



Gender Mainstreaming in PRRINN-MNCH

1. CONCEPTUAL APPROACH

There are two distinct approaches to gender within the health sector: the **women's health needs approach** and the **gender equity approach**:

- i. The **women's health needs approach** looks at the specific health needs of women and girls as a result of their biological differences with men. This approach usually focuses on whether women's needs for maternal and reproductive health services are being met, and whether these needs are reflected in health policy, plans and budgets. However, the approach does not stop at maternal and reproductive health issues, but asks whether women's health needs are being met throughout their lifecycle.
- ii. The **gender equity approach** looks at how gender relations (i.e. the relationship between men and women) influence:
 - Differences in men's and women's vulnerability to ill-health
 - Responses to men's and women's ill-health
 - Differences between men and women in access to services
 - Differences between men and women in the affordability of services
 - Differences between men and women in perceptions of service quality
 - The impact of family ill-health on women's work burden

The gender equity approach also looks at how gender works with other factors such as age, education, location, ethnicity etc to affect women's and men's health. For example, in some parts of northern Nigeria where ANC utilisation is low, utilisation may be even lower among very young women.

We believe both approaches – the **women's health needs approach** and the **gender equity approach** – to be important in the Northern Nigerian context.

The women's health needs approach is important since it emphasizes the importance of providing and funding some essential health services for women. Within PRRINN-MNCH our strategy has been to build stakeholder consensus around and support for the MDG 5 agenda, ensuring that women's health issues that have been neglected in the past become policy priorities.

However, health policy-makers and planners also need to be aware of how gender inequality affects women's access to health information, their health care access and their health status. Having an understanding of these issues can help ensure that programme strategies are appropriate and effective. There is plenty of evidence internationally to indicate that health policy, programmes and budgets that fail to address gender issues result in inefficiencies in resource allocation, delayed progress in reaching key health goals and targets, or can reinforce inequities in health.



2. MAINSTREAMING STRATEGY

PRRINN-MNCH's approach to gender mainstreaming is characterised by the following:

- Systematic integration of gender issues into all key Output 6 activities, while working opportunistically to identify appropriate entry points for intervention in other areas of the programme (see Table 1 below)
- Identifying ways to work on gender issues that are appropriate and acceptable within the Northern Nigerian context; local stakeholders need to 'own the gender agenda' (Box 1)
- Building a shared vision around gender issues within the programme's core gender team (comprising the National Social Development and Community Engagement Officer and State Programme Officers – Demand), but moving forward to roll out capacity building support for greater gender awareness within the PRRINN-MNCH team as a whole.

Box 1: Working on Gender Issues in Northern Nigeria

All too often 'gender' is understood as an 'outsiders agenda'. Programmes that intend to work on these issues in the northern Nigerian context need to be smart, flexible and quick-footed. The two examples below illustrate how gender issues can be tackled in ways that are culturally appropriate:

Early marriage and child-bearing in the Northern Nigerian context are often presented by women's advocates inside and outside Nigeria as being a manifestation of women's low status. However, these are sensitive issues. Tackling the issues tangentially, by building local consensus around the benefits of girls attending school, has produced some positive results – many girls attending school are getting married and having children later.

The Centre for Islamic Legal Studies at Ahmadu Bello University, Zaria, was involved in the 'Promoting Women's Rights Through Sharia' research project a few years ago, supported by DFID's Security, Justice and Growth programme. The Centre carried out a careful analysis of how women's rights are advocated for within the Koran, and challenged the attitudes and practices that had, over time, obfuscated the Koran's provisions. This ground-breaking work provides an important enabling framework for challenging women's poor health (among other issues).

Members of the Output 6 team are focal persons for gender issues within PRRINN-MNCH. To date, two approaches have been used to sensitise and build the capacity of other members of the PRRINN-MNCH team to gender issues:

- **Formal training:** a one-day gender sensitisation workshop was held in September 2010 for programme management and senior technical staff. The purpose of the workshop was to orient participants on the importance of gender to PRRINN-MNCH's mandate and to build consensus around mainstreaming priorities for 2011. Further gender capacity building initiatives are



planned at state level in 2011. These will be targeted to key government stakeholders and PRRINN-MNCH ‘front-line personnel’ such as Local Engagement Officers.

