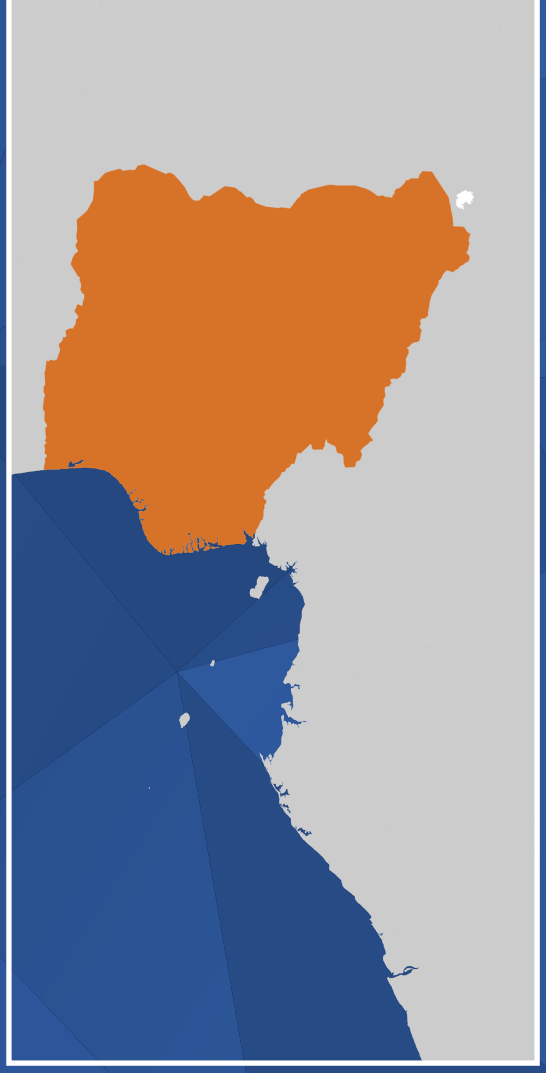

June 2020

GENDER AND EQUITY CONSIDERATIONS UNDER THE BASIC HEALTH CARE PROVISION FUND

Findings from Abia, Osun, Ebonyi, and the FCT

USAID FROM THE AMERICAN PEOPLE

HP+ HEALTH POLICY PLUS

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Contents

Abbreviations

BHCPF	Basic Health Care Provision Fund
CSO	civil society organization
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GBV	gender-based violence
HP+	Health Policy Plus
IGWG	Interagency Gender Working Group
LGA	Local Government Authority
LGHA	Local Government Health Authority
NHIS	National Health Insurance Agency
NPHCDA	National Primary Health Care Development Agency
PHC	primary health care
PHCUOR	Primary Health Care Under One Roof
SPHCB	State Primary Health Care Board
SSHIA	State Social Health Insurance Agency
UHC	universal health coverage
USAID	U.S. Agency for International Development
WDC	Ward Development Committee

Introduction

This report summarizes four state-level gender and equity analyses, conducted in Abia, Ebonyi, and Osun states and the Federal Capital Territory (FCT). The analyses examined gender and equity considerations, challenges, and opportunities related to the rollout of the Basic Health Care Provision Fund (BHCPF) in Nigeria. The findings were used to develop recommendations to inform rollout of the fund. Specifically, the analyses intended to inform the rollout of interventions under two of the three core fund stakeholders or "gateways": (1) the National Health Insurance Agency to set-up and operationalize state health insurance schemes and (2) the National Primary Health Care Development Agency to strengthen State Primary Health Care Boards and improve primary health care facilities and service delivery. Applying a gender and equity lens to BHCPF rollout is critical, as reaching poor and vulnerable groups is a key focus of the fund. Given the magnitude of the BHCPF, understanding the challenges, opportunities, and gaps in reaching vulnerable groups is imperative to design and implement rollout approaches that can help move the needle in achieving the primary purpose of the fund—to reduce out-of-pocket spending on health, enhance access to quality health services, and help Nigeria move one step closer to achieving its goal of universal health coverage.

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), supported efforts in Abia, Ebonyi, the FCT, and Osun to strengthen state-level institutions and capacities in preparation for rollout of the BHCPF at the state, facility, and ward level. This support entails ensuring policies, guidelines, and processes are defined and in place, and coordination mechanisms are instituted. Further, this support involves assisting the states to identify and mobilize predictable and sustainable revenues in support of BHCPF rollout, while improving transparency, accountability, and efficiency. In the ultimate pursuit of BHCPF objectives, given the focus on vulnerable groups—pregnant women, children under five years of age, persons with disabilities, and the elderly, as defined by the BHCPF—applying a gender and equity lens is essential. Factors determining service access, use, and desired health outcomes typically go beyond adequate and affordable primary health care service delivery and are more complex, often involving issues of poverty and accessibility, decision-making power, access to information, and deeply entrenched gender norms, beliefs, and practices. In response, this report seeks to uncover some of those factors and make recommendations for how to enhance activities and approaches to implement the BHCPF in Abia, Ebonyi, the FCT, and Osun—with the end goal of enhancing outcomes and moving considerably closer to achieving the goals of the fund.

Methodology

Guiding Framework

HP+ applied the Interagency Gender Working Group (IGWG) gender analysis framework to elucidate the state-by-state gender and equity context, as it applies to the BHCPF. The framework examines the relationships between men and women, and boys and girls, across five key domains: (1) practices, roles, and participation; (2) knowledge, beliefs, and perceptions; (3) access to assets; (4) legal rights and status; and (5) power and decision making. The IGWG framework closely links to USAID's Gender Equality and Female Empowerment Policy (2012), which identifies gender analysis as a tool for "examining the differences between the roles that women and men play in communities and societies, the

various levels of power they hold, their differing needs, constraints and opportunities, and the impact of these differences on their lives" (p. 12). In applying the IGWG framework, HP+ examined the differential dimensions of equity when reviewing contextual information, particularly in the desk review stage. This follows guidance highlighted in the USAID policy to include conditions of age, sexual orientation, ethnicity, disability status, religion, socioeconomic status, geographic status, migratory status, and forced displacement.

Process

Desk Review

A key first step was to conduct a desk review, applying the five domains of the IGWG framework. HP+ first gathered and reviewed all previous USAID Nigeria gender assessments and analyses and pulled relevant content to ensure its own state-level analyses were not duplicative. The 2014 USAID Nigeria Gender Analysis for Strategic Planning provided a broad overview of the gender context across the country, with information relevant to the HP+ areas of focus in the south. The other assessments, however, were largely program-specific and focused on the north.

