do not like coming to health facility to access care because they believe that at old age, they do not need medical services. As one elderly respondent stated, *"Most of our sicknesses are just a symptom of old age that has no cure."* Key informants also mentioned that culturally, in many communities in the state as one gets older, they are expected to stay at home and go out only when it becomes necessary. *"My father is very old and when he is sick, would not allow us to take him to hospital but can allow a service provider to treat him at home."*

Key informants also mentioned that social norms do not favor giving birth at the hospital. Many women particularly in urban areas would use facilities for antenatal care (ANC) but, when it was time for delivery, they would give birth at home. As one female respondent in an FGD stated, *"there is a widespread perception that women give birth at hospital only when there is a complication and this is preventing many women from choosing to give birth at a health facility because they would not like other people to think that they had complications.*'' In addition, some female respondents believed that if God gave them the pregnancy, he would help them deliver safely.

3.2.3 Service Coverage of Quality Essential Services

On whether the gender of service providers affects health outcomes, most female respondents in Nasarawa State said that was not the case. Some of them however observed that most times, Hausa and Fulani women would prefer to be attended to by female service providers; adding that since majority of the service providers were female, that was not a major problem in the State.

In Plateau State also, culturally, many male clients, particularly the elderly, prefer to be attended to by male service providers, the implication of which is that the absence of male service providers in such facilities may impact their health outcomes. *"When you are in a consulting room and they see that you are a woman, they will go back, that is why, most of the times, it is men we assigned to consulting room because people here believe that men are the doctors and women are nurses"*, a female service provider reported. The analysis also learned that some men do not want to be attended to by female service providers for reasons of confidentiality. As one male key informant stated: *"you see in this part of the country, many men think that they cannot reveal their health status to a woman who is not their wife."* According to some key informants, many people think that a service provider of the same sex may be more inclined to maintain the confidentiality of their client.

On whether the gender of service providers affects the utilization of health services by women and girls, most of the female respondents said that they had no preference over who attended to them. Some of them however observed that most times, like reported in Nasarawa State, Hausa women would prefer to be attended to by female service providers, adding that since majority of the service providers were female, that was not a major problem in the state.

The analysis observed the tendency for some people to turn to cultural practices to solve their problems, including seeking traditional or religious healing. This is reinforced by the lack of adequately equipped health facilities with sufficient male and female service providers.

In Zamfara State, the situation is similar. The analysis observed that the sex of a service provider seemed to be more important for men than for women. While some female respondents stated that they had no preference about the sex of the provider, others affirmed that they preferred to be attended to by a female service provider, especially for antenatal consultations. According to a service provider, ‘‘for illnesses outside ANC and pregnancy, most women would not mind the sex of the service provider but, when men brought their wives [to the facility] they often request their wives be treated by a female staff.’’

Several key informants also noted the tendency for some men not to allow their wives to give birth at health facilities due to such concerns as being treated by male service providers. As one key informant reported, *‘‘due to misunderstanding of religious teachings even at point of death, some men will not allow their wives to give birth at hospital because they will not like another man to see the nudity of their wives.’’* The analysis learned that this often lead to worsened birth complications, higher maternal mortality, decreased newborn health.

Key informants mentioned that cultural norms do not expect a woman to stay far away from the place/town where her husband or parents reside, preventing many female service providers from working in PHCs in remote rural areas. The norms do not also expect a man to follow his wife and stay with her in the community she was deployed to. This is in addition to the insecurity and the terrain in most remote rural areas which would be unbearably tough for women, according to the key informants. The implication of this is that the absence of female staff in such centers may impact women’s health outcomes.

3.3. Gender Roles, Responsibilities and Time Use

3.3.1 Financial Risk Protection

Normatively, women in Nasarawa State are expected to do unpaid domestic duties, such as cooking for the family, childcare and cleaning of the family compound, limiting their opportunities to participate in many income-generating activities. On average, the analysis learned, married women spend 3.5 or more hours on household chores per day. Such normative expectations often relegate women to the domestic sphere, and to unpaid or low paid productive economic activities, limiting their ability to earn enough money to pay their medical bills or participate in health insurance schemes.

Several key informants in Lafia noted that a man’s role within the family health care domain was to provide both permission and financial resources for his wife to seek health care during pregnancy or when she fell sick. However, many women reported that their husbands were not always in the position to provide those financial resources, which often limit their access to care. *‘‘Many a times a man will make you pregnant and travel to Benin [Edo State – Southern Nigeria usually in search of menial jobs] and leave you with no support’’*, a female respondent in Akwanga stated.

Interviews and FGDs in Plateau State reveal that societal expectations for women to meet domestic responsibilities limit their participation in income-generating activities. Key informants noted that many women, particularly those in the rural areas work mostly in the informal sector and spend more time doing unpaid jobs at home, making them unable to earn enough income to afford health services or pay health insurance premiums. *‘‘If you don’t have money you cannot think of coming to hospital because you need money to access care in our hospitals,’’* a female respondent in an FGD lamented. Another female respondent stated that, *‘‘sometimes our*

husbands refuse to allow us to come to hospitals because they don't have any money to give us, and we too don't have the money to access care." This situation is further aggravated by a widespread perception, particularly among the rural populace that one needs a lot of money to access care at a hospital.

Gender roles and responsibilities in many communities in Zamfara State are aligned with the society's patriarchal norms, ideologies and perceptions, which tend to limit a woman's roles to the private sphere; spending more time doing unpaid job at home. Furthermore, family and household responsibilities seem to prevent many women from taking formal jobs outside the towns/local government areas where their husbands reside. A 2019 WHO report validates this finding, and reports that in African countries (including Nigeria), 90 percent of women work in the informal sector and are often excluded from formal sector, employer-based health financial protection programs.[48]

Furthermore, key informants mentioned that a man's role within the family health care domain was to provide both permission and financial resources for his wife to seek care during pregnancy or when she fell sick as exactly reported in Nasarawa State. However, some female respondents reported that at some time or the other in their lives, they could not access health care because their husbands lack the financial resources.

3.3.2 Population Health Coverage

Findings in Nasarawa State revealed a de facto segregation of duties between women and men, with family health care falling under the purview and responsibility of women. Some respondents mentioned that men were expected to provide both permission and resources for the family members to seek care, while the burden of caring for the sick including taking them to the facility fell on the shoulder of the woman. *"Part of the responsibilities of a woman is to take children to hospital and the man should settle the bill"*, a key informant in Lafia stated. However, the analysis observed that there is increasing openness in Karu and Akwanga to the idea that medical bills can be shared between women and men, but women still bear the responsibility for taking children and other family members to hospital.

A synthesis of the tasks in the six PHCs visited (during the data collection exercise) showed that female service providers do more work than their male counterparts, in part because women and children who constitute the larger proportion of clients patronizing the PHCs often prefer to be attended to by female service providers. *"I would prefer to be attended to by a female service provider because as a woman she will understand my pain [sickness/condition] better than a man"*, a client found in a facility in Akwanga stated.

Key informants in Plateau State reported that differences in gender roles in the family lead to different time use that has potential impact on health outcomes. For example, in many communities on the Plateau women often woke up before dawn to perform domestic chores such as cooking, bathing children, and cleaning the home compound, which potentially increase their risk of being bitten by mosquitos because most of these tasks were carried out outside the building of the family compound. According to a female respondent in an FGD with a group of women in Shendam, *"If you need to go to hospital, you must wake up as early as 4 a.m. and do all the household chores and leave your compound for the hospital as early as 7 a.m."* When asked if leaving their compounds for the hospital at 7 a.m. was convenient, the female respondents explained that *"if you didn't go early enough, you may not receive adequate service and a long queue will greet you."* It also emerged from the analysis of the KIIs and the FGDs that in some communities, particularly Muslim communities in the state, women's restricted mobility, heavy

[48] WHO (2019). Breaking Barriers: Towards More Gender Responsive and Equitable Health Systems. Accessed at: https://www.who.int/healthinfo/universal_health_coverage/report/gender_gmr_2019.pdf?ua=1

household workloads, and time constraints due to domestic duties hamper their ability to seek health care.

Although the gender roles of men do not limit their ability to participate in IGA that could enable them to earn money and pay their medical bills, over 90 percent of the male respondents reported that their work schedules do not always allow them to access care at the health facility. According to a male key informant, *"as a man you must always strive to provide the material needs of your family, and unless the sickness is severe, one will prefer to continue managing it because of lack of time to go the hospital. […] I wanted to come to this hospital since, but my work schedule didn't allow me, but I say today [Saturday] I must come since it is weekend."* He further stated that *"even organizations tend to sympathize with women more than men when it comes to health seeking. If you are a man and always request permission to go to hospital, it can negatively affect your growth or even make you lose your job. But women don't face this challenge because they are seen as weak and so, organizations do give them more considerations."*

In Zamfara State also, it emerged from the analysis of the interviews and FGDS with groups of women that women's restricted mobility, heavy household workloads, and time constraints tend to hamper their ability to seek health care. As one female respondent in an FGD stated, ''if you have many children to care for, your day may always be hectic and will have little time to seek care for your minor health needs.''

3.3.3 Service Coverage of Quality Essential Services

Findings reveal a general absence of a balance between male and female service providers in all the three states. In Nasarawa State, findings reveal there being far more female than male service providers. However, there were no tasks that were overwhelmingly shifted down to either category of service providers. It was observed that more male staff work as pharmacists, laboratory technicians and health information management personnel rather than as nurses and midwives – professions often left for female service providers. This is also the case for Plateau State.

The situation is different in Zamfara State though. The male-controlled nature of Zamfara society engenders a de facto job segregation between male and female PHC staff with certain roles or tasks shifted down to female service providers, adding more workload to female service providers resulting in their over-utilization. Certain tasks such as antenatal, labor, immunization, and family planning fell to female service providers, while emergency typically fell to men; this creates challenges in the efficient use of time and overburdening, which may in turn affect their productivity and ability to provide quality services.

3.4 Access to and Control Over Assets and Resources

3.4.1 Financial Risk Protection

Findings indicate that the Nasarawa State health insurance scheme is currently available for the relatively small number of people that are employees of the State Government. The analysis learned that although the scheme was introduced about five years ago in the State, it is yet to be rolled out to local government staff including PHC workers and people in the informal sector. This places women, unemployed youths, and retirees at a disadvantage, since there seems to be more men in the service of the State government than women.

Findings in Plateau State reveal that many persons with disabilities lack the money and other resources that would allow them to access health insurance. *"Most of the Persons with disabilities are street beggars and seem to depend on alms, and with the current cash crunch in the country, many people don't have any cash to give them as alms. Some of them are sick but don't have any money to come to hospital and access care,"* a community leader reported. According to a service provider, *"the problem for persons with disability is that he [sic] comes to the hospital and*

after you treat him [sic] he will tell you that he [sic] has no money to pay the medical bill. Sometimes we treat them free because of their condition [disability status].'' A 2020 World Bank situational analysis validates this finding and reports that: *''Many people with disabilities do not have equal access to health care, education, and employment opportunities, do not receive the disability-related services that they require.''*[49]

As was stated in sub-section 1.2, BHCPF and the state health insurance scheme awareness is generally low, particularly among people in the informal sector in the rural areas. Many key informants stressed the importance of engaging local faith-based organizations (FBOs), civil society organizations (CSOs) and other organized structures at the grassroots, to reach out and sensitize potential enrollees, especially women who dominate the informal sector in the state.

Going by the BHCPF definition of vulnerability, many individuals and groups have been enrolled into the scheme. However, the analysis learned that the enrollment was not done properly, citing several instances of enrollees assigned to far away facilities. The implication of this ''improper'' enrollment is that many enrollees, particularly pregnant women, elderly persons, and persons with disabilities could not access services due to the distance between their communities/villages and the health facilities they were assigned to. Key informants noted that many enrollees only travel to the facilities in cases of extreme illness.

Most female respondents in Zamfara State stated that inability to pay for health services, or even afford a hospital card, is a barrier faced by women and persons with disabilities, limiting access to care for vast majority of the poor.

Several key informants maintained that women dominate the informal sector in Zamfara and their participation in health financial risk protection schemes is often a consequence of limited access to tertiary education – most families marry off their daughters after completion of secondary school education – which in turn, excludes them from formal sector employment opportunities. As such, the Zamfara health insurance agency, in its efforts to identify and plan for informal sector enrollment, should embrace a gender and equity-sensitive approach to analyze the potential needs, barriers, and constraints to reaching those within the informal sector.

It was also found that many women in Zamfara do not have access to the family's economic resources. Key informants mentioned that the degree to which a woman could manage household finances largely depended on what level of responsibility her husband/man gave her. ''Some men will not involve their wives in household financial management, but others, particularly educated men give household money management responsibilities to their wives because they believe that women are better money managers.'' Thus, the degree to which a woman has access to finances may determine her ability to pay for health care services or even participate in health financial risk protection.