- **On-going sensitisation:** as part of its remit, the Output 6 team is responsible for ensuring that gender issues are addressed across different programme outputs. By drawing attention to gender in management, technical and policy discussions the programme’s gender focal persons aim to build awareness and capacity to address gender issues among a wider group of programme personnel and among stakeholders. Specifically, the gender team has provided support in the following areas:
 - Engaged and raised the awareness of Human Resource Forum members on the need to address gender in the state human resource policy in Yobe state. As a result of these discussions a draft chapter on gender and human resources is being developed for inclusion in the Yobe HRH Policy. The final draft will be shared with other states and adapted for inclusion in their HRH policy documents.
 - Engaged and raised the awareness of Directors in the Ministries of Health, Local Government and Chieftaincy Affairs and LGA PHC Coordinators on the need to mainstream gender issues in health planning and budgeting. This work has so far focused on Yobe and Zamfara states.
 - The programme has started engaging with Ministries for Religious Affairs and Islamiyya schools to collaborate over gender and equity issues such as getting and retaining female health workers, gender discrimination in the enrolment of girls in school, and discrimination between co-wives all of which have serious implications for health outcomes.
 - In response to clustering survey, women’s groups have been piloted in a community per state to provide a space for women to discuss issues that concern them, and to be supported to mobilise community and government resources for action. A review of the women’s groups will be carried out in May 2011.

3. GENDER IN KEY PROGRAMME ACTIVITIES

3.1 Examples of Gender Mainstreaming Across Programme Outputs

The table below highlights some of the ways in which a focus on gender has been integrated into core programme activities. The table does not cover all areas of programme; it is intended to be illustrative rather than exhaustive.

Governance	
Free MNCH	The <i>Financial Burden of Paying for Emergency Maternal Care Study</i> , undertaken in late 2009, was designed to provide information that could be used to inform the planning of free MNCH services in Katsina, Yobe and Zamfara states. The study looked at what households pay when accessing emergency maternal health care, what different households have to do to raise cash in the event of an emergency, and how expenditure on maternal emergencies affects households financially and in other ways in the short- and long-term. One component of the study looked at what women contribute financially to their



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	<p>own health care. This is an important issue in a context where it is assumed that men are the primary providers of funds for health care.</p> <p>The study as a whole demonstrates how fulfilling women’s essential health needs impacts on household poverty and vulnerability. The findings of the study have been disseminated at state level and extensive advocacy in support of lessening the financial burden of emergency maternal care services within the free MNCH package has been undertaken.</p> <p>Documentation</p> <ul style="list-style-type: none"> • PRRINN-MNCH Policy Brief: <i>Free MNCH – An Essential Poverty Reduction Strategy</i>
Service Delivery	
<p>Community-based service delivery</p>	<p>The community based service delivery (CBSD) initiative was designed in response to the findings of the demand-side rapid social assessments, which comprised part of the programme baseline. These highlighted how women’s household responsibilities and the lack of prioritisation of their health at household level combine with physical and financial access barriers to prevent women from using essential health services. Under the CBSD initiative the provision of services ‘on the door-step’ – in intervention sites where parallel efforts are underway to create community-wide social approval for new MNCH behaviours – will be tested to assess whether close proximity to services addresses some of the constraints, including gender-constraints, of access to health care.</p> <p>Preparatory work in support of the community-based service delivery (CBSD) initiative took place throughout 2010. Key activities during the year included: design of a CBSD strategy appropriate to northern Nigeria; drafting of CBSD training materials; agreement of pilot intervention sites; training of JCHEWS who will be the front-line providers; buy-in of the states to the CBSD strategy. As of December 2010 JCHEWS were ready to be deployed, drugs had been committed and equipment was on order.</p> <p>The training curriculum for JCHEWS includes modules on the impact of gender and social exclusion on maternal and child health, and how to recognise social exclusion and mechanisms for addressing it – both in the work of the JCHEWS themselves and more generally at community level. PRRINN-MNCH’s experience with training and supporting JCHEWs throughout 2011 will be disseminated at national level with the intention of building consensus around the need to revise the national JCHEW training curriculum.</p> <p>Documentation</p> <ul style="list-style-type: none"> • PRRINN-MNCH, 2010, <i>Facilitators Guide for the Training of JCHEWS for Community Based Service Delivery</i>