Using the USAID Nigeria gender analysis as well as secondary sources, such as journal articles, reports, briefs, and relevant policy documents, HP+ examined the context for women, men, and adolescents across the five domains, with careful attention to intersectionality within groups— such as the differential circumstances for women or men in rural and urban areas, persons with disabilities, and adolescent girls and boys—and differentiators on the basis of education level, income, and employment (formal sector versus informal sector). Beyond context, the desk review explored gender- and equity-specific considerations, challenges, and opportunities as they related to elements of the BHCPF, and more broadly, universal health coverage in Nigeria. Under the BHCPF, this included factors around health insurance, such as level of demand, sociocultural views and beliefs about health insurance, and equitable coverage, including among the informal sector. Furthermore, related to primary health care service delivery, the desk review considered gender and equity as it relates to service accessibility and use, demand and perceptions around primary health care facilities and services, and patterns of use among different groups.

Key Informant Interviews

Using the results of the desk review, HP+ identified a list of key informants in Abia, Ebonyi, the FCT, and Osun. Key informants were selected based on their involvement in the BHCPF as well as their ability to speak on behalf of, or have knowledge of, the barriers and constraints of potential fund beneficiaries. As interviews took place, HP+ identified additional informants to reach, based on information gathered or recommendations from other key informants. HP+ developed a series of structured interview guides, based on type of key informant, yet with questions largely along the same lines and scope. Each guide, with about 10 questions and associated prompts, looked at level of understanding of the BHCPF and general gender and equity awareness; barriers to service access and use and potential constraints in fund implementation; importance of addressing gender and equity in implementation; fund beneficiaries and their relative needs, constraints, and challenges; implementation roles and responsibilities; and fund structures, core functions, and influencers. Questions were tailored to the respondent, grouping versions of the guide with questions, or prompts, relevant to state primary health care boards, state social health insurance agencies, local government health authorities, ward development committees, or

civil society organizations and other local community members, leaders, or representatives (see Annex A for full collection of guides). In total, HP+ conducted 95 key informant interviews—30 in Ebonyi, 25 in Abia, 21 in the FCT, and 19 in Osun. In addition to the types of informants listed above, according to type of guide, HP+ also reached private and informal sector associations and groups, state assembly members, and special assistants to state governors.

Analysis and Application of Findings

Following completion of the key informant interviews, HP+ analyzed the findings across Abia, Ebonyi, the FCT, and Osun based on key topics, including (1) general BHCPF awareness and level of understanding of gender and equity as it relates to fund implementation; (2) gender and equity considerations as it relates to core functions, roles, and responsibilities for relevant state institutions and entities; and (3) gender and equity barriers and potential impacts on fund implementation.

HP+ compiled and shared results with multiple state-level institutions at various trainings and technical working group meetings, as states prepared for BHCPF implementation. Furthermore, HP+ collaborated with the three BHCPF gateways—the National Primary Health Care Development Agency, National Health Insurance Agency, and Federal Ministry of Health—to create gender and equity training content and include it in formal BHCPF training materials for state institutions, local governments, facility-level staff, and ward development committee members. HP+ intends to continue sharing key findings from these analyses, while working with state stakeholders to consider, appreciate, and integrate gender and equity into their efforts.

Overview

Nigeria's health system is at a critical juncture—it is one of six countries, that combined, account for half of global deaths of children under the age of five. In 2016, 733,000 children died before their fifth birthday in Nigeria (UN IGME, 2017). Similarly, Nigeria accounts for a relatively substantial proportion of maternal deaths worldwide, contributing about 15 percent of the global burden (FP2020, 2016). In 2015, the country experienced 58,000 maternal deaths and a maternal mortality ratio of 814 per 100,000 live births (WHO, 2015). In Nigeria, inequities in access to primary health care, education, and other vital social services are pervasive and ultimately tied to conditions of gender, age, disability, ethnicity, geographic location, and socioeconomic standing. Men are the primary decisionmakers at all levels; many women, particularly in the north, need permission from their husbands to leave their homes. This reality, coupled with financial constraints, distance to a facility, and traditional beliefs and norms around giving birth in the home, fuels devastating maternal health outcomes. Early marriage and subsequent childbearing are widespread, and combined with a shortage of female teachers, violence within schools and poor sanitation weakens girls' retention rates or prevents enrollment altogether (NPC and ICF International, 2014). Gender-based violence is widespread, particularly in the south, as over half of women and girls have experienced physical and/or sexual violence—and close to half have undergone female genital mutilation (28 Too Many, 2016). Despite the passage of the Violence Against Persons Act in 2015, which expanded the definition of violence—and included female genital mutilation—state-level adoption of the law has been slow and, ultimately, Nigeria's harmful dual legal system takes precedence.

The World Health Organization's 2011 *World Report on Disability* found approximately 25 million Nigerians have some form of disability. Disability brings an added layer of vulnerability, with the ability to make decisions often being taken away. In January 2019, Nigerian President Muhammadu Buhari signed into law the Discrimination Against Persons with Disabilities (Prohibition) Act, 2018. This law prohibits discrimination based on disability and imposes fines and potential prison sentences on those who break it. In addition, the law establishes a National Commission for Persons with Disabilities (Ewang, 2019). Despite this gain, persons with disabilities in Nigeria face considerable barriers when it comes to accessing services and, further, women with disabilities experience unique barriers, different than their male counterparts—such as discrimination and poor provider treatment during pregnancy. As one study found, women with disabilities seeking antenatal care found that providers felt they were not equipped to handle a pregnancy and it would be a burden with their disability. Moreover, within health facilities and within the community, many people misunderstand the needs, and capabilities, of women with disabilities; discriminatory behavior is often exacerbated by already existent gender inequities (Eleweke and Ebenso, 2016).

The 2014 National Health Act established the Basic Health Care Provision Fund, which is intended to substantially increase resources for health and ensure a basic package of health care services to all Nigerians. Together with the 2016 National Health Policy, a sound policy framework to improve primary health care is in place. With the promise of adequate funding, Nigeria could experience a potential acceleration toward achieving universal health coverage. Financing plans for the BHCPF consist of funding from the federal government—not less than one percent of the Federal Government of Nigeria Consolidated Revenue Fund—grants from international donors and partners, and funds from other sources. The BHCPF will be disbursed through the National Health Insurance Agency (50 percent) to purchase a basic package and through the National Primary Health Care Development Agency (45 percent) for improvements in human resources for health, drugs and commodities, and health infrastructure. The remaining 5 percent will be expended for emergencies through the Federal Ministry of Health. The National Health Insurance Agency will disburse funds to the states through the establishment and operationalization of state health insurance schemes, as directed by the National Council on Health in 2015 (the highest health decision-making body in Nigeria). The National Primary Health Care Development Agency then disburses funds through state health care boards or agencies for distribution to primary health care facilities. These funds are intended for use toward drugs, vaccines, and consumables via eligible primary health care facilities; facility maintenance, equipment, and transport for eligible primary health care facilities; and human resources for primary health care facilities. Recognizing the need for state-level engagement and readiness, the Federal Government of Nigeria also launched the Primary Health Care Under One Roof initiative to streamline primary health care delivery at the state level. The initiative integrates primary health care structures and programs under state primary health care boards. Monitoring of the initiative will aid in determining whether equitable uptake is occurring.