3.4.2 Population Health Coverage

The analysis observed that there were shortage of Information, Education and Communication (IEC) materials about the state health insurance scheme in most of the facilities visited across the three states. The few facilities with the IECs, the materials are produced in English language – a language many clients, particularly rural women, may find difficult to read and understand. The absence of visual illustrations on the IEC materials further makes it more difficult for many clients to relate with the messages and make informed decisions about enrolling in the state financial risk protection scheme.

During interviews in Nasarawa State, key informants reported that due to heavy workloads, service providers did not always give a client the attention they deserved unless they noticed that

[49] https://blogs.worldbank.org/nasikiliza/social-inclusion-persons-disabilities-nigeria-challenges-and-opportunities

such client was in serious pain. ‘‘If you don’t appear to be in pain, you may not get their attention and those attitudes [sic] are common among service providers’’, a staff of an implementing partner stated. Such kind of provider biases can negatively impact care.

Several key informants in Plateau State stressed the need for the BHCPF to cover other groups to ensure their access to health services. A government official in Jos explained that although BHCPF was intended to provide free services for vulnerable groups enrolled into the program, there were situations where the definition of the term ‘‘vulnerable’’ may miss other groups in need of health services.’’ Many respondents called for the inclusion of services for adolescents, and this should include training of service providers to offer adolescent-friendly health care services.

A critical point noted by the analysis, however, is that none of the key informants mentioned the link between those in the informal sector and certain vulnerabilities or the high number of women in the informal sector in the state. This should necessitate a more GESI-focused approach in any outreach and enrollment drive.

Another reason why many enrollees do not patronize the facilities is that essential drugs and equipment were not always available. According to a key informant in Mangu, *‘‘it is not uncommon to visit a facility and find that it lacks essential drugs. Even with your enrollment card, sometimes you will have to buy your prescribed drugs at a chemist*[50] *[because the facility lacks the medicine].’’*

In Zamfara State, several key informants stressed the need for greater male engagement in PHC service demand. They noted that men rarely used services at PHC facilities; instead, most of them would be managing the sickness or buy over-the-counter drugs. Most key informants largely linked this to the common notion among many men that PHCs were for women and children. This thinking could be strengthened by the fact the BHCPF specifically targets women and children, as its service beneficiaries.

Key informants maintained that rural women suffered more than their urban counterparts by travelling long distances to reach health facilities. This situation is further worsened by the insecurity in Zamfara which restricts people’s mobility. People could only travel within certain hours of the day. This is especially problematic for women on labor attempting to access a facility.

Similarly, key informants mentioned that many persons with disabilities do not have access to health services because they seem to lack of knowledge of available services and other factors. According to a service provider: *‘‘Because of their low self-esteem and the necessity of asking other people to assist them to go to hospital, many disabled people prefer to manage their sicknesses or self-medicate.’’*

The analysis also found that the absence of health facilities accessible by persons with disabilities in many communities in Zamfara tend to discourage many of such persons from accessing care. *‘‘My husband has a disability and we are supposed to go to the hospital three times a week for physiotherapy but he does not like coming to hospital because of lack of facilities for persons with disabilities’’*, a female respondent in a FGD stated. For example, none of the six facilities visited in the State had dedicated toilets and accessible beds for persons with disabilities. However, two out of the six facilities visited had wheelchair ramps. Lack of access to free health care services and inconvenient schedules were also cited as factors affecting the well-being of persons with disabilities.

In terms of access to information, almost all the respondents agreed that men have more access to information than women because most women stay at home due to the purdah system and do

[50] This refers to a shop where medicinal drugs are dispensed and sold. In Nigeria, such shops are usually owned and operated by private individuals.

not tend to listen to the radio. In addition, as a female key informant observed, men would learn about new information faster than women because "they are both household and community gatekeepers.'' However, both male and female respondents agreed that in terms of spreading and utilizing information about health services, women have an edge over men. As one female key informant noted, ''women generally seem to take health information seriously, and the tendency of a woman sharing health related information she learned with other women is higher compared to men who tend to develop more interest on sharing information about politics, sport and the economy.'' The analysis also observes that across the three states several health care messages are well known to many men, but they seem to lack self-efficacy to put them into practice.

3.4.3 Service Coverage of Quality Essential Services

In Nasarawa State, key informants lamented that the services they received by the PHCs were usually inadequate, as highlighted in many of the KIIs and FGDs with both male and female respondents of different age groups and people with disabilities. The analysis also found that across all the six facilities visited, there were shortages of full-time staff and inadequate equipment to aid diagnosis. Perhaps, this explains why some people, particularly the elites, rarely patronize the PHCs. According to a service provider in Lafia, *''even for a small sickness some people will prefer to go to DASH [Dalhatu Araf Specialist Hospital – a tertiary health facility] than a PHC because they think PHCs are incapable of providing quality care.''*

In Plateau State, non-availability of service providers was cited by both young and adult female respondents as a constraint against accessing services at many PHC facilities. Several key informants noted that many PHC facilities in the state were understaffed. Commenting on the shortage of PHC service providers in the state, a key informant and also a government official reported that in 2015, the state had more than 8000 PHC staff but due to increased loss of service providers, currently the number had gone down to 3830 employees. In other words, within a span of eight (8) years the state lost more than 4000 PHC workers to retirement, death and service provider migration to higher paying federal government organizations or abroad. This situation was further made worse by the embargo on the employment of service providers in the state. Key informants lamented that for over ten (10) years there was not any recruitment of service providers in the state.

Interviews showed that female service providers faced many challenges on active participation in in-service training because most of the times, the training required more time away from home, despite the fact that some of the trainings were pre-requisites for license renewal and promotion opportunities. This creates an obstacle not only to the professional development of female PHC staff but also to their productivity and ability to provide quality services.

Both male and female service providers said there was no motivation to serve in the state-owned health facilities, particularly PHCs. They complained about delays in promotion, poor remuneration, dilapidated PHC structures and heavy workload. There was however a consensus among all the respondents that there was no gender pay gap among PHC staff, but data was not available to confirm this.

Findings also show that although BHCPF requires that PHC facilities be open and available 24 hours a day, over 90 percent of female respondents explained that due to shortage of service providers, one needed to come to a facility as early as 7 a.m. so that they could receive adequate service. According to a female respondent, *''if you want to receive adequate service you must come to the hospital as early as 6 a.m. or 7 a.m. When you come late you will meet a long queue and by the time your turn comes, the service providers might be tired and exhausted and you will not receive adequate service. […] Sometimes out of work stress and tiredness they [service providers] will shout at you even for a small thing.''*

With regards to reception of clients, while some clients thought their PHC staff members were flexible with the financial capabilities of the clients and treated them with decorum, many others complained about poor reception and lack of respect of client's rights. There were several reports of clients being asked to pay before treatment. *''If you don't have money, you can't even think of coming to hospital. […] On average I need five hundred to three thousand Naira to seek care at our community health facility,*'' a female respondent in an FGD in Shendam stated. The GESI analysis team was told of several instances of poor reception of persons with disabilities at many health facilities.

Many key informants cited the poor state of many PHC facilities as a common barrier to service utilization. For example, of the six facilities visited across the three senatorial zones in the state, only one had electricity in patient wards and consulting rooms. A service provider in Mangu told the analysis team that lack of electricity in the facility prevented many people from wanting to access services at night. He added that, **''in the event of delivery at night, we used torch lights in the labor room.''**

The analysis observed that almost all the service providers in the health facilities visited during the data collection exercise were not well-equipped to care for persons with disabilities because they lacked training on that. Similarly, some key informants noted the need for further training to enhance GESI sensitivity and awareness of service providers. This, according to a service provider in Jos North, ''will help to increase service providers ability to, for instance, recognize, treat, and effectively manage cases of gender-based violence, which are on the rise on the Plateau.''

The analysis also observed that although (GBV) services were not included in the BHCPF benefit package, many facilities informally offered limited services to GBV survivors because the staff were not trained on how to give trauma-informed care to GBV survivors. The service providers also demonstrated poor knowledge of services to which to refer a GBV survivor, such as psychosocial and legal support. However, a service provider noted that GBV had negative impacts on women's and adolescent girls' reproductive health, stating that it caused unintended pregnancy, unsafe abortion, and vulnerability to sexually transmitted infections (STIs). Although GBV could negatively impact desired health outcomes for adolescent girls and women outside of pregnancy, a desk review of the BHCPF operational guidelines showed that the scheme (BHCPF) did not capture the health needs of women outside of pregnancy.

In Zamfara State, the analysis found that across all the facilities visited, there were dilapidated structures and inadequate equipment to aid diagnosis. Availability of service providers was also a frequently cited issue. The BHCPF required PHCs to be open and available 24 hours a day. However, none of the six facilities visited operated 24 hours a day. Service providers interviewed cited poor remuneration and insecurity as reasons for many facilities being unable to meet the 24-hour requirement.

The analysis noted the absence of GBV services across all the six facilities visited. Despite the fact that GBV has significant negative impacts on women's and girls' health, the analysis learned that there was only one health facility providing GBV screening, counseling, and treatment in Zamfara. According to a government official, *''so far only King Fahad Women and Children Hospital provides full GBV services. However, there are proposals to establish one GBV service center in each senatorial district in the state.''*

With regards to reception of clients, while some clients appreciated the way service providers respected and treated them with decorum, many others complained about poor reception. *''I once go to a facility very early in the morning but the doctor did not come until 11:00 a.m. and when it was my turn around 1:00 p.m., the doctor told us that he would not attend to us because he was*

tired. That experience discourages me from wanting to seek care at government health facilities again'' a female respondent stated during an FGD.

The analysis observed that there was a general perception of lack of competence of PHC staff. As one key informant reported, ''despite the existence of many PHCs, you will find that many people still chose to go to the general hospital or even specialist hospital''. This perception is further justified by the failure of the government to equip service providers with supplies and necessary equipment to offer adequate services.

3.5 Patterns of Power And Decision-Making

3.5.1 Financial Risk Protection

A summary of responses to questions on the patterns of power and decision-making in Zamfara and Plateau states from the KIIs and FGDs pointed to the dominance of men in decision-making related to health care expenses. In this regard, men decide whether and when their wives and daughters would visit health facilities for ANC and childbirth. Almost all the female respondents reported that they needed the consent of their husbands to use money for health services – whether it be for transportation, drugs, or the cost of the health care service itself. Such gender power dynamics, the analysis learned, were closely connected to the mind-set about gender roles and responsibilities, locating more gender roles for women within the household – doing unpaid jobs, rendering them dependent on men for all their financial needs. This has an adverse effect on the health of women and girls, limiting their opportunities to seek health care services because they lack financial resources. Furthermore, this poses a problem when the husband is away and emergencies occur, when a woman must rely on others before she can seek care for herself or her children.

However, in Nasarawa findings reveal that men in many communities in the State did not always maintain power and influence in decision-making pertaining to health care. KIIs and FGDs indicate that apart from family planning services, women did not necessarily need to always seek men's consent to seek care in a facility, particularly if they could afford to pay their medical bills. *''I don't need to always tell my husband that I need to go to hospital unless if I need some money from him, but when I know that I can pay for my drugs I will just go and seek care […] the sickness is in my body not his body,''* a female respondent in Akwanga stated. Similarly, a male respondent in Karu stated that *''I am not always at home so why should I feel offended if my wife goes to hospital without informing me [asking for my consent].*''

Another relevant finding is that both male and female respondents reported that in urban areas, it was common for husbands and wives to share medical expenses (incurred by the woman or the children) based on their individual incomes. *''My wife is a petty trader. So, we always share medical expenses,''* a male respondent in Akwanga stated. *''You see marriage is about supporting each other, my wife and I do share cost of drugs but if one of us don't have money, the other will pay the expenses''*, another male respondent in Karu stated.

3.5.2 Population Health Coverage

The analysis observes that in almost all the facilities visited across the three states the relationship between clients and service providers is paternalistic, with the provider directing the client on a treatment path that should mitigate a health concern. Some respondents interviewed reported that sometimes they did not know how best to report a health care concern in this setting. Additionally, a few female respondents reported hesitation when talking to male service providers or when fear been rebuked for non-adherence. This can result in limited treatment or medication adherence, which can affect a client's health care. This underscores a need for providers to create a space in which clients feel comfortable describing their conditions and contributing their opinions

and care goals. Research has shown that a balanced client-provider relationship involves shared decision-making or lead to the practice of making treatment decisions based upon the provider expertise and client lifestyle needs and preferences.[51]

The analysis learned in Nasarawa State, that women, particularly those in Akwanga and Karu experience higher level of participation in decision-making on matters relating to health care compared to women in other parts of Northern Nigeria including Plateau and Zamfara states. Around 65 percent of female respondents including women with disabilities reported that they make decisions about their own health care and that of the children. This indicates a high level of women participation in decisions, which could suggest that women face reduced barriers to participation in decisions about health care access in Nasarawa. However, it was found that adolescents are not usually involved in decision-making at both household and community level because they are considered to be inexperienced.