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Gender and Immunisation Study	<p>PRRINN-MNCH collaborated with the Programme for Appropriate Technology in Health (PATH) to undertake a study on gender and immunisation. The study focused on two states – Jigawa and Lagos and aimed to: identify factors influencing parents’ and caregivers’ willingness to have children immunized; examine family decision-making patterns regarding child immunization; examine gender relationships with regard to providers’ and parents’ interactions; ascertain the relationship between sex preference and health care- and immunization-seeking behaviors; identify challenges in accessing immunization services; determine accessible and credible sources of information and advice about health and immunization; and identify the feasibility and challenges of collecting sex disaggregated coverage data.</p> <p>Documentation:</p> <ul style="list-style-type: none"> • PATH, 2010, <i>Understanding the role and impact of gender in the use of immunisation services</i>
Strengthening Systems	
PPRHAA	<p>The PPRHAA methodology integrates gender concerns by recognising that women and men have different health and health-related needs, and therefore expectations of services. The methodology also acknowledges the fact that women generally have less opportunity than men to participate in the public domain and may lack voice at community level. Hence within the client and community views (CCV) component the methodology promotes separate male and female discussion groups, leading to the capture of sometimes very different perspectives on local health services. While PPRHAA has focused stakeholder attention on the need to consult with clients, and has highlighted the importance of listening to women’s views on services, the challenge is to ensure that any gender-specific concerns that emerge through the process translate into changes in the way health services are delivered.</p>
Integrated Supportive Supervision	<p>Integrated supportive supervisory teams are now operational in all programme states. Supervisory checklists provide a means of assessing whether health facilities are client-including women-friendly, and an opportunity to get feedback on services from both male and female clients. The fact that women and men have different needs, and therefore expectations of services, is acknowledged in the way in which the ISS checklists have been devised and ISS teams trained. Both PPRHAA and ISS have provided an opportunity to sensitise front-line health workers – and their managers – to important gender concerns.</p>
Gender and HR	<p>This is reported on in a separate document.</p>
Improving Information	
HMIS and Equity Initiative	<p>This initiative began with a review of the extent to which the Nigerian HMIS currently provides equity-related, including gender disaggregated data. The review found that limited equity-related data are collected, and even this is not reported ‘up the system’. This deprives policy makers and planners of essential information on which to base resource allocation decisions. The findings will inform the way in which PRRINN-MNCH provides support for HMIS strengthening, and a focus for advocacy efforts around the need to understand differences (by gender and other markers of difference) in health care access and outcomes if MDGs 4 and 5 commitments are to be fulfilled in a way that promotes</p>



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	<p>health equity. In 2010 work to progress this initiative by the Output 6 team was put on hold due to the prioritisation of other activities. It is anticipated that the work will be picked up and progressed in 2011.</p> <p>Documentation</p> <ul style="list-style-type: none"> • Overview of Equity Analysis of Nigerian HMIS Study, Briefing Paper Prepared for February 2010 OPR team
<p>Increasing Demand</p>	
<p>Rapid Social Assessments</p>	<p>The rapid social assessments of MNCH barriers were undertaken as part of the programme baseline. Gender issues were fully mainstreamed into the assessment methodology, and all rapid assessment teams comprised strong gender expertise. The findings of the assessments fed into the design of a gender aware community engagement strategy which is intended to create demand for MNCH services.</p> <p>Documentation</p> <ul style="list-style-type: none"> • Report of a Rapid Demand Side Assessment of Barriers to Use of MNCH Services and Care, Katsina State, Cathy Green, Fatima Abdulkadir, and Umar Farouk Wada, January 2009 • Report of a Rapid Demand Side Assessment of Barriers to Use of MNCH Services and Care, Yobe State, Susan Beckerleg, February 2009 • Report of a Rapid Demand Side Assessment of Barriers to Use of MNCH Services and Care, Zamfara State, Dr. Garba Ahmed Gusau, Dr. Larai Kabir Umar, February 2009
<p>Community Mobilisation</p>	<p>The design of the states' community engagement strategies reflects and responds to a comprehensive understanding of the challenges associated with improving women's health care access in a context of highly unequal gender relations. For example:</p> <ul style="list-style-type: none"> * An emphasis within community mobilisation activities on generating wide male approval for new behaviours reflects men's primary role in intra-household decision-making and the important influence of male religious and traditional leaders on men's opinions and practices more generally. Promoting male involvement is fundamental to the PRRINN-MNCH community mobilisation approach. * The community mobilisation approach was designed in recognition of three key factors: the fact that rural women in the MNCH states generally have lower literacy than men, less access than men to different types of mass media, and face restrictions on their mobility. These factors meant that priority had to be given to a community-based awareness raising approach, and one that drew on traditional methods of information dissemination: group discussion, songs, and drama. Facilitated community discussion groups were chosen as the key intervention strategy in response to these challenges. * An emphasis on separate male and female discussion groups at community level reflects the prevailing system of keeping male and female 'domains' separate. However, as community social approval for change develops and the appetite for improved dialogue between men and women on health and other related issues grows, the hope is that joint discussion groups will become feasible, resulting in wider social change (as happened in Kano as a result of the safe motherhood initiative). * The original emphasis within the emergency savings schemes component of the community mobilisation work was to build on existing savings schemes and preferences, recognising that resource management at household and community level