While the BHCPF is a welcome and much-needed health reform in Nigeria, a relatively poor state of primary health care services, characterized by inadequate facilities, human resource shortages, drug stockouts, and high user fees, largely propel poor health outcomes and the inadequate state of the health sector overall in Nigeria (Uzochukwu et al., 2015). Furthermore, Nigeria has one the highest out-of-pocket spending rates on health globally (Gustafsson-Wright and Schellekens, 2013), and extremely low health insurance penetration (Uzochukwu et al., 2015). Gender and equity are central to all of these concerns and challenges. Health service delivery constraints and inadequacies often disproportionately impact vulnerable groups. Further, without attention to underlying, yet often deeply

entrenched, gender and equity norms and considerations, the best laid plans for improving service delivery and expanding insurance programs will likely fail. Instead, if gender and equity is central to the thinking and planning around the BHCPF, the success of this potentially monumental health reform could, in turn, serve to substantially improve the health sector, health outcomes, and push the country more squarely onto the road toward universal health coverage.

Findings

Overall Basic Health Care Provision Fund, Gender, and Equity Awareness

Generally, BHCPF awareness is low across Abia, Ebonyi, the FCT, and Osun and any level of understanding of the fund and its purpose is largely confined to frontline state ministry and board staff. Many local government health authorities, along with ward development committee members, health workers, and civil society organizations had little to no understanding of the fund. Lack of awareness and understanding among local government health authorities and ward development committees is troublesome, as under the BHCPF, both play key roles in the implementation of the fund. In meeting the objectives of the fund, local government health authorities will provide supportive supervision of primary health care facilities at the local government level. Ward development committees are essentially the link between primary health care facilities and the community and will continue to serve that purpose under BHCPF implementation. The lack of awareness among civil society organizations is also an issue, as community support and buy-in is crucial for effective implementation of the fund. Initial rollout planning should involve local voices to ensure community-specific needs are addressed—once key informants learned about the fund, as explained by interviewers, many echoed this sentiment.

While general awareness of the BHCPF is not necessarily a gender and equity issue, the issue is important because the fund is designed to target vulnerable groups, which the fund defines as "(a) pregnant women, (b) children under (5) years, (c) the elderly >85 years, (d) the disabled, (e) the poor (to be) and others falling within the group" (FMOH et al., 2018). Targeting vulnerable groups to improve their access and use of services—and mitigate negative health outcomes, such as high maternal and under-five deaths—inherently requires a gender- and equity-sensitive approach. Such an approach must first begin with a level of awareness of what it means to gender- and equity-sensitive and why it is important. Most respondents had a very cursory understanding of gender and equity and what it means to apply a gender and equity approach to the BHCPF (i.e., how the fund can expand access for vulnerable groups). Most viewpoints from interviewees centered around issues of need more generally—addressing the needs of pregnant women and children under five years of age is necessary for reducing mortality. Others simplified, stating that with the BHCPF in place, there is no longer an excuse for high maternal and child death rates. Many key informants equated gender with "women only"—noting the emphasis on pregnant women as a vulnerable group as representative of a gender-responsive BHCPF. Others understood gender to also include addressing the needs of men, specifically noting the barriers men face in accessing care. Men often see primary health care facilities as a woman's domain and not tailored to their health needs. Others mentioned the needs of adolescents, and specifically adolescent girls, as a neglected group under the BHCPF. The needs of adolescent boys were not specifically mentioned, and it is unclear whether those needs are provided for in facilities. Barriers that were most noted were related to lack of information and awareness of

services and health risks, especially among women; transportation options and/or distance to facilities; and money for services or transportation to facilities. Lastly, some respondents demonstrated an almost subtle denial of the existence of gender and equity disparity in the delivery of, and access to, health services at all levels—especially primary health care facilities.

Several respondents spoke of the need to cover services for persons with disabilities, with some stating that *all* services covered under the Basic Minimum Package of Health Services should be free for persons with disabilities. Presently, the package of services is specific to target groups, such as antenatal care for pregnant women or prevention and management of acute malnutrition for children under the age of five. Screenings, such as blood pressure checks, and treatment for malaria are covered for all Nigerians, allowing those not falling within defined vulnerable categories to access free treatment. As such, services for persons with disabilities are not specified and further, disability is undefined, which could heighten the possibility of certain forms of disability being overlooked or missed entirely. Some respondents in the FCT felt facilities were not yet prepared to offer accessible services to persons with disabilities. One respondent, a disability advocate, noted the disproportionate level of inaccessibility for women with disabilities in facilities, such as inaccessible toilets and a lack of trained staff to assist females with disabilities.

State-to-Ward Composition and Representation

Concerning state primary health care boards, the BHCPF requires each state to have a functioning board, operating under the National Primary Health Care Development Agency. In each state, per Primary Health Care Under One Roof guidelines, the state primary health care board represents a single unit to manage and oversee all primary health care services in the state. This spans stewardship responsibilities and coordination with local government health authorities; management of financial and material resources for primary health care; training and capacity development of primary health care managers and various cadres of health workers; setting service delivery standards and conducting supportive supervision; and program monitoring and evaluation. State primary health care boards should consist of a governing board, led by a chairman, and a management team, led by an executive secretary. While no specific quota for female representation exists—either within the governing board or management team, the Primary Health Care Under One Roof implementation guidelines do recognize the common gender imbalance within governing boards and recommend membership of both men and women.

Despite this recommendation, leadership structures within state primary health care boards largely follow traditional gendered patterns. The governing board in the FCT is entirely male and in Ebonyi, only one woman sits on the board. In Abia, however, female representation is a bit greater, as a little under half of the governing board members are women. Across Abia, Ebonyi, the FCT, and Osun, the positions that are the most influential when it comes to decision making within the board's governing—board chairmen and executive secretary—are all held by men. Within the management teams, female representation is a bit more common. Again, in Abia, the management team is evenly split between women and men. In Ebonyi, women outnumber men in the management team. Just two women hold positions in Osun's State Primary Health Care Board's management team.

For state social health insurance agencies, the BHCPF mandates that each state set up their agency in a manner that aligns with guidelines and support from the National Health Insurance Agency, and with the intent to effectively implement the National Health Insurance Agency gateway through a state health insurance scheme. Like the state primary

health care board, the state social health insurance agency does not have a specific mandate to include, or enforce, a quota of women as members and in leadership positions. Across the four locations studied in this analysis, most state social health insurance agencies did not have an equal balance between women and men in leadership or management positions. Women were more likely to serve as agency staff, reaching almost fifty-fifty in the FCT. None of the state agencies had a gender focal point, however the importance of having such a person was recognized among some key informants. Instead, attention to gender and equity issues, with respect to the operationalization of state health insurance schemes, was largely thought to be confined to local civil society organizations, as they would ultimately draw attention to those issues.