The analysis learned that in many families in Zamfara, the eldest man in the family holds the power for decision-making. Key informants stated that on matters related to going to the hospital to give birth, he (the eldest man) must give approval, which is not always forthcoming because many elderly people do not seem to believe in giving birth at hospital because during their child-bearing age women usually gave birth at home. *''For me, I don't have problem with my wife to give birth at hospital, but my father would not allow that,''* a male respondent stated. This poses a problem when the eldest person is away and emergencies occur; when a woman must rely on others before she can seek care for herself or her children.

It was also found that although unmarried adolescent girls have health needs, they could not make decisions about their health. According to a young female respondent*, ''you must always request permission from you parents or the eldest person to receive health care. Even if you feel like you will die because of the pain, if your parents do not allow you to go [to health facility], you will not go.''*

3.5.3 Service Coverage of Quality Essential Services

The analysis observed that top leadership positions in the health sector are mostly occupied by men in Nasarawa State. This can be a formidable obstacle to gender equivalence in health outcomes. Of the four relevant government agencies visited, only one (i.e., Ministry of Women Affairs and Social Development) is headed by a woman. However, the permanent secretary (the second top ranking official) and 60 percent of the management team are men. The implication of this under-representation is that viewpoints and differential health needs of women and girls may not always be considered in the development and implementation of new health service policies. It was also found that there were no persons with disabilities and young people in both the governing boards and management boards of the ministries and agencies visited, so their perspectives are not included in discussions about health services.

Findings from Plateau State reveal that in all the government agencies visited, leadership positions in the health sector are mostly occupied by men. A synthesis of responses to this question indicates that the domination of decision-making processes at all levels by men is a strong barrier to gender equality in health outcomes, as health needs of women and girls may not always be given the attention they deserve because there are a few women in leadership positions to add their perspectives.

A summary of responses from Zamfara State indicates that the domination of decision-making process at high level in the health sector by men is a great impediment to gender equivalence in health outcomes. Of the five relevant government agencies visited, only one (i.e., Ministry of

[51] Heath, S., 2018. Understanding the Power Hierarchy in Patient-Provider Relationships. https://patientengagementhit.com/news/understanding-the-power-hierarchy-in-patient-provider-relationships

Women Affairs) is headed by a woman. None of the agencies has a person with disability as a member of the management team. On the involvement of youth in decision-making, key informants explained that decisions in respect of health services were usually taken by top ranking officers while most youth were only beginners or in the middle level of their careers. The implication of this under-representation is that viewpoints and health needs of women, persons with disabilities, and young people may not always be considered in the development and implementation of new health service policies.

4. STAKEHOLDER MAPPING

As LHSS Nigeria is committed to implementing programs and activities with GESI lens, the analysis has identified some stakeholders[52] that can be engaged in project implementation across target states. Please refer to Annex C for a list of stakeholders identified. The analysis recommends that the capacity of the stakeholders/local partners be built on GESI within the health sector in Nigeria to ensure that a commitment to GESI integration is locally owned and extends beyond the project's life in support of the journey to self-reliance. The GESI training will increase knowledge and equip stakeholders/local partners with the skills to enable them to recognize and address gender and other social inequalities, raise awareness about GESI issues, and explore ways to respond to the GESI issues within the context of health systems strengthening in focus states.

5. CONCLUSIONS

This analysis investigated GESI considerations that affect access to and utilization of health care services in Nasarawa, Plateau and Zamfara states. The analysis shows and concludes that across the three states, gender-blind health policies, regulations, institutional practices[53], and health sector policy makers' limited knowledge of GESI issues results in insufficient institutionalization of efforts to address GESI-based and other types of barriers in health financial risk protection schemes, as well as population health coverage efforts and service coverage of quality essential health services. Pervasive cultural norms and beliefs about gender roles, responsibilities and relations continue to influence access to and utilization of health services, particularly at PHC level, often to the detriment of women and children, adolescents, people living with disabilities, and men as well.

Furthermore, lack of equitable access of both women and men, youth and persons with disabilities to top leadership and management positions in the health sector prevents diverse leadership opinions, which could positively influence health outcomes for women and men, girls and boys from different social groups. Although women and adolescent girls across the three states tend to face higher health care costs than their male counterparts due to RMNCAH needs, they have less ability to pay for health services and have limited access to employer-based health insurance programs, which affects their health outcomes.

The absence of facilities accessible for persons with disabilities in most of the health facilities across the three states hinders access to health services for many of these individuals. This is further exacerbated by the lack of well-trained service providers on providing care to persons with

[52] A stakeholder is an individual or organization who are interested in or can influence the process of gender integration in the implementation of LHSS Nigeria project.

[53] A gender-blind policy, regulation or institutional practice tends to ignore gender norms, roles, and relations and may potentially reinforce gender-based discrimination, biases and stereotypes.

disabilities, elderly populations and adolescents. Furthermore, due to poor service provider treatment during ANC, labor and childbirth, many pregnant women and pregnant adolescent girls with disabilities do not often seek care at health facilities.

Finally, shortage of service providers, equipment to aid diagnosis and dilapidated structures in many PHC facilities across the three states results in some people particularly those in urban areas not seeking care at the facilities because they tend to perceive PHCs as lacking the capacity to provide quality essential health care services.

6. RECOMMENDATIONS

The findings of this GESI analysis report offer the following key recommendations to strengthen the project implementation approaches and ensure GESI integration in LHSS Nigeria programs and activities:

6.1 Financial Risk Protection

- Invest in sensitizing the population on the importance of health financial protection programs. Evidence from this GESI analysis shows that a general lack of awareness exists about the schemes, particularly among people in the informal sector, which impacts women and their children more than men.
- Design health financial protection programs to enhance and expand understanding and knowledge of GESI among policy makers, decision makers and government agency staff tasked with implementing the state health financial risk programs and the BHCPF intervention. This can include GESI awareness-raising activities, training, and hands-on technical assistance to integrate GESI considerations into financial risk protection schemes and the BHCPF program implementation efforts.
- Collaborate with the USAID/Nigeria Economic Growth Office and relevant implementing partners to support policy makers in target states to design, allocate resources for, and implement more women and youth economic empowerment programs that could reduce the financial barriers to health services they (women, youths and other persons facing vulnerability) face across the three states.
- Provide technical support to reviewing the state health financial protection policies and strategic plans to ensure they are GESI-sensitive.
- Encourage policy makers in target states to develop policies that would reduce financial barriers to health services for women and girls, youths, persons with disabilities, retirees, and persons facing vulnerability.

6.2 Population Health Coverage

- Support state health insurance agencies in target states to embrace a GESI-sensitive approach to analyze the potential needs, barriers, and constraints to reaching more people with health care services in the informal sector and underserved, marginalized populations in general.
- Coordinate social and behavior change interventions with partners and USAID funded projects, including Breakthrough Action at the grassroots level to transform socio-cultural norms that create misperceptions which negatively impact health outcomes, such as preventing pregnant women from giving birth at health facility. This can involve designing

programs that will enable people at the grassroots level to realize that their preconceived ideas or beliefs, for example, about giving birth at home, are no longer valid or relevant.

- 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 top leadership in health sector in target states. Complete the recommendation by adding how this will improve population health coverage for women, youth, people with disabilities, the elderly.
- Build the advocacy skills of some women-led civil society organizations to advocate for an affirmative action program to ensure that a significant percentage of top leadership and management positions in health sector are held by women, people with disabilities and youth.
- Support the state health insurance agencies to ensure that demand generation and community mobilization efforts involve meaningful engagement of men (including male teenagers) as supportive partners, GESI champions, and health service users. Campaigns to target men should enlist the support of traditional and religious leaders. It should also involve recording and sharing testimonies of men who have used PHC services and are satisfied with their experience.
- Invest in training health service providers on evidence-based techniques to improve care provision to elderly populations, adolescents and persons with disabilities.

6.3 Service Coverage

- Work with implementing partners such Breakthrough Action to coordinate social and behavior change interventions at the grassroots to encourage receiving care from both male and female service providers. This can be done through enrollee town hall meetings, engagement of traditional and religious leaders, and sponsoring radio programs that would employ the strategy of creating reality around issues to make people see reasons for receiving care from service providers irrespective of their gender.
- Build advocacy skills of relevant CSOs to advocate for recruitment of more health service providers and timely payment of their salaries and other benefits. This should involve training the CSOs on strategies of engaging policy makers to see reasons for improving the working conditions for service providers at PHC facilities – salary increase, on-time and regular payment of salaries, implementation of promotions, and provision of essential supplies and equipment to perform their jobs. These measures are particularly important for women health service providers who are often paid less than men, experience GBV and harassment on the job, do not receive the same professional development opportunities as men, and often do not have adequate personal protective equipment.
- Support policy makers to equip more BHCPF supported facilities with necessary infrastructure accessible to enhance access and ease-of-use by persons with disabilities.
- Support policy makers to ensure that facilities are open for longer hours to allow men and adolescent boys returning late from farms and other workplaces and women to access the facilities at time convenient for them, giving their many responsibilities.
- Support government agencies tasked with implementation of the BHCPF to clarify, expand and finalize the definition of disability to ensure clients are not overlooked and efforts to enhance accessibility of facilities are inclusive and considerate of all needs for persons with disabilities.

- Build capacity of relevant local CSOs to advocate to policy makers to equip more PHCs with adequate space and privacy measures for all clients, to ensure confidentiality, especially for pregnant women, women in labor and adolescent clients.
- Support government agencies tasked with BHCPF implementation to expand benefits packages to include GBV services. This should also involve designing a program to train health service providers on evidence-based ways to provide first-line support to GBV survivors.
- Invest in research on GESI issues, gaps and opportunities facing access to and utilization of health services at PHC level; disseminate the results widely to partners and stakeholders and use them to guide the design and implementation of LHSS Nigeria programs and activities.

Implementation Of The Recommendations

To ensure effective implementation of the recommendations, a twin-track approach should be employed. Applying this (twin-track) approach means ensuring women, men, girls and boys from different social groups have equal rights and opportunities to participate and benefits from LHSS Nigeria interventions.

7. GESI ACTION PLAN

The GESI Action Plan is designed to support LHSS Nigeria leadership to ensure implementation approaches are gender and socially inclusive, and advance GESI goals to create transformative change. The plan provides framework for supporting work plan development, MEL, and communications and knowledge management activities. Using this Action Plan, LHSS Nigeria will ensure better integration of GESI considerations in developing and implementing specific programs and activities in target states.

Table 4. GESI Action Plan

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
LHSS Nigeria Results Area 1: Financial Risk Protection						
Expand financial risk protection	Hold validation workshops to present findings of the GESI analysis to relevant stakeholders and partners	Nasarawa, Plateau and Zamfara states	FY23 Q4		LHSS Nigeria leadership/GESI Advisor	Number of stakeholders and partners that participated in the workshop and agreed that the GESI analysis findings obtained from the data collected achieves the underlying objectives that formed the basis of the study
	Pay courtesy visits to relevant policy makers and decision makers to discuss relevant GESI findings with them and explore ways of addressing them (ex: absence of gender policies to guide GESI integration in the implementation of the state health insurance programs, opportunities for reducing financial barriers to health services faced by women, unemployed youths, persons	Nasarawa, Plateau and Zamfara states	FY23 Q4		LHSS Nigeria Leadership/GESI Advisor	Number of policy makers and decision makers visited and participated in the discussion on the GESI findings.