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	<p>is usually highly gendered. However, in practice women in Yobe, Katsina and Zamfara states have saved funds for emergency maternal care in both women only savings groups and in mixed groups. In the latter case, this represents an important shift towards improved interaction and co-operation between the sexes.</p> <p>Gender-specific successes captured by the safe motherhood community monitoring system throughout 2010 are as follows:</p> <ul style="list-style-type: none"> * A good gender balance was achieved among community discussion group participants in all three MNCH states. Gender ratios (female to male) in Katsina, Yobe and Zamfara states were respectively: 49:51; 40:60; and 54:46. All three states therefore performed well in terms of women’s participation and male involvement. * Evidence that women are actively participating in both women only and mixed savings groups in all three states. * The fact that a high proportion of women suffering a maternal emergency were transferred to a health facility by community emergency transport systems (59% in Yobe, 93% in Katsina and 89% in Zamfara) and many were assisted by the community savings schemes demonstrates the priority that communities are giving to women’s health. <p>In the MNCH states, the capacity of state agencies is also being built so that they can play an effective stewardship role in relation to demand-side MNCH and RI issues. Ministries of Women’s Affairs in all three states are involved in political advocacy around maternal and newborn health as a neglected women’s health issue. In addition, they are being supported to manage and monitor the community engagement work and to source funding to sustain the work beyond the lifetime of PRRINN-MNCH. (Also see notes below on gender-specific findings of recent community engagement review).</p> <p>Documentation</p> <ul style="list-style-type: none"> • <i>Success Story: Empowering Communities to Save Women’s Lives</i> • <i>Analysis of Safe Motherhood Community Engagement Performance in 2010 – Three States</i> • <i>Review of PRRINN-MNCH Community Engagement Activities</i> (draft report)
<p>Strengthening of Facility Health Committees</p>	<p>The design of the PRRINN-MNCH supported strengthening of facility health committees initiative was informed by a gender analysis of the constraints to women’s participation in ‘voice initiatives’. The facility health committee training, delivered in January 2010 for PHC committees, and in August 2010 for secondary health committees, includes a strong focus on improving the extent and quality of women’s participation on health committees. Traditionally these committees have had low female participation, and where women have participated, their role has often been confined to ‘going door to door’ to mobilise women to use health services. The committee training focuses on supporting committee members to devise strategies for improving the quality of women’s participation on the committees. This includes: introducing mechanisms to ensure women’s participation on the committee (aiming over time for at least one third female membership of the committee; ensuring that all members of the committee vote on key issues; encouraging the female members of the committee to establish a women’s sub-committee; reserving selected executive posts for women members of the committee); introducing a code of conduct for meetings (e.g, ensuring that all members of the committee are given notice of upcoming meetings; observing the rule that speakers will not be interrupted unnecessarily; observing the rule that different viewpoints within the committee will be respected rather than criticised; giving praise and encouragement to members of the health committee in order to encourage their participation); and taking affirmative action to encourage women’s participation in meetings (e.g. actively soliciting the opinion of women members; ensuring that feedback and ideas</p>