Regarding gender focal points among the state primary health care boards, existence across Abia, Ebonyi, the FCT, and Osun was mixed. For areas that had a focal point, there was a recognized need for further capacity development in gender and equity integration. This need is common, even outside of Nigeria—in some instances, gender focal points may lack technical expertise in gender, may be assigned to a woman because of her sex, or may have less influence within the larger decision-making structure of the organization or institution (Pendleton et al., 2015). Outside of the state primary health care boards, key informants frequently cited the wives of state governors as influential champions for gender and equity—or in the case of Abia, there is a special advisor to the governor on disability.

Local government health authorities are essentially extensions of the state primary health care board at the local government authority level. In Ebonyi, 8 out of 13 local government health authority administrative secretaries are women—a notable shift in leadership from the state level. Like the executive secretaries of the state primary health care boards, these administrative secretaries are in charge of the local government health authorities. Reporting to the executive secretary of the state primary health care board, the local government health authority coordinates and supervises primary health care services at facility and community levels, within their respective local government authority. Rather than a governing board, the local government health authority has an advisory committee, and like the state primary health care board, includes a management team. In Ebonyi, a female administrative secretary serves as the chairman of all the administrative secretaries in the state; this role includes being a member of all state health policy technical teams.

Down to the ward level, ward development committees are mandated to have a set proportion of female members. Interestingly, there are discrepancies regarding the exact percentage—the BHCPF operations manual states that women should make up at least 40 percent of membership, holding “effective roles” (FMOH et al., 2018), whereas the Primary Health Care Under One Roof implementation guidelines state that at least 30 percent of membership should be women, including at least one executive position in the ward development committee (NPHCDA, 2018). Regardless of the exact amount, many key informants acknowledged the quota as 30 percent. In looking at whether states have reached the quota in their wards, achievement is largely uneven. For example, within the FCT, the primary health care board has not been able to achieve the required representation of women across ward development committees, with key informants claiming that in many wards, women are not interested in participation. Ward development committees in Abia, on the other hand, largely have the required number of women, according to key informants representing various wards. Women’s representation falls short among ward development committee chairperson positions—in Osun, for example, these are largely political appointments and very influential.

At the facility level, key informants, either officers-in-charge or others, noted that officers-in-charge are often women. While officers-in-charge oversee and manage day-to-day facility operations, some key informants noted that because primary health care facilities are seen as women's and children's domain, the officer-in-charge posting is viewed as a less than desirable position among men. Overall, many key informants noted that the core of the work—related to working within facilities and seeing patients—is carried out by women, while leadership and decision-making is largely carried out by men.

Core Functions and Status

Ward Development Committees and Community Engagement

As mentioned previously, ward development committees are essentially regarded as the link between the community and the state government. Working alongside primary health care facilities in Nigeria, ward development committees are tasked with identifying and prioritizing the health and social needs of the community in local planning, working with the state government and other stakeholders to find solutions to health and social issues within their ward, and providing feedback to the community on primary health care facilities and local government structures themselves, sharing how funds raised are disbursed, for example. Women's representation aside, in Abia, for example, key informants cited the need for better interaction between ward development committees and primary health care facilities and their officers-in-charge. For example, in the event that the state primary health care board issues materials to the officer-in-charge/primary health care facility, ward development committees should be strongly involved in the process for rolling out those materials, as they represent the interests of the communities the primary health care facilities are tasked with serving. Furthermore, key informants noted the limited mobility of ward development committees and the need for stipends to boost their interest and commitment.

Service Delivery

A key component of primary health care service delivery is provision of the Basic Minimum Package of Health Services. Presently, the BHCPF mandates that the package provide nine broad interventions: four maternal health interventions for pregnant women (antenatal care; labor and delivery; emergency, obstetric and neonatal care; and caesarean section); two child health interventions for children under the age of five (curative care and immunization); urinalysis screening and cardiovascular disease screening (blood pressure check); and malaria treatment. Linking back to the BHCPF-defined vulnerable groups (pregnant women, children under five years of age, persons with disabilities, the elderly, and the poor), the package of services, as matched against the defined groups, does not necessarily address gender and equity concerns and needs. For example, while pregnant women are vulnerable and in need of additional efforts to ensure they receive the care they need, this classification fails to capture women and adolescent girls outside of pregnancy and further, enhancing services and ensuring certain offerings are free does not address underlying gender constraints. Many key informants called for the inclusion of services for adolescent girls and this should include requisite training of staff to offer youth-friendly health services.

Across Abia, Ebonyi, the FCT, and Osun, key informants noted the absence of gender-based violence (GBV) services—inclusion of GBV screening, counseling, treatment, and referral is critical in primary health care settings. GBV has significant negative impacts on women's reproductive health—this includes increased unintended pregnancy, unsafe abortion, higher vulnerability to sexually transmitted infections, complications during pregnancy, and

increased adolescent pregnancy (Pallitto et al., 2013; Maxwell et al., 2018). Therefore, incidence of GBV could negatively impact desired outcomes for pregnant women and further, for women and adolescent girls outside of pregnancy, which the BHCPF might fail to capture.

Key informants stressed the need for the Basic Minimum Package of Health Services to cover other groups and services. Some stressed the need for services for persons with disabilities, with one key informant advocating free services for all persons with disabilities. A key informant in Ebonyi felt that more services for men should be included in the package. Overall, while the Basic Minimum Package of Health Services is intentional in capturing and including free services for vulnerable groups, there are several situations where the definition of vulnerable may miss others in need of services and those who face access barriers due to certain gender or equity constraints.

Reaching the Informal Sector

Key to the set-up and operationalization of the state health insurance schemes is the task of reaching and enrolling the informal sector. Given the extremely limited penetration of health insurance enrollment and use before the BHCPF, expanding coverage, especially to the informal sector, will be a challenge. At the time of analysis, most states had not begun to think about how to do this—or if they had, they were unclear of the steps to take to effectively carry this out. Many key informants across the states noted the importance of reaching various groups, such as trade and market associations, faith-based groups, traditional and community leaders, and local civil society organizations, to then better identify and reach the informal sector—which in Nigeria, is quite vast and diverse. A critical point to note, however, is that no key informants mentioned the link between those in the informal sector and certain vulnerabilities, or in Nigeria's case, the high instance of women in the informal sector. This could necessitate a more gender- and equity-focused approach.

Women largely dominate the informal sector in Nigeria and their participation is often a consequence of limited access to critical resources, such as education, credit, technology, and land—which in turn, exclude them from formal sector employment opportunities. Furthermore, family and household responsibilities, as well as other barriers to formal employment opportunities, in addition to critical resources, often leave informal sector employment as the only option for women (Fapohunda, 2012). As such, state-level institutions, in their efforts to identify and plan for informal sector enrollment, should analyze and pinpoint the exact makeup of the informal sector in their respective states. Further, they should utilize a gender- and equity-aware approach to analyze the potential needs, barriers, and constraints to reaching those within the informal sector.

Demand Generation

A core function of state health insurance schemes, in addition to expanding reach and ensuring enrollment of the informal sector, is demand generation. At the time of analysis, demand generation plans among the four-state social health insurance agencies were either just getting started or in the initial planning stage. Key informants noted the importance of engaging local civil society organizations, as well as other organized structures at the grassroots level, to reach potential enrollees, especially the informal sector. Furthermore, key informants noted that ward development committees, women in the community, and traditional and religious leaders should inform demand generation efforts.