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
	with disabilities, lack of gender-balance of service providers, shortage of persons with disabilities-friendly facilities and equipment at PHC level, poor working conditions for PHC staff and its impact on service delivery, etc.)					Number health financing policies and action plans that are GESI responsive
	Design programs to enhance and expand GESI understanding and knowledge among decision makers and staff of government agencies tasked with implementing the state health financial risk programs and the BHCPF intervention.	Nasarawa, Plateau and Zamfara states	FY23 Q4		LHSS Nigeria GESI Advisor/MEL Specialist	Number of decision makers and staff of local partners with increased understanding of GESI issues with health sector in Nigeria. Improved understanding and commitment to supporting enrollment of women and men, girls and boys from different social groups into the state financial risk protection programs
	Work with identified gender champions in target states to mobilize traditional and religious leaders to sensitize people at grassroots level about the advantages of supporting women and men, girls and boys from different social groups to enroll in the health financial risk protection scheme	Nasarawa, Plateau and Zamfara states		FY24 Q1-4	LHSS Nigeria GESI Advisor/Health Finance Advisor/Communication Specialist/MEL Specialist	
Increase knowledge, skills and attitudes among health service providers on GESI issues in pre-service training	Invest in training service providers on client reception to promote gender-responsive service delivery at health facilities	Nasarawa, Plateau and Zamfara states		FY 24 Q1-2	LHSS Nigeria GESI Advisor/MEL specialist	Improved understanding of GESI issues affecting service delivery and rights of male and female clients

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
LHSS Nigeria Results Area 2: Population Health Coverage						
Influence changes in existing social norms and beliefs that prevent men from seeking care at health facilities	Coordinate social and behavior change interventions with Breakthrough Action and relevant local CSOs to transform cultural norms to increase men's health seeking behavior.	Nasarawa, Plateau and Zamfara states		FY24 Q1-4	LHSS Nigeria communication specialist/GESI Advisor/MEL Specialist	Number of men that seek care at BHCPF supported PHC facilities
To build capacity of decision-makers and staff of relevant government agencies on how to collect and use gender-related data for decision-making.	Design a program to build capacity of decision makers and staff of relevant government agencies to collect, analyze, use, and report sex- and age-disaggregated data.	Nasarawa, Plateau and Zamfara states	FY23 Q4	FY 24 Q1	LHSS Nigeria MEL Specialist/GESI Advisor	Number of decision makers and staff of relevant government agencies with necessary skills needed for the collection, analysis, reporting and use of sex-disaggregated data
	Implement a program to build capacity of HRH decision makers and staff of relevant government agencies to collect, analyze, use, and report sex- and age-disaggregated data.		FY23 Q4	FY24 Q1		
	Support state health insurance agencies (SHIAs) and state primary health care agencies/boards (SPHCDAs/Bs) to integrate GESI in strengthening their health planning, research and statistics departments/units	Nasarawa and Zamfara	FY23 Q4	FY24 Q1-4	LHSS Nigeria MEL Specialist/GESI Advisor LHSS Nigeria MEL Specialist/GESI Advisor	Number of databases, policies, or procedures in use for gender-responsive decision-making
	Develop an accountability mechanism for measuring the extent to which sex- and age- and disability disaggregated data is being collected and used for decision-making.	Nasarawa, Plateau and Zamfara states		FY24 Q2		

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
Strengthen GESI integration with governance and management of health insurance schemes.	Work with decision-makers to ensure that GESI is integrated into Monitoring and Evaluation frameworks and capacity-building plans across the SHIAs and SPHCDAs/Bs	Nasarawa, Plateau and Zamfara states	FY23 Q4			
Promote women in leadership positions	Design a program to strengthen the capacity of some identified women-led civil societies to push for affirmative action in health leadership.	Nasarawa, Plateau and Zamfara states		FY 24 Q2-3	LHSS Nigeria GESI Advisor	
Change in social norms and beliefs that prevent clients from seeking care from service provider of opposite sex	Work with Breakthrough Action Nigeria to design social and behavior change interventions at the grassroots to encourage receiving care from health providers irrespective of their gender.	Nasarawa, Plateau and Zamfara states		FY 24 Q1-4	LHSS Nigeria Communication Specialist/GESI Advisor	Belief of some clients and families that seeking care from health service provider of opposite sex in PHCs is acceptable
Strengthen the capacity and authority of gender focal points to make them more effective in discharging their duties and responsibilities	Advocate for the establishment of gender focal points across all SHIAs and SPHCDAs/Bs	Nasarawa, Plateau and Zamfara	FY23 Q4		LHSS Nigeria leadership	Number of gender focal points established
	Design a program to strengthen the capacity of gender focal points and actively engage them in designing and implementing LHSS Nigeria Project programs and activities.	Nasarawa, Plateau and Zamfara	FY23 Q4	FY 24 Q1-4	LHSS Nigeria GESI Advisor/LHSS Nigeria leadership	Number of trained gender focal points
	Build political will for the gender focal points within the government institutions to push for gender equity and inclusion in population health coverage beyond donor-driven interventions.	Nasarawa, Plateau and Zamfara	FY23 Q4		LHSS Nigeria leadership/GESI Advisor	

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
LHSS Nigeria Results Area 3: Service Coverage of Quality Essential Services						
Advocate better working conditions for PHC staff	Build capacity of relevant local CSOs to advocate for better working conditions for PHC staff to ensure retention of more health service providers that would provide quality services women and children who constitute the larger proportion of clients patronizing PHC facilities.[54]	Nasarawa, Plateau and Zamfara		FY 24 Q1-2	LHSS Nigeria Leadership	Monthly payment of reasonable salary and other benefits
Increase number of female service providers	Collaborate with the Health Workforce Management (HWM) to support pre-service training of more PHC female health service providers	Zamfara	FY23 Q4	FY24 Q1-4	LHSS Nigeria leadership	Number of trained female service providers
Improve understanding of GESI barriers and constraints that affect access to and utilization of health services	Invest in research on GESI issues, gaps and opportunities facing access to and utilization of health services at PHC level	Nasarawa, Plateau and Zamfara	FY 23 Q4	FY 24 Q1-4	LHSS Nigeria leadership	Improved understanding of GESI barriers and constraints that affect access to and utilization of health services among project staff
Cross-cutting						
Integrate GESI across MEL and communications and knowledge management activities in LHSS Nigeria.	Design a system for integrating GESI into LHSS Nigeria knowledge management activities related to GESI. This should involve developing effective ways/tools of gathering, organizing, storing, sharing relevant GESI research findings.	Abuja	FY 23 Q4	FY 24 Q1-4	LHSS Nigeria Communications Specialist/GESI Advisor/MEL Specialist	Number of studies and information on GESI in health sector shared with relevant partners and stakeholders

[54] However, to make this case or support others to, a budget analysis might be necessary to see how much each target state allocate for salaries and other entitlements of service providers so that the project can advise how much to increase this by.

OBJECTIVES	ACTIVITIES	TARGET STATES	TIME LINE		RESPONSIBILITY	INDICATORS
			FY23	FY24		
	Disaggregate relevant MEL indicators by sex and age.	Abuja, Nasarawa, Plateau and Zamfara	FY23 Q4	FY24 Q1-4	LHSS Nigeria MEL Specialist	N/A

8. REFERENCES

Abimbola, S., U. Okoli, O. Olubajo, M.J. Abdullahi and M.A. Pate. 2012. The midwives service scheme in Nigeria. *PLoS Med. 2012;9(5): e1001211*.

Automated Directive System (ADS) 205. https://www.usaid.gov/sites/default/files/documents/1870/205.pdf

Barau, M. (2021). Gender and Health care in Northern Nigeria. *Degel: The Journal of FAIS*, 18(1): 47-60.

Dataphyte (2023). Nasarawa governor improves IGR but poverty, joblessness still big issues. https://www.dataphyte.com/latest-reports/nasarawa-governor-improves-igr-but-poverty-joblessness-still-big-issues/

Gustafsson-Wright and Schellekens (2013) Achieving Universal Health Coverage in Nigeria One State at a Time. https://www.brookings.edu/wp-content/uploads/2016/06/Achieving-Universal-Health-Coverage-in-Nigeria.pdf

Lindenberg, S, Joly, J.F, & Stapel, D.A. 2011. The Norm-Activating Power of Celebrity: The Dynamics of Success and Influence. *Social Psychology Quarterly*, 74 https://journals.sagepub.com/doi/full/10.1177/0190272511398208

Mohammed, A., P. Agwu and U. Okoye. 2020. When Primary Health care Facilities are Available but Mothers Look the Other Way: Maternal Mortality in Northern Nigeria. *Social Work in Public Health. 35 (1).*

Nasarawa State Ministry of Health, Nasarawa State Strategic Health Development Plan, 2016-2022 (Unpublished document).

National Population Commission (NPC) and ICF. 2019. 2018 Nigeria Demographic and Health Survey (DHS). Abuja: National Population Commission and ICF.

Nnamuchi, O., et al. (2019), Successes and Failures of Social Health Insurance Schemes in Africa-Nigeria versus Ghana and Rwanda: A Comparative Analysis. *Annals of health law* / Loyola University Chicago, School of Law, Institute for Health Law, 28: p. 127 – 148

Okerere, E., G. Unumeri. A. Akinola, G. Eluwa and S. Adebajo. 2020. Female clients' gender preferences for frontline health workers who provide maternal, newborn and child health (MNCH) services at primary health care level in Nigeria. *BMC Health Services Research, 20: 441.*

Oni, M. Abiodun, and B. Olayinka (2019). Awareness of and Access to National Health Insurance Scheme in Nigeria and Ghana. https://www.iosrjournals.org/iosr-jhss/papers/Vol.%2024%20Issue4/Series-10/J2404105769.pdf

Plateau State Ministry of Health, Plateau State Strategic Health Development Plan, 2016-2022. https://www.nipc.gov.ng/nigeria-states/nassarawa-state/

Statista (2022). Poverty Headcount in Nigeria. https://www.statista.com/statistics/1121438/poverty-headcount-rate-in-nigeria-by-state/

The Initiative for Equal Rights (2019). 2019 Report on Human Rights Violations based on Real or Perceived Sexual Orientation and Gender Identity in Nigeria. https://www.africaportal.org/publications/2019-report-human-rights-violations/

The Lancet (2018). Measuring performance on the Health care Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from

the Global Burden of Disease Study 2016. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30994-2/fulltext

Umeh, C.A. (2018), Challenges toward achieving universal health coverage in Ghana, Kenya, Nigeria, and Tanzania. Int J Health Plann Manage, 33(4): p. 794-805

UNICEF (2021). Situation of Women and Children in Nigeria. https://www.unicef.org/nigeria/situation-women-and-children-nigeria

USAID Local Health Systems Sustainability Nigeria (2022). Request For Applications (RFA) #Nigeria-Yr1-001. https://www.lhssproject.org/about/grants-and-rfps/organizational-capacity-assessment-and-strengthening-nigeria

USAID/Nigeria. 2020. USAID/Nigeria Gender Analysis Report. Prepared independently by a Gender

Analysis Team under the USAID Monitoring, Evaluation and Learning (MEL) Activity.

USAID (2022). Global Health. https://www.usaid.gov/nigeria/global-health

World Bank (2020). Social inclusion of persons with disabilities in Nigeria: Challenges and opportunities.

https://blogs.worldbank.org/nasikiliza/social-inclusion-persons-disabilities-nigeria-challenges-and-opportunities

World Bank (2019a). https://datatopics.worldbank.org/world-development-indicators/stories/many-economies-in-ssa-larger-than-previously-thought.html

World bank (2019b). UHC service coverage index. https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD

WHO (2019c). Breaking Barriers: Towards More Gender Responsive and Equitable Health Systems. https://www.who.int/healthinfo/universal_health_coverage/report/gender_gmr_2019.pdf?ua=1

WHO (2016). Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals. Human Resources for Health Observer Series No. 17. 16117-Health workforce requirements for universal health coverage and the Sustainable Development Goals _ for Web (who.int)

World Health Organization, World Report on Disability, (2011), http://www.who.int/disabilities/world_report/2011/report.pdf?ua=1

ANNEXES

ANNEX A: ETHICAL APPROVAL LETTERS TO CONDUCT THE GESI ANALYSIS

Institutional Review Board Notice of Approval

Principal Investigator/Project Director: Bolanle Olusola-Faleye

Project Title: LHSS Nigeria Gender Equality and Social Inclusion (GESI) Analysis

Sponsor Agency: USAID

Abt IRB #: 2195

Determination: Exempt (with Limited IRB review) per 45CFR46.104(d)(2)(iii)

Protocol Approval Date: 2/28/2023

Review Type: Limited IRB Review

Please note the following requirements:

Problems or Adverse Reactions: If any problems in treatment of human subjects or unexpected adverse reactions occur as a result of this study, you must notify the IRB Chairperson or IRB Administrator immediately.

Changes in Study: This exemption and approval only applies to the protocol submitted to the IRB for review at this time. Should there be changes to the protocol (including the data security plan) in the future, the study changes should be submitted to determine whether further IRB review is required.

Teresa Doksum, Ph.D., M.P.H.
IRB Chair
Abt Associates Inc.
10 Fawcett Street, Suite 5
Cambridge, MA 02138
Irb@abtassoc.com
617-349-2896

Date: 3/2/2023

Cc: Ekpenyong Ekanem

National Health Research Ethics Committee of Nigeria (NHREC)

Promoting Highest Ethical and Scientific Standards for Health Research in Nigeria

Federal Ministry of Health

NHREC Protocol Number NHREC/01/01/2007-10/03/2023
NHREC Approval Number NHREC/01/01/2007-15/03/2023
Date: 15th March, 2023

Re: Gender Equality and Social Inclusion (GESI) Analysis

Health Research Committee assigned number: NHREC/01/01/2007

Name of Principal Investigator: Umar Ahmed
Address of Principal Investigator: LHSS Project Nigeria
No. 12, T.O.S Benson Crescent
Utako District, Abuja
Email: uahmed@banyaglobal.com
Tel: +2347021569155

Date of receipt of valid application: 10/03/2023
Date when final determination of research was made: 15-03-2023

Notice of Expedited Committee Review and Approval

This is to inform you that the research described in the submitted protocol, the consent form, advertisements and other participant information materials have been reviewed and *given expedited committee approval by the National Health Research Ethics Committee.*

This approval dates from 15/03/2023 to 14/03/2024. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. ***All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.*** **In multiyear research, endeavour to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.**

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit to your research site without previous notification.