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	<p>from the women’s sub-committee are included as regular agenda items and so on).</p> <p>Other facility health committee training modules attempt to raise awareness among committee members of the gender and other barriers that prevent timely utilisation of MNCH services, and to stimulate discussion about how the community can respond.</p> <p>Documentation</p> <ul style="list-style-type: none"> • PRRINN-MNCH, 2009, Training Manual for Health Committees at Primary Health Care Level, December (draft) • PRRINN-MNCH, 2009, Training Manual for Health Committees at Secondary Health Care Level, December (draft) • Operational Manual for Health Committees at Primary Health Care Level • Operational Manual for Health Committees at Secondary Health Care Level
<p>Clustering of Health Problems Studies</p>	<p>The clustering of health problems studies, undertaken in 2010, were designed to measure that extent of clustering of child deaths within rural communities in Katsina, Yobe, Zamfara and Jigawa and to find out the reasons for this. Gender analysis was used to inform the design of the study methodology, which looked at, among other issues, gendered decision-making within the household; social hierarchies and support systems among co-wives; and how the degree of social approval and support from husbands affected not only women’s confidence and sense of well-being but also health outcomes within individual households. The findings of the studies were striking. A heavy skew in child mortality was identified and found to be linked to a lack of respect and social support shown to women at family level. The policy implications of the studies are profound – unless attention is paid to gender and social inclusion in policy and programmes, it is likely that progress towards health targets will be far slower than anticipated. Substantial work was done by PRRINN-MNCH in 2010 (to be continued in 2011) to disseminate the findings of the studies and to advocate for appropriate local and state responses. A key target group for advocacy were Ministries of Religious Affairs and religious leaders in the programme intervention sites. The results of the clustering studies are also being fed into the ongoing discussions with policy makers on free MNCH.</p> <p>Documentation</p> <ul style="list-style-type: none"> • PRRINN-MNCH Policy Brief: <i>Adjusting Health Strategies to Include Women and Children with Least Social Support</i>

3.2 Gender-Related Findings of Community Engagement Review

A review of the programme’s Community Engagement activities was conducted in January-February 2011. The review found the following:

Empowerment of Women and Changes in Gender Dynamics at Community Level

- “The increase in self-confidence was particularly noticeable with the female CVs. Within the CE communities, the status of women has been enhanced. The women said that they are pleased to have a good reason to leave the compound more and that their husbands see it as worthwhile and encourage them. Husbands are often congratulated and recognised by other men for the actions taken by their wives. There has been a shift in gender relations within the families of CVs and in the community as the potential and capability of women has been recognised – in fact most community members, including male CVs and leaders, stated women



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make the best CVs – they work harder and have more impact – and that there should be more of them”.

- “Husbands and wives now talk together about maternal and child health issues, however, this mostly seems to occur when at least one of them is a CV. Discussions between husbands and wives where neither are CVs still appears quite limited”.
- “Both men and women CVs said how they now realised the importance of getting men involved in what had been previously thought of as women’s issues. In all communities gaining husbands permission is no longer an issue now that men understand the danger signs and that help can be attained at very little cost. Particularly in relation to RI, there is probably a need to work more with women to ensure that they do take the necessary action once the husband’s permission is given”.
- “The programme has clearly made a significant difference to women. The programme might consider working more with women CVs and community members to further build their confidence and capacity to act”.

Male Involvement

- “In traditional communities, engaging the men in women-related issues such as maternal health is often problematic. Thus male involvement in reproductive health has been a major challenge. The CE approach has proven to be effective in mobilizing men to participate as major stakeholders in the community in relation to MCH. A male community member in Runji observed that “if you go to the hospital on time, you will spend less and come back home with the mother and baby alive”.
- “In all the CE communities visited, the men are also aware of the SPP [safe pregnancy plan], they know the danger signs, contribute in saving towards safe delivery and donate blood. This is a significant achievement of the CE approach. One of the major concerns is how to mobilize more women (to overcome “kunya” [shyness]). The involvement of men also results in high level of social acceptability of the approach and improvement in gender relations”.

Ways to Further Strengthen the Gender Sensitivity of Community Mobilisation Activities

- The review also noted the need for the CE approach to be more gender sensitive in terms of the different constraints men and women faced in participating in community activities. Areas identified included:
 - Need to increase the number of female community volunteers rather than opt for a gender balance.
 - Getting husband’s permission is not enough to mobilise women for action; women in their own right need to be specifically targeted. Women are not passive receivers of husband’s directives.
- Female community volunteers and women in general are constrained by household chores and childcare and therefore sometimes find it difficult to take part in regular, structured community discussion sessions. The community mobilisation process (and the CE discussion guide) will be revised so that a wider range of appropriate ways to reach women are provided as options.