Considerable cultural beliefs around insurance were highlighted as potential barriers to enrollment. According to several key informants, many people see insurance enrollment—or

planning for health—as wishing for ill health. For some, sharing information on health insurance may be met with a response such as, “Are you praying for me to be sick?” Religious beliefs also come into play. Some Christians believe there is no need for insurance as their health is in the hands of God; for some Muslims, Allah protects them, not vaccines or other health services. Further, those that have a comfortable income take pride in being able to pay their health bills rather than relying on insurance. Overall, demand generation barriers are similar to some of the other gender and equity constraints and those constraints ultimately propel those barriers (discussed in further detail below). In response, efforts to craft demand generation strategies and approaches should be fully informed by relative constraints and include strategies to address them.

Health Worker Coverage

Under the BHCPF, state primary health care boards are responsible for oversight and management of primary health care service delivery. With this responsibility in mind, it is important to assess the status of primary health care service delivery in each state from the perspective of gender and equity as well as relative barriers, opportunities, and challenges. As mandated under the BHCPF, each primary health care facility must have five skilled health workers—two of which must be midwives. Coverage and availability of health workers, however, was frequently cited as a constraint to accessing much needed services at the facility. Key informants across Abia, Ebonyi, the FCT, and Osun explained that primary health care facilities were commonly understaffed and that there was a general lack of expertise to address the health problems and issues patients were visiting the facility for. Many perceived health personnel to be corrupt and have bad attitudes, which often deterred patients from using the facility.

Availability of providers and services was also a frequently cited issue. The BHCPF requires primary health care facilities to be open and available 24 hours a day, especially in rural areas. If those hours are not possible, providers must be on call. This is often not the case, however. In Abia, for example, there is a general lack of nurses and other providers to run night shifts. A few key informants mentioned that security for providers, especially female providers, working night shifts was a reason for many facilities being unable to meet the 24-hour requirement. Further, in Abia, informants often cited the shortage of male health workers as a barrier to men using primary health care facilities. As a few key informants noted, there is a perception that because primary health care facilities are perceived to be a woman’s space, they are often neglected when it comes to proper staffing and facility improvements to ensure adequate service delivery.

State of Facilities

In addition to human resource constraints, key informants frequently cited the poor state of primary health care facilities as a common barrier to service use. In Osun state, primary health care facilities, especially in rural areas, are often in bad shape—space is extremely limited and in the event of deliveries, in some cases, providers are only able to admit two at a time, which can be a significant barrier for pregnant women. Many facilities lack essential drugs and equipment, and electricity is hard to come by. Rural facilities are often hard to reach or largely inaccessible due to poor roads, especially during the rainy season, while some are only accessible by bike. This is especially problematic for persons with disabilities attempting to access a facility. These characteristics are not limited to rural primary health care facilities in Osun, however, as key informants noted that urban facilities have similar issues. For example, in one primary health care facility in the state capital, staff are forced to

bring their own equipment, such as blood pressure machines, due to shortages. These barriers were similarly cited among key informants across Abia, Ebonyi, and the FCT.

In Abia, key informants noted a lack of essential drugs and equipment—"mama kits" often lacked critical items. They also noted space issues—facilities often had to use other spaces, such as churches, or find makeshift areas to offer services. In the FCT, primary health care facilities frequently need additional space and rooms are often too small and lack privacy—even delivery suites. Many key informants noted the extent of inaccessibility of facilities for persons with disabilities and the need for structural improvements. In the FCT, this extended to some of the equipment available—for example, delivery equipment for pregnant women with a disability, such as accessible beds, are often not available. To reach the goals of the BHCPF in ensuring service delivery for vulnerable groups—one of which is defined as "disabled persons"—vast improvements to facilities themselves, as well as viable, accessible transportation options, will be a considerable undertaking, given the current state of most facilities, yet, it will be a critical one.

Gender and Equity Barriers to Basic Health Care Provision Fund Implementation

To fulfill the goal of the BHCPF—to ensure effective delivery of primary health care services to all Nigerians, and further, with the intent of reaching vulnerable groups in mind—pinpointing the relative gender and equity barriers to seeking care is a critical step. As mentioned earlier, when considering gender and equity barriers that are faced by women when using primary health care services, most key informants commonly stated a lack of information, or access to information, and poverty. Inability to pay for services, or even afford a hospital card, as was a cited case in Abia, is a significant barrier faced by women.

As is the case across much of Nigeria, this analysis found that men across Abia, Ebonyi, the FCT, and Osun largely control household income and spending and women often need the consent of their husbands to use money for services—whether it be for transportation, medicines, or the cost of the service itself. This is further complicated by the enforcement of arbitrary fees. In Abia, for example, many key informants cited discrepancies over whether services were supposed to be free, with midwives or officers-in-charge demanding payment but offering little explanation as to why the payment was required—or, services were only offered on the condition that fees were paid upfront. In Osun, key informants noted that, in some instances, providers would give pregnant women long lists of items that they needed to bring to the facility if they wished to deliver their baby—items ranged from diesel fuel to run the facility generator, kerosene to fuel lanterns, and other necessary medical supplies. These situations are further exacerbated by a lack of awareness or understanding, among women and other patients, as to what they should be required to pay for, if anything at all. Further, this links back to the inadequate levels of facility readiness to offer services and the failure of states to equip providers with the necessary equipment and supplies to offer adequate services.

A lack of access to adequate information among women also extends to awareness and understanding of health needs, risks, and the importance of seeking care. For example, in Ebonyi, one key informant noted that despite the existence of facilities and a private hospital, women from one community still chose to go to the traditional birth attendant. While traditional birth attendants are often well-entrenched in the community and are a cheaper option than a skilled attendant or facility, they often do not have formal medical training and overall, key informants had largely negative views of them. In other instances, key

informants would note that women would use facilities for antenatal care but then revert to a traditional birth attendant when it came time for delivery. As one recent study in Nigeria found, women who used traditional birth attendants were more likely to reside in a rural area, have a lower level of education, and have less decision-making power when it came to their health care options and choices. The same study noted that traditional birth attendants often live within the rural communities they serve and have a better understanding of local cultural and social norms (Ugboaja et al., 2018). Overall, preference for traditional birth attendants was quite common.

Inadequate access to information and a lack of awareness of health needs, risks, and availability and importance of facility-based services is further impacted by religious beliefs, in some instances. In Ebonyi, key informants noted that many women believed that if God gave them the pregnancy, he would deliver the healthy baby, or in other cases, some women did not use facilities during pregnancy for antenatal care or delivery because their church was against it. In Osun, women may use a local primary health care facility for antenatal care but seek a faith-based facility or private facility for delivery. Many Muslim women in Osun complained about health worker intolerance of their preferences—for example, health workers asking women to unveil or having a male health worker attend to them, rather than a female health worker.