Signed

Professor Zubairu Iliyasu MBBS (UniMaid), MPH (Glasg.), PhD (Shef.), FWACP, FMCPH, FFPH(UK)
Chairman, National Health Research Ethics Committee of Nigeria (NHREC)

NASARAWA STATE OF NIGERIA

MINISTRY OF HEALTH

Ministry of Health Headquarters Private Mail Bag 032 Lafia, Nasarawa State
E-mail: healthnasarawa@gmail.com

NHREC Protocol No: 18/06/2017
31st March 2023

Principal Investigator: Bolanle Olusola Felaye
Chief of Party
LHSS Nigeria,
No. 12 TOS Benson Crescent,
Utako, Abuja.

ETHICAL APPROVAL FOR THE STUDY:
To conduct Baseline Study of Gender Equality and Social Inclusion(GESI) in Nasarawa State

With reference to your letter 14th March, 2023. Requesting ethical approval to conduct a study with the above title, the Health Research Ethics Committee has studied your proposal and determined that it has not more than minimal risk for the participants. You have therefore been given Expedited approval for the study in line with the recommended National Health Research Ethics Committee approved with effect from 31st March, 2023

You are required to send a progress report to the ethical committee and to report any adverse event accordingly should they occur.

You are to adhere strictly to the approved research protocol and submit a copy of the outcomes of the research and a policy brief to the Ministry of Health HREC secretariat.

Dr. Danjuma O. Baba
Secretary, Nasarawa State HREC

SECRET

GOVERNMENT OF PLATEAU STATE

MINISTRY OF HEALTH HEADQUARTERS

P.M.B. 2014, JOS, PLATEAU STATE MOH/MIS/202/VOL.T/X

Ref:

In replying please quote reference and date all correspondence should be directed to the commissioner

Ministry of Health Headquaters,
Private Mail Bag No. 2014,
Jos, Plateau State.

Date: 20th March, 2023

Plateau State Coordinator,
Local Health System Sustainability (LHSS) Project,
Jos, Plateau State,
Nigeria.

RE: APPLICATION FOR ETHICAL APPROVAL TO CONDUCT BASELINE STUDY OF GENDER EQUALITY AND SOCIAL INCLUSION (GESI) IN PLATEAU STATE

I have been directed to refer to your communication on the above subject dated 8th March 2023.

The Ministry has granted you permission to conduct a baseline study of Gender Equality and Social Inclusion **(GESI)** as it relates to access to and utilization of health services for the poor and vulnerable among the LHSS supported States between **March and April 2023** titled "**Gender Equality and Social Inclusion (GESI) Analysis** in Plateau State.".

Please note that the participation of any individual or group in this study is optional and you are required to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly.

You are also requested to send a copy of your research findings to the Ministry, please.

Victoria M. Pam
DHPRS
For: Hon. Commissioner

ZAMFARA STATE OF NIGERIA

ZAMFARA STATE HEALTH RESEARCH ETHICS COMMITTEE
MINISTRY OF HEALTH
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Notice of Full Approval after full Committee Review

Health Research Committee assigned number:	ZSHREC28032023/111
Project Title:	Baseline Study of Gender Equality and Social Inclusion (GESI) in Zamfara State
Researcher's Name	Umar Ahmad Deji Bodunde
Supervisors	Dr. Bolanle Olusola-Faleye
Purpose of Study:	The purpose of this GESI analysis is to inform the implementation approaches for LHSS Nigeria, ensuring that gender equality and social inclusion considerations are addressed and fully integrated in all elements of the project. Understanding the differential needs and vulnerabilities of men and women, boys and girls, PWD, the poor, elderly, and other marginalized groups will help to identify target populations, tailor the response, and dedicate resources where they are most needed.
Institution / University	LHSS-USAID, Bayan Global

This is to inform you that the research described in the submitted protocol, the consent forms, advertisements and other participant information materials have been reviewed and given full approval by the Health Research Ethics Committee. This approval dates from **28th March, 2023 to 28th March, 2024** . If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the ZSHREC assigned number and duration of ZSHREC approval of the study. The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the ZSHREC. No changes are permitted in the research without prior approval by the ZSHREC except in circumstances outlined in the Code. The ZSHREC reserves the right to conduct compliance visit to your research site without previous notification and to have copy of your findings after the research.

AHMAD RUFAI HALILU
SECRETARY ZSHREC
For: Chairman, ZSHREC

ANNEX B: DATA COLLECTION TOOLS

KII and FGD Guide for Women and Adolescent Girls (Ages 18-21 years)
LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

Table 5. Data Collection Tools

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Have you been enrolled in any financial risk protection scheme in your state? If yes, when? If no, why do you think you are left out? **Probe:** If you are enrolled, which of the financial risk protection scheme you belong to, e.g., BHCPF, SHIA, NHIA, Private HMO? 2. Are there any laws, policies, regulations, or hospital institutional practices that you think will facilitate or prevent women and girls from enrolling in financial risk protection scheme in your state. insurance scheme?
Improve population health coverage	3. What laws, policy or hospital institutional practices needs to be changed, amended or reformed to improve health coverage for women and girls in your state? 4. Are there any enabling laws, policies or hospital institutional practices that are increasing or could increase women's and girls' access to health care services?
Increase number of fully functional facilities	5. Within the last one year, do you seek care at a PHC? If yes, is the facility providing quality health care services? Tell me about your experience at the facility you visited. **Probe:** If no, what prevents you from seeking care at a PHC health facility? 6. In your opinion, would you say that hospital institutional practices at health facilities in your state are girls and women-friendly? Please explain your response. **Probe:** how could the health facilities be made more girl and women-friendly?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	7. What cultural norms and beliefs do you think prevent women and girls from enrolling in financial risk protection scheme in your state?
Improve population health coverage	8. What cultural norms and beliefs impact on efforts to provide health services to more women and girls? 9. Does being a woman or girl affects your health seeking behaviors? Please explain your response. 10. What cultural norms and beliefs barriers do women and adolescent girls face when accessing sexual and reproductive health services and information about such services?
Increase number of fully functional facilities	11. Between male and female health workers, who would you prefer to receive care from, and why? 12. How do traditional beliefs about gender impact on demand for modern health care for women and girls in your community/state?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	13. Would you say that your household chores and caregiving roles prevent you from affording and accessing health services? Please explain your response. 14. What financial barriers to health services do you face as a result of your gender roles and responsibilities? How could such barriers be reduced? Who could play what role?
Improve population health coverage	15. Are health services in your community/state provided at a time and place where women and girls can balance care and family responsibilities? Please elaborate your response.
Increase number of fully functional facilities	16. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	17. Are you aware of health services provided by the PHC in your community? **Probe:** If yes, do you think women and girls have equitable access to such services? Give specific examples. If no, what do you think prevents you from having such access?
Improve population health coverage	18. Do women and girls have equitable access to information regarding health services provided in the health facilities in your community/state? If yes, how and where do women and girls access such information? If no, what prevents them from having such access? 19. Can an 18-year-old unmarried girl access RH/FP information and services in health facilities in your community without a male partner or guardian? 20. What are the impacts of disability on women and girls comparative to men and boys in terms of access to health services in your state?
Increase number of fully functional facilities	21. Would you say that there is equal representation of male and female health workers in the PHC in your community that could address your needs as a woman/girl? 22. Do you face any transportation or distance related barriers to accessing health services? If yes or no, please give specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	23. Who decides if and how health care is accessed at household level, and why? **Probe:** How could this gender power relations be transformed? Who could play what role? 24. If you want to enroll in a financial risk protection scheme, would you need consent of your husband or male guardian? If yes or no, please explain.
Improve population health coverage	25. If there is a new information about health services, between women and men who is likely going to learn about it first, and why?
Increase number of fully functional facilities	26. Between a health facility headed by a woman and the one headed by a man, which would you prefer to seek care, and why? 27. Would you say that health workers in health facilities in your community/state treat women and girls with respect?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII and FGD Guide for Men and Adolescent Boys (Ages 18-21 years)

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Have you been enrolled in any financial risk protection scheme in your state? If yes, when? If no, why do you think you are left out? **Probe:** If you are enrolled, which of the financial risk protection scheme you belong to, e.g., BHCPF, SHIA, NHIA, Private HMO? 2. Are there any laws, policies, regulations, or hospital institutional practices that you think will facilitate or prevent women and girls from enrolling in financial risk protection scheme in your state?
Improve population health coverage	3. What laws, policy or hospital institutional practices needs to be changed, amended or reformed to improve health coverage for men and boys in your state? 4. Are there any enabling laws, policies or hospital institutional practices that are increasing or could increase men's and boys' access to health care services?
Increase number of fully functional facilities	5. Within the last one year, do you seek care at a health facility? If yes, is the facility providing quality health care services? Tell me about your experience at the facility you visited. **Probe:** If no, what prevents you from seeking care at a health facility? 6. In your opinion, would you say that hospital institutional practices at health facilities in your state are men and boys-friendly? Please explain your response. **Probe:** how could the facilities be made more men and boys-friendly?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	7. What cultural norms and beliefs do you think prevent men and boys from enrolling in financial risk protection scheme in state?
Improve population health coverage	8. What cultural norms and beliefs impact on efforts to provide health services to more men and boys? 9. Does being a man or boy affects your health behaviors? Please explain your response. 10. In your opinion, would you say men and boys benefit from health services the same way as women and girls? Who benefit more, and why?
Increase number of fully functional facilities	11. Between male and female health workers, who would you prefer to receive care from, and why? 12. What challenges are you facing in terms of access to health care services at your community PHC as a result of cultural norms and beliefs?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	13. How do your gender roles influence you when taking certain health risks? How do this impact the health of your family and their ability to access health insurance or afford health services. 14. What financial barriers to health services do you face as a result of your masculine gender roles and responsibilities?
Improve population health coverage	15. Are health services in your community/state provided at a time and place where men can balance work and/or business activities? Please elaborate your response.
Increase number of fully functional facilities	16. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	17. Are you aware of health services provided by the PHC in your community? **Probe:** If yes, do you think men and boys have equitable access to such services? Give specific examples. If no, what do you think prevents you from having such access?
Improve population health coverage	18. Do men and boys have equitable access to information regarding health services provided in the health facilities in your community/state? If yes, how and where do men and boys access such information? If no, what prevents them from having such access? 19. What are the impacts of disability on women and girls comparative to men and boys in terms of access to health services in your state?
Increase number of fully functional facilities	20. Would you say that there is equal representation of male and female health workers in the PHC in your community that could address your needs as a man/boy? 21. Do you face any transportation or distance related barriers to accessing health services? If yes or no, please give specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	22. If your woman/wife or daughter leave home and get family planning or reproductive health services without your permission, what would be your reaction? 23. Does your wife/woman or mother influence your decision to seek health services? **Probe:** Does your wife or woman influence your decision to enroll in a financial risk protection scheme?
Improve population health coverage	24. If there is a new information about health services, between women and men who is likely going to learn about it first, and why?
Increase number of fully functional facilities	25. Between a health facility headed by a woman and the one headed by a man, which would prefer to seek care, and why? 26. Would you say that health workers in health facilities in your community/state treat men/boys with respect?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for PWD (over 18 years old)

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Have you been enrolled in any financial risk protection scheme in your state? If yes, when? If no, why do you think you are left out? **Probe:** If you are enrolled, which of the financial risk protection scheme you belong to e.g., BHCPF, SHIA, NHIA, Private HMO? 2. Are there any laws, policies, regulations, or hospital institutional practices that you think will facilitate or prevent PWD from enrolling in a financial risk protection scheme in your state?
Improve population health coverage	3. What laws, policy or hospital institutional practices needs to be changed, amended or reformed to improve health coverage for PWD in your state? 4. Are there any enabling laws, policies or hospital institutional practices that are increasing or could increase PWD's access to health care services?
Increase number of fully functional facilities	5. Within the last one year, do you seek care at a PHC? If yes, is the health facility providing quality health care services? Tell me about your experience at the health facility you visited. **Probe:** If no, what prevents you from seeking care at a health facility? 6. In your opinion, would you say that hospital institutional practices and infra-facilities at PHCs in your state are PWD-friendly? Please explain your response. **Probe:** How could the health facilities be made more PWD-friendly?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	7. What cultural norms and beliefs do you think prevent PWD from enrolling in a financial risk protection scheme in your state scheme?
Improve population health coverage	8. What cultural norms and beliefs impact on efforts to provide health services to more PWD? 9. Does being a male or female PWD affects your health seeking behaviors? Please explain your response. 10. What cultural norms and beliefs barriers do female PWD face accessing sexual and reproductive health services and information about such services?
Increase number of fully functional facilities	11. Between male and female health workers, who would you prefer to receive care from, and why? 12. How do traditional beliefs about gender impact on demand for modern health care for PWD particularly female PWD in your community/state?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	13. Would you say that your household chores and caregiving roles prevent you from affording and accessing health services? Please explain your response. 14. What financial barriers to health services do you face as a result of your gender roles and responsibilities? How could such barriers be reduced?
Improve population health coverage	15. **Female PWD:** Are health services in your community/state provided at a time and place where female PWD can balance care and family responsibilities? Please elaborate your response.

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	Male PWD: Are health services in your community/state provided at a time and place where male PWD can balance work and/or business activities? Please elaborate your response.
Increase number of fully functional facilities	16. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	17. Are you aware of health services provided by the PHC in your community? **Probe:** If yes, do you think male and female PWD have equitable access to such services? Give specific examples. If no, what do you think prevents male or female PWD from having such access?
Improve population health coverage	18. Do male and female PWD have equitable access to information regarding health services provided in the health facilities in your community/state? If yes, how and where do male or female access such information? If no, what prevents them from having such access? 25. Can an 18-year-old unmarried PWD woman or adolescent girl access RH/FP information and services in health facilities in your community without a male partner or guardian? 19. What are the impacts of disability on women and girls comparative to men and boys in terms of access to health services in your state?
Increase number of fully functional facilities	20. Would you say that there is equal representation of male and female health workers in the PHC in your community that could address your needs as a woman/girl? 21. Do you face any transportation or distance related barriers to accessing health services? If yes or no, please give specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	22. **FEMALE PWD:** Who decides if and how health care is accessed at household level, and why? **Probe:** How could this gender power relations be transformed? If you want to enroll in a health insurance scheme, would you need consent of your husband or male guardian? If yes or no, please explain. 23. **MALE PWD**: If your woman/wife or daughter leave home and get family planning or reproductive health services without your permission, what would be your reaction? Does your wife/woman or mother influence your decision to seek health services? **Probe:** Does your wife or woman influence your decision to enroll in a health insurance scheme?
Improve population health coverage	24. If there is a new information about health services, between male and female PWD who is likely going to learn about it first, and why?
Increase number of fully functional facilities	25. Between a health facility headed by a woman and the one headed by a man, which would prefer to seek care, and why? 26. Would you say that health workers in health facilities in your community/state treat PWD with respect?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for Community Leaders (traditional rulers, religious leaders, women leaders, PWD leaders, youth leaders)

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged people in your community? How do you identify/determine that particular individual/group is disadvantaged? 2. Have people in this community been enrolled in any financial risk protection scheme? If yes, when? If no, why do you think they are left out? **Probe:** If you are enrolled, which of the financial risk protection scheme you belong to, e.g., BHCPF, SHIA, NHIA, Private HMO? 3. What laws, policy or hospital institutional practices prevent or facilitate enrollment of more people, particularly women and girls, PWD, the poor, and disadvantaged individuals/groups in your state health insurance scheme? 4. What opportunities exist for increasing financial risk protection for people in this community particularly women and girls, PWD, the poor and disadvantaged individuals/groups? What role could you play in creating or utilizing such opportunities? Who else could play a role?
Improve population health coverage	5. What laws, policy or hospital institutional practices related barriers do women and girls, PWD, the poor and disadvantaged individuals face when seeking health services? **Probe:** Give some specific examples. 6. What laws, policy or institutional practices needs to be changed, amended or reformed to improve health coverage for people in this community, particularly women and girls, the poor, PWD and disadvantaged people? And what opportunities exist for changing the laws? Who role could you play? Who else could play a role? 7. Are there any enabling policies or institutional practices that are increasing or could increase your people access to health care services?
Increase number of fully functional facilities	8. In your opinion, would you say that developing or changing particular laws or policies or institutional practices could result in making more health facilities to function well or provide quality services to the people in this community/state, particularly women and girls, the poor, PWD, and disadvantaged people? **Probe:** Please elaborate your response. 9. In your opinion, would you say that institutional practices at health facilities in your state are gender response and socially inclusive? Please explain your response. **Probe:** How could the health facilities be made more gender and socially inclusive?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	10. What cultural norms and beliefs prevent people in this community, particularly women and girls, PWD, and disadvantaged individuals from enrolling in any financial risk protection in your state health insurance scheme? **Probe:** How could such norms be transformed? What role could you play? Who else could play a role?
Improve population health coverage	11. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes, please elaborate.
Increase number of fully functional facilities	12. Would a woman or an adolescent girl allow a male health worker to provide for care to her? If yes, which care could she allow? If no, why? **Probe:** What about men and boys – could they allow a female health worker to provide care to them? Please give specific examples. 13. How do traditional beliefs about gender impact on demand for modern health care for women and girls in your community/state? 14. What cultural norms and beliefs related barriers do people in this community, particularly women and girls face in accessing sexual and reproductive health services and information about such services? **Probe:** What role could you play in transforming such beliefs? Who else could play a role? 15. What cultural norms and beliefs related challenges do you face in helping your people to access health services? 16. What traditional beliefs about age of an individual or his/her disability status impact his/her seeking care services at health facilities?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	17. What financial barriers to health services do people in this community, particularly women and girls face as a result of their gender roles and responsibilities? **Probe:** How could such barriers be reduced? What role could you play? Who else could play a role?
Improve population health coverage	18. Are health services provided at a time and place where women and girls can balance care and family responsibilities? Please elaborate your response. 19. Are health services provided at a time and place where men and boys can balance work and family responsibilities? Please elaborate your response.
Increase number of fully functional facilities	20. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	21. Are many people in this community including women and girls, PWD, and disadvantaged individuals aware of health services provided by the PHCs in your community? **Probe:** If yes, do the people in this community have access to such services? Please give specific examples. If no, what do you think prevents them from having access?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	22. What can be done to improve awareness? What role could you play? Who else could play a role? 23. How could equitable access to health services be promoted in this community/state? What role could you play? Who else could play a role?
Improve population health coverage	24. How do men's and women's access to and control over community resources affect their ability to: a. Decide to seek care? b. Reach the right level of care? c. Access transport to care? d. Access health information? e. Get appropriate care? 25. What are the impacts of disability on women and girls comparative to men and boys in terms of access to health services in your state?
Increase number of fully functional facilities	26. Would you say that there is equal representation of male and female health workers in the PHC in your community that could address differential needs of women and men, girls and boys?

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	27. What role do women and men in this community play in family health? Who takes health decisions? Who pays for the services, and why? **Probe:** How could this gender power relations be altered or transformed?
Improve population health coverage	28. Do you think women and men receive equal information related to health services? **Probe:** If there is a new information about health services, between women and men who is likely going to learn about it first, and why?
Increase number of fully functional facilities	29. Would you say that health workers in health facilities in your community/state treat people, particularly women and girls, and PWD with respect? Please elaborate your answer with specific examples.
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for WDC

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged people in your community? How do you identify/determine that particular individual/group is disadvantaged? 2. Have people in this community been enrolled in any financial risk protection scheme? If yes, when? If no, why do you think they are left out? **Probe:** If you are enrolled, which of the financial risk protection scheme you belong to, e.g., BHCPF, SHIA, NHIA, Private HMO? 3. What laws, policy or hospital institutional practices prevent or facilitate enrollment of more people, particularly women and girls, PWD, the poor, and disadvantaged individuals/groups in your state health insurance scheme? 4. What opportunities exist for increasing financial risk protection for people in this community particularly women and girls, PWD, the poor and

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	disadvantaged individuals/groups? What role could you play in creating or utilizing such opportunities? Who else could play a role?
Improve population health coverage	5. What is your understanding of the BHCPF, including the state social health insurance scheme, and its implementation in X state, in terms of 1) reach and coverage over the years and 2) specific clients/target beneficiaries? 6. In your oversight of primary health care service delivery in this ward, what would you say are the major gender and equity issues that affect 1) health outcomes and 2) access to PHC services? 7. BHCPF including the state health insurance scheme, if implemented effectively, are key to increasing health care coverage for Nigerians, and reducing out-of-pocket spending on health care services, which for many can be devastating. How are gender and equity issues important to increasing this coverage? 8. What laws, policy or hospital institutional practices related barriers do women and girls, PWD, the poor and disadvantaged individuals face when seeking health services? **Probe:** Give some specific examples. 9. What laws, policy or institutional practices needs to be changed, amended or reformed to improve health coverage for people in this community, particularly women and girls, the poor, PWD and disadvantaged people? And what opportunities exist for changing the laws? Who role could you play? Who else could play a role? 10. Are there any enabling policies or institutional practices that are increasing or could increase your people access to health care services? 11. A key mandate of the WDC is to essentially bridge the gap between the health facility and the community served, acting as a monitor of service quality. How is gender and equity important to that mandate? How does the WDC address gender and equity issues? 12. Are there active civil society groups that champion community needs (prompt: gender and equity issues, women's groups, youth groups, men's groups, etc.)? Which ones do you work with? 13. What other community leaders, champions, or gatekeepers do you interact with in your work? Who has the most influential voice?
Increase number of fully functional facilities	14. In your opinion, would you say that developing or changing particular laws or policies or institutional practices could result in making more health facilities to function well or provide quality services to the people in this community/state, particularly women and girls, the poor, PWD, and disadvantaged people? **Probe:** Please elaborate your response. 15. In your opinion, would you say that institutional practices at health facilities in your state are gender response and socially inclusive? Please explain your response. **Probe:** How could the health facilities be made more gender and socially inclusive?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	16. What cultural norms and beliefs prevent people in this community, particularly women and girls, PWD, and disadvantaged individuals from enrolling in any financial risk protection in your state health insurance scheme? **Probe:** How could such norms be transformed? What role could you play? Who else could play a role?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Improve population health coverage	17. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes, please elaborate.
Increase number of fully functional facilities	18. Would a woman or an adolescent girl allow a male health worker to provide for care to her? If yes, which care could she allow? If no, why? **Probe:** What about men and boys – could they allow a female health worker to provide care to them? Please give specific examples. 19. How do traditional beliefs about gender impact on demand for modern health care for women and girls in your community/state? 20. What cultural norms and beliefs related barriers do people in this community, particularly women and girls face in accessing sexual and reproductive health services and information about such services? **Probe:** What role could you play in transforming such beliefs? Who else could play a role? 21. What cultural norms and beliefs related challenges do you face in helping your people to access health services? 22. What traditional beliefs about age of an individual or his/her disability status impact his/her seeking care services at health facilities?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	23. What financial barriers to health services do people in this community, particularly women and girls face as a result of their gender roles and responsibilities? **Probe:** How could such barriers be reduced? What role could you play? Who else could play a role?
Improve population health coverage	24. Are health services provided at a time and place where women and girls can balance care and family responsibilities? Please elaborate your response. 25. Are health services provided at a time and place where men and boys can balance work and family responsibilities? Please elaborate your response.
Increase number of fully functional facilities	26. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	27. Are many people in this community including women and girls, PWD, and disadvantaged individuals aware of health services provided by the PHCs in your community? **Probe:** If yes, do the people in this community have access to such services? Please give specific examples. If no, what do you think prevents them from having access? 28. What can be done to improve awareness? What role could you play? Who else could play a role? 29. How could equitable access to health services be promoted in this community/state? What role could you play? Who else could play a role?
Improve population health coverage	30. How do men's and women's access to and control over community resources affect their ability to: a. Decide to seek care?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	b. Reach the right level of care? c. Access transport to care? d. Access health information? e. Get appropriate care? 31. What are the impacts of disability on women and girls comparative to men and boys in terms of access to health services in your state?
Increase number of fully functional facilities	32. Would you say that there is equal representation of male and female health workers in the PHC in your community that could address differential needs of women and men, girls and boys?