Provider attitudes, or the expectation or fear of judgment from a provider, was a commonly cited barrier to health service use, both among women and adolescents. Key informants cited that many adolescents do not use facilities as they fear a lack of confidentiality from nurses; many do not know who to confide in. Key informants noted this as especially problematic, given the high rates of teenage pregnancy in Nigeria—among girls ages 15–19, an estimated 23 percent have begun childbearing. Urban/rural disparities are striking as 32 percent of rural girls in that age group have begun childbearing opposed to 10 percent of their urban counterparts (NPC and ICF International, 2014). Given the partial BHCPF focus on pregnant women, many key informants across Abia, Ebonyi, the FCT, and Osun acknowledged the need to include services and a focus on the health needs of adolescents, especially adolescent girls. Key informants also noted that providers were not well-equipped to care for persons with disabilities and should be trained to do so to make services more accessible. Similarly, there were calls for further training to enhance the gender and equity sensitivity and awareness of providers; increase their ability to effectively recognize, treat, and manage cases of GBV; and better engage men—both as partners and service users.

Several key informants across Abia, Ebonyi, the FCT, and Osun discussed the need for greater male engagement in primary health care service delivery. Key informants commonly noted that men largely do not use services at primary health care facilities—instead, most either deny sickness or use traditional remedies. In some cases, such as in Osun, men will use private facilities. Most key informants largely link this lack of public health service use to the common notion among men that primary health care facilities are women's and children's domain. Some men, such as those in Abia, feel they do not need to be involved. This thinking could be further exacerbated by the fact the BHCPF specifically targets women and children as its critical service beneficiaries. Furthermore, providers in primary health care facilities are often women, while male clients would prefer services from a male provider. Interestingly, many key informants that mentioned this barrier among men, often also reduced the severity of women's barriers to health services due to poverty and lack of information without acknowledging other, more deeply entrenched gender issues, such as women's lack of decision-making power and mobility, when it comes to accessing health services. In extreme cases, key informants that largely fixated on male barriers to service

access and use, and health behaviors in general, felt that there were no gender issues or constraints for women seeking services.

For the BHCPF to be successful, male engagement is critical. The BHCPF should focus on not only men as clients, but men as supportive partners as well as community champions for health service improvements and more gender- and equity-responsive measures to enhancing service access and use. Engaging men as supportive partners is important because they may be more likely to receive, or be exposed to, messaging and mobilization efforts to initiate and increase BHCPF enrollment. As the messenger within their families and households, it is important that they understand and appreciate the utility of the BHCPF and the need to enroll not only their female spouses or partners, but also their children—male and female. In some cases, key informants noted this as a potential barrier, especially for adolescent girls, as benefits could fail to trickle down through the household, particularly to female children, who are more likely to receive less preferential treatment than male children.

Conclusion

This report provided an overview of important gender and equity considerations that shape access and use of primary health care services in Abia, Osun, and Ebonyi states and the FCT. These considerations may ultimately propel or hinder the achievement of critical objectives and goals under state-level BHCPF implementation. Applying a gender- and equity-analysis framework, this report sought to identify the relative gender and equity constraints, challenges, and opportunities in each location, while also pinpointing the core functions and roles of state-level institutions and areas for improvement in ensuring BHCPF efforts are successful and reach the desired beneficiaries under their leadership. As states prepare for the BHCPF and put in place the required structures, processes, and guidelines for implementation, this report should provide some guidance on how gender and equity should be addressed alongside those efforts.

Recommendations

The findings of this report offer the following key recommendations to bolster BHCPF implementation efforts:

- **Enhance and expand gender and equity understanding and knowledge among key state- and local-level institutions tasked with implementing BHCPF interventions**. This may include awareness-raising activities, training or workshops, or hands-on technical assistance to better integrate gender and equity considerations and interventions into BHCPF tasks and efforts.
- **Constitute quotas across essential state- and local-level institutions to secure women's leadership and decision-making roles in BHCPF implementation.** This effort should expand to include designated gender focal points across institutions, equipped with the requisite gender and equity knowledge, understanding, and expertise to enforce and monitor integration efforts and progress.
- **Equip primary health care facilities with infrastructure accessible to persons with disabilities to enhance access and ease-of-use.** Under the directive of state-level institutions, local-level governments and facilities should clarify, expand, and finalize the definition of disability to ensure patients are not overlooked and efforts to enhance accessibility of facilities are inclusive and

considerate of all needs for persons with disabilities. *Primary health care facilities should also be equipped with adequate space and privacy measures for all clients, to ensure confidentiality, especially for adolescent clients.*

- **Expand benefits packages to include gender-based violence services.** Primary health care providers should be trained and equipped to provide first-line support to patients, including complete history-taking, screening for HIV and sexually transmitted infections, and provision of emergency contraception, counseling, and referral for further treatment and support. *Benefits packages should also consider including youth-friendly services and support, accessible services for persons with disabilities and targeting within the Basic Minimum Package of Health Services, and sexual and reproductive health services for women (outside of pregnancy), men, and adolescents.*
- **Work toward more equal availability and distribution of female and male health workers across primary health care facilities**. In ensuring better health worker coverage across primary health care facilities, states should make strides to ensure consistent availability of female health workers and increased availability of male health workers—especially in the event a male patient prefers a male provider. These strides should be accompanied with efforts to improve the working conditions for health workers at primary health care facilities (adequate salaries and on-time and regular payments, manageable working schedules, and required support and supplies to perform their jobs). *All primary health care facilities should be equipped with perimeter fencing and other security measures, especially to protect health workers during night shifts and ensure the availability of 24-hour services.*
- **Demand generation and community mobilization efforts should intentionally engage men as supportive partners, champions, and service users.** *Efforts should also be cognizant of potential barriers for women, adolescents, and persons with disabilities to access or participate in mobilization events or campaigns and put in place alternative mechanisms to share information on available services, potential health risks, and importantly, rights to free services under the BHCPF.* Campaigns to target men may enlist the support of community or religious leaders or further, record and share testimonials of men who have used primary health care services and have been satisfied with their experience. Primary health care facilities should also be better equipped, including with trained providers, to provide health care services for men.
- **Free and accessible transportation options to primary health care facilities should be made available to BHCPF beneficiary groups.** These options should also be made available 24-hours a day, especially in the event of deliveries or health emergencies that occur outside of regular facility hours.

References

28 Too Many. 2016. *Country Profile: FGM in Nigeria*. London, UK: 28 Too Many.

Eleweke, C.J. and J. Ebenso. 2016. "Barriers to Accessing Services by People with Disabilities in Nigeria: Insights from a Qualitative Study." *Journal of Educational and Social Research* 6(2): 113-124.

Ewang, A. 2019. "Nigeria Passes Disability Rights Law, Offers Hope of Inclusion, Improved Access." Human Rights Watch, January 25. Available at: https://www.hrw.org/news/2019/01/25/nigeria-passes-disability-rights-law.