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	33. What role do women and men in this community play in family health? Who takes health decisions? Who pays for the services, and why? **Probe:** How could this gender power relations be altered or transformed?
Improve population health coverage	34. Do you think women and men receive equal information related to health services? **Probe:** If there is a new information about health services, between women and men who is likely going to learn about it first, and why?
Increase number of fully functional facilities	35. Would you say that health workers in health facilities in your community/state treat people, particularly women and girls, and PWD with respect? Please elaborate your answer with specific examples. 36. Tell me about the structure of the Ward Development Committee (WDC) – what is the sex ratio within the committee? What types of community members and interests are represented? Are there any gaps?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for NGOs/CSOs

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Are you aware of government established health insurance scheme in this state? If yes, what laws, policies or institutional practices you identified that prevent or facilitate enrollment of more people, particularly women and girls, PWDs, the poor and disadvantaged individuals in the schemes? 2. Who are the disadvantaged individuals/groups in the communities you work in this state? How do you determine that particular person/group is disadvantaged? 3. In your understanding of the primary health care service delivery in this state, what would you say are the major gender and equity issues that affect 1) health outcomes and 2) access to PHC services? 4. BHCPF including the state health insurance scheme, if implemented effectively, are key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	5. What opportunities exist for developing or implementing policies that could help increase enrollment of more people, particularly women and girls, PWD, the poor in the state health insurance schemes? What role could your organization play in creating or utilizing such opportunities? Who else could play a role?
Improve population health coverage	6. What policy reforms needs to be done to improve health coverage for women and men, girls and boys, PWD, elderly, the poor, and people facing vulnerability in this state? 7. What resources and skills do you need to enable you and/or your organization to function well and support efforts towards improving population health coverage in this state? 8. Out-of-pocket spending on health is a critical issue in Nigeria and in this state. In your opinion, how are gender and equity issues relevant? 9. In response to reducing out-of-pocket, the BHCPF and the state health insurance scheme are intended to cover the informal sector, which is largely dominated by women. How should the scheme reach these women? What inequities or obstacles are important to consider? 10. Per the BHCPF, states have the choice to expand the benefit package. The current package is designed to target children under 5 and pregnant women. Do you feel it adequately addresses considerations of gender, equity, and inclusivity and those requisite health needs? How might it expand? What is missing? 11. GBV (such as rape, assault, domestic violence) treatment and referral services are not included in the benefit package. Is there support for or acknowledgment of the need to include these services? Please explain.
Increase number of fully functional facilities	12. In your opinion, would you say that developing or changing, amending or reforming particular laws or policy or institutional practices could result in making more health facilities to function well or provide quality services to women and girls in the state? **Probe:** If yes or no, please explain. 13. What has your organization done in the past, in terms of policy advocacy and also creating local initiatives towards getting government to increase the number of fully functional facilities? 14. How do you work with/interact with state government (SPHCB, SHIA, SMoH, etc.) agencies and departments in addressing gender issues/disparities? 15. What community groups, leaders, and/or champions are critical to involve in addressing gender and equity in the BHCPF and the state health insurance scheme?

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	16. What cultural norms and beliefs prevent people, particularly women and girls, PWD, the poor and disadvantaged people from enrolling in the state health insurance scheme?
Improve population health coverage	17. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes, please elaborate. 18. What cultural norms and beliefs impact on PWD access to health services and health behaviors?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase number of fully functional facilities	19. Are there cultural norms that impact equitable access to health services or health outcomes you observed at the beginning of your intervention changing or have they remained the same? **Probe:** Are the norms limiting or advancing women's and girls' access to health services, and how?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	20. What financial barriers to health services do people, particularly women and girls face as a result of gender roles? How could such barriers be reduced? What role could your organization play towards reducing the barriers? Who else could play a role?
Improve population health coverage	21. In your opinion, would you say that gender roles/responsibilities of women and girls prevent them from having equitable access to quality health services in this state? Please elaborate your response. 22. Would you say that there sufficient and appropriate HRH to deliver equitable accessible services to women and girls, men and boys, PWD, Elderly in this state? What are the gaps?
Increase number of fully functional facilities	23. What cultural norms and beliefs related barriers do adolescent girls and young women face accessing sexual and reproductive health services and information about such services? 24. Who has the responsibility of promoting and monitoring GESI in your organization? Is there a Gender Focal Point/Taskforce? **Probe:** Do staff with responsibility for GESI have the capacity to implement their mandate? If yes or no, please explain.

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	25. What financial barriers to health services do women and girls face as a result of their gender roles and responsibilities? How could such barriers be reduced? Who could play what role?
Improve population health coverage	26. Are health services provided at a time and place where women and girls can balance care and family responsibilities? Please elaborate your response.
Increase number of fully functional facilities	27. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	28. What role do women and men in the communities you work play in family health? Who takes health decisions at household level, and why? How could such power relations be transformed? What role could your organization play?
Improve population health coverage	29. Do women and men equally receive health services information in this state? **Probe:** If there is a new information about health services, which gender or category of people is likely going to know about it first, and why? 30. What could you or your organization do to ensure equitable and inclusion access to health services information?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase number of fully functional facilities	31. In what ways could your organization support and be supported in making advocacy to the state government to increase number of fully functional facilities and make the facilities gender and socially inclusive?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for SHIA

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged individuals/groups in your state? How do you identify/ determine that particular individuals/groups are disadvantaged? **Probe:** Do you conduct vulnerability mapping? If yes, how does it guide your state health insurance plans and perhaps implementation? If no, what technical support do you need to conduct the vulnerability mapping? 2. In your work in primary health care over time, what would you say are the major issues and barriers to women's as different from men's access to 1) health outcomes and 2) PHC [primary health care] services? 3. What laws, policies or institutional practice related factors/issues affect financial risk protection for women and girls, PWD, the poor, disadvantaged individuals/groups? 4. What opportunities exist for increasing financial risk protection for women and girls, PWD, the poor, and disadvantaged individuals/groups in the state? How could your organization play a role in utilizing or creating and facilitating such opportunities?
Improve population health coverage	1. BHCPF and state health insurance scheme, if implemented effectively, are key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC? Probe: What is SHIA's role, with respect to addressing gender and equity issues related to achieving UHC? 2. Has your organization ever developed a policy or design programs for improving population health coverage? If yes, what works well and what has not in terms of increasing health access for women and girls, men and boys, young people, PWD, elderly, the poor, and disadvantaged individuals/groups? 3. What technical skills do you need to enable you and/or your organization to develop and implement gender-responsive policies that would facilitate access to health care services?
Increase number of fully functional facilities	4. In your opinion, would you say that developing or changing, amending or reforming particular laws or policy or institutional practices could result in making more health facilities to function well or provide quality services to women and girls in the state? **Probe:** If yes or no, please explain.

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	5. What cultural norms and beliefs prevent people, particularly women and girls, PWD, the poor and disadvantaged individuals/groups from enrolling in the state health insurance scheme?
Improve population health coverage	6. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes or no, please elaborate. 7. What cultural norms and beliefs impact on PWD access to health services and health behaviors? **Probe:** Are there other barriers that young people or PWD might face from a health worker?
Increase number of fully functional facilities	8. Would the gender of a health worker make a difference in whether people get health care in your state?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	9. What financial barriers to health services do people, particularly women and girls face as a result of gender roles and responsibilities? How could such barriers be reduced? What role could your organization play towards reducing the barriers? Who else could play a role?
Improve population health coverage	10. Do gender roles and responsibilities impact your organization's efforts towards improving population health coverage in the state? Please explain. 11. Are health services provided at a time and place where women and girls can balance care and family responsibilities?
Increase number of fully functional facilities	12. Are there certain tasks shifted down or overwhelmingly to female or male health workers at PHCs in the state?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	13. Are there any differences in how women and men obtain health insurance information, differences in ability to enroll (e.g., some schemes require the head of household to apply), and differences in managing it and health-related expenses (e.g., sometimes women have to ask a male partner for funds for health expenses)? 14. How could LHSS Project provide your organization technical support to fulfill its mandate regarding making health services accessible, affordable to the poor and disadvantaged individuals/groups?
Improve population health coverage	15. The state health insurance scheme, under the BHCPF, is intended to reach the vulnerable – defined as pregnant women, children under 5, the aged, and people with disabilities. In your opinion, is that adequate for addressing gender and equity under the scheme? Is there anyone left out (prompt: adolescent girls, young married women, considerations of income, geographic distribution, etc. – other dimensions of equity)? **Probe:** Is there someone within the agency (i.e., designated focal point or champion) who is responsible for overseeing attention to reaching those vulnerable groups?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	What about attention to gender issues overall? If there is someone, how influential are they? 16. Considering vulnerable groups, what civil society groups are active around those issues, as well as other gender and equity issues? Which ones do you work with? 17. State health insurance schemes under the BHCPF are also intending to cover the informal sector. In your opinion, what are the potential challenges or obstacles to reaching that informal sector? 18. What is your organization doing to provide equitable and inclusive access to health care services for disadvantaged individuals/groups, including women and girls, PWD, the poor, and elderly? **Probe:** What more could your organization do to make health service access more equitable and responsive to different health needs of these populations? 19. Per the BHCPF, states have the choice to expand the benefit package. The current package is designed to target children under 5 and pregnant women. Do you feel it adequately addresses considerations of gender, equity, and inclusivity and those requisite health needs? How might it expand? What is missing? 20. GBV (such as rape, assault, domestic violence) treatment and referral services are not included in the benefit package. Is there support for or acknowledgment of the need to include these services? Please explain. 21. What would you say are the major barriers to widespread enrollment in the state health insurance scheme? What are the opportunities? How does the SSHIA plan to address the barriers?
Increase number of fully functional facilities	22. Do women and men have equal access to top leadership and management positions within the health sector in your state? Please elaborate your response with specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	23. What role do women and men play in family health? Who takes health decisions at household level, and why? 24. How could this gender power relations be transformed? What role could your organization play? Who else could play a role?
Improve population health coverage	25. If there is a new information about health services, between women and men who is likely going to know about it first, and why? 26. How do you collect or use sex- and age-disaggregated data in your work? If gaps or inequities are identified, how do you address them?
Increase number of fully functional facilities	27. Are women well represented in decision making and management process of health facilities in this state? If yes or no, please explain. 28. Tell me about the structure of the SSHIA and governing board. What is the sex ratio in terms of staffing and within SSHIA structures in general? At the leadership level?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for SPHCDA

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged individuals/groups in your state? How do you identify/ determine that particular individuals/groups are disadvantaged? **Probe:** Do you conduct vulnerability mapping? If yes, how does it guide your state health insurance plans and perhaps implementation? If no, what technical support do you need to conduct the vulnerability mapping? 2. What is your understanding of the BHCPF, including the state social health insurance scheme, and its implementation in X state, in terms of 1) reach and coverage over the years and 2) specific clients/target beneficiaries? 3. What laws, policies or institutional practice related factors/issues affect financial risk protection for women and girls, PWD, the poor, disadvantaged individuals/groups? 4. What opportunities exist for increasing financial risk protection for women and girls, PWD, the poor, and disadvantaged individuals/groups in the state? How could your organization play a role in utilizing or creating and facilitating such opportunities?
Improve population health coverage	5. In your work in primary health care over time, what would you say are the major gender and equity issues that affect 1) health outcomes and 2) access to PHC services? 6. BHCPF including the state health insurance scheme, if implemented effectively, are key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC? 7. Has your organization ever developed a policy or design programs for improving population health coverage? If yes, what works well and what has not in terms of increasing health access for women and girls, men and boys, young people, PWD, elderly, the poor, and disadvantaged individuals/groups? 8. What technical skills do you need to enable you and/or your organization to develop and implement gender-responsive policies that would facilitate access to health care services? 9. Core functions of the SPHCB are to ensure and manage state-wide PHC health worker availability and skills at all PHC facilities, as well as supervision of service quality and oversight of service deployment to ensure equitable distribution. Explain how the SPHCB factors and/or addresses gender and equity under these functions. 10. If gender and equity is addressed, who leads this – is there a focal point or champion within the board? 11. How do you factor in/address gender balance/ratio in assessing PHC health worker distribution and coverage? How is ensuring the availability of both male and female health workers critical to service availability? What strategies are in place to ensure the presence of skilled, female as well as male health workers in rural PHCs [primary health care facilities]? 12. Do PHC health workers receive gender sensitization training? What of members of the SPHCB?
Increase number of fully functional facilities	13. In your opinion, would you say that developing or changing, amending or reforming particular laws or policy or institutional practices could result in

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	making more health facilities to function well or provide quality services to women and girls in the state? **Probe:** If yes or no, please explain.

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	14. What cultural norms and beliefs prevent people, particularly women and girls, PWD, the poor and disadvantaged individuals/groups from enrolling in the state health insurance scheme?
Improve population health coverage	15. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes or no, please elaborate. 16. What cultural norms and beliefs impact on PWD access to health services and health behaviors? **Probe:** Are there other barriers that young people or PWD might face from a health worker?
Increase number of fully functional facilities	17. Would the gender of a health worker make a difference in whether people get health care in your state?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	18. What financial barriers to health services do people, particularly women and girls face as a result of gender roles and responsibilities? How could such barriers be reduced? What role could your organization play towards reducing the barriers? Who else could play a role?
Improve population health coverage	19. Do gender roles and responsibilities impact your organization's efforts towards improving population health coverage in the state? Please explain. 20. Are health services provided at a time and place where women and girls can balance care and family responsibilities?
Increase number of fully functional facilities	21. Are there certain tasks shifted down or overwhelmingly to female or male health workers at PHCs in the state?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	22. Are there any differences in how women and men obtain health insurance information, differences in ability to enroll (e.g., some schemes require the head of household to apply), and differences in managing it and health-related expenses (e.g., sometimes women have to ask a male partner for funds for health expenses)? 23. How could LHSS Project provide your organization technical support to fulfill its mandate regarding making health services accessible, affordable to the poor and disadvantaged individuals/groups?
Improve population health coverage	24. What is your organization doing to provide equitable and inclusive access to health care services for disadvantaged individuals/groups, including women and girls, PWD, the poor, and elderly? **Probe:** What more could your organization do to make health service access more equitable and responsive to different health needs of these populations?
Increase number of fully functional facilities	25. Do women and men have equal access to top leadership and management positions within the health sector in your state? Please elaborate your response with specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	26. What role do women and men play in family health? Who takes health decisions at household level, and why? 27. How could this gender power relations be transformed? What role could your organization play? Who else could play a role?
Improve population health coverage	28. If there is a new information about health services, between women and men who is likely going to know about it first, and why? 29. A core function of the SPHCB is around community participation and ensuring ward development committees have adequate representation by women (at least 30 percent). In your opinion, is this result generally achieved? What are the obstacles to achieving this? How can the participation of younger women/men be assured/increased? 30. How do you collect or use sex- and age-disaggregated data in your work? If gaps or inequities are identified, how do you address them?
Increase number of fully functional facilities	31. Tell me about the structure of the State Primary Health Care Board (SPHCB) – governing board and management team. What is the sex ratio within both?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for SMoH and MOWA & SD

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged individuals/groups in your state? How do you identify/ determine that particular individuals/groups are disadvantaged? **Probe:** Do you conduct vulnerability mapping? If yes, how does it guide your state health insurance plans and perhaps implementation? If no, what technical support do you need to conduct the vulnerability mapping? 2. What laws, policies or institutional practice related factors/issues affect financial risk protection for women and girls, PWD, the poor, disadvantaged individuals/groups? 3. In your understanding of the primary health care service delivery in this state, what would you say are the major gender and equity issues that affect 1) health outcomes and 2) access to PHC services? 4. What opportunities exist for increasing financial risk protection for women and girls, PWD, the poor, and disadvantaged individuals/groups in the state? How could your organization play a role in utilizing or creating and facilitating such opportunities?
Improve population health coverage	5. BHCPF including the state health insurance scheme, if implemented effectively, are key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC? 6. Has your organization ever developed a policy or design programs for improving population health coverage? If yes, what works well and what has not in terms of increasing health access for women and girls, men and

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
	boys, young people, PWD, elderly, the poor, and disadvantaged individuals/groups? 7. What technical skills do you need to enable you and/or your organization to develop and implement gender-responsive policies that would facilitate access to health care services?
Increase number of fully functional facilities	8. In your opinion, would you say that developing or changing, amending or reforming particular laws or policy or institutional practices could result in making more health facilities to function well or provide quality services to women and girls in the state? **Probe:** If yes or no, please explain.

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	9. What cultural norms and beliefs prevent people, particularly women and girls, PWD, the poor and disadvantaged individuals/groups from enrolling in the state health insurance scheme?
Improve population health coverage	10. Are there cultural norms and beliefs that impair women's and girls' access to health services? If yes or no, please elaborate. 11. What cultural norms and beliefs impact on PWD access to health services and health behaviors? **Probe:** Are there other barriers that young people or PWD might face from a health worker?
Increase number of fully functional facilities	12. Would the gender of a health worker make a difference in whether people get health care in your state?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	13. What financial barriers to health services do people, particularly women and girls face as a result of gender roles and responsibilities? How could such barriers be reduced? What role could your organization play towards reducing the barriers? Who else could play a role?
Improve population health coverage	14. Do gender roles and responsibilities impact your organization's efforts towards improving population health coverage in the state? Please explain. 15. Are health services provided at a time and place where women and girls can balance care and family responsibilities? 16. What community groups, leaders, and/or champions are critical to involve in addressing gender and equity in the BHCPF and the state health insurance scheme?
Increase number of fully functional facilities	17. Are there certain tasks shifted down or overwhelmingly to female or male health workers at PHCs in the state?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	18. Are there any differences in how women and men obtain health insurance information, differences in ability to enroll (e.g., some schemes require the head of household to apply), and differences in managing it and health-related expenses (e.g., sometimes women have to ask a male partner for funds for health expenses)? 19. How could LHSS Project provide your organization technical support to fulfill its mandate regarding making health services accessible, affordable to the poor and disadvantaged individuals/groups?
Improve population health coverage	20. What is your organization doing to provide equitable and inclusive access to health care services for disadvantaged individuals/groups, including women and girls, PWD, the poor, and elderly? **Probe:** What more could your organization do to make health service access more equitable and responsive to different health needs of these populations? 21. BHCPF and the state health insurance schemes are intended to cover the informal sector, which is largely dominated by women. How should the scheme reach these women? What inequities or obstacles are important to consider? 22. Per the BHCPF, states have the choice to expand the benefit package. The current package is designed to target children under 5 and pregnant women. Do you feel it adequately addresses considerations of gender, equity, and inclusivity and those requisite health needs? How might it expand? What is missing? 23. GBV (such as rape, assault, domestic violence) treatment and referral services are not included in the benefit package. Is there support for or acknowledgment of the need to include these services? Please explain.
Increase number of fully functional facilities	24. Do women and men have equal access to top leadership and management positions within the health sector in your state? Please elaborate your response with specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	25. What role do women and men play in family health? Who takes health decisions at household level, and why? 26. How could this gender power relations be transformed? What role could your organization play? Who else could play a role?
Improve population health coverage	27. If there is a new information about health services, between women and men who is likely going to know about it first, and why?
Increase number of fully functional facilities	28. Are women well represented in decision making and management process of health facilities in this state? If yes or no, please explain.
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

KII Guide for Health Workers

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	1. Who are the disadvantaged individuals/groups in your community/state? How do you determine that particular individuals/groups are disadvantaged? 2. What is your understanding of the BHCPF, including the state social health insurance scheme, and its implementation in X state, in terms of 1) reach and coverage over the years and 2) specific clients/target beneficiaries? 3. In your work in primary health care over time, what would you say are the major gender and equity issues that affect 1) health outcomes and 2) access to PHC services? 4. What laws, policy or institutional practice related factors/issues facilitate or prevent enrollment of more people, particularly women and girls, PWD, and the poor in the state health insurance scheme? 5. What opportunities exist for increasing financial risk protection for women and girls, PWD, the poor, and disadvantaged individuals/groups in the state? What role could you or your health facility play in utilizing such opportunities?
Improve population health coverage	6. What laws, policy or hospital institutional practices facilitate or prevent effective utilization of health services at PHCs by women and girls? Men and boys? PWD? 7. Are there any institutional practice change you would want to see change that would make it easy for people, particularly disadvantaged individuals/groups to access health services at state-owned health facilities?
Increase number of fully functional facilities	8. In your opinion, would you say that developing or changing, amending or reforming particular laws or policy or hospital institutional practices could result in making more health facilities to function well or provide quality services to women and girls in the state? **Probe:** Please explain your response.

CULTURAL NORMS AND BELIEFS

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	9. What cultural norms and beliefs prevent people, particularly women and girls, PWD, the poor and disadvantaged individuals/groups from enrolling in the state health insurance scheme?
Improve population health coverage	10. Are there cultural norms and beliefs that impair women's and girls' access to health services? Please elaborate your response. 11. What cultural norms and beliefs impact on PWD access to health services and health behaviors? 12. Would the gender of a health worker make a difference in whether people get health care in your state?
Increase number of fully functional facilities	13. How do gender norms strengthen or impede your work as a health service provider?

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	14. What financial barriers to health services do people, particularly women and girls face as a result of gender roles and responsibilities? How could such barriers be reduced? Who could play what role?
Improve population health coverage	17. Are health services provided at a time and place where women and girls can balance care and family responsibilities? Please explain your response with specific examples. 18. Tell me about the structure of the Ward Development Committee (WDC) – what is the sex ratio within the committee? What types of community members and interests are represented? Are there any gaps?
Increase number of fully functional facilities	19. Are there certain tasks shifted down or overwhelmingly to female or male health workers at your community PHC?

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	20. What opportunities exist for improving access to health services and providing associated financial support for women and girls, PWD, and disadvantaged individuals/groups? What could what role in utilizing such opportunities?
Improve population health coverage	21. Do unmarried young women and adolescent girls have equitable access to family planning and reproductive health in health facilities in the state? If yes, give specific examples. Can they access them without a male guardian? 22. What would you say are the major barriers to widespread enrollment in the state health insurance scheme? What are the opportunities? How does the SSHIA plan to address the barriers?
Increase number of fully functional facilities	23. Are GBV treatment and referral services offered in this facility? 24. Do women and men have equal access to information about essential services at the state-owned health facilities? Please explain your response with specific examples. 32. If a young woman or adolescent girl learns about a new family planning method, can she go to a health facility to obtain it on her own, without a male partner or guardian? 25. Do women and men have equal access to top leadership and management positions within the health sector in this state? Please elaborate your response with specific examples.

PATTERNS OF POWER AND DECISION-MAKING

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase financial risk protection	26. What role do women and men in this community play in family health? Who takes health decisions? Who pays for the services, and why? How could this gender power relations be altered or transformed?
Improve population health coverage	27. Could a woman or adolescent girl independently act on the health information she receives without having to involve male partner or guardian? 28. How do gender power dynamics influence equitable access to care at health facilities in this state?

LHSS Objectives	Suggested GESI Analysis Questions, per ADS 205 Domain
Increase number of fully functional facilities	29. Between a health facility headed by a woman and the one headed by a man, which would you prefer to be deployed to work there, and why?
	Is there anything relevant to our discussion you want to tell me, which I didn't ask you about?

ANNEX C: STAKEHOLDER MAPPING OF GESI CHAMPIONS

Table 6. List of stakeholders identified [55]

Name of organization	Contact person (Title and level)	Level of influence	Type of influence	Priority of engagement	Role and type of engagement
Plateau State Contributory Health Care Management Agency, Jos	Director General	High	Develop and implement local health insurance policies and plans	Important (Inform, consult, collaborate and involve)	Engagement in planning, implementation and monitoring of project's programs and activities
Ministry of Women Affairs	Director Women	High	Develop and implement policies and plans on women empowerment	Important (Inform, consult, collaborate and involve)	Engagement in the implementation of project's programs and activities
Individual Advocate	Department of Health Planning, and Research Staff, Plateau State Ministry of Health	Moderate	Catalytic	Somewhat important (Advocate)	Launch meeting
State Coordinating Operating Unit (SOCU), Jos	Deputy Director	Moderate to High	Identification of the poor and persons facing vulnerability	Important (Inform, consult, collaborate and involve)	Engagement in the implementation of project's programs and activities
Kingdom Kids Club, Jos	CEO and founder	High	Catalytic	Important (inform, collaborate and involve)	Continous engagement

[55] Table 6 is adapted from the WHO medical eligibility criteria for contraceptive use (MEC) and Selected practice recommendations for contraceptive use (SPR) into national family planning guidelines. stakeholder-mapping-tool.pdf (who.int)

Name of organization	Contact person (Title and level)	Level of influence	Type of influence	Priority of engagement	Role and type of engagement
Christian Women for Excellence and Empowerment in Nigeria (CWEEN), Jos	Program Officer	Moderate to High	Community mobilizer	Important (inform, collaborate and involve)	Continous engagement
Nasarawa State Health Insurance Agency	Director General	High	Develop and implement local health insurance policies and plans	Important (Inform, consult, collaborate and involve)	Engagement in the planning, implementation and monitoring of project's programs and activities
Ministry of Health, Lafia	Permanent Secretary	High	Develop and implement local health services policies and plans	Important (Inform, consult, collaborate and involve)	Engagement in the planning and implementation of project's programs and activities
Nasarawa State Ministry of Women Affairs	Permanent Secretary	High	Develop and implement policies and plans on women empowerment	Important (Inform, consult, collaborate and involve)	Engagement in the implementation of project's programs and activities
Child Education and Community Development Initiative, Lafia	Program Officer	High	Community mobilizer	Important (inform, collaborate and involve)	Continous engagement
Family health Care Foundation, Lafia	Program Officer	High	Community mobilizer and service provider	Important (inform, collaborate and involve)	Continous engagement
Breakthrough Action Nigeria, Lafia	State Coordinator	High	Community mobilizer	Important (Inform, consult, collaborate and involve)	Continous engagement

Name of organization	Contact person (Title and level)	Level of influence	Type of influence	Priority of engagement	Role and type of engagement
Individual Advocate	Chairman Karu PHC Ward Development Committee	Moderate	Catalytic	Somewhat important (Advocate)	Launch meeting
Zamfara State Ministry of Women and Children Affairs, Gusau	Director Women Affairs	High	Develop and implement policies and plans on women empowerment	Important (Inform, consult, collaborate and involve)	Engagement in the implementation of project's programs and activities
Zamfara State Operating Coordinating Office, Gusau	Permanent Secretary	High	Identification of the poor and persons facing vulnerability	Important (Inform, consult, collaborate and involve)	Engagement in the implementation of project's programs and activities
Zamfara Social Protection Platform, Gusau	Chairman	High	Catalytic	Community mobilizer	Continuous engagement
Sabil Initiative	Chairman and founder	Moderate to high	Catalytic	Somewhat important (Advocate)	Launch meeting