Family Planning 2020 (FP2020). 2016. *Country Action: Opportunities, Challenges, and Priorities: Nigeria*. FP2020.

Fapohunda, T. 2012. "Women and the Informal Sector in Nigeria: Implications for Development." *British Journal of Arts and Social Sciences* 4(1): 35-45.

Federal Ministry of Health (FMOH), National Health Insurance Scheme (NHIS), and National Primary Health Care Development Agency (NPHCDA). 2018. *Basic Health Care Provision Fund Operations Manual*. Abuja, Nigeria: FMOH, NHIS, and NPHCDA.

Gustafsson-Wright, E. and O. Schellekens. 2013. *Achieving Universal Health Coverage in Nigeria One State at a Time: A Public-Private Partnership Community-Based Health Insurance Model*. Brooke Shearer Working Paper Series, Working Paper 2. Brookings Institute.

International Labour Office (ILO). 2018. *Women and Men in the Informal Economy: A Statistical Picture (Third Edition)*. Geneva, Switzerland: ILO.

Maxwell, L., A. Nandi, A. Benedetti, K. Devries, J. Wagman, et al. 2018. "Intimate Partner Violence and Pregnancy Spacing: Results from a Meta-Analysis of Individual Participant Time-To-Event Data from 29 Low-and-Middle-Income Countries." *BMJ Global Health* 3(1).

National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria and Rockville, Maryland, USA: NPC and ICF International.

National Primary Health Care Development Agency (NPHCDA). 2018. *Implementation Guidelines for Primary Health Care Under One Roof*. Abuja, Nigeria: NPHCDA.

Pallitto, C.C., C. García-Moreno, H.A. Jansen, L. Heise, M. Ellsberg, et al. 2013. "Intimate Partner Violence, Abortion, and Unintended Pregnancy: Results from the WHO Multi-Country Study on Women's Health and Domestic Violence." *International Journal of Gynecology and Obstetrics* 120(1): 3-9.

Pendleton, J., L. Irani, M. Mellish, R. Mbuya-Brown, and N. Yinger. 2015. *Promoting Gender-Responsive Health Governance: Lessons and Next Steps*. Washington, DC: Futures Group, Health Policy Project.

Ugboaja, J.O., C.B. Oguejiofor, E.O. Oranu and A.O. Igwegbe. 2018. "Factors Associated with the Use of Traditional Birth Attendants in Nigeria: A Secondary Analysis of 2013 Nigeria National Demography and Health Survey." *Nigerian Journal of General Practice* 16: 45-52.

United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). 2017. *Levels & Trends in Child Mortality: Report 2017, Estimates Developed by the UN Inter-Agency Group for Child Mortality Estimatio*n. New York: United Nations Children's Fund.

U.S. Agency for International Development (USAID). 2012. *Gender Equality and Female Empowerment Policy*. Washington, DC: USAID.

Uzochukwu, B., O. Onwujekwe, and C. Mbachu. 2015. *Implementing the Basic Health Care Provision Fund in Nigeria: A Framework for Accountability and Good Governance*. Policy Brief. Abuja: Health Policy Research Group.

World Health Organization (WHO). 2011. *World Report on Disability*. Geneva: WHO.

World Health Organization (WHO). 2015. *Trends in Maternal Mortality: 1990-2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva: WHO.

Annex A. Key Informant Interview Guides

<u>Key Informant Interview Questions</u>: State Social Health Insurance Agencies (SSHIAs)

1. 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?
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?
    a. How have these obstacles changed over time?
    b. In your opinion, how would BHCPF rollout reduce or remove these obstacles?
3. BHCPF, if implemented effectively, is key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC?
    a. What is SSHIA's role, with respect to addressing gender and equity issues related to BHCPF rollout and ultimately, achieving UHC?
    b. What is the role of NHIS [National Health Insurance Agency]? How do these roles drive attention to or discussion around issues of gender and equity? In that regard, what is their level of influence?
4. 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?
    a. Within the agency, who do you generally go to for buy-in and support? What about for making a decision or approval on a task or initiative? *(Prompt: If naming only men in positions of power, ask about the women – do they have a voice? Do any women have decision-making power or influence?)*
5. 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)*?
    a. Is there someone within the agency (i.e., designated focal point or champion) who is responsible for overseeing attention to reaching those vulnerable groups? What about attention to gender issues overall?
        i. If there is someone, how influential are they?
        ii. If there is not someone, how might the agency be strengthened with a gender and equity focal point in place?
6. 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?
7. State health insurance schemes under the BHCPF are also intending to cover the informal sector. How would you define the informal sector in X state? Who is included?
    a. In your opinion, what are the potential challenges or obstacles to reaching that informal sector?

b. Is there someone within the agency (i.e., designated focal point or champion) who is responsible for overseeing attention to reaching those informal sector groups?

    i. If there is someone, how influential are they?

c. Are there active civil society groups, associations, etc. that champion informal sector issues? Which ones do you work with?

8. 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?
9. 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?
    a. 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.
    b. Within SSHIA, who has the most influence over decisions to change or expand the benefit package? Who would you go to for support for a particular change?
10. 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?
    a. How will the agency generate demand?
    b. Considering potential gender and equity obstacles, how might the agency adjust or shift their demand generation strategies to respond to those obstacles? *(prompt: remind them of previous answers/discussion around gender and equity barriers to PHC services – if women lack mobility, how are they to be exposed to messaging, pamphlets, billboards, etc. promoting the scheme? What about seeing impaired? Those located in remote areas; tackling sociocultural norms, myths around insurance? Any consideration of using local languages? How friendly are enrollment/registration procedures for non-literate beneficiaries (who can neither read nor write)? In some states, there are Muslim women in seclusion (purdah) who are prohibited from receiving treatment from a male medical) personnel.*

<u>Key Informant Interview Questions</u>: State Primary Health Care Boards/Agencies (SPHCB/As)

1. 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?
2. 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?
    a. How have these obstacles changed over time?
    b. In your opinion, how would BHCPF rollout change these obstacles?
    c. What is the role of NPHCDA [National Primary Health Care Development Agency]? How do they drive attention to or discussion around issues of gender and equity? In that regard, what is their level of influence?
3. BHCPF, if implemented effectively, is key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC?

    a. How does the SPHCB/A fit in, with respect to addressing gender and equity issues related to BHCPF rollout and ultimately, achieving UHC?

4. Further in line with UHC, Primary Health Care Under One Roof (PHCUOR) is intended to improve health service equity by increasing access to affordable high-quality basic health care services for all, especially for the poor and vulnerable. In your work and experience, how would PHCUOR improve equity? What about addressing gender issues and constraints?
5. 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?
    a. Aside from the governing board chairman and management team executive secretary, who else holds considerable influence within the SPHCB?
    b. Within the SPHCB, who do you generally go to for buy-in and support? What about for making a decision or approval on a task or initiative? *(Prompt: If naming only men in positions of power, ask about the women – do they have a voice? Do any women have decision-making power or influence?)*
6. 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?
    a. Why is women's participation important? Do you feel they have a voice?
    b. What other groups, if any, should be guaranteed adequate representation within WDCs [Ward Development Committees]?
    c. What is the role of WDCs in ensuring gender responsive, equitable PHC service delivery?
7. Additional 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.
    a. If gender and equity is addressed, who leads this – is there a focal point or champion within the board?
    b. 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]?
    c. In addition to addressing beneficiary needs, does the SPHCB address gender and equity constraints and/or needs of PHC health workers (*prompt: if a female health worker is uncomfortable with a remote post, security concerns, etc.)*?
    d. Do PHC health workers receive gender sensitization training? What of members of the SPHCB?
8. A key responsibility of the SPHCB is to deliver the Minimum Service Package (MSP). What is the status of MSP development?
    a. How is gender and equity important to designing a high-quality MSP? Has the SPHCB taken into account gender and equity in this process? If yes, explain how.

b. One challenge is a lack of good data. Is sex- and age-disaggregated data available and/or used (or are there plans to use such data) in developing the MSP? Why is that type of data important?

c. Are GBV treatment and referral services offered in the MSP – or are there plans to include?

d. Another aspect of the defining the MSP is to sensitize and mobilize policymakers, health teams and consumers on MSP benefits. Where do you foresee obstacles, especially related to services for vulnerable and marginalized groups?

9. Describe the process for repositioning under PHCUOR. Who has been a leader in this process? Who has influence?

    a. Returning to the earlier question about SPHCB sex ratio, do women have a voice or influence in the repositioning process?

    b. In your opinion, throughout the repositioning process, who are winners? Who are the losers?

    c. What other interests have been captured/factored throughout the repositioning process? (*prompt: communities, special interest groups, CSOs [civil society organizations], champions, etc.)*

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?

    a. 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.

<u>Key Informant Interview Questions</u>: Local Government Health Authorities (LGHAs)

1. 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?
2. 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?

    a. How have these obstacles changed over time?

    b. In your opinion, how would BHCPF rollout change these obstacles?

3. BHCPF, if implemented effectively, is key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC?

    a. How does the LGHA fit in, with respect to addressing gender and equity issues related to BHCPF rollout and ultimately, achieving UHC?

    b. What about the SPHCB? Describe their leadership or direction around gender and equity issues.

4. Further in line with UHC, Primary Health Care Under One Roof (PHCUOR) is intended to improve health service equity by increasing access to affordable high-quality basic health care services for all, especially for the poor and vulnerable. In your work and experience, how would PHCUOR improve equity? What about addressing gender issues and constraints?

5. Tell me about the structure of the Local Government Health Authority (LGHA) – advisory committee and management team -- what is the sex ratio within both?
    a. Within the LGHA, who do you generally go to for buy-in and support? What about for making a decision or approval on a task or initiative? *(Prompt: If naming only men in positions of power, ask about the women – do they have a voice? Do any women have decision-making power or influence?)*
    b. Describe your working relationship with the SPHCB.
6. A core function of the LGHA, per PHCUOR guidelines, is to ensure community participation in the planning and implementation of health activities. How does the LGHA ensure those activities respond to local needs? Whose local needs?
    a. Are there active civil society groups that champion community needs *(Prompt: gender and equity issues, women's groups, youth groups, men's groups, people living with disability, etc.)*? Which ones do you work with?
    b. What other community leaders, champions, or gatekeepers do you interact with in your work? Who has the most influential voice?
    c. What strategies do you have in place to generate demand in the LGAs [Local Government Authorities] and remote communities and ensure that all are informed about these critical services? *How will LGHAs convince potential beneficiaries that this scheme does not have hidden user fees?*
7. Another core function of the LGHA is to ensure improved service delivery, greater coverage, and improved quality of health services. How do you ensure this? Why is gender and equity important to this function?
8. Describe the role of the LGHA Advisory Committee. How is gender and equity important to its role?
    a. PHCUOR guidelines push for a "balanced inclusion of voices" within the committee. What do you think that means? And is that fully realized?
9. 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?
    a. 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.

<u>Key Informant Interview Questions</u>: Ward Development Committees (WDCs)

1. 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?
2. 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?
    a. How have these obstacles changed over time?
    b. In your opinion, how would BHCPF rollout change these obstacles?
    c. *(if they are aware)* What is the role of NPHCDA? How does it drive attention to or discussion around issues of gender and equity? In that regard, what is its level of influence?
3. BHCPF, if implemented effectively, is 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?

   a. How does the SPHCB/A fit in, with respect to addressing gender and equity issues related to BHCPF rollout and ultimately, increasing widespread coverage of primary health care and reducing out-of-pocket spending on health?

4. Further in line with UHC, Primary Health Care Under One Roof (PHCUOR) is intended to improve health service equity by increasing access to affordable high-quality basic health care services for all, especially for the poor and vulnerable. In your work and experience, how would PHCUOR improve equity? What about addressing gender issues and constraints?
5. 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?

   a. Within the WDC, who do you generally go to for buy-in and support? What about for making a decision or approval on a task or initiative? *(Prompt: If naming only men in positions of power, ask about the women – do they have a voice? Do any women have decision-making power or influence? Are young women/men represented?)*

6. 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?
7. 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?

   a. What other community leaders, champions, or gatekeepers do you interact with in your work? Who has the most influential voice?

8. 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?

   a. 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.

<u>Key Informant Interview Questions</u>: CSOs, community groups, community leaders, other local champions, advocates, associations, etc.

1. 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?
2. 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?

   a. How have these obstacles changed over time?

   b. In your opinion, how would BHCPF rollout change these obstacles? How well positioned and prepared is the state government to implement the BHCPF?

3. BHCPF, if implemented effectively, is key to achieving universal health coverage (UHC) in Nigeria. How are gender and equity issues important to achieving UHC?

4. Further in line with UHC, Primary Health Care Under One Roof (PHCUOR) is intended to improve health service equity by increasing access to affordable high-quality basic health care services for all, especially for the poor and vulnerable. In your work and experience, how would PHCUOR improve equity? What about addressing gender issues and constraints?
5. Out-of-pocket spending on health is a critical issue in Nigeria and in X state. In your opinion, how are gender and equity issues relevant?
    a. In response to reducing out-of-pocket, the BHCPF seeks to expand and operationalize state health insurance schemes. These 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?
6. Please give a brief overview of your program(s) and major projects or efforts in the primary health care sector. How do you address gender and equity issues? Any specific components to address GBV? *(Note: targeting women alone does not count as addressing gender; probe around gender and equity issues.)*
7. How do you work with/interact with state government (SPHCB, SHIA, LGHA, etc.) agencies and departments in addressing gender issues/disparities?
    a. Considering the gender and equity issues identified earlier, which of those departments or agencies address gender and equity in their efforts?
    b. How about other CSOs, community groups, etc.?
8. What community groups, leaders, and/or champions are critical to involve in addressing gender and equity in the BHCPF?
9. 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?
    a. 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.